SUMMARY PLAN DESCRIPTION

for the

Walgreen Health and Welfare Plan

Effective January 1, 2024

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Introduction

Walgreen Co. ("Walgreens" or the "Company") is pleased to provide its team members with a comprehensive package of health and welfare benefit options. To assist you in better understanding these options, known as the Walgreen Health and Welfare Plan, we have prepared this Summary Plan Description ("SPD"). The Walgreen Health and Welfare Plan includes medical and prescription drug, dental, and vision coverage, Healthcare and Dependent Care Flexible Spending Accounts ("FSAs"), Limited Purpose Healthcare FSA ("Limited Purpose FSA"), Health Reimbursement Arrangement ("HRA"), Health Savings Account ("HSA"), Employee Assistance Program (EAP) programs, and a Commuter Benefit Plan (also known as Benefit Programs). A summary of all the benefits available is shown below.

Information on disability, accidental death and dismemberment and group life insurance is covered in separate SPDs.

The complete Walgreen Health and Welfare Plan document (the "Plan") includes this SPD, including any Summary of Material Modifications, and summary plan descriptions covering other benefits that are not covered by this SPD. Several Benefit Programs described in this SPD are also governed by the applicable coverage summaries, insurance policies, and contracts. The Benefit Programs and applicable plan documents are shown in the ***Administrative Information*** section of this SPD.

In the event that any term or provision in the SPD is in conflict with any of the terms or provisions of the Plan, the terms or provisions in the Plan document will govern.

Walgreens employs a diverse group of people with ever-changing lifestyles and personal goals. The needs of team members beginning their careers may differ from those of long-service team members approaching retirement. Team members with families may have requirements that vary greatly from those without dependents. Recognizing these differences, and in an effort to retain a highly qualified workforce, the Company continually reviews and updates its comprehensive benefits program to ensure it remains competitive and meets the needs of all our team members and their eligible dependents.

Walgreens maintains these benefit plans to provide you with flexibility in selecting your benefits coverage. Because you can design your own personal benefits program, take special care to review your coverage alternatives before making elections. You also may want to discuss your available benefits choices with your spouse or partner.

The Plan and certain Benefit Programs, as identified herein, have been written and are intended to conform to all applicable legal requirements, including, but not limited to, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Internal Revenue Code of 1986, as amended (the "Code"), the Patient Protection and Affordable Care Act of 2010, as amended ("Affordable Care Act") and all implementing guidance and regulations issued thereunder. It is further intended that the Plan meet the requirements of a Cafeteria Plan under Code Section 125 and Treasury Regulations thereunder and that the benefits a team member elects to receive under the Plan, to the extent such benefits are qualified benefits, be eligible for exclusion from the participating team member's income under Code Section 125(a). This means you have the opportunity to pay for certain benefits on a before-tax basis as well as the ability to

be reimbursed for eligible healthcare, dependent care, and commuter expenses on a before-tax basis.

The Healthcare Flexible Spending Account and Limited Purpose Healthcare Flexible Spending Account are each intended to qualify as a "self-insured medical reimbursement plan" under Code Section 105 and are each intended to be a limited excepted benefit under Code Section 9831, and eligible expenses reimbursed thereunder are intended to be eligible for exclusion from participating team members' gross income under Code Section 105(b).

The Dependent Care Flexible Spending Account is intended to qualify as a "dependent care assistance plan" under Code Section 129, and eligible expenses reimbursed thereunder are intended to be excludable from participating team members' gross income under Code Section 129(a). Transportation (commuter) benefits are provided under Code Section 132(f) and eligible expenses reimbursed thereunder are intended to be excludable from gross income. NOTE: This Commuter Benefit Plan, the Health Savings Account and the Dependent Care Flexible Spending Account are **not** covered under ERISA.

The following health and welfare benefits are available as of January 1, 2024, to both you and your eligible dependents, if applicable. The first column lists the benefits that are described in this SPD. In all cases, the benefits apply only to the extent you are eligible pursuant to the terms and conditions of this SPD and the benefit in question.

Benefits Described in This SPD	**Benefits Described in Separate SPD/Benefit Summary**
Options you may elect: ▪ Medical Coverage ▪ Dental Coverage ▪ Vision Coverage ▪ Flexible Spending Accounts — Healthcare Flexible Spending Account — Dependent Care Flexible Spending Account — Limited Purpose Healthcare Flexible Spending Account ▪ Commuter Benefit Plan ▪ Health Reimbursement Arrangement ▪ Health Savings Account **Company-paid coverage you automatically receive**: ▪ Employee Assistance Program	▪ Company-Paid Disability Coverage ▪ Voluntary Disability Coverage ▪ Company-Paid Life Insurance ▪ Voluntary Life Insurance ▪ Company-Paid Accidental Death and Dismemberment (AD&D) ▪ Voluntary Accidental Death and Dismemberment (AD&D) If you have questions about these other benefits or need a copy of the separate SPDs/benefit summaries, contact the Benefits Support Center at **1-855-564-6153**, Option 1.

IMPORTANT NOTICE

The Company reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law. The Company further reserves the right to change the amount of required participant contributions for coverage at any time, with or without advance notice to participants.

IMPORTANT – PLEASE READ: This SPD and the booklets and other descriptive material provided to you by Walgreens and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. ***Also, please keep in mind that the Plan, any changes to the Plan, or any payments to you under its terms, does not constitute a contract of employment with Walgreens and does not give you the right to be retained in the employment of Walgreens.*** No one speaking on behalf of the Plans or Walgreens can alter the terms of the Plans.

If you have questions concerning any part of this SPD, contact the Benefits Support Center at ***1-855-564-6153****.*

About This Document

As shown in the following chart, certain benefits are Fully Insured while others are Self-Insured. For Fully Insured benefits, Walgreens has contracted with various Insurers to administer benefits and pay claims under the terms of an insurance contract. For Self-Insured benefits, Walgreens has contracted with third-party administrators to handle certain day-to-day administrative functions such as claims processing. Together, the Insurers and third-party administrators are considered Claims Administrators.

In addition to the detailed information provided in this SPD about the benefits offered, additional coverage details about all benefits can be obtained from the applicable Claims Administrator of a program; or, additionally, for Fully Insured benefits, the insurance certificates or coverage summaries provided by the applicable Insurer; or the Benefits Support Center website.

This SPD, along with the schedules of benefits, summaries of insurance coverage, booklets and other descriptive material (collectively referred to as "coverage summaries"), can help you better understand and use your benefits. This document and the coverage summaries form part of the official Plan documents, serving as the sources of specific information relating to your health and welfare benefits. As of the effective date, this SPD replaces previous SPDs you may have in your possession. Coverage summaries and SPDs are available in paper form **free of charge** via the applicable carrier websites.

In addition to these documents, as part of the Affordable Care Act, Walgreens also provides a concise statement of your **medical** coverage in a Summary of Benefits and Coverage ("SBC") document that is prepared for each medical option available to you. This document(s) will be made available electronically for each team member as part of the Open Enrollment process. It summarizes the benefits and coverage for each medical option and includes a useful glossary of terms frequently used in health insurance coverage. The SBC also provides examples of certain medical conditions and what they would cost under the medical option. You can use this document to compare the Company's coverage to other employer coverage that you may have access to as you make your enrollment decisions for the coming year. The SBC is available at the Benefits Support Center website. You may also request a copy, at no cost to you, from the Benefits Support Center.

References to "you" or "your" refer to the covered team member and covered eligible dependents. For enrollment elections, the references refer to the covered team member only.

This document uses a variety of terms that are specifically defined under the ***Terms to Know*** section at the end of this SPD. It is important that you familiarize yourself with these terms, because they help specifically describe the coverage and benefits that are available to you.

Covered Employers and Special Rules

The benefits described in this SPD apply to team members in the U.S., Puerto Rico (and any other indicated jurisdictions) who meet the applicable eligibility requirements and who are employed by Walgreens or by another company that is part of the same tax "controlled group" as Walgreens, except to the extent any such other company offers separate benefit coverage to its employees (as applied to each component benefit hereunder). In addition, certain union employee and other component groups may have differences in eligibility and/or benefits than described in this SPD, based on collective bargaining agreement provisions or otherwise. In each of those cases, a separate supplement to this SPD describing such variations shall be issued to the applicable team members.

Whom to Contact		
Option	**Contact**	**Reasons to Access**
Medical Options **All Self-Insured unless otherwise noted** (NOTE: Prescription drugs and supplies for medical options are offered through Optum Rx, or in certain cases through the medical insurance companies for fully insured coverage.) ▪ **Premier Copay** — BCBS of Illinois — UnitedHealthcare — Dean / Prevea360* (Fully Insured) — Kaiser Permanente* (Fully Insured) ▪ **Premier HSA** — BCBS of Illinois — UnitedHealthcare — Dean / Prevea360* (Fully insured) — Kaiser Permanente* (Fully Insured) ▪ **Core Copay** — BCBS of Illinois — UnitedHealthcare — Dean / Prevea360* (Fully Insured) — Kaiser Permanente* (Fully Insured) ▪ **Core HSA** — BCBS of Illinois — UnitedHealthcare	**Medical:** **BlueCross BlueShield of Illinois (BCBS of Illinois)** **www.bcbsil.com/walgreens** **1-800-247-9207** **UnitedHealthcare** **www.myuhc.com** **Ongoing: 1-844-859-5007** **Dean / Prevea360** **aon.deanhealthplan.com** **1-877-232-9375** **Kaiser Permanente** **www.kp.org** **1-800-464-4000 (CA)** **1-800-632-9700 (CO)** **1-888-865-5813 (GA)** **1-800-777-7902 (DC, MD, and VA)** **1-800-813-2000 (OR and S. WA)** **1-888-901-4636 (WA)** **Prescription Drug:** **Optum Rx (BCBS of Illinois or UnitedHealthcare)** **www.optumrx.com** **1-855-376-3214**	**Medical & Pharmacy** ▪ Request coverage information. ▪ Locate participating providers. ▪ Request information about a network provider, free of charge. ▪ Submit claims, if necessary. ▪ Check on the status of a claim. ▪ Call to avoid penalties if you have an emergency or need surgery, hospitalization, or certain other procedures requiring precertification. ▪ Order an ID card or print a temporary one. ▪ Fill or refill a prescription. ▪ Locate a participating pharmacy near you. ▪ Obtain prescription medication information (such as side effects). ▪ Learn about patient care. ▪ Estimate costs for common treatments. **Mail-Order Prescription Drugs** ▪ Obtain prescription medication information (such as pricing and side effects). ▪ Print a mail-order form or extra mail-order envelopes.

Whom to Contact		
Option	**Contact**	**Reasons to Access**
— Dean / Prevea360* (Fully Insured) — Kaiser Permanente* (Fully Insured) ▪ **BCBS IL myVirtualCare Access** * Not available in all areas.	**www.trustmarkbenefits.com/walgreens/intro** **1-855-453-4747**	▪ Send online member service inquiries. ▪ Order claim forms. ▪ Learn about patient care. ▪ Link to other sites for information about diseases, diagnoses, prevention, and treatment.
Health Reimbursement Arrangement ("HRA") (limited applicability)	**Your Spending Account™ ("YSA")** **(HRA Claims Administrator)** **www.benefitssupportcenter.com** **Benefits Support Center** **1-855-564-6153**	▪ Submit claims ▪ Check on status of a claim ▪ Verify account balances ▪ Information on eligible expenses
Health Savings Account ("HSA") (Enrolled in eligible HSA Options only)	**Optum Bank** **www.optumbank.com/health-accounts/hsa.html** **1-866-234-8913**	▪ See above.
Health Maintenance Organization ("HMO") for Hawaii Team Members **Fully Insured** ▪ **HMSA (Hawaii)** ▪ **Kaiser Foundation Health Plan of Hawaii**	**Hawaii Medical Service Association (HMSA) BCBS of Hawaii** **www.hmsa.com** **1-800-776-4672** **Kaiser Permanente Member Service – Hawaii** **1-800-966-5955**	▪ See Medical & Pharmacy above.
Dental Options **All Fully Insured** ▪ **Value PPO** — UnitedHealthcare ▪ **Premier PPO** — UnitedHealthcare ▪ **ENDP Dental** (select areas only) — UnitedHealthcare	**UnitedHealthcare** 1-866-660-7181 myuhc.com	▪ Request coverage information. ▪ Locate a participating dentist. ▪ Request a provider directory. ▪ Submit claims. ▪ Check on the status of a claim. ▪ Obtain useful information about oral health. ▪ Order an ID card or print a temporary one.

Whom to Contact		
Option	**Contact**	**Reasons to Access**
Vision Options **All Fully Insured** ▪ Value — EyeMed ▪ Premier — EyeMed	**EyeMed** https://member.eyemedvisioncare.com/walgreens **1-844-844-0896**	▪ Verify vision care eligibility. ▪ Review your benefits. ▪ Locate a participating network provider. ▪ Speak with member services. ▪ Request or download a claim form. ▪ Order an ID card or print a temporary one.
Health coverage for Team Members Working in Puerto Rico **Medical (including prescription drug), Dental and Vision** **All Fully Insured, except prescription drug coverage**	**Medical Card System (MCS)** **www.mcs.com.pr** **1-888-758-1616** **Triple-S** **www.ssspr.com** **1-787-774-6060 or 1-800-981-3241 (toll-free)** **Prescription Drug:** **www.optumrx.com** **1-855-376-3214**	▪ See Medical, Dental, and Vision above.
Health coverage for Team Members Working in the US Virgin Islands **Medical (including prescription drug), Dental and Vision** **All Fully Insured, except prescription drug coverage**	**ELAN** **Myhealth.elan.insure** **844-464-4277 (HealthSmart Customer Service)** **Prescription Drug:** **www.optumrx.com** **1-855-376-3214**	
Health coverage for Team Members Temporarily Working Outside the United States (Expatriates) **Medical, Dental, Vision and Rx Fully Insured**	**Cigna Global Health Benefits** **www.CignaEnvoy.com** **Toll Free Number 800-441-2668** **Direct (collect calls accepted) 302-797-3100** **Toll Free Fax Number 800-243-6998** **Direct Fax Number 302-797-3150**	▪ See Medical, Dental, and Vision above.
Flexible Spending Accounts (“FSAs”)	**Your Spending Account™ (“YSA”) through the Benefits Support Center** **www.benefitssupportcenter.com** **Benefits Support Center: 1-855-564-6153**	▪ Verify your Healthcare, Dependent Care Account and Limited Purpose FSA balance. ▪ Ask about covered expenses. ▪ Submit claims.

Whom to Contact		
Option	**Contact**	**Reasons to Access**
		▪ Check on the status of a claim.
Life 365 Employee Assistance Program (EAP)	**Curalinc®** **www.walgreenslife365.com** Group code: life365 **1-855-777-0078** **MCS Solutions*** **1-866-627-4327** **INSPIRA (Triple S) *** **1-800-284-9515** **EAP LatinA*** **www.eaplatina.com** ***EAP provider options for Puerto Rico team members – in addition to Curalinc**	▪ 24/7 toll-free telephone access. ▪ Online Live Chat ▪ Obtain resource and referral information on: — Child & Elder care. — Wellness. — Adoption. — Legal consultation, including simple wills. — Finances. — Stress management. — Substance abuse. — Depression — Identity theft.
365 Get Healthy Here Team Member Wellness Program	**Benefits Support Center website** **www.benefitssupportcenter.com** **1-855-564-6153**	▪ $0 Rx Copay Program ▪ Quit Tobacco Program
Commuter Benefit Plan	**Your Spending Account™ ("YSA")** **www.benefitssupportcenter.com** **Benefits Support Center** **1-855-564-6153**	▪ Enroll in and/or stop contributions ▪ Verify your account balance. ▪ Ask about covered expenses. ▪ Submit a claim
Benefits Support Center 1-855-564-6153, Fax: 1-847-554-1845 Representatives are available between the hours of 8 a.m. and 5 p.m. Central time, Monday through Friday.	**Benefits Support Center website** **www.benefitssupportcenter.com**	▪ Verify overall eligibility and coverage. ▪ Review personal benefits information. ▪ Obtain a benefit summary. ▪ Compare health care coverage options.

Whom to Contact		
Option	**Contact**	**Reasons to Access**
COBRA Administrator **Benefits Support Center** **1-855-564-6153, Fax: 1-847-554-1845** Representatives are available between the hours of 8 a.m. and 5 p.m. Central time, Monday through Friday.	**Benefits Support Center website** **www.benefitssupportcenter.com**	▪ Ask questions about your coverage or eligibility. ▪ Inquire about COBRA premiums ▪ Pay COBRA premiums including setting up direct debit.

Eligibility

You Are Eligible If...

You are eligible to participate in benefits coverage under the Plan if you are a salaried or hourly team member employed by Walgreens or an affiliated company whose team members participate in this Plan. The following eligibility and participation requirements also apply:

- All salaried team members and all support center and centralized services hourly team members become eligible on the day after 30 days of employment.

- All store, distribution center and area/district office hourly team members become eligible on the first day of the following month after 60 days of continuous service if the team member works at least 30 hours per week.

    - NOTE: As part of the Affordable Care Act ("ACA"), medical plan eligibility for hourly team members with variable work schedules must be measured on a continual basis, which means your eligibility for benefits may change from time to time. To continue to be considered full-time and eligible for Walgreens healthcare benefits, store, distribution center and area/district office hourly team members must meet the requirements under the ACA as applied by Walgreens. Please see the section entitled "Additional Medical Plan Eligibility Requirements for Hourly Team Members Subject to Employer Mandate" for additional information.

- A Hawaii team member becomes eligible the day after 28 days of employment.

Both salaried and hourly team members must also meet the following criteria:

- Be actively at work when you first enroll for coverage and on the effective date of your coverage (unless your health is the reason you are not actively at work, in which case your eligibility for coverage would not be delayed).

- Live in the U.S. mainland, U.S. Virgin Islands, Alaska, or Canada but work at a U.S. location. Your covered dependents must also live in the U.S. mainland, Alaska, or Canada. If you and your dependents live in Canada, you must use U.S. medical providers to receive coverage under the Plan. **NOTE: If you live in Hawaii, you are eligible for health coverage through HMSA of Hawaii and Kaiser Foundation Health Plan of Hawaii. If you live in Puerto Rico, you are eligible for health coverage through Medical Card System (MCS) and Triple-S; and if you live in the US Virgin Islands, you are eligible for different health coverage (ELAN).**

The following individuals are not eligible for the benefits outlined herein:

- Team members working within a Walgreens company or business unit that is covered by a separate group health plan providing medical and prescription drug, dental, and/or vision benefits;

- Team members of a temporary or staffing firm, payroll agency, or leasing organization;

- Independent contractors or employees of a person or entity other than Walgreens or an affiliated company treated or classified in good faith: (i) under the terms of a contract or agreement, (ii) pursuant to your consent to such classification, or (iii) according to the Company's records; and

- Team members who are covered by a collective bargaining agreement, except for any benefits under this Plan that are explicitly offered to applicable team members pursuant to any such agreement.

If a court or any other enforcement authority or agency, such as the Internal Revenue Service ("IRS"), finds that an individual excluded from coverage is an eligible team member, the individual still will be considered ineligible for coverage and benefits without regard to any court or agency decision determining common-law employment status.

Notwithstanding the foregoing, employees who are otherwise ineligible for coverage but are determined to be "full-time employees" under the Affordable Care Act (as determined by the Company) may nonetheless be eligible for medical coverage under the Plan.

NOTE: See ***The Commuter Benefit Plan and Employee Assistance Program*** sections of this SPD for eligibility information on those benefits.

Additional Medical Plan Eligibility Requirements for Hourly Team Members Subject to Employer Mandate

Under the Affordable Care Act, employers are required to offer medical coverage that is affordable[1] and provides minimum value to their full-time employees and their children up to age 26 or be subject to penalties. This is known as the "Employer Mandate." Under the Employer Mandate, medical plan eligibility for all field hourly team members whose schedules are variable must be measured on an initial and on a continual basis. This means that after your initial eligibility is determined, you will participate in an ongoing measurement process that will continue as long as you are an hourly, field team member. The Company may use any method of determining full-time employee status as may be permitted under Treas. Reg. §54.4980H-3 and may establish any permitted administrative period. The determination method need not be the same for all classifications of employees and may be changed at the Company's discretion and to the extent permitted by Treas. Reg. § 54.4980H-3. Notwithstanding the foregoing, the Company may elect to be subject to a penalty rather than offer coverage under the Plan pursuant to this paragraph. Currently, the Company uses the following method for determining full-time employee status for hourly, field team members:

[1] Effective January 1, 2023, the government is allowing spouses and dependents to enroll in health insurance marketplace coverage and potentially receive a premium tax credit towards the plan's premium if your employer-provided family coverage is not considered "affordable" based on your household income. Additional details are available on the federal government exchange (www.healthcare.gov).

- **Initial Eligibility**: Your initial eligibility will be assessed after your first 60 days of employment. If you average at least 30 paid hours per week during this time, you will be eligible for medical (including prescription), dental, vision, and flexible spending account benefits on the first day of the following month. (Example: If you are hired on January 15, and you average 30 paid hours per week for 60 days [March 15], you would become eligible for benefits on April 1.) If you do not average at least 30 hours per week in your first 60 days, then there is an override period over the next four weeks. If you average 30 hours a week in this twelve-week period, then you will be eligible for benefits on the first day of the following month.

- **Ongoing Eligibility**: Then, during every six-month "Measurement Period" (defined below), your actual hours worked will be measured, and your eligibility for benefits will be determined. If you regularly average at least 30 paid hours per week or 779.01 hours during the six-month Measurement Period, you will continue to be eligible for coverage. **If a team member does not average at least 30 hours per week or 779.01 hours during the six-month Measurement Period, then Walgreens will offer eligibility to team members who have a 12-week average of at least 30 hours per week. Accordingly, if you average at least 30 hours a week in a twelve-week period, then you will be eligible for benefits on the first day of the following month.**

There are three phases in this ongoing benefits eligibility cycle:

- Measurement Period: First, there is the Measurement Period—a six-month period when your actual hours worked are measured. You must work a total of at least 779.01 hours during this Measurement Period. If you average 30 paid hours per week, you will meet this requirement.

- Administrative Period: After the Measurement Period ends, there is an 87- or 90-day Administrative Period when your hours worked are calculated and your eligibility for the remainder of the cycle is determined.

- Stability Period: The third phase is the Stability Period—a six-month period that follows the Administrative Period, where your benefits will begin, continue, or end, based on what is determined during the Administrative Period.

In other words, your hours are measured during the Measurement Period, calculated during the Administrative Period and your eligibility is determined. If you are eligible for benefits, they will begin or continue when the Stability Period begins.

Specifically, you must work an average of at least 30 hours per week or 779.01 hours during the Measurement Period of April 4 to October 3 for a January 1 effective date or October 4 to April 3 for a July 1 effective date. NOTE: New hires have an initial Measurement Period start date and end date that lasts six months from the start of their employment. Once this initial Measurement Period is completed, there will be corresponding initial Administrative and Stability Periods.

In accordance with the Affordable Care Act guidelines, average hours worked for hourly team members are continuously measured during the six-month Measurement Periods described above, and then eligibility is re-assessed during an 87 to 90-day Administrative Period, which may result in a gain or loss of eligibility for healthcare coverage under this Plan during the Stability Period. NOTE: If you don't meet the 30-hour per week or 779.01 hour requirement during the applicable Measurement Period, your coverage will end on the last day of the applicable Administrative Period (December 31 or June 30). **NOTE: If you average at least 30 hours a week in a twelve-week period, your coverage will not end.**

Important: To avoid counting pay period hours that fall in two Measurement Periods twice, the pay period hours that overlap a Measurement Period end date do not count towards that Measurement Period. Instead, those pay period hours will be accounted for in the next Measurement Period. Accordingly, all hours worked will be accounted for in one of the two Measurement Periods.

If you are deemed ineligible, your benefits and your premium deductions end when the administrative period ends, but you would be measured again when the cycle starts over, i.e., during the next Measurement Period. **IMPORTANT: If you average at least 30 hours a week in a twelve-week period, your coverage will not end.** If your coverage is terminated, you can elect COBRA coverage (see the ***Continuation Coverage Under COBRA*** section of this SPD booklet for more information) or in any of the Health Insurance Marketplace options (visit www.healthcare.gov). Since your coverage has been terminated, you have the option to continue coverage by enrolling in COBRA or in any of the Health Insurance Marketplace options (visit www.healthcare.gov). NOTE: If your coverage is terminated and you opt to enroll in any of the Health Insurance Marketplace options, you should use your Benefit Confirmation Statement to show the loss of coverage.

NOTE: If your hours decrease, your benefits will continue until the end of the current six-month Stability Period, although you may be able to **drop your coverage** right away as explained in the ***Changing Your Coverage*** section of this SPD booklet.

Eligible Dependents

For the benefits applicable to dependents, your eligible dependents include those individuals described below. You will be required to provide evidence to demonstrate that a dependent satisfies the eligibility requirements.

Eligible dependents include your:

- **Legal spouse, unless legally separated**: Common-law spouses are excluded (except for team members who work in San Francisco who are not members of Local 648) but may be covered as domestic partners (see below). This includes civil unions where applicable under state law. See the ***Terms to Know*** section of this SPD for definition of "spouse."

- **Children**: Eligible children include:

  — Children covered by a court order.

  — Foster children.

  — Legally adopted children.

  — Natural children.

  — Other children for whom the team member is a legal guardian.

  — Stepchildren.

  — Children placed for adoption (if legally required to provide support).

  — Domestic partner's children.

  — Disabled dependents as defined below.

You may cover your dependent children up to the end of the month of their 26th birthday regardless of their place of residence or marital status, even if they are not full-time students. Also, you do not need to claim them as dependents on your tax return. Both married and unmarried young adults can qualify for coverage extension, but it does not extend to their spouses or children. NOTE: Some states have special tax provisions and premiums for adult children that may be taken on an after-tax basis.

- **Disabled dependents**: A child covered as an eligible dependent before age 26 may continue dependent coverage after age 26 if the child is unable to be self-supporting due to a physical or mental disability, and if the disability begins prior to attaining age 26. Proof of the dependent's continued disability and continued reliance on the covered employee for financial support will be periodically required, as administered by the applicable medical carriers.

  NOTE: Parents and grandchildren are not considered eligible dependents.

Domestic Partner

You may cover your domestic partner who is the same or opposite sex on your health care coverage. You will be required to certify the domestic partnership during enrollment. After you enroll your domestic partner, you will be required to provide proof that your partner meets certain eligibility and residency guidelines and that you and your partner are financially interdependent. NOTE: Domestic partner means the team member and the domestic partner: (1) are members of the same or opposite sex (2) are not related by blood closer than would bar marriage in the team member's state of residence, (3) are not married to or legally separated from anyone else, or have any other partner, and (4) affirm that the domestic partnership has been in existence for a period of at least six months and intend to remain domestic partners indefinitely.

Imputed Income

Under current law, you are required to be taxed on the value of health benefits provided to a domestic partner (and their covered children) who do not qualify as a dependent under Internal Revenue Code Section 152(d). Due to this requirement, the value of your partner's coverage is taxable to you and treated as "imputed income." When you cover your domestic partner (and their covered children) on health benefits, and they are not qualified as your tax dependents, then the full value of this coverage will be included in your pay as taxable wages (even though you do not receive the cash) and federal income tax, FICA, state, and other applicable payroll taxes will be withheld. You will see this imputed income on your paychecks and your Form W-2.

Most dependents are considered Internal Revenue Service ("IRS") tax dependents. You do not pay imputed income for tax dependents.

If you cover a person who is not a tax dependent under IRS guidelines, Walgreens is required to report imputed income for you that reflects the value of the coverage for tax-reporting purposes. Walgreens assumes all dependents are IRS tax dependents, except domestic partners and their children.

It is your responsibility to notify the Benefits Support Center if you cover dependents who are not IRS tax dependents on your federal tax return. Any change in the status of a dependent will be made by Walgreens for the current tax year and on a prospective basis.

If you and your domestic partner get married, contact the Benefits Support Center. With proof of marriage, adjustments will be made to your status on the Company's benefit recordkeeping system. With regard to Company-subsidized health care coverage, the taxable imputed income applicable to coverage for a domestic partner does not apply to coverage for a spouse.

When Your Spouse or Other Eligible Dependents Are Also Team Members

If you and your spouse or other eligible dependent are both team members of Walgreens or an affiliated company and eligible to participate in the Walgreen medical and prescription drug, dental, and vision plans, look at the plan designs and premiums to see if it would be more cost-effective for you to enroll in individual coverage or enroll as a family. Keep in mind that:

- Dual coverage for Company spouses or other eligible dependents is not allowed, meaning an individual cannot be covered as both a spouse or other eligible dependent and as an employee.

- Your other eligible dependents may not be covered under the plans unless you or your eligible spouse or domestic partner is enrolled. If you and your spouse or domestic partner are enrolled separately, eligible children can only be enrolled as a dependent by one parent. In addition, you may not be enrolled individually and covered as a dependent on your spouse's or domestic partner's plan.

Enrollment

You can enroll for coverage after you meet the eligibility requirements (see the ***Eligibility*** section of this SPD for more information). NOTE: See ***The Commuter Benefit Plan*** and ***Employee Assistance Program*** sections of this SPD for enrollment information on those benefits.

As a New Team Member

Once you are eligible to enroll, go to the Benefits Support Center website to review and record your choices, even if that choice is to waive coverage. You must make your initial enrollment election within 31 days of your eligibility date.

If you do not enroll at the time you are eligible, you will not have coverage through Walgreens and will not have another opportunity to enroll until Open Enrollment unless you have a "qualifying life event" as described in the ***Changing Your Coverage*** section of this SPD.

If You Leave the Company and Are Rehired

- If you are not considered a "full-time employee" under the employer mandate and you are rehired within 30 days in the same benefit year, your previous coverage will be reinstated with no gap. If you are rehired across Plan Years and would like to make a change to your coverage, you must call the Benefits Support Center to make another selection.

- If you are considered a "full-time employee" under the employer mandate and you are rehired within 26 weeks of your termination date, your eligibility upon rehire will be based on your eligibility as of your termination date (i.e., if you were not eligible when you left the Company, you will not be eligible upon your rehire date). Your ongoing eligibility will be determined under the Hourly Eligibility/Employer Mandate rules explained in the ***Eligibility*** section.

If you are rehired outside either of these windows—after 30 days or 26 weeks, whichever applies - you will be treated as a new hire, not a rehire, for purposes of determining your eligibility and elections.

Your Dependents

When you enroll your eligible dependents, you will need to provide their names, genders, birth dates, and Social Security Numbers. See below for additional information about providing Social Security Numbers.

In addition, you will be required to provide proof of dependent status once enrollment is complete. Proof of dependent status may include:

- A Government issued marriage certificate, including date of marriage.
- A Government issued birth certificate that includes parent's names.
- Court Ordered Document of Guardianship/adoption certificate or Placement agreement.
- Federal Tax Return within last 2 years
- Current proof of joint ownership issued within the last 6 months, examples include credit card statements, rental/lease agreement, bank statements.

You may upload, mail or fax your required documentation to the Benefits Support Center. Include your Dependent Verification ID with your documentation, which is found on the bottom of your Dependent Verification Request notice which will be mailed to your home address on file. Please contact the Benefits Support Center at www.benefitssupportcenter.com or 1-855-564-6153 for more information.

If you are unable to provide the required documentation, your dependent will be dropped from coverage prospectively and they will not be eligible for COBRA. From time to time, Walgreens may audit dependents who are enrolled in the Plan. If you are unable to provide proof of dependent status upon request, your dependent will be dropped from coverage prospectively and they will not be eligible for COBRA. In addition, you may be required to reimburse the Company for any costs associated with fraudulently covering an individual who is not an eligible dependent and your coverage, as well as your dependents' coverage, may be terminated.

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), the Centers for Medicare & Medicaid Services ("CMS") generally require Social Security Numbers for team members and dependents to assist with reporting under the Medicare Secondary Payer requirements.

For a newborn child, the newborn may be enrolled within 31 days from the date of birth under your coverage without a Social Security Number. You are, however, required to apply for the child's Social Security Number and submit it to the Benefits Support Center once received.

Open Enrollment

For each Plan Year, during a designated Open Enrollment period, you will be given the opportunity to enroll in coverages, drop coverages, change your coverage elections, and/or change the dependents you cover. Open Enrollment communication materials will direct you to the Benefits Support Center website that will provide:

- The options available to you and your share of the premium cost, if any, for the coverages you elect; and
- What actions you must take to continue certain coverages and will explain any applicable default coverage that you will be deemed to have elected if you do not make the required elections by the specified deadline.

The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a qualifying life event that permits you to make a midyear election change.

NOTE: You should verify that the deductions made from your paycheck correctly reflect the elections you made during Open Enrollment or after a midyear election change. Contact the Benefits Support Center immediately if a correction needs to be made.

You can enroll at the Benefits Support Center website or contact the Benefits Support Center during Open Enrollment with any questions or if you need assistance in making changes to your election coverages.

If You Do Not Enroll

If you do not re-enroll or confirm your coverage by the designated Open Enrollment deadline, your plans will generally carry over (with the exception of FSAs) (Hawaii team members will be enrolled in individual medical coverage at minimum), unless the Open Enrollment materials for the plan year indicate otherwise. In that case, you will not be able to enroll in or change coverage elections until the next Open Enrollment period, unless you have a qualifying life event or other event that allows you to change your coverage midyear. See the ***Changing Your Coverage*** section of this SPD for additional information. Each year, the Open Enrollment communications will indicate the extent to which your existing coverage elections will be applied to the upcoming coverage year if you do not cancel or change those elections in Open Enrollment.

Declining Enrollment and Special Enrollment Period Rules

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents under a health care Benefit Program if you or your dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other health care coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, legal guardianship, adoption, or placement for adoption.

If you or your dependent is eligible, but not enrolled, for health care coverage under the Plan, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event:

- You or your dependent loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage.

- You or your dependent becomes eligible for premium assistance with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

These and other midyear change requirements are outlined in the ***Changing Your Coverage*** section of this SPD.

Enrollment Under a Qualified Medical Child Support Order ("QMCSO")

You may be required to provide medical, dental, or vision coverage for a child under the terms of a QMCSO (or a National Medical Support Notice). This coverage applies when:

- You do not have legal custody of the child.
- The child is not dependent on you for support.

When the Company receives a valid QMCSO for your dependent, you do not have to wait for the Open Enrollment period to enroll the child. However, the child does have to otherwise meet the terms of an eligible dependent to be enrolled on your coverage.

As explained under the QMCSO definition in the ***Terms to Know*** section of this SPD, you may obtain a copy of the QMCSO administrative procedures, free of charge, by contacting the Benefits Support Center.

Paying for Coverage

Your Contribution

The amount you contribute toward the cost of your benefits generally is determined by:

- The coverage options you choose.
- The number of dependents you cover.
- The Walgreens credit, which is applied to medical, prescription drug and dental plan costs and which all enrolled team members receive, may also lower your cost. Your cost for the upcoming year is communicated during the Open Enrollment period. You can enroll online as described in your enrollment materials.

Any required employee contributions will be deemed to be applied to pay benefits under the Plan. Employer contributions pay the remaining cost of benefits and all administrative expenses under the Plan.

In general, you will pay your portion of any required premiums through before-tax payroll deductions each pay period (or after-tax deductions in certain situations*). If the required premium cannot be deducted (or mistakenly not deducted) from your paycheck, your premiums go into arrears and are taken from the next available paycheck(s). By enrolling in coverage under this Plan, you are authorizing all such required payroll deductions in accordance with ERISA and any applicable state laws. Failure to remit your premiums on a timely basis will result in cancellation of your coverage. If your coverage is canceled due to nonpayment of premiums, you will not be eligible to re-enroll in coverage, except as may otherwise be required by law.

> * *After-tax deductions apply for any applicable Plan benefits that are not provided on a pre-tax basis, and in situations where pre-tax benefits coverage is provided on a retroactive basis (for example due to a mid-year election made within the required post-effective date deadline), and the retroactive premiums may not be paid on a pre-tax basis pursuant to applicable legal requirements.*

Federal law requires that domestic partner benefits be provided after taxes. This means the premiums for your domestic partner must be deducted from your paycheck after tax. The Walgreens portion of the premium for your domestic partner is treated as taxable income to you (as wages), subject to the applicable tax withholdings. Team members considering domestic partner coverage may want to consult with a tax advisor. Please refer to the ***Imputed Income*** under ***Domestic Partner*** section of this SPD.

Medical Premium Surcharge for Tobacco Users

You will be subject to an additional surcharge applied to your medical plan premiums if you and/or your covered dependents age 18 and older have used any tobacco product(s) in the last three months and therefore must declare your tobacco user status during enrollment. There are two ways to avoid this surcharge, as follows:

Submit your tobacco-free status during enrollment. If the tobacco-free status for you or your dependents changes during the year, and you or your dependents are no longer tobacco-free, you must change your tobacco status at that time by contacting the Benefits Support Center.

Complete the tobacco cessation program within 180 days of the eligible plan start date, the surcharge will be removed retro to January 1 for those who enrolled during Open Enrollment or the date of plan eligibility. You will be refunded via payroll. Also, if your personal physician recommends that you not participate in this program but proposes a reasonable alternative standard for you to avoid the surcharge, that recommendation will be considered.

To learn more about the tobacco cessation program, log on to the Benefits Support Center or call Vida Health at 1-855-442-5885.

See "Managing Your Health" in the ***Your Medical Coverage*** section of this SPD for more information about this and other available wellness programs.

Paying for Coverage—Active Team Members

With regard to medical and prescription drug, dental, and vision coverage, you pay for coverage with dollars deducted from your pay before taxes are withheld (subject to the exception scenario described above). This also is referred to as a salary reduction election. Company contributions to a Health Reimbursement Arrangement and Health Savings Account are also made on a before-tax basis to the extent applicable.

Contributions are withheld as soon as administratively possible after you become eligible and enroll for coverage. The amount of the salary reduction election available to you to pay for coverage is equal to your share of the premium required to pay for coverage or, in certain cases, the amount you elect to contribute to an account. By enrolling in coverage, you are acknowledging and agreeing to the applicable payroll deductions to satisfy your premium obligations and other healthcare account contributions in accordance with ERISA and any applicable state laws, including any deductions that are applied in arrears or otherwise on a delayed basis to correct administrative errors.

Paying for Coverage - While on Leave

If you are on a leave of absence and are receiving a paycheck from Walgreens, contributions for your medical and prescription drug, dental and vision coverage will continue to be deducted from your Walgreens pay while your active coverage continues.

If you are on an unpaid Family and Medical Leave (FMLA), Military Leave or Medical Leave of Absence (and choose to continue Walgreens coverage), contributions for your medical and prescription drug, dental and vision coverage will go into arrears to be repaid upon your return to work, or otherwise subject to repayment if you do not return to work.

If you are on an unpaid Personal Leave of Absence, premiums for active medical, prescription drug, dental and vision coverage will be direct billed to your home address (on an after-tax basis) until the end of your active coverage period (generally the end of the current or next Stability Period (June 30 or December 31)) based on the Hourly Eligibility/Employer Mandate rules applicable to you (see section ***When Health Coverage Ends***). If your required premiums are paid and your coverage ends at the end of the Stability Period, you will then be offered the opportunity to continue coverage under COBRA (see section ***Continuation Coverage Under COBRA***). If your active team member premiums are not paid by the applicable deadline(s), your coverage will end for non-payment, and you would not be eligible for COBRA continuation.

When Coverage Begins

New Team Members

Coverage begins for you and your dependents on the first day after you become eligible as described in the ***Enrollment*** section of this SPD, as long as you enroll before the deadline described in the ***Enrollment*** section.

For example, if you are eligible after 30 days of employment, and you are hired on April 10 and enroll April 23, coverage begins on May 11, 31 days after your hire date.

Current Team Members: For You and Your Dependents

If you enroll during Open Enrollment, participation begins on the next January 1.

Changing Your Coverage

During the Year

Once you enroll in coverage, your elections generally stay in effect for the calendar year. However, you can change your elections during the year if you experience one or more of the following: a qualified change in status, a special enrollment event, or other change in circumstance. These midyear changes are collectively referred to as "**qualifying life events**."

Qualified Change in Status

A qualified change in status is a specific change in circumstance that could affect eligibility for all coverages under the plans. Changes to your coverage must be due to and consistent with the qualified change in status, which is any of the following:

- You get married, divorced, or legally separated and the separation causes a loss of eligibility under your spouse's plan, or your marriage is annulled.
- Your spouse or dependent dies.
- You gain a domestic partner or lose one through separation or death.
- You have a baby, become a child's legal guardian, adopt, or have a child placed in your care for adoption.
- You lose benefits eligibility due to a reduction in hours or other work situation change.
- Your dependent gains or loses eligibility status (for example, becomes a legal dependent or attains age 26).
- You move to a new place of residence, resulting in a loss or gain of eligibility for coverage.
- You, your spouse, or your dependent has a change in employment status resulting in a loss or gain of eligibility for coverage. For example, one of you begins or ends employment. NOTE: Midyear changes are not allowed when your coverage is reinstated because you left the Company and were rehired within the time frames noted in the ***Enrollment*** section of this SPD.

Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you additional flexibility regarding **whom and when you can enroll in medical and prescription drug, dental, and vision benefits** due to marriage, birth, adoption, or placement for adoption:

- If you are eligible but not enrolled, you can enroll as of the date of the event.
- If you are enrolled, you can enroll your spouse when you marry. In addition, you can enroll your spouse if you acquire a child through birth, legal guardianship, adoption, or placement for adoption.
- If you are eligible but not enrolled, you can enroll your spouse or child who becomes your eligible dependent as a result of the event. However, you also must enroll in coverage.

If you or your dependent is eligible, but not enrolled for coverage, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event:

- You or your dependent loses eligibility for Medicaid or CHIP coverage.
- You or your dependent becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

Other Changes in Circumstance

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health care coverage for a dependent.
- You, your spouse, or your dependent becomes eligible for or loses Medicaid coverage.
- You elected "no coverage" because you had coverage elsewhere (for example, under a spouse's plan) and that other coverage later ends.
  - The coverage must end because of a loss of eligibility, for reasons such as a divorce, termination of employment, or the other employer's stopping contributions to the other plan.
  - You cannot make a change during the year if your "other coverage" is lost because of something you do or do not do, such as not making your required contributions.
- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage from another employer for you, your spouse, or your dependent is exhausted.
- The enrollment period of another plan—for example, your spouse's—is different from the Walgreens Open Enrollment period and a comparable election could be made under each plan.

Special Enrollments in a Qualified Health Plan

- You may revoke your coverage election under the Plan if (1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an "exchange" pursuant to guidance issued by the Department of Health and Human Services and other applicable guidance; and (2) the revocation of your coverage election corresponds to the intended enrollment of you or a dependent in a qualified health plan through an exchange for new coverage that is effective no later than the day immediately following the last day of your coverage under the Plan.

Reduction in Hours of Service

- You may revoke your coverage election under the Plan if (1) you reasonably expected to average at least 30 hours of service per week but you experience a change in your employment status so that you are now reasonably expected to average less than 30 hours per week; and (2) the revocation of your coverage election corresponds to the intended enrollment of you (and any dependents who also lost coverage due to your revocation) in another plan that provides "minimum essential coverage," with the new coverage effective no later than the first day of the second month following the month in which your coverage under the Plan was revoked.

See the chart below for a more complete description of events that permit you to change your coverage during the year.

How to Make Changes During the Year

Report your qualifying life event through the Benefits Support Center website or by calling the Benefits Support Center within 31 days (60 days if due to CHIP or Medicaid eligibility).

As long as you take the appropriate action through the Benefits Support Center website or by calling the Benefits Support Center within the required time frame, coverage changes will take effect on the date of the event. For example, if you get married and you enroll your spouse through the Benefits Support Center website or by calling the Benefits Support Center after the marriage, but within 31 days of the marriage, your new spouse's coverage will be effective retroactive to the date of your marriage.

The following chart shows the changes you may be allowed to make to your health care coverage based on common life events. In specific instances notated with an asterisk (*), the changes outlined below will occur automatically and will not require action on your part. For information on making changes to coverage due to a life event, contact the Benefits Support Center.

Event	Allowable Changes May Include:
Marriage	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself, spouse, and/or any eligible children ▪ Drop coverage for yourself and/or any eligible children if coverage was gained under your spouse's plan ▪ Drop coverage for your spouse if he or she becomes covered under his or her own plan* ▪ Increase or decrease your Healthcare and Dependent Care FSA contributions
Domestic Partnership	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself, domestic partner, and/or any eligible children ▪ Drop coverage for yourself and/or any eligible children if coverage was gained under your domestic partner's plan ▪ Drop coverage for your domestic partner if he or she becomes covered under his or her own plan* ▪ Increase or decrease your Dependent Care FSA contributions
Divorce **Legal separation** **Annulment of marriage** **Spouse dies**	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself and/or any eligible children if coverage is lost under your ex- or deceased spouse's plan ▪ Drop coverage for your ex- or deceased spouse and any eligible children if they become covered under your ex-spouse's plan ▪ Increase or decrease your Healthcare and Dependent Case FSA contributions
Loss of domestic partnership **Domestic Partner dies**	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself and/or any eligible children if coverage is lost under your ex- or deceased spouse's/domestic partner's plan ▪ Drop coverage for your ex- or deceased spouse/domestic partner and any eligible children if they become covered under your ex-spouse's/domestic partner's plan ▪ Increase or decrease your Dependent Care FSA contributions
Birth **Adoption** **Legal guardianship** **Child gains coverage eligibility**	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself, spouse/domestic partner, and/or any eligible children

Event	Allowable Changes May Include:
	▪ Drop coverage for yourself and/or any eligible children if you become covered under your spouse's/domestic partner's plan ▪ Increase or decrease your Healthcare and Dependent Care FSA contributions *In the event of a QMCSO, you can enroll only the child(ren) named in the QMCSO. You may not use the event to enroll other dependents.*
Child loses coverage eligibility; child dies (your child losing coverage eligibility may continue health care coverage through COBRA)	▪ Drop coverage for the affected/deceased child ▪ Increase or decrease your Healthcare and Dependent Care FSA contributions *You cannot change your own or any other family member's coverage.*
Move to a new address that causes loss of current medical and/or dental coverage	▪ Enroll yourself, spouse/domestic partner, and/or any eligible children ▪ Change your plan option if you have a work site transfer or zip code change that results in a change of plan eligibility
Take a leave of absence	▪ Drop coverage for yourself, spouse/domestic partner, and/or any eligible children* ▪ Increase or decrease your Healthcare FSA contributions
Return from a leave of absence	▪ Enroll yourself, spouse/domestic partner, and/or any eligible children within 31 days from the date you return to active employment* ▪ Increase or decrease your Healthcare FSA contributions
You gain benefits eligibility due to a work situation change or you go on an expatriate assignment	▪ Enroll yourself, spouse/domestic partner, and any eligible children if not previously enrolled ▪ Increase or decrease your Healthcare and Dependent Care FSA contributions
You lose benefits eligibility due to a reduction in hours or other work situation change	▪ Drop coverage for yourself and/or any eligible children* ▪ Drop coverage for your spouse/domestic partner and any eligible children*
You lose benefits eligibility for another employer's group health plan or you lose an employer subsidy from another employer's group health plan	▪ Enroll yourself, spouse/domestic partner, and/or any eligible children in coverage if coverage or a subsidy was lost under another employer's plan ▪ Increase or decrease your Healthcare and Dependent Care FSA contributions

Event	Allowable Changes May Include:
Family member gains benefit eligibility due to a work situation change	▪ Drop coverage for yourself, spouse/domestic partner, and/or any eligible children if coverage is gained under your spouse's/domestic partner's plan ▪ Decrease your Healthcare and Dependent Care FSA contributions
Family member loses benefit eligibility due to a work situation change	▪ Change your medical plan option ▪ Enroll yourself, spouse/domestic partner, and/or any eligible children if coverage was lost under your spouse's/domestic partner's plan ▪ Decrease your Healthcare and Dependent Care FSA contributions
Family member gains a benefit option	▪ Drop coverage for yourself and/or any eligible children if coverage was gained under your spouse's/domestic partner's plan ▪ Drop coverage for your spouse/domestic partner if coverage was gained under his or her own plan ▪ Decrease your Healthcare and Dependent Care FSA contributions *Healthcare FSA changes are not permitted if the impacted dependent is your domestic partner or their child.*
Family member loses coverage under another employer's plan	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself and/or any eligible children if coverage was lost under your spouse's/domestic partner's plan ▪ Enroll spouse/domestic partner if he or she lost coverage under his or her employer's plan ▪ Increase or start your Dependent Care FSA contributions
You or your family member's cost for coverage increases significantly (only if there is no similar medical and dental coverage under your family member's plans)	▪ Change your medical, dental, vision plan option ▪ Enroll yourself and/or any eligible children if coverage was lost under your spouse's/domestic partner's plan ▪ Enroll spouse/domestic partner if he or she lost coverage under his or her employer's plan ▪ Increase or decrease your Dependent Care FSA contributions
Family member's cost for coverage decreases significantly	▪ Drop coverage for yourself and/or any eligible children if coverage was gained under your spouse's/domestic partner's plan ▪ Drop coverage for your spouse/domestic partner if they become covered under their own plan ▪ Increase or decrease your Dependent Care FSA contributions

Event	Allowable Changes May Include:
Family member makes new coverage choices during another employer's annual enrollment period	▪ Enroll yourself, spouse/domestic partner, and any eligible children ▪ Drop coverage for yourself and/or any eligible children if coverage was gained under your spouse's/domestic partner's plan ▪ Drop coverage for your spouse/domestic partner if he or she becomes covered under his or her own plan ▪ Increase or decrease your Dependent Care FSA contributions
COBRA coverage from another employer expires	▪ Change your medical plan option ▪ Increase or start your Healthcare FSA contributions If your coverage under **your family member's COBRA** coverage expires: ▪ Enroll yourself, spouse/domestic partner, and/or any eligible children if coverage was lost
You discontinue COBRA coverage from another employer	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself, spouse/domestic partner, and/or any eligible children ▪ Increase or start your Healthcare FSA contributions
You or your family member becomes entitled to Medicare or Medicaid	▪ Drop coverage only for the person who becomes entitled to Medicare or Medicaid ▪ Decrease your Healthcare FSA contributions *Healthcare FSA changes are not permitted if the impacted dependent is your domestic partner or their child.* *No changes are allowed for any other family member's coverage.*
You or your family member loses Medicare or Medicaid coverage	▪ Change your medical, dental and/or vision plan option if your family member loses Medicare or Medicaid coverage ▪ Enroll yourself if you are not already covered ▪ Enroll your spouse/domestic partner or any eligible children who lose Medicare or Medicaid coverage ▪ Increase or start your Healthcare FSA contributions
Your child becomes eligible for premium assistance due to Children's Health Insurance Plan ("CHIP") coverage	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself and spouse/domestic partner if you are not already covered ▪ Drop coverage only for the person who becomes entitled to CHIP ▪ Decrease your Healthcare FSA contributions

Event	Allowable Changes May Include:
	Healthcare FSA changes are not permitted if the impacted dependent is your domestic partner or their child. *No changes are allowed for any other family member's coverage.*
Your child loses CHIP coverage	▪ Change your medical, dental and/or vision plan option ▪ Enroll yourself and any eligible child who loses CHIP coverage ▪ Increase or start your Healthcare FSA contributions *Healthcare FSA changes are not permitted if the impacted dependent is your domestic partner or their child.* *No changes are allowed for any other family member's coverage.* ▪
You or your family member loses coverage under a government or educational institution's plan	▪ Change your medical, dental and/or vision plan options ▪ Enroll yourself, spouse/domestic partner, and any eligible children if not previously enrolled or if coverage was lost ▪
You experience a reduction in hours from more than 30 hours per week on average to less than 30 hours per week on average that does not result in a loss of eligibility for coverage.	▪ Drop medical coverage for yourself, spouse/domestic partner, and any eligible children to enroll in other qualifying coverage.
You are eligible to enroll on a Health Insurance Marketplace, either through special enrollment or open enrollment.	▪ Drop medical coverage for yourself, spouse/domestic partner, and any eligible children to enroll in other qualifying coverage ▪ Change medical coverage election so that spouse/domestic partner or any eligible children can take advantage of a premium tax credit in a Health Insurance Marketplace provided such individual is eligible for a special enrollment or open enrollment on the Marketplace and the revocation of election of medical coverage corresponds to the intended enrollment of the family members in a Marketplace plan

In order to verify that you qualify to make mid-year changes to your elections as described above, the Benefits Support Center will require that you complete the required certification(s) and may also require that you provide confirming documentation (e.g., divorce decree to confirm the completion and timing of a divorce).

Your Medical Coverage

Walgreens provides several Self-Insured and Fully-Insured medical options. Each medical option offers coverage for medical services and prescription drugs. Prescription drug coverage is available through Optum Rx, or in limited cases through your selected medical insurance company. A Health Savings Account ("HSA") is available for certain eligible medical options. Note that enrollment in one of these HSA-eligible medical options is required to participate in an HSA.

All options provide full—or 100%—comprehensive coverage for in-network preventive care for you and your covered dependents. You can choose traditional coverage (Copay options) or a market-competitive high deductible health care plan (HSA options), depending on your individual needs.

All out-of-network care will not be reimbursed unless due to a medical emergency.

With an HSA option, you will pay 100% of the cost of covered services until you meet your annual deductible for any non-preventive care. Also, you need to meet your annual deductible before copays for prescription drug and the in-store clinic apply. After you meet the annual deductible, you pay a portion of the cost—known as "coinsurance" or "copay".

Copay options provide 100% coverage for certain routine services at in-network providers, like office visits, after you pay the applicable copay for primary care physician (PCP) office visits. They also have an annual deductible, but it only applies to certain services.

The BCBSIL myVirtualCare Access option requires participants, age 18 or older, to see a virtual primary care provider via a smartphone, tablet or other connected device and receive a referral to see in-person providers in order to receive the best benefit under tier 1. However, participants can go directly to an in-person provider, without a referral, and pay more for their care under tier 2 benefits. Children under age 18 must seek care from in-person providers therefore their care will be covered under tier 1 regardless of referral.

See ***Emergency Room Coverage*** section of this SPD for more details on in-network and out-of-network coverage for emergencies. For all medical options, you should refer to the coverage summaries provided by the medical carriers for detailed information about limitations on benefits, covered preventive care services, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for obtaining in-network services. Any cost-sharing provisions, such as your deductible, copay, coinsurance, or annual out-of-pocket maximum, are also explained in the coverage summaries.

NOTE: See ***Medical Coverage in Hawaii, Puerto Rico and US Virgin Islands*** later in this section as well as the coverage summaries for more information about coverage in Hawaii, Puerto Rico and US Virgin Islands.

What Medical Options Will Be Available?

Depending on your employment status and where you live, you may have a choice of medical options available to you under the Plan. All medical options include prescription drug coverage.

Some medical options require you to select a PCP who will direct your care. In addition to helping keep premiums down, these networks also offer ongoing savings opportunities through the year based on negotiated discounts**.**

To become a participant under a medical option, you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined above. If you are changing plans or carriers, or newly electing coverage, then you will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

The Insurer and/or Claims Administrator for each medical option have provided detailed information about the various options available to you. These coverage summaries are available at the Benefits Support Center and can also be requested in print, free of charge, from the Insurer and/or Claims Administrator. The coverage summaries will cover all terms and conditions not addressed in this SPD, including but not limited to the following:

- Include any cost-sharing provisions, such as copays, coinsurance, deductibles, and out-of-pocket maximum amounts.
- Include any applicable annual maximums or other limits.
- Define in-network health care providers, such as a doctor, physician, or hospital.
- Describe what care services are covered and what other services and expenses are covered or not covered.

Care Coordination and Health Pros

You'll also have access to enhanced care coordination programs offered through Blue Cross and Blue Shield of Illinois and UnitedHealthcare for certain plans. These programs are designed for you and your covered family members, helping you navigate important decisions about your health, along with understanding the new features of your plan. A care coordinator is specially trained to help guide you through the health care process, assisting you with questions ranging from your benefits to choosing lower-cost, quality providers, and so much more.

Team members and their dependents enrolled in one of the applicable plans can access this service by calling their medical carrier at the number on their medical ID card, or by visiting the carrier's website. Through July 31, 2024, the Health Pro service is an added benefit to Care Coordination services. Team members should continue to contact their health plan's Care Coordinators for help with anything from claims, clinical programs, ID cards, and more. The Health Pro service is designed to help team members find the right care, with high quality

providers at the most efficient cost. This is offered through Alight Healthcare Navigation Solutions, and it is a free service that helps team members and their dependent(s) find quality healthcare at a lower cost. Health Pros® can help team members and their families:

- Shop for quality healthcare: locate highly rated doctors based on cost, quality, and experience and save money.
- Compare prices and choose more cost-effective options and locations for medical treatments such as ultrasounds and MRIs.
- Care Coordinators or Health Pros are not available to those enrolled in the BCBS IL myVirtualCare Access plan.

The Health Pro service is discontinued after the end of July 2024.

Carrum Health Medical and Surgery Benefits

If your medical carrier is Blue Cross Blue Shield of Illinois (BCBSIL) or UnitedHealthcare, you have access to a Center of Excellence Program through Carrum Health.

Designed to streamline the elective surgery process, this program covers eligible expenses for certain surgeries at 100%—including travel for you and a caregiver. There's no annual deductible if you're enrolled in one of the copay plans. The 100% coverage applies after the deductible if you enroll in one of the HSA plans.

This program also covers certain breast and thyroid cancer treatments.

It's mandatory to use this program for hip and knee replacement, spinal fusion, and bariatric surgery, but it's voluntary for cardiac, breast and thyroid cancer treatments, and other orthopedic procedures.

See the separate Carrum Health coverage summary for further details, terms, and conditions.

Overview of Medical Plan Options and Networks

Your medical plan options are designed to simplify your choices, make it easier to plan for expected costs, and help you connect with high-quality healthcare providers.

Copay options give you access to care for low copays before the deductible is met.

Copay options provide 100% coverage for certain routine services, like office visits, after you pay a copay per primary care physician (PCP) office visit. They also have an annual deductible, but it only applies to certain services. The Copay options have higher premiums.

HSA options feature lower per-paycheck costs and the tax benefits of a Health Savings Account (HSA). There is a combined medical and Rx deductible, which means you'll need to pay the full cost for non-preventive services and prescriptions until your deductible is met.

With an HSA option, you will pay 100% of the cost of covered services until you meet your annual deductible (except for preventive care and all telehealth services). Also, you need to meet your annual deductible before copays for prescription drug and the in-store clinics apply. The HSA options have lower premiums.

The BCBSIL myVirtualCare Access medical plan allows you to choose a virtual primary care physician (PCP) who will support you through appointments on your smartphone, tablet or other connected device at low or no cost. "Visits to an in-person healthcare provider require a referral from your virtual PCP in order to get Tier 1 benefits and pay a lower out-of-pocket cost for care. If you go to an in-person healthcare provider without referral from your virtual PCP you will receive Tier 2 benefits and pay a higher out-of-pocket cost." Children under age 18 will always see in-network BCBSIL providers at no or low cost. The myVirtualCare Access plan option generally has a lower premium as compared to other coverage options.

When you enroll in coverage, the Benefits Support Center will show the various options and networks available to you based on where you live. In most cases, you will have either Blue Cross Blue Shield of Illinois, UnitedHealthcare as the medical carrier with an assigned network for all medical plan options available to you. The carrier network(s) you're eligible for is determined by where you live. In some geographies, you will have a choice between carrier medical plan options.

Not all networks or carriers will be available in all areas, so it's important to review your options and decide what coverage best meets the needs of you and your family. In all cases, you should check the network to confirm whether your chosen providers participate. Also see the Summary of Benefits Coverage (SBC) for each coverage option for more specific plan information, which is found at www.benefitssupportcenter.com or by calling the toll-free number on your health ID card.

The Plan arranges for healthcare providers to participate in a network. At your request, you can be sent a directory of network providers free of charge. Keep in mind, a provider's network status may change. Before obtaining services, you should always verify the network status of a provider. To verify a provider's status or request a provider directory, call your medical plan option's customer service number on your ID card or log onto your medical plan's website. If a provider's status is incorrectly listed as in-network in the directory, you may be entitled to protection. See the ***Plan Updates Due to the Consolidated Appropriations Act, 2021*** section for additional information.

Primary Care Provider (PCP) Requirements

PCPs play an important role in your healthcare support. Some medical options do require you to select or have your care coordinated through a PCP as noted below. You may also need a referral to see a specialist in these options. Even if your medical option does not require a PCP designation, it's important that you do have a PCP and that they are in-network. Assistance to select a PCP is available through www.benefitssupportcenter.com or by calling the toll-free number on your health ID card.

- You may be required to designate a primary care provider (PCP) when you enroll so it's important to check the network to see if your PCP participates.
- Your PCP can help you navigate care when you need it—including connecting you with specialists, hospitals, and other providers. You may be required to get a referral from your PCP for all care, except for behavioral health and obstetrics/gynecology (OB/GYN subject to certain exceptions).
- The Affordable Care Act provides you with the following patient protections with respect to benefit options that require the designation of a PCP:
  - You have the right to designate any PCP who participates in the provider network and who is available to accept you or your family members.
  - For children, you may designate a pediatrician as the PCP.
  - You do not need prior authorization from your carrier or from any other person (including a PCP) to obtain access to obstetrical/gynecological care or behavioral health care from a health care professional in the network who specializes in these services. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals.

Note: Out-of-network care is not covered under any of these plans, unless due to a medical emergency (see below for details) or as may otherwise be required by law.

EPO Network — Common Features Applicable to Most Options

Most medical options offer access to an Exclusive Provider Organization (EPO) network of physicians, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You must receive care from network providers that are included in the specific network in which you are enrolled. If you or your dependents receive care from a provider who is not in the assigned network, benefits will not be paid unless due to a medical emergency.

With an HSA option, you will pay 100% of the cost of covered services until you meet your annual deductible (except for preventive care and all telehealth services). Also, you need to meet

your annual deductible before copays for prescription drug and the in-store clinics apply. After you meet the annual deductible, you pay a portion of the cost—known as "coinsurance" or "copay".

Copay options provide 100% coverage for certain routine services, like office visits, after you pay the applicable copay for primary care physician (PCP) office visits. They also have an annual deductible, but it only applies to certain services.

All out-of-network care will not be reimbursed unless due to a medical emergency.

See the ***Emergency Room Coverage*** section of this SPD for more details on in-network and out-of-network coverage for emergencies.

UnitedHealthcare (UHC) Networks

For all UHC networks, your UHC Care Coordinator (UnitedHealthcare Care Connect) is also available to help you optimize your plan and answer any questions you may have. They can be reached by calling the toll-free number on your health ID card.

UnitedHealthcare (UHC) Nexus Medical Plan Network

If you are enrolled in a UHC plan with access to the Nexus network of providers, you have access to UHC's large, national network and access to a set of preferred providers. UHC designates these top-rated primary and specialty providers as Tier 1.

- You are required to select a PCP when you enroll.
- For services where a Tier 1 provider is available, you will receive the highest level of coverage when you use these Tier 1 providers (you will generally pay 20% after deductible).
- If a Tier 1 provider is available but you use another UHC in-network provider that is not Tier 1, you will generally pay 40% after deductible, plus copays for certain services.
- Referrals are required when the PCP refers a member to a network specialist. Members won't have coverage for services received without a referral or for services from an out-of-network care provider.

UnitedHealthcare (UHC) Navigate Medical Plan Network

If you are enrolled in a UHC plan with access to the Navigate network:

- You have access to preferred providers within UHC's Navigate network.
- You are required to select a PCP when you enroll.
- Referrals are required when the PCP refers a member to a network specialist. Members won't have coverage for services received without a referral or for services from an out-of-network care provider.

UnitedHealthcare (UHC) Choice Medical Plan Network

If you are enrolled in the UHC Choice network, you have access to UHC's large national network without the need to select a PCP to coordinate your care.

UnitedHealthcare (UHC) Core Medical Plan Network

If you are enrolled in the UHC Core network, you have access to a group of PCPs specialists, hospital and other providers that are part of the Core network. You are not required to designate a PCP.

Blue Cross Blue Shield of Illinois (BCBSIL) Networks

BCBSIL High-Performance networks (HPNs) include a specific selection of PCPs, specialists, hospitals or other providers that are focused on delivering high-quality, lower cost care.

BCBSIL Broad and Select networks offer access to BCBSIL's large national network.

BCBSIL Core Copay and HSA medical plans do not require that you designate a primary care provider (PCP), but you'll get the most value when you get care from a network provider with the BCBSIL Blue Distinction® designation. You may want to consider one of these providers even if your current provider remains in-network.

Your BCBSIL Care Coordinator also is available to help you optimize your plan and answer any questions you may have. They can be reached by calling the toll-free number on your health ID card.

BCBSIL myVirtualCare Access plan

The BCBSIL myVirtualCare Access plan allows adult participants to choose a virtual PCP on the Blue Element Mobil app or on myBlueElement.com. The virtual PCP will coordinate all in-person care and make referrals needed to a Tier 1 in-person provider when necessary.

Participants have the option to receive in-person care from a Tier 2 BCBSIL in-network provider without a referral, but at a higher cost.

POS Network Option—Options Through Kaiser Permanente

The POS medical option is a type of medical plan that combines the freedom of an EPO with the lower cost of an HMO. You must designate a PCP from within the network to coordinate your care under the POS option. The PCP may make referrals to providers both in- and out-of-network (out-of-network coverage not available in CA), but benefits are paid at a higher level when care is received from network providers.

For medical visits within the network, paperwork is completed for you. If you are referred to an out-of-network provider, you are responsible to fill out forms, send in payments, and keep an accurate account of health care receipts.

Generally, copays for in-network care are low and there is no annual deductible. However, there is a deductible for out-of-network care and copays are high.

HMO Network Option—Only Applicable in Certain States

Depending on where you live, the HMO option, if available, offers access to networks of physicians, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You and your dependents are required to use a PCP to coordinate care under the HMO option. If you or your dependents receive care from a provider who is not in the HMO option's network, services are not covered.

Emergency Room Coverage

To receive the most cost-effective treatment and coverage, you are encouraged to seek care in the emergency room (ER) only for emergency care.

Examples of life-threatening or disabling health problems that are generally considered emergency care include: sudden loss of consciousness, major injuries, chest pain, numbness in the face, arm or leg-, problems speaking, high fever with stiff neck, mental confusion, trouble breathing, coughing up or vomiting blood, cut or wound that won't stop bleeding, a wound that needs stiches, possible broken bones, severe or sudden start of pain, gall stones or kidney stones where the patient is in severe pain, vomiting and/or diarrhea that does not go away, seizure, paralysis.

Examples of situations where an ER might not be the best place for care generally include: cold or flu, mild headache, sore throat, or earache.

These examples do not represent a comprehensive list, so if you are in doubt about heading to the emergency room for care, be sure to call your health plan at the toll-free number on the back of your ID card. They have Care Coordinators and 24/7 nurses standing by to help you navigate

through decisions like this—and they will guide you to the appropriate care setting. As always, if you feel you are having a life-threatening emergency, you should call 911.

You should refer to the coverage summaries provided by the medical carriers for detailed information about ER and other emergency services cost-sharing provisions, which shall be no less generous than required by the ACA. The special cost-sharing requirements imposed under the ACA in connection with emergency services are as follows:

a. any copayment amount or coinsurance rate cannot be higher for out-of-network services than those amounts, and rates imposed on in-network services; and
b. benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts (referred to as "the minimum payment standards"):
    i. the median of the amount negotiated with in-network providers for emergency services without regard to copayments and coinsurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded);
    ii. the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable (UCR) amount, but without regard to in-network copayments or coinsurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services; and the amount that would be paid under Medicare Parts A and B, without regard to copayments and coinsurance.

Provider Directory Information

A directory of providers is available online or upon request by contacting your Claims Administrator. You generally should receive a response within one business day of a telephone request. The Plan will send you a directory of in-network providers free of charge. The Claims Administrators strive to keep this information as current as possible; however, a provider's network status may change. If you receive covered services from an out-of-network provider and were informed incorrectly prior to receipt of services that the provider was an in-network provider, either through a database, provider directory, or in a response to a request for such information (via telephone, electronic, or internet-based means), you will not be responsible for paying a cost sharing amount that is higher than the in-network amount that would have applied if you had seen an in-network provider. Further, any cost-sharing amounts paid by you will count towards your in-network deductible and out-of-pocket maximum.

Continuity of Care Benefits

If you are currently receiving treatment from a provider whose network status changes from in-network to out-of-network during such course of treatment (due to expiration or non-renewal of the provider's contract), you may be eligible to request continued care from the current provider at the in-network level. This continued care is available for specified conditions (for example, undergoing a course of treatment for a serious and complex condition, in institutional or inpatient care, scheduled for non-elective surgery, pregnant or terminally ill) and may last up to the ***earlier***

of 90 days or until you are no longer a continuing care patient. (This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud.) If you would like assistance in finding out if you are eligible for continuity of care benefits, please call the customer service telephone number on your medical ID card.

No Surprises Act and Balance Billing

When you receive emergency medical care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgery center, you are protected from balance billing by federal law – the No Surprises Act.

For designated network benefits and network benefits for covered services provided by a network provider, you are not responsible for any difference between eligible expenses and the amount the provider bills (other than your usual cost-sharing obligations). There are certain situations where you may consent to be balance billed, but such consent must be in writing and obtained in advance of services performed.

You are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your copay, coinsurance, or deductible which is based on the recognized amount for the following:

- For covered services that are ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians;

- For covered services that are non-ancillary services received at certain network facilities on a non-emergency basis from out-of-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied;

- For covered services that are emergency health services provided by an out-of-network provider;

- For covered services that are air ambulance services provided by an out-of-network provider.

Please call customer service at the telephone number on your medical ID card for assistance if you are billed for amounts in excess of your applicable cost sharing. In addition, you may refer to the Notice Regarding Patient Protections Against Surprise Billing which is available on the Benefits Support Center website at www.Benefits.Support.Center.com. If you choose the Reference Library menu at the top of the home page and reference the other section, compliance notice will give you the appropriate details. For more information on these balance billing protections, visit www.cms.gov/nosurprises.

Health Savings Account (HSA) Plans

To give you more flexibility to save for short- and long-term medical costs, you also have access to high-deductible health plan ("HDHP") options that are compatible with a Health Savings Account ("HSA"). Walgreens does not intend the HSA to be a benefit subject to ERISA.

You may make before-tax contributions to your HSA. For 2024, the contribution limit is $4,150 (single) or $8,300 (family)—plus an additional $1,000 catch-up contribution if you're age 55 or older. Funds in your account may be used to pay for IRS-approved health care expenses on a before tax basis, providing you with a tax benefit. Any unused funds remaining in your HSA will automatically roll over from year to year, and can be used for future expenses, even if you are no longer employed by Walgreens. The terms and conditions of the HSA are governed by the HSA custodial agreement, which is not part of this Plan. You may obtain a copy from the Plan Administrator.

While on an unpaid leave, pre-tax deposits to your HSA are no longer made via Payroll deductions, however, contributions may be made directly to Optum Bank. Call Optum Bank at 1-866-234-8913 for information on making deposits.

Please note you may increase, decrease, or revoke your HSA contribution election at any time for any reason by requesting this change through the Benefits Support Center at 1-855-564-6153 or online at www.benefitssupportcenter.com. Your election change will be prospectively effective as soon as administratively possible following the date you submit your election change.

IRS regulations state that before-tax dollars contributed to an HSA cannot be used to reimburse expenses incurred by Domestic Partners and their Eligible Dependents, unless the person receiving the reimbursement qualifies as your Tax Dependent. However, your Domestic Partner can open his or her own HSA and contribute up to the family HSA annual maximum (plus catch-up contributions, if applicable). An adult child must still be considered a tax dependent in order for their medical expenses to qualify for payment or reimbursement from a parent's HSA.

Enrollment in Medicare

If you are enrolled in Medicare, you cannot contribute to an HSA. This means that some individuals upon reaching age 65 will no longer be eligible to contribute to an HSA.

How Health Savings Account Plans Work

As with any Walgreens medical plan, the HSA plans pay 100% for **in-network preventive care** (such as regular checkups). Out-of-network preventive care isn't covered.

Prescription medications that are considered preventive under IRS rules are also covered at 100%, and you'll just pay the applicable copay or coinsurance for any medications on the HDHP Preventive Drug List.

The major difference with an HSA plan is that you'll pay the **full** Plan cost for non-preventive healthcare services and prescription medications out of your pocket—including doctor visits and prescriptions—until you reach your deductible. At that point, the HSA plans work like all other Walgreens medical plans: You'll pay a portion of the cost of services through coinsurance—and in some cases, copays—until you reach your out-of-pocket maximum. See the medical plan comparison chart for a high-level look at how this option pays benefits. Also take time to review the Summaries of Benefits and Coverage (SBCs) for these plans. You'll find more details about how benefits are paid, including a look at coverage for three common conditions.

Coordination with Healthcare FSA

Limited Purpose FSA

If you enroll in both a medical plan with a Health Savings Account (HSA) and a Healthcare Flexible Savings Account ("FSA"), your FSA will automatically become a Limited Purpose FSA, which can only be used for eligible dental and vision expenses so plan accordingly when allocating funds with just dental and vision expenses in mind. This is due to IRS rules, which restrict the use of non-limited purpose FSAs for those also participating in HSAs.

Eligible expenses under a Limited Purpose FSA/HRA may include:

- Eligible vision, and dental expenses that are not covered by insurance
- Dental and vision deductibles, copays, and coinsurance
- Contact lenses and glasses

For other qualified dental and vision expenses, refer to www.irs.gov/publications/.

The Healthcare Flexible Spending Account ("Healthcare FSA") and Limited Purpose FSA are all administered by YSA. If you participate in any of these, the debit card that YSA provides you will work with that particular account. See the ***Your Flexible Spending Accounts ("FSAs")*** section of this SPD for more information.

Tax Information

Any expense reimbursed through your HRA account is generally not taxable.

Highly Compensated Individuals

If you are a highly compensated individual, FSA reimbursements may be limited or treated as taxable compensation to comply with Sections 105(h) and 125 of the Internal Revenue Code, as determined by the Plan Administrator. If this applies to you, you will be notified.

Medical Coverage in Hawaii

Medical coverage for team members who live in Hawaii is offered through BlueCross BlueShield of Hawaii's HMSA or Kaiser Foundation Health Plan of Hawaii. You must complete and submit an HC-5 form, even if you waive coverage, or you will be enrolled in individual coverage. These Hawaii medical plans are fully-insured.

Under the Hawaii medical option, rates are based on whether the tobacco user surcharge applies to you; see "Premium Surcharge for Tobacco Users" in the ***Paying for Coverage*** section of this SPD.

You must designate a PCP who will coordinate your care, although there are services you can arrange yourself described in the coverage summary. For more information about the patient protections available to you under the Affordable Care Act when a PCP must be designated, see the Primary Care Provider (PCP) Requirements section above. You will receive a member card that you must display whenever you get medical services. See the coverage summary for benefits details.

Medical Coverage in Puerto Rico

Medical, dental and vision coverage for team members who live in Puerto Rico is offered through Medical Card System and Triple-S. These Puerto-Rico plans are fully-insured.

Medical, dental and vision rates are bundled and include a tobacco user surcharge if applicable; see "Premium Surcharge for Tobacco Users" in the *Paying for Coverage* section of this SPD.

Medical Coverage in U.S. Virgin Islands

Medical, dental and vision coverage for team members who live in U.S. Virgin Islands is offered through ELAN. This US Virgin Islands plan is fully-insured.

Medical, dental and vision rates are bundled and include a tobacco user surcharge if applicable; see "Premium Surcharge for Tobacco Users" in the *Paying for Coverage* section of this SPD.

Rescission of Coverage

Health care coverage under the Plan may be rescinded (cancelled retroactively) if you or a covered dependent performs an act, practice, or omission that constitutes fraud against the Plan or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage also may be rescinded to your date of divorce if you fail to notify the Plan of your

divorce and you continue to cover your ex-spouse under the Plan. Coverage will be cancelled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefit paid as a result of the wrongful activity that is in excess of the contributions paid. In the event the Plan terminates, continuation coverage under COBRA may also be denied to you and your covered dependents.

Continuation of Coverage Through COBRA

If your medical coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under COBRA. You and your covered dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section of this SPD for additional information.

Your Prescription Drug Coverage

As part of your medical option election, prescription drug coverage is included for medications that are approved by the U.S. Food and Drug Administration ("FDA"), prescribed by a physician, and filled at participating retail and specialty pharmacies or through the mail service or retail 90 program.

Detailed information about prescription drug coverage is included in the Prescription Drug Program Overview available via the Benefits Support Center. The Prescription Drug Program Overview will include any cost-sharing provisions including copays, applicable maximums or other limits. Program details are also included about covered prescription drugs and supplies, limitations and exclusions, other plan benefits, clinical programs, utilization management, preventative drugs and formulary tiers.

Managing Your Health

Walgreens knows that there is more to staying well than getting your annual physical and taking your medications. While these activities are very important, there is more that you can do throughout the year to stay well—and there are resources available to help. An important part of your health benefits is your access to the Health Support programs provided by either your medical plan carrier, or the Care Coordinators available through BCBS and UnitedHealthcare. These carriers work in partnership with your medical plan to offer tools and resources to help you understand your personal health, and take steps to living a longer, healthier life.

Please know that all health information received by the carriers and their affiliates is kept confidential and protected by federal law and is never shared with the Company on an individualized basis.

Telehealth Services

Your medical carrier offers telehealth vendors for acute and behavioral health care. These vendors provide virtual care separately from your network provider/doctor that you may see regularly. Refer to the chart below for cost and contact information.

Your cost for telehealth services will vary by medical carrier, as noted. For questions about the services offered and the associated costs for telehealth, please call the number on the back of your medical ID card.

Medical Carrier	Telehealth Vendor	Cost+	Website
Blue Cross Blue Shield Copay and HSA plans	98point6	- $0 co-pay	www.98point6.com/walgreens
UnitedHealthcare Copay and HSA plans	98point6	$0 co-pay	www.98point6.com/walgreens
Dean/Prevea 360	DeanHealthPlan Virtual Visits	Contact Dean for pricing	www.deancare.com/wellness/care-management/virtual-visit
Kaiser Permanente	My Doctor Online	Contact Kaiser for pricing	www.kp.org/getcare
HMSA	HMSA's Online Care	Contact HMSA for pricing	www.hmsa.com/well-being/online-care/

The BCBSIL myVirtualCare Access is excluded from a telehealth provider as it is a virtual program. This is a virtual first plan with all Teladoc Health virtual services being offered at $0 copay.

Telehealth options for behavioral health services may be available for some telehealth vendors. Contact your medical carrier or your medical carrier's telehealth vendor for more information. In addition, up to five FREE Behavioral Health Counseling visits per Team Member (and their immediate household member), per issue, are available to all team members and immediate family through Life 365, Walgreens Employee Assistance Program. For additional details, please visit www.Walgreenslife365.com, group code: life365.

Wellness Programs

From time to time, the Plan may offer wellness programs designed to promote the health and well-being of all Walgreens team members. These wellness programs provide the opportunity to access tools and resources to stay healthy. It also hosts an Quit Tobacco program, providing those who want to quit the support needed, including free NRTs (gum and patches) and where applicable, the opportunity to avoid a premium surcharge based on not using tobacco. Collectively, these programs are designed to engage Plan participants in programs that encourage healthy lifestyle choices and give you the opportunity to participate in health and well-being programs designed to help you to be more involved in your healthcare. Any information collected as part of a wellness program will be de-identified and may be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communications. Any wellness program and any related financial incentive offered under the Plan shall comply with all applicable legal rules and regulations. The current wellness programs are described below.

365 Get Healthy Here

The Plan supports your health and well-being goals by offering free tools, resources, and incentives that help you improve your health and wellness. The Plan's wellness program is designed to offer an integrated wellness experience for those enrolled in the medical plan.

Our commitment to supporting your health and well-being, will include providing you with access to tools and resources, via the Benefits Supports Center. . The 365 Get Healthy Here Well-being Program can be accessed through the Benefits Support Center by team members on a Walgreens Health Plan. Eligible spouses/domestic partners or children are able to access the $0 Rx Copay program and Tobacco-Free Program by contacting the vendors directly (Optum for $0 Rx Copay, Vida Health for Tobacco).

$0 Rx Copay Program

The $0 Rx Copay Program applies to team members and covered spouses/partners and dependents enrolled in medical coverage under this Plan (subject to any exceptions noted). If you or any of your covered dependents enrolled in medical coverage are being treated for high cholesterol, coronary artery disease, diabetes, high blood pressure (hypertension), asthma, and/or weight loss, you may be eligible for this program. It covers the following medications:

- Generic cholesterol medications
- Generic diabetes medications
- Generic blood pressure medications
- Blood glucose testing supplies
- Generic and select brand asthma medications, including many inhalers

To learn about the several ways to qualify, and to see a full list of available medications/testing supplies, visit 365 Get Healthy Here at www.benefitssupportcenter.com

This program does not apply to the following groups under this Plan:

- Kaiser
- Alameda Grandfathered
- Duane Reade Union
- Medicare-eligible Retirees

Tobacco-Free Program

If you designate your status as a tobacco user during open enrollment, you can get help with quitting and remove your tobacco surcharge from the cost of your coverage by participating in the 365 Get Healthy Here Tobacco-Free Program through Vida Health. If the 365 Get Healthy Here Tobacco-Free Program is completed within 180 days of eligibility, surcharges are removed and refunded retroactively. If the 365 Get Healthy Here Tobacco-Free Program is not completed within 180 days of eligibility, no surcharges will be refunded and the surcharge remains in place until the following year, when the participant will have the opportunity to attest as tobacco-free during Open Enrollment.

Enroll and complete the program at Vida Health Once you're enrolled, you'll receive the option to receive two free nicotine replacement gum or patches to support your efforts to go tobacco-free—plus online support with a Vida health coach.

Important reminder about the tobacco surcharge: The online enrollment system defaults everyone to their prior year's s tobacco user status. If you and your spouse/domestic partner have had a change in tobacco user status since the prior year you will need to change this for yourself and your spouse/domestic partner when you enroll. The surcharge is:

- $750 per year for a team member or pre-Medicare eligible retiree who uses tobacco, PLUS
- $750 per year for a spouse/domestic partner of a team member or pre-Medicare eligible retiree who uses tobacco.
- $250 per year for a team member or pre-Medicare eligible retiree who uses tobacco on the Puerto Rico/USVI plan(s), PLUS
- $250 per year for a spouse/domestic partner of a team member or pre-Medicare eligible retiree who uses tobacco on the Puerto Rico/USVI plan(s).
  You'll also pay higher tobacco-user rates for your voluntary life insurance coverage and Critical Illness plan (if any).

Per Internal Revenue Service (IRS) regulation, the company may be required to treat 365 Get Healthy Here myWalgreens Cash rewards as a cash equivalent, which is taxable for the participant. It is required that all myWalgreens Cash rewards earned for participation in Walgreens team member benefits programs, such as 365 Get Healthy Here be reported to payroll and taxes be withheld. The tax amount is based on individual tax brackets. If this applies to you, you'll see an earnings code of IMP myWalgreens Cash rewards on your paycheck. You must be an active team member at the time of points being deposited to earn this program incentive. Please allow up to 24 hours for points to appear in your myWalgreens Cash rewards account.

Healthy Living Centers

On-site Healthy Living Centers are offered at certain locations. These Centers are staffed by physicians, pharmacists, nurse practitioners, and/or other medical professionals, and, depending on location may offer the following services to Walgreens and affiliated company team members, retirees, and eligible family members under this Plan:

Health Center

- Primary care visits.
- Urgent care visits.
- Physical exams.
- Immunizations.
- Lab services.
- Wellness coaching.
- Disease management.
- Physical therapy.
- Massage therapy.

Pharmacy

- Fill prescriptions (including 90-day fills).
- Health tests.
- Immunizations.
- Adherence.
- Medication therapy consultation.
- Travel consultation.

A fitness center may also be available at one or more of these locations, including a virtual membership option for those interested in both live and on demand group fitness classes, challenges, personal training and accountability sessions.

All prescriptions and other pharmacy services are handled through the Plan (or your other health plan), just as if you had received the prescription/services from a Walgreens retail pharmacy. For Healthy Living Center services:

- If you are a participant in this Plan, you may be responsible for a copay, and Walgreens pays the remainder of the cost – or you may be responsible for the full cost if enrolled in an HSA option.

- If you are covered under another health plan, the fees will be billed to you and your health plan. You should confirm with your health plan that the Healthy Living Center is an in-network provider; otherwise out-of-network costs may apply.

- If you are not covered by any health plan, you are responsible for the entire cost of the services. Fees are subject to established fee schedules discounted to the Walgreens usual and customary rates.

- Certain services, such as massage therapy, may not be covered as indicated above, such that you will be responsible for the full cost.

If you work at a location with a Healthy Living Center, additional information will be provided to you regarding the services, cost, providers, and scheduling appointments. For more information, go to www.walgreenshealthylivingcenter.com.

Special Disease Management/Prevention Programs

From time to time, special disease management and disease prevention programs may be offered under this Plan on a pilot or full basis to members who qualify based on the specific requirements that apply under the program. For example, programs may be offered to members diagnosed with (or at risk for) diabetes. Any such program will be documented and communicated, including eligibility requirements, program details and any special cost-sharing provisions.

Immunizations

From time to time, Walgreens may provide on a no-cost or subsidized-cost basis seasonal flu shots and other vaccinations (including the COVID-19 vaccine) to team members and family members. The administration and payment process for such vaccinations may vary depending on whether the team member has medical coverage under this Plan, another health plan, or not at all. To the extent the individual in question is not participating in medical coverage under this Plan, such vaccination shall be considered a benefit offered through an on-site clinic and thereby an excepted benefit under the Affordable Care Act. For this purpose, such clinics include the Healthy Living Centers, Walgreens stores and any other applicable Company facilities.

Coordination with Medicare

If you (or a covered dependent) become eligible for Medicare while still an active team member, the Plan will remain primary.

See your medical benefit coverage summary for information about how your prescription drug coverage and medical coverage coordinates with Medicare.

Your Dental Coverage

Regular dental care is important to your overall health. Dental coverage under the Plan is Fully Insured and offered through UnitedHealthcare. Your coverage helps to pay for dental care for you and your covered dependents.

To become a participant in the dental program, you must meet the same eligibility requirements as for medical coverage and you must enroll in coverage. You may also enroll your eligible dependents. Any required premiums will be deducted from your pay on a before-tax basis.

Detailed information about the dental coverage and the options available to you is included in the coverage summaries. These materials will provide any cost-sharing provisions, including copays, coinsurance, deductibles, and any applicable annual or lifetime maximums or other limits. In addition, they will explain what services are covered, such as exams, dental cleanings, fillings, and extractions. You may contact the Claims Administrator to confirm that your provider participates in its dental network before receiving benefits.

NOTE: For information on the benefits for which Puerto Rico team members are eligible, see the ***Eligibility*** section of this SPD.

What Dental Options Will Be Available?

Coverage is provided through a value dental Preferred Provider Organization ("PPO") and a premier dental PPO option. A Exclusive Network Dental Plan ("ENDP") option is offered in certain areas. You may enroll in dental coverage even if you do not elect medical benefits under the Plan.

If you enroll in one of the PPO options, you may use any licensed dentist or physician providing dental services for which he or she is licensed. However, if you receive dental services from a dentist who participates in the provider network, your share of the cost generally will be lower. You may choose a different participating dentist for each covered member of your family.

If you enroll in the ENDP, covered dental expenses are paid only when you receive benefits from a participating provider (in-network).

Overview of Options

When you enroll in coverage, the Benefits Support Center will show the various options available to you based on where you live. You will have access to each dental insurance company that offers benefits in your geographic area that match the designated plan design for each dental care option. Not all options will be available in all areas, so it's important to review your options and decide what coverage best meets the needs of you and your family.

Value PPO Option

The Value PPO option covers in- and out-of-network care but does not cover orthodontia expenses. You can receive care from any health care provider you choose, but benefits are paid at a higher level when care is received from network providers. If you or your dependents receive care from a provider who is not in the PPO option's network, benefits are paid at a lower level or may be limited entirely in some areas.

Preventive care is covered at 100%, and you pay the deductible plus a percentage of the cost—known as "coinsurance"—for other dental expenses. Also, if your expenses for out-of-network care are more than the Eligible Charge, as described in the applicable coverage summary or insurance policy, you will pay the excess amount.

Premier PPO Option

The Premier PPO option has the same basic coverage as the Value PPO, but it covers orthodontia, has a higher annual maximum and pays a greater percentage for major care.

Exclusive Network Dental Plan ("ENDPs")—

Depending on where you live, the ENDP option, if available, covers in-network care only. If you or your dependents receive care from a provider who is not in the ENDP option's network, services are not covered.

You must designate a primary care dentist to coordinate care in this option. Preventive care is generally covered at 100%, and there is no annual maximum or deductible. You'll pay coinsurance for minor care, major care, and orthodontia.

Continuation of Coverage Through COBRA

If your dental coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under COBRA. You and your covered dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section of this SPD for additional information.

Your Vision Coverage

You'll have two EyeMed vision plan options to choose from. The vision coverage under the Plan is Fully Insured and helps you pay for vision care expenses for you and your covered dependents.

Your vision coverage offers:

- Access to thousands of private-practice credentialed optometrists and ophthalmologists across the United States. Strict guidelines are used to credential all participating doctors.
- Protection for you and your family, including a thorough eye exam, which can detect and diagnose numerous medical problems.

Your coverage summaries provide additional information on how benefits are paid when you access in-network and out-of-network providers.

Detailed information about the vision coverage and the options available to you is included in the coverage summaries that are available at the Benefits Support Center. These materials will provide any cost-sharing provisions, including copays, coinsurance, deductibles, and any applicable annual or lifetime maximums or other limits. In addition, they will explain what services are covered, such as exams, eyeglass frames and lenses, and contact lenses. You may also contact the Claims Administrator to confirm that your provider participates in the vision network before receiving benefits.

NOTE: For information on the benefits for which Puerto Rico team members are eligible, see the ***Eligibility*** section of this SPD.

What Vision Options Will Be Available?

Two vision plans are offered through EyeMed— Value and Premier PPO plans. You may enroll in vision coverage even if you do not elect medical benefits under the Plan.

If you enroll in one of the PPO options, you may use any vision care provider. However, if you receive vision care from a provider who participates in the provider network, your share of the cost generally will be lower. You may choose a different participating provider for each covered member of your family.

Overview of Options

When you enroll in coverage, the Benefits Support Center will show the various options available to you.

Value Vision

The Value Vision Plan, a basic plan that includes coverage for eye exams, lenses and frames from in-network or out-of-network providers. The plan provides a discount and allowance for most covered services. Both the premium and discounts will be lower for the Value Vision Plan.

Premier Vision

The Premier Vision Plan also includes coverage for eye exams, lenses and frames from in-network and out-of-network providers. The plan provides a higher level of discounts- and allowances for most covered services than the Value Vision Plan provides. The premium is also higher for the Premier Vision Plan.

When you use out-of-network providers, the Plan pays an allowance of covered expenses to your provider, and you are responsible for the difference between what the Plan pays and what your provider charges. You may also be required to file claim forms for reimbursement. When you receive services from an out-of-network provider, request a copy of the itemized bill and send a copy to your Claims Administrator for reimbursement of covered expenses. Your claim must be submitted within the time frame specified by the Claims Administrator, generally six months from the date of service.

Continuation of Coverage Through COBRA

If your vision coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under COBRA. You and your covered dependents may continue coverage at your own expense for a specific length of time. See the ***Continuation Coverage Under COBRA*** section of this SPD for additional information.

Health Coverage for Team Members Temporarily Working Outside the United States

This section references the Plan coverage that is provided to you and your eligible dependents during periods of time that you are temporarily assigned to work within Walgreen Co. or an affiliated company outside of the United States. This means that your home country is the United States, but you are relocated to a foreign country on a temporary basis.

In this situation, your health care coverage is provided through Cigna Global Health Benefits. This includes medical and prescription drug, dental, and vision coverage for you and your eligible dependents, with international provider networks. Where applicable, information regarding these coverage options will be provided to you.

Your Flexible Spending Accounts ("FSA")

Flexible Spending Accounts allow you to pay out-of-pocket (unreimbursed) medical, prescription drug, dental, and vision expenses through the Healthcare Flexible Spending Account ("Healthcare FSA"), or dental and vision expenses only through the Limited Purpose FSA (if enrolled in an HSA), or dependent care expenses through the Dependent Care Flexible Spending Account ("Dependent Care FSA").

You contribute to the FSAs on a before-tax basis—before taxes are taken out of your pay. Since you do not pay federal income or Social Security ("FICA") taxes (and in most locations, state or local taxes) on your contributions to an FSA, your taxable income is lowered, and you pay less in taxes.

Your Spending Account™ ("YSA") assists in the administration of your Healthcare FSA, Limited Purpose FSA and Dependent Care FSA and applies the plan's provisions to process claims for reimbursement. You can access YSA through the Benefits Support Center.

When you enroll in an FSA, you determine the amount of money you want to deposit into the Healthcare FSA, Limited Purpose FSA or Dependent Care FSA or both of the accounts, up to the applicable annual limits described below, for the coverage period. Eligibility requirements for this plan are the same as the medical plan requirements listed in the ***Eligibility*** section.

Electing How Much to Contribute

To become a participant in either the Healthcare FSA, Limited Purpose FSA or Dependent Care FSA, you must meet all eligibility requirements and enroll in coverage. If you are a new team member, you must enroll within 31 days of your initial eligibility date or you cannot participate until the next Open Enrollment period, unless you have a qualified change in status or special enrollment period. To continue participation in any FSA in the next Plan Year, you must re-enroll each year during the Open Enrollment period.

When you enroll in an FSA, you decide how much you want to contribute to that account. The Claims Administrator will establish a Healthcare FSA, Limited Purpose FSA and/or Dependent Care FSA on your behalf that will be maintained for recordkeeping purposes only and will not be funded. Each account established for a period of coverage (the Plan Year) will be credited with the before-tax contributions you authorize to be deducted for that period.

Annual Limitation on Use of FSAs

The maximum annual amount that you may contribute to the Healthcare FSA or Limited Purpose FSA is $3,200 for 2024 and may change in future years. The maximum annual amount that you may contribute to the Dependent Care FSA is the lesser of $5,000 ($2,500 if you and your spouse file separate federal tax returns) or the Earned Income limitation described in Code Section 129(b). If you are considered a highly compensated employee (HCE) under IRS rules, your maximum contribution to the Dependent Care FSA for 2024 will be limited to $850. You fall into this category for the 2024 Plan Year if your W-2 earnings for 2023 are at least $150,000.

If the plan administrator receives indication of your HCE status prior to the end of the prior calendar year (2023), then it will be applied to the current year (2024). If your HCE status is received during the current year, then it will be applied the first of the next plan year (2025). The minimum amount you may contribute to either account for the Plan Year is $120.

If you experience a qualified change in status as described below, you may be able to change your FSA contribution elections midyear. If you make a midyear change to your elections, any change in contributions will also change the maximum reimbursement amount for the balance of the period of coverage, commencing with the election change.

Here's an annual tax savings example for someone who makes $50,000 per year and contributes $3,200 to the Healthcare FSA to help pay for his family's (spouse plus one child) health care costs.

	Using a Healthcare FSA	**Using After-Tax Dollars to Pay for Expenses**
Annual salary	$50,000	$50,000
Before-tax dollars used for expenses	$3,200	$0
Taxable income	$46,800	$50,000
30% estimated tax (federal, FICA and state)	$14,040	$15,000
Tax savings*	$960	—
Pay after taxes	$32,760	$35,000
After-tax dollars used for expenses	$0	$3,200
Annual take-home pay	$32,760	$31,800
Increased take-home pay	$960	—

*Based on estimated tax. Consult your tax advisor for advice specific to your tax circumstances.

How the Healthcare FSA Works

Your Healthcare FSA is equal to your total elected amount and available for reimbursement for eligible expenses starting as of your enrollment date if you're a new team member or as of January 1 if you enrolled during Open Enrollment. Furthermore:

- You will be issued a YSA "debit" card, which will have your annual election amount as an available balance. Before you use the card, call the toll-free number shown on the card to activate it and sign the back of your card.

- Do not use your card to pay for expenses incurred in prior plan years. You should only use your card for expenses that you incur during the new plan year.

- You can use your YSA card to pay for eligible health care expenses when you visit eligible providers and purchase eligible health care items or services. Using the YSA card for eligible health care expenses will save you from paying out of pocket and then seeking reimbursement. The YSA card has been designed for use at merchants and providers that primarily sell health care products (for example, pharmacies, physician's offices, hospitals,

and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to choose either "credit" or "debit." If you choose the debit option, you may be required to enter your four-digit Personal Identification Number ("PIN") that you selected when your YSA card was issued. If you select "credit," the transaction will require your signature.

- You should save your receipts, as you may be required to submit additional documentation later.

- While some YSA card claims are automatically validated when you use your card, federal regulations occasionally require us to confirm the expense is eligible for reimbursement. Remember to keep your receipts!

- You can also file claims to receive reimbursement (unless you use the YSA card to pay for eligible expenses at the time of service). See "Filing an FSA Claim" below for details. Once your claim has been processed, you'll receive notification regarding the status of your claim and whether any follow-up documentation is needed.

- Using either approach, you will receive tax-free reimbursement from the appropriate account for the incurred expense.

- An FSA is what is known as a "use it or lose it" arrangement, which means if you do not spend all of the money in your account, you lose the unspent balance. However, you may roll over a maximum of $640 at the end of the year. The $640 carryover does not impact the indexed maximum FSA contribution. In other words, you could roll over $640 and still contribute the indexed maximum for that year.

Eligible Healthcare FSA or Limited Purpose FSA Dependents

An eligible dependent is your spouse or your dependent child who satisfies the definition of an IRS tax dependent. Your domestic partner's expenses, and his or her child(ren)'s expenses, are not eligible for reimbursement, even if they otherwise satisfy the definition of IRS tax dependent, for purposes of the Healthcare FSA.

You also can use the account for your child's eligible expenses even if you are divorced or separated and have agreed to let your ex-spouse claim the child as a dependent for tax purposes.

Coordination with the Health Reimbursement Arrangement ("HRA") account (limited applicability)

The YSA card is used for both the Healthcare FSA and the HRA. When you pay for a covered expense, you'll automatically be reimbursed from the FSA first. After you've used your FSA balance for the year, reimbursements will be deducted from the remaining balance of your HRA account, if any. If you have an HSA, there is a separate card provided by Optum Bank.

How the Healthcare FSA, Limited Purpose FSA, and HSA Work in Tandem

Here's a comparison of how the accounts work:

	Healthcare FSA	HSA	Limited Purpose FSA
Do I need to be enrolled in a particular medical plan to participate?	No Medical plan coverage is not required. Medical plan options without an HSA allow you to also use an FSA that is not limited purpose.	Yes Certain medical plan options include an HSA	Yea Medical plan options with an HSA allow you to also use a Limited Purpose FSA.
Can I contribute to my account before taxes?	Yes	Yes	Yes
Does Walgreens contribute to my account?	No	No	No
Do unused dollars roll over from year to year?	Yes, up to $640 into the following year.	Yes	Yes, up to $640 into the following year.
Does the money in the account earn interest?	No	Yes	No
Can I use a debit card to pay for expenses?	Yes	Yes	Yes
Can I use the account to pay for vision or dental expenses?	Yes	Yes	Yes, dental and vision expenses only.
How much can I contribute to the account per year (2024 limits)?	$3,200	$4,150 (single) /$8,300 (family) Plus $1,000 if age 55 or older	$3,200

The full amount of your Healthcare FSA or Limited Purpose FSA contribution is available for you to use once coverage begins.

Qualified Change in Status

A qualified change in status is a specific change in circumstance that affects eligibility for participation in the FSAs. Changes must be due to, and consistent with, the qualifying event. See the ***Changing Your Coverage*** section of this SPD for more information.

Eligible Healthcare FSA Expenses

Eligible Healthcare FSA expenses are out-of-pocket "medical care expenses" (as defined in Code Section 213(d) and IRS Publication 502) for you and your eligible dependents that are not covered by another health care or insurance plan. Most, but not all, of the tax-deductible expenses are reimbursable through your Healthcare FSA.

Examples of expenses incurred during the Plan Year that are eligible for reimbursement include those listed below (Note: The Limited Purpose FSA only allows for the reimbursement of eligible dental and vision expenses).

- Copays, coinsurance, and deductibles for your medical, dental, and vision benefits.
- Prescription copays.
- Eligible over-the-counter medical supplies (itemized receipt required). Examples include:
  - Contact lens solution;
  - Insulin and other diabetic supplies;
  - First aid supplies;
  - Hearing aid batteries;
  - Heat wraps;
  - Pregnancy test kits;
  - COVID and other diagnostic test kits.
- Eligible over-the-counter items. Examples include:
  - Allergy medications;
  - Anti-itch medications;
  - Cold and flu remedies;

  - Diaper rash ointment;
  - First aid creams;
  - Lactose intolerance pills; and
  - Pain relievers.
- Acupuncture, chiropractic expenses, or physical therapy.
- Childbirth preparation classes.
- Diabetic supplies, respirators, and other medical supplies.
- Smoking-cessation programs.
- Mental health counseling and psychotherapy.
- Vision correction surgery.
- Orthodontics.
- Hearing aids.
- Feminine care products.

Ineligible FSA Expenses

Examples of expenses that are not eligible for reimbursement under the Healthcare FSA are:

- Expenses claimed as a deduction on your income tax return.
- Expenses reimbursed by other sources, such as insurance companies.
- Fees for fitness clubs where there is no specific medical reason for membership.
- Hair transplants.
- Insurance premiums.
- Weight-reduction programs for general well-being.
- Certain over-the-counter products such as:
  - Cosmetic expenses;
  - Insect repellants;

- Lip balms;
- Shampoo and soap;
- Toothpaste and toothbrushes;
- Teeth whitening products; and
- Wrinkle reducers.

To obtain a list of reimbursable expenses, contact the Claims Administrator or go to the Benefits Support Center. You may also refer to IRS Publication 502 for additional information. This publication can be obtained at **www.irs.gov/publications/p502**.

Eligible and Ineligible HSA Expenses

The expenses eligible for reimbursement from your HSA account mirrors the rules described above for your Healthcare FSA.

Payment of Eligible Healthcare FSA Expenses (including Limited Purpose FSA)

The maximum reimbursement you will receive for eligible Healthcare FSA expenses will be the lesser of:

- The amount of eligible expenses you submit for reimbursement; or
- The total annual amount you have elected to contribute to your FSA for the Plan Year.

The full amount of your annual FSA contribution election is available to you at any point in the Plan Year (less any reimbursements previously paid to you during the Plan Year) even if you have not made all of the contributions to your account at the time you incur the expense. Reimbursement payments will be payable directly to you unless you request that payment be made directly to a service provider. Your Healthcare FSA will be reduced by the amount of each reimbursement previously paid to you.

Limited Purpose Flexible Spending Account

If you enroll in both a medical plan with a Health Savings Account (HSA) and a Healthcare Flexible Spending Account (FSA), your FSA will automatically become a Limited Purpose FSA that can only be used for eligible dental and vision expenses. Limited Purpose FSA debit card transactions for medical or prescription drug expenses will be declined. You will not be reimbursed if you use a Limited Purpose FSA for medical or prescription drug expenses.

Note: If based on rules that apply to certain groups under the Plan, you have an HRA balance remaining available in 2023, and you elect an HDHP with a Health Savings Account ("HSA"), your HRA will become a Limited Purpose HRA that can only be used for eligible dental and vision expenses during the period you are enrolled in an HDHP with an HSA.

Eligible expenses may include:

- Eligible vision, and dental expenses that are not covered by insurance
- Dental and vision deductibles, copays, and coinsurance
- Contact lenses and glasses

For other qualified dental and vision expenses, refer to www.irs.gov/publications/.

Using Your Spending Account ("YSA") Card

Paying Expenses Using Your YSA Card

The YSA card allows you to pay for eligible expenses at the time that you incur the expense. When you enroll in an FSA, you'll receive a package containing one YSA card issued in your name, activation instructions, a Cardholder Agreement, Additional Disclosures, and information explaining approved use of the card. You may request additional cards at no additional cost for your spouse and/or eligible dependent(s) through the YSA website.

The YSA card remains active as long as your account is in good status, you continue to participate in an FSA, and you remain actively employed. Your card will be cancelled upon termination of employment—inactive participants may not use the YSA card, even during a COBRA continuation coverage period.

By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care or Limited Purpose expenses and those of your eligible dependents under the Plan.
- Incurred expenses were for health care or Limited Purpose services or supplies purchased on or after the date your FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

The YSA card can be used at providers that primarily sell health care products and services (for example, pharmacies, physicians' offices, hospitals, and dentists' offices). Each time you use the card at an approved merchant location for an eligible FSA expense, you'll be required to provide your signature or PIN. With each YSA card purchase, your available FSA balance is reduced by that amount. Other ineligible expenses, such as cosmetics or food items, must be paid for separately using another method of payment.

Note: Do not use your card to pay for expenses incurred in prior plan years. You should only use your card for expenses that you incur during the new plan year.

Validation of YSA Card Transactions

All YSA card transactions must be validated electronically at the point of sale or, as required, by submitting paper documentation afterward. This process involves requesting itemized receipts or other supporting documentation from you to verify that the card transaction is for an eligible health care expense. You should retain your itemized receipts for all transactions, as they may be required for validation purposes.

Receipts should be retained for one year following the close of the Plan Year in which the expense is incurred. You will receive a letter from the Claims Administrator when a third-party statement is needed.

Manual claim submission and supporting documentation are sometimes required for the purchase of any health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. The process for supporting documentation is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available FSA balance is reduced.
- You'll be sent a letter or email informing you that itemized receipts or other documentation are required to validate the YSA card transaction.
- If the documentation you provide is insufficient, you'll be sent a letter or email instructing you to provide more documentation.

Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See "Overpayment Process" below for more information.

You must provide the third-party statement to the Claims Administrator within 45 days (or such longer period provided by the Claims Administrator) of the request. In accordance with applicable guidance, there may be situations in which the Claims Administrator does not ask for substantiation related to a card swipe.

Automatic Validation with Approved Merchants

When you purchase eligible health care items by using your YSA card with approved merchants, your transaction can be validated automatically without having to provide an itemized receipt or supporting documentation. To be "approved," a merchant must have an inventory information approval system ("IIAS") installed. These IIAS-certified merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to allow only eligible items and services to be processed on the YSA card.

Any ineligible items must be paid for with another form of payment. For a complete listing of eligible expenses and approved merchants, visit the YSA website. Please note that the listing is subject to change at any time.

Overpayment Process

If you use your YSA card to purchase products or services that are ineligible for reimbursement through your Healthcare FSA or Limited Purpose FSA, you'll receive notification from YSA that your transaction has been deemed an overpayment.

The primary situations that could result in an overpayment are:

- You fail to respond to documentation requests for YSA card transactions after the initial request was sent by YSA.
- Your YSA card transactions were authorized at the point of sale, and then later deemed ineligible after the validation process was completed.
- Claim adjustments were made because of contribution amount changes, ineligible expenses, or improper processing of the claim.

You must pay back any improperly paid claims. YSA will allow you to resolve an overpayment on your account in several ways. You'll be given the option to:

- Resubmit your claim with additional information;
- Make a one-time payment transaction via the YSA website from your bank account;
- Submit a new claim to reduce the overpayment amount; or
- Repay your overpayment by mailing a check to the address provided.

Failure to pay back any improperly paid claims may result in Walgreens taxing you on the outstanding balance by applying an imputed income deduction amount against your paycheck.

In Case of Errors Relating to Your YSA Card

Call YSA at the number provided on the back of your card as soon as possible if you think a YSA card transaction is wrong, or if you need more information about a transaction listed in the statement or receipt. When you contact YSA, be prepared to:

- Provide your name, Social Security Number (when applicable), and YSA card number;
- Describe the error or the YSA card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information; and
- Provide the dollar amount of the suspected error. If you call YSA, you may be required to send your complaint or question in writing within 10 business days.

If you believe a charge on your YSA Card is incorrect, first attempt to resolve the problem directly with the merchant. Most cases can be solved directly with the provider. An attempt to resolve the dispute with the merchant must be made first before YSA can take action on your claim. If working with the merchant didn't resolve the transaction, you have no knowledge of who the merchant is, or you believe the transaction may be fraudulent then notify YSA. YSA must receive notification of any errors no later than 60 days from the service date of the transaction to dispute it by submitting a YSA Card Dispute Form. This form can be located on the Benefits Support Center website.

Once the YSA Card Dispute form is received, YSA will coordinate with the card issuer to determine whether an error occurred within 10 business days after it receives notification from you and will correct any error promptly. If more time is needed to correct the error, however, YSA may take up to 45 days to investigate your complaint or question. If this additional time is necessary, you may receive a phone call and an affidavit in the mail for you to sign and return. The address will be on the form. If you don't return the affidavit within 21 days, a second form will be mailed to you. Once the signed affidavit is received, YSA will credit the amount that you think is in error, so that you will have use of the total amount during the investigation. If YSA doesn't receive the signed affidavit YSA may not provide this credit. You will be mailed a letter advising you of the outcome of the case. The case will either be approved and the temporary credit equal to the fraudulent amount will remain in your account or the case will be denied, and the temporary credit will be reversed. The

Continuation of Healthcare FSA and Limited Purpose FSA Coverage Through COBRA

You may be able to continue your Healthcare FSA and Limited Purpose FSA under COBRA for the remainder of the Plan Year in which your participation terminates. Generally, the contributions you make for COBRA coverage for Healthcare FSA or Limited Purpose FSA benefits are made on an after-tax basis. See the ***Continuation Coverage Under COBRA*** section of this SPD for additional information.

How the Dependent Care FSA Works

For the Dependent Care FSA, you can request reimbursement up to the amount that has been deducted from each paycheck up to that point (less any previous reimbursements). Furthermore:

- Save your receipts, as you may be required to submit additional documentation later.
- File a claim to receive reimbursement. See "Filing an FSA Claim" below for details. Once your claim has been processed, you'll receive notification regarding the status of your claim and whether any follow-up documentation is needed.
- Receive tax-free reimbursement from the appropriate account for the incurred expense.

Eligible Dependent Care FSA Dependents

An eligible dependent for purposes of the Dependent Care FSA is:

- A qualifying child, under age 13.
- Your spouse or dependent of any age if he or she is physically or mentally incapable of caring for himself or herself and lives with you for more than one-half of the calendar year. In addition, he or she must be a U.S. citizen or resident.

If you are divorced or separated and are the:

- Custodial parent, your child is an eligible dependent even if you do not claim him or her as a dependent on your federal income tax return.
- Noncustodial parent, you generally cannot treat your child as an eligible dependent for Dependent Care FSA purposes, even if you claim him or her as a dependent on your federal income tax return. However, if the custodial parent signs an agreement, and the noncustodial parent attaches the agreement to his or her tax return, he or she may be able to treat the child as an eligible dependent. You should check with your tax advisor regarding the details of this procedure.

For this purpose, custodial parent means the parent that the child lives with for the greater part of the calendar year.

Dependent care expenses must meet all of the following requirements to be eligible for reimbursement:

- The expenses must be provided primarily for the well-being and protection of the dependent.
- The care provider must meet certain tax-identification requirements and comply with state and local laws.
- The care or service must be necessary for you to work or look for work and, if you are married, for your spouse to work, look for work, or attend school full time (unless your spouse is disabled).

Qualified Change in Status

A qualified change in status is a specific change in circumstance that affects eligibility for participation in the FSAs.

You can make **a change in the Dependent Care FSA only** due to a significant change in cost or coverage. For example, if you find a new childcare provider, you may make a change to your Dependent Care FSA to account for the change in cost of the new childcare provider. However, the new childcare provider cannot be your relative. Other life events (e.g., marriage, divorce,

birth or adoption of a child, etc.) may also result in allowable changes your Dependent Care FSA election, but only if they result in a significant change in your cost or coverage.

Eligible Dependent Care FSA Expenses

Eligible Dependent Care FSA expenses are those expenses you incur for services necessary for the care of your dependent—including child and/or elder day care services—for you to be gainfully employed, as long as:

- Such services are provided in your home; or
- If such services are provided outside your home, they are incurred either (a) for a qualifying child under age 13; or (b) for a qualifying dependent who regularly spends at least eight hours per day in your household.

If the services are provided outside your home, the facility providing care must comply with all state and local laws and regulations, including licensing requirements. Eligible Dependent Care FSA expenses do not include amounts you pay to your child who is under age 19, to your spouse, or to your former spouse.

Examples of expenses eligible for reimbursement through the Dependent Care FSA include:

- Before- and after-school care (if not included with tuition; i.e., other than tuition expenses).
- Late pick-up fees due to work schedule.
- Day care centers (including adult day care facilities).
- In-home day care providers.
- Wages or salary paid to a care provider—such as a neighbor or a home health aide, whether inside or outside your home.
- Nursery schools.
- Social Security ("FICA") and other wage taxes you pay on behalf of a care/service provider.
- Expenses for certain household services, such as a housekeeper, maid, or cook, provided those services are related to the care of an eligible dependent.
- Occasional babysitter—evenings and overnight—to allow you to work late or travel for work.
- Certain transportation costs provided by a care provider of an eligible dependent.

In addition, day camp may be an eligible expense, even if the camp specializes in a particular activity, such as computers or soccer.

Ineligible Dependent Care Expenses

Examples of expenses that are not eligible for reimbursement under the Dependent Care FSA are:

- Education expenses, including kindergarten or private school tuition fees.
- Entertainment.
- Expenses reimbursable under any other plan or program.
- Expenses applicable to the care of a child age 13 or over.
- Food and clothing.
- Full-time nursing home care.
- Health care expenses.
- Overnight camp.
- Payments related to care of an eligible dependent while you are home from work due to illness.

  Costs for dependent care when you—or your spouse—are not working.
- Payments to an individual you claim or who could be claimed as a dependent on your (or your spouse's) tax return.
- Payments to your child who is under age 19.
- For each calendar year, expenses incurred before your participation in the Dependent Care FSA begins or after your participation ends.
- Charges for services of a care provider who has no Social Security or taxpayer identification number, excluding churches and other tax-exempt organizations.
- Expenses incurred for an individual you cannot claim as a dependent for income tax purposes. An exception may apply if you are divorced or separated.

To obtain a list of covered expenses, contact the Claims Administrator or go to the Benefits Support Center. You may also refer to IRS Publication 503 for additional information. This publication can be obtained at **www.irs.gov/publications/p503**.

Payment of Eligible Dependent Care Expenses

You will be reimbursed for expenses you incur on behalf of a qualifying dependent, as defined under federal tax law, which generally includes your children under age 13 and a dependent who lives with you who is mentally or physically unable to care for himself or herself.

The maximum reimbursement you will receive for eligible Dependent Care FSA expenses at any point during a Plan Year will be the lesser of:

- The amount of allowable expense you submit for reimbursement; or
- The amount credited to your Dependent Care FSA at the time you incur the expense, less any reimbursements previously paid to you during the Plan Year.

No Dependent Care FSA reimbursement will be made for expenses incurred after the date on which you are no longer eligible to participate in the Plan.

Dependent Care FSA Annual Statement of Benefits

On or before January 31 of each calendar year, the Plan will provide you with a summary of all the dependent care benefits paid to you during the previous calendar year. This information is typically included on your Form W-2.

Dependent Care Tax Credit

The Dependent Care FSA is an alternative to taking a "tax credit" on your federal income tax return. You must choose whether to use the "tax credit" or the Dependent Care FSA. If you participate in the Dependent Care FSA, you are required to file an informational Schedule 2 or Form 2441 with your federal tax return to support the amount you contributed for the Plan Year and to notify the IRS of your use of the Dependent Care FSA. For more information about the childcare tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

Filing an FSA Claim

You have several choices as to how to be paid for eligible FSA claims. You can:

- Submit a claim via the Benefits Support Center;
- Submit a claim using the "Reimburse Me" Mobile App for Apple® and Android™ devices; or
- Use your YSA card (Healthcare FSA and Limited Purpose FSA only and described above).

Claims must be submitted by March 31 of the year following the year in which the claim was incurred. All claims must be submitted by that date. Claims submitted after that date will not be eligible for reimbursement and will be denied.

Any claims that are incomplete due to insufficient documentation will be denied, subject to applicable appeal rights.

See "ERISA Benefit Claims—Healthcare FSA and Limited Purpose FSA Only" under the Claims Procedure section for more information.

Submitting a Claim via the Benefits Support Center

When you incur an eligible health care or dependent care expense, you can submit a claim via the Benefits Support Center. Simply log on to the website and select the "Spending and Savings Accounts" tab to continue filing your claim. You may be asked to send in additional information to support your claim (e.g., a receipt or explanation of benefits ["EOB"]) that shows the following:

- The nature of the expense (i.e., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug.
- The date the expense was incurred or services were provided.
- Amount of the product or service.
- Who the service or product is for (i.e., self or dependent name).
- Service provider (i.e. name of the doctor or pharmacy).

For dependent care expenses, you are generally required to provide the taxpayer identification number of the dependent care service provider on your federal income tax return.

Reimbursement for expenses that are determined to be eligible expenses will be made as soon as possible after your claim is received and processed.

If the expense is determined not to be an eligible expense, you will receive notification of this determination. If you are denied a benefit, you may file an appeal as explained in the Claims Procedure section of this SPD.

Debit Card Claims

The YSA card is a fast way for you to pay for eligible health care expenses and avoid paying out of pocket.

Keep all of your itemized receipts after using your YSA card, because IRS rules require that every YSA card transaction be validated as an expense eligible for reimbursement under your plan.

YSA makes every effort to validate your expense as eligible and will notify you when a transaction requires a receipt or documentation. An outstanding balance occurs when you don't send a receipt to YSA by the due date to validate that your expense is eligible. March 31st is the

deadline to submit documentation for the prior plan year. Unresolved outstanding balances will be treated as taxable income if not resolved by March 31st.

Do not use your card to pay for expenses incurred in prior plan years. You should only use your card for expenses that you incur during the new plan.

Submitting a Claim Using the "Reimburse Me" Mobile App

The YSA Reimburse Me mobile app makes it easy for you to get current information about your FSA on your Apple or Android device. Follow the directions for adding the app to your Apple or Android phone. With the Reimburse Me app, you can submit claims, attach documents and receipts, check your account balances, and view the status of claims. Log on to by entering your company name, as well as the user ID and password you use to access YSA through the Benefits Support Center website. From the Accounts page, select "Submit Claim". Once you enter your YSA User ID and password, you'll be ready to submit claims or access your accounts anywhere. You may also wish to print a copy of the YSA Mobile App Participant Guide booklet for future reference at www.BenefitsSupportCenter.com.

Nondiscrimination Testing

Under the Code and related federal regulations, Flexible Spending Accounts are subject to nondiscrimination testing each year to ensure the Plan does not provide an unfair advantage to highly compensated employees. The Dependent Care FSA is also subject to an average benefits test.

Depending on the results of the annual tests, contributions of certain team members could possibly be reduced or returned. You will be notified if this impacts you.

Forfeitures

If you have not used all the funds credited to your Healthcare FSA, Limited Purpose FSA, or Dependent Care FSA as of the end of the Plan Year (and after processing all claims for the Plan Year), you will forfeit such funds and they will not be available to pay your future expenses, subject to the Healthcare FSA $640 maximum rollover noted above.

Termination of Participation

If your employment terminates, or if you otherwise cease to be an eligible participant for purposes of the Dependent Care FSA, your participation in the Dependent Care FSA will end on the last day of the month in which you terminate.

If your employment terminates, or if you otherwise cease to be an eligible participant for purposes of the Healthcare FSA or Limited Purpose FSA, your participation in the FSA will end on the last day of the month in which you terminate, unless you are eligible for COBRA continuation coverage for the Healthcare FSA or Limited Purpose FSA and you affirmatively make an election to continue your coverage.

Claims for you and your eligible dependents may be submitted after your termination of employment and up to the applicable claim submission deadline if the claims are incurred prior to the date your coverage terminates.

The Commuter Benefit Plan

The Walgreens Commuter Benefit Plan (the "plan") allows you to pay for eligible transportation expenses commuting to and from work. Deductions are taken from your paycheck before federal, Social Security, and in most cases, state taxes are computed, saving you money on your taxes.

Advantages to the plan are:

- Before-tax payroll deductions lower your taxable income, so you pay lower taxes overall.
- As a participant in the plan, you can set aside money for commuting expenses.
- For transit pass users, the passes can be conveniently sent to your home.
- Registered parking vendors may be paid automatically.

Eligibility

Eligibility requirements for this plan are the same as the requirements listed in the ***Medical Plan Eligibility*** section with the exception of team members working state or local jurisdictions that provide for more generous eligibility requirements, in which case those state/local eligibility requirements are applied.

Those Who Are Not Eligible

You are not eligible for coverage under this plan if you are:

- A team member working in Puerto Rico.
- A team member who is covered by a collective bargaining agreement that does not include benefits under this plan.
- A temporary or leased employee (including, but not limited to, those individuals defined in Code Section 414[n]).
- Any team member treated or classified in good faith as an independent contractor or as the employee of a person or entity other than Walgreens or an affiliated company under the terms of a contract or agreement, pursuant to your consent to such classification, or according to Company records.

How to Enroll

You can enroll in the plan at any time, as long as you continue to meet the eligibility requirements.

To enroll in the plan, place an order for a transit or parking pass by going to the Spending and Savings Accounts (YSA)tab at **www.benefitssupportcenter.com**. Under Reimbursement Accounts you will see Commuter Account.

By placing your first order, you are also agreeing to payroll deduction(s). You will be asked to specify if you want your elections to carry over automatically from month to month or you can initiate a new election each month – the deadline to place orders is the 3rd of the month proceeding the benefit month. For example, the deadline to order September benefits is midnight Eastern time on August 3rd. You can start, stop, or change your elections each month during this same timeframe. When you enroll, you'll make contributions one month before the date you'll need the funds.

If your initial eligibility occurs at the beginning of the month, there may be a possibility YSA will not receive indication of your eligibility until after the cut-off period (3rd of each month). If this occurs, please contact the Benefits Support Center at 1-855-564-6153 for assistance.

Eligible Expenses

Transit Pass Expenses

Transitpass expenses are costs incurred for a pass, token, fare card, voucher, or similar item (a "Pass") for transportation to and/or from work:

- On publicly or privately owned mass transit facilities; or
- Provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle that seats at least six adults (excluding the driver).
- Expenses for commuting to work by bus, light rail, regional rail, streetcar, trolley, subway, ferry, or vanpool are included.

Parking Expenses

Parking expenses are costs paid by you to park your car at, near your work location, or at a location from which you commute to work by mass transit facilities, or carpool.

How the Plan Works

The plan allows you to deduct money before taxes to pay for eligible transportation expenses. Once you have reached the monthly IRS limits for the before-tax deductions, you can continue to set aside money through after-tax payroll deductions for your transportation expenses.

You can participate in two ways:

1. Transit: You can purchase bus, train, subway, ferry, streetcar, and vanpool transit passes online through payroll deductions so you can commute to and from work.

2. Parking: You pay your parking provider for parking near or at your place of work or near a place from which you commute to work using mass transit. Reimbursement can be to you or payment can be made directly to your provider.

Here's how it works:

Determine Your Expenses

Decide how much you will need for transportation expenses so you can have that amount taken from each paycheck. For transit passes, allow the full value. For parking, estimate your monthly expense.

Before-Tax Payroll Deductions

Money for your transportation expenses is deducted from your paycheck before federal, Social Security, Medicare, and (in most cases) state taxes are withheld. You can set up an online, recurring deduction so that the payroll deductions are automatic. If your order exceeds the pretax monthly limit allowed by law, you will see both a pre-tax and after-tax deduction from your paycheck.

Pay Your Commuter Expenses

You pay for transit or parking expenses through payroll deductions.

Receive Pass or Reimbursement

Transit pass or reimbursement check (for parking) is mailed to you no later than the 23rd of the month for use the following month.

Deductions are taken after the first full pay period following the 3rd of the month. Your deductions will pre-fund your account and pay for your passes for the following benefit month. For example:

1. You place your order on August 1st.

2. The money is deducted in the first full pay period following August 3rd .

3. Payment is processed and passes are generated.

4. Passes are mailed to your home no later than August 23rdh to use in the benefit month of September.

You are responsible for checking the accuracy of your deductions on your paycheck. Once you agree to a payroll deduction, it cannot be changed for that period. However, changes may be made to your election for future time periods provided that the change is made before:

1. The expenses are deducted from your paycheck;

2. You receive the transit pass or parking transportation expense benefit; or

3. The month in which the pass or parking benefit applies. For example, you cannot change your payroll deduction in November for your November transit pass.

Changes to your elections will be effective the first pay period after the Payroll department has processed the change.

You are responsible for making sure that your home address is current and accurate. If you haven't received your product by the 1st of the month, notify Your Spending Account as soon as possible because you may be eligible for a reimbursement of your out-of-pocket cost to purchase an exact replacement pass. It's important that you notify YSA by the 3rd of the month to help you determine if you are eligible.

Go to People Central from wbaworldwide.wba.com/web/Walgreens or your work intranet to verify or update your home address and other personal information.

If you obtain a transit pass or parking voucher that is purchased directly through payroll deduction, your account will be debited directly for the cost. You should not submit a request for reimbursement.

How the Plan Can Save You Money

You pay for eligible transportation expenses with before-tax dollars through monthly payroll deductions. The use of before-tax dollars reduces your taxable income, and you save on your Social Security and income taxes.

The table below illustrates the savings:

	With Transportation Program	Without Transportation Program
Gross annual pay	$30,000	$30,000
Before-tax payroll deduction for transit	$1,200	$0
Taxable income	$28,800	$30,000
28% estimated tax (federal, FICA, and	$8,064	$8,400
After-tax parking payment	$0	$1,200
Take-home pay	$20,736	$20,400
Annual savings	$336	$0

Commuter Payment

You pay for commuter expenses by payroll deductions. You can purchase your pass each month or set up an automatic recurring transaction. If you select the recurring transaction, you can deselect any months you do not need a transit pass.

Parking Payment

You also pay for parking expenses by payroll deductions. You have two options:

- **Monthly Direct -** Set up direct payment to your parking provider for your recurring monthly parking expenses.
- **Commuter Check -** Check is payable to your parking provider and mailed to your home address for you to pay your parking provider.
- **Debit Card -** You will receive one card which will be funded each month with the amount you designate.

Filing a Claim

You have up to 180 days after incurring the parking expense, to file a claim. If you terminate employment, any money remaining in your account will be forfeited under IRS rules. You will be notified in writing if any request for reimbursement is denied. If your claim is denied in whole or in part, YSA will notify you in writing within 90 days of the date they received your claim.

If you purchase your transit pass or parking voucher directly from Edenred via **www.benefitssupportcenter.com**, you do not need to file a claim. Your account is automatically debited for the cost.

Maximum Qualified Benefit Allowed

Federal tax law limits the amount you can contribute on a before-tax basis to the transit and parking accounts. You cannot exceed the maximum amounts listed below.

For 2024, the maximum benefit amounts are:

- **Parking Expenses:** $315/month.
- **TransitPasses:** $315/month. These amounts may change annually.

NOTE: You can continue to set aside money through after-tax payroll deductions once you have reached these limits. The maximum before and after tax is $2000/month.

Overestimated Expenses

Under a reimbursement option, if your reimbursement request was for less than your current account balance, the unused amounts in your account will roll over and be available for future reimbursements as long as you actively participate in the plan. You may need to adjust the election for the next coverage period in order to use up your surplus account balance. For example, if your monthly parking election (and anticipated monthly expense) is $100, but you only incur $75 worth of eligible parking expenses, you might want to change your future election to $50 for the next benefit month so that your account balance will be $75 (with the $25 surplus from the previous month). You can then increase your election back to $100 after you have used up the surplus.

Underestimated Expenses

You cannot be reimbursed for any expenses above your available credits to your account. You may not be reimbursed for any expenses incurred before your payroll deduction agreement becomes effective. In other words, you may only be reimbursed for either the lesser of the total credits in your account or the IRS monthly maximum as stated above while you are a participant. If your out-of-pocket expenses are more than that, you cannot be reimbursed for those on a before-tax basis.

Walgreens also complies with any applicable state and local commuter or transportation benefit requirements that provide for eligibility and/or benefits that are more expansive than described above. If applicable, those are communicated to eligible team members.

Employee Assistance Program (EAP)

Life can get complicated at times, affecting your work, health, family, and emotions. Thinking "I can handle it myself" can add to the pressures you may feel. Walgreens helps to assist you through tough times by providing no-cost counseling services (in-person, telephonically or by video/online) to eligible team members and their families as well as work/life resources available online.

Walgreens will not have access to the confidential issues discussed with your EAP counselor by you or your family member(s).

You are automatically enrolled in the Employee Assistance Program (the "program") if you meet the eligibility requirements.

See the Benefits Support Center website for additional information and resources on the program and as a place to ask questions.

Eligibility

To be eligible for the program, you must be an actively employed team member of Walgreens or an affiliated company or a team member's eligible dependent or family member living in the same household. Dependent full-time students not living in your household are also eligible.

Team members covered by a collective bargaining agreement will be subject to the terms of such agreement and may or may not be eligible for this program.

Dependents covered by the program include:

- Your spouse, unless legally separated;
- Your domestic partner;
- Your unmarried children, including:
  - Adopted children;
  - Children placed for adoption if you are legally required to provide support until the adoption is finalized;
  - Stepchildren; and
  - Children of your domestic partner.

Parents and grandchildren are not considered eligible dependents, unless they reside in your household.

Once you are divorced, or your domestic partnership ends, your former spouse/domestic partner is not eligible for coverage under the program.

Loss of Eligibility

Coverage under the program ends when you terminate employment with the Company. For more information on situations that may cause you or your dependents to lose coverage, see "When Coverage Ends" and "When Benefits End" below.

Benefits

To receive benefits under the program, you or your dependents should follow these steps:

1. **Call the EAP Claims Administrator**

   Call the program at **1-855-777-0078** any time, 24 hours a day, seven days per week, or go online to www.walgreenslife365.com, group code: life365. Hearing-impaired individuals may call for a TTY line at 1-866-228-2809. For phone numbers outside the United States call at 1-855-777-0078.

2. **Explain Your Needs and Concerns**

   When you call, you'll speak to a counselor. Explain any issues you have, along with your needs and concerns. Depending on your situation, the coordinator will schedule an appointment for you to talk to an experienced EAP counselor over the phone. You may also be referred to another resource or online service.

3. **Talk to a Counselor**

   Your counselor can work with you to develop a solution-focused plan of action. All counselors are trained to help you or your family members with a variety of personal issues including:

   - Relationships;
   - Bereavement;
   - Major life changes;
   - Eating disorders;
   - Drug and alcohol abuse;
   - Physical or emotional abuse;
   - Marital and family conflicts;

- Career transition;
- Child or elder care;
- Anxiety and stress; and
- Depression.

Session Maximums

The program provides you and your eligible family members with unlimited telephonic counseling or up to a maximum of five face-to-face sessions with your counselor for each issue. If you and your counselor decide that you need more than five sessions, or need to speak with another specialist, you'll be referred to another source.

The program will work with you to find the best counselor or service to support your personal needs, taking into account your location, available hours, and insurance coverage. Sessions must be authorized by a program representative, or your care may not be covered.

If you use all five face-to-face sessions, you may call the program again if a different (unrelated) issue arises or utilize behavioral health services through your medical plan.

Coordination with the Medical Plan

If you and your EAP counselor agree that you need additional care beyond the first five visits covered under this program, you may receive benefits under your Walgreens medical coverage or other medical coverage. EAP can assist you in arranging your continued treatment with your health carrier and provider.

When Benefits End

In the event you lose eligibility for coverage under this program because you terminate employment from Walgreens, benefits end when your employment ends. COBRA coverage for EAP will automatically begin on your termination date and will continue for up to 18 months at no cost to you.

In addition, benefits for your dependents will continue under this program for up to 36 months if your dependent loses eligibility for coverage due to any of the following reasons:

- Divorce, legal separation, or termination of a domestic partnership.
- Your death.

Also, if you or a covered dependent is determined to be disabled under Social Security at the time coverage ends due to termination of employment, or within 60 days of the end of coverage, benefits under this program will continue for the disabled person for up to an additional 11 months (total of 29 months).

Benefits under this program usually end after the 18-month COBRA period. However, coverage and benefits under this program will end earlier if Walgreen Co. no longer offers EAP coverage to its team members.

When Coverage Ends

Your coverage ends when:

- Your employment with Walgreens or an affiliated company ends.
- Your employment end date is your last day worked or, if later, the last day for which you receive vacation or other final pay.
- You otherwise no longer meet the eligibility requirements.
- For military leave terms, please refer to the Military Leave Policy.
- The Company no longer offers the EAP.
- You die.

In general, coverage for your dependents ends when your coverage ends, or on the date any of the following situations occur:

- Your dependent no longer meets the eligibility requirements.
- The Company no longer offers dependent coverage under the program.

When Health Coverage Ends

Health coverage for you and your covered dependents ends if:

- Your employment with Walgreens or an affiliated participating employer ends (unless you are eligible for coverage as a retiree). Your coverage would end on the last day of the last month in which you work. For example, if your last day of work is May 15, your coverage would end on May 31.

- You no longer meet the eligibility requirements under the Hourly Eligibility/Employer Mandate rules if applicable to you (see Hourly Eligibility/Employer Mandate rules described in the ***Eligibility*** section of this SPD). Note that if you are otherwise ineligible under the Plan but were offered medical coverage solely on the basis of your "full-time employee" status under the Affordable Care Act and not the Plan's general eligibility rules, your coverage will terminate on the last day of the Stability Period for which you were determined to be a "full-time employee" under the Affordable Care Act during a preceding Measurement Period (as determined by the Company in accordance with Treas. Reg. § 54.4980H-3).

- You fail to make the required contributions (except that you will be provided a 30-day notice and cure period before coverage terminates). The Plan is discontinued or otherwise altered in a way that results in your loss of eligibility.

- You go on a personal leave of absence, and:

    - **You are <u>not</u> a salaried team member or otherwise considered a "full-time employee" under the employer mandate**: Coverage will end on the last day of the Stability Period during which your leave begins (i.e., if your leave starts March 15, your coverage will end on June 30 unless premiums are not paid timely before that date). However, if you are credited with sufficient hours worked during the Measurement Period in which your leave begins, then coverage would continue to the end of the <u>next</u> Stability period (after the Stability period in which you started your Personal LOA (i.e., if your leave starts March 15, your coverage would end December 31 if you are credited with sufficient hours worked during that Measurement Period, and pay all premiums timely). You may contact the Benefits Support Center at 1-855-564-6153 for information on when coverage will end.

    - **You are a salaried team member or otherwise considered a "full-time employee" under the employer mandate:** Coverage will end on the last day of the next Stability Period after the Stability Period in which your leave begins (i.e., if your leave starts March 15, your coverage will end December 31, unless premiums are not paid timely before that date).

- You are on a Company-approved leave that lasts beyond 12 months - coverage will end on the last day of the month of the 12-month anniversary of your approved leave (i.e., if your leave starts March 16, 2023, your coverage will end on March 31, 2024 unless premiums are not paid timely before that date).

- You enter the armed forces of any country on a full-time basis; as explained below you may have rights to continue coverage at the active team member premium rate for the greater of the period of time applicable under USERRA or Walgreens Military Leave Policy.

- You submit a fraudulent claim for benefits under this Plan or if fraudulent information is submitted on an enrollment application when you enroll yourself or an ineligible spouse/domestic partner or dependent in the Plan. You and your dependents may be irrevocably and retroactively denied enrollment and coverage in the Plan. If you submit a fraudulent claim, you also put your continued employment at risk. Plan records are subject to audit.

- You die.

NOTE: See "Leaves of Absence" in the ***Continuing Coverage*** section of this SPD for more information.)

Coverage for your dependents will end:

- If your own coverage is terminated (for reasons other than your death).

- If you fail to make the required contributions for your dependents' coverage.

- If dependent coverage under the Plan is discontinued or otherwise altered in a way that results in loss of eligibility.

- If your covered dependents cease to qualify according to the definition of a "dependent." See the Eligibility section of this SPD for details.

- If you are a covered retiree, coverage for your dependent children ends when both you and your covered spouse/domestic partner become eligible for Medicare.

- Your spouse's/domestic partner's coverage ends when you divorce or become legally separated or when your domestic partnership ends.

- If you submit a fraudulent claim for benefits under this Plan or if fraudulent information is submitted on an enrollment application in order to enroll yourself or an ineligible spouse/domestic partner or dependent in the Plan, you and your spouse/domestic partner and dependents may be irrevocably and retroactively denied enrollment and coverage in the Plan. If you submit a fraudulent claim, it also puts your continued employment at risk. Plan records are subject to audit.

  Coverage for a dependent will terminate on the same date as your coverage terminates, except when a dependent ceases to be an eligible dependent. In circumstances where a dependent ceases to be an eligible dependent, the dependent's coverage will terminate on the date he/she ceases to be an eligible dependent.

Retiree Health Plan Coverage

You may be eligible for retiree health plan coverage if you meet certain requirements at the time of retirement. (See the ***Retiree Health Plan Coverage*** section of this SPD.)

Continuation of Coverage Through COBRA

You may be able to elect COBRA continuation coverage for medical, dental, and vision coverage. If eligible, you will receive the COBRA continuation notice and additional information from the Benefits Support Center. (See the ***Continuation Coverage Under COBRA*** section of this SPD.)

Coordination of Benefits

See the coverage summaries for information on coordination of benefits.

Retiree Health Coverage

Subsidized Retiree Health and Life Insurance Coverage

You must meet the following requirements to be eligible for premium-subsidized retiree health coverage (and $5,000 of retiree life insurance coverage until age 65):

- Have a Company start date of December 31, 2001 or earlier;
- At a time when you are enrolled in medical and prescription drug coverage under this Plan, (1) retire in good standing with the Company or (2) cease to be eligible for active medical and prescription coverage under this Plan while remaining employed by the Company.
- At the time of such retirement or cessation of eligibility for active coverage:
    - Have at least 25 years of continuous service; and
    - Be at least age 55.

In addition to the above, you must also meet all of the following to be eligible for premium-subsidized retiree health coverage:

- As of January 1, 2010, be at least age 40 or your age plus years of service equal 50 or more (only full years of age and service are counted); as of May 31, 2017, be at least age 50 with 20 or more years of service; **and** as of March 31, 2019, be at least age 64 with at least 24 years of service.

Among other requirements, this means if you were under age 64 or had less than 24 years of service on March 31, 2019, you are **not** eligible for premium-subsidized retiree health coverage. Premium-subsidized retiree health coverage and retiree life insurance coverage ended as of December 31, 2019, for any retiree health participants who did not meet these age and/or service thresholds as of March 31, 2019.

However, the following applies as communicated to eligible individuals at the end of September 2019: Retirees who (1) meet all of the above requirements except the 64/24 cut-off in the paragraph immediately above, and (2) are eligible for and enrolled in premium-subsidized retiree health coverage as of the end of 2019 (i.e., for at least December 2019)* are eligible for HRA-subsidized pre-Medicare eligible retiree health coverage beginning in 2020. Such coverage is the same as applies to retirees eligible for premium-subsidized coverage, except that no premium subsidy applies, and instead the Company provides a health reimbursement arrangement (HRA) credit each year for the retiree and eligible family members, subject to enrolling in the pre-Medicare eligible coverage each year. The terms and conditions of this HRA are as follows:

- Walgreens will automatically fund an HRA for your use to pay for eligible healthcare expenses, including retiree medical plan premiums. You cannot contribute additional dollars, per IRS rules.

- Funds in your account may be used to pay for IRS-approved health care expenses. Any unused funds remaining in your HRA account at the end of the year automatically roll over to the following year and can be used for future eligible expenses.

- Funds are deposited by February each calendar year. You cannot use the funds until they are in your account.

- The amount Walgreens contributes depends on whether you have individual coverage, or you cover yourself plus one or more eligible family members. The amount of the annual HRA credit is subject to change from year to year and is communicated to eligible retirees in enrollment materials.

- Retiree premiums may be reimbursed from this HRA (because paid after tax).

- The amount of the annual HRA credit will be adjusted to the number of months that a participating retiree is enrolled in pre-Medicare eligible retiree health coverage. For example, if a participating retiree turns age 65 in July, the retiree would receive half of the annual HRA allocation.

- If a participating retiree ceases to participate in the pre-Medicare eligible retiree health coverage (including the scenario where such individual resumes active employment and becomes eligible for and enrolled in active employee medical coverage under the Plan), the HRA shall be discontinued at that time – subject to reimbursement of eligible expenses incurred prior to that time through the applicable claims filing deadline (i.e. June 30th of the following plan year), at which time any unused HRA balance is forfeited, and subject to resumption of HRA participation and credits if and when the retiree subsequently resumes participation in pre-Medicare eligible retiree health coverage.

    * For purposes of satisfying this end of 2019 enrollment requirement, any Plan restrictions on mid-year enrollment that would otherwise apply were lifted.

NOTE: Employment service with a company that joins Walgreens or an affiliated company via acquisition does not count for purposes of subsidized retiree health eligibility, regardless of the team member's original hire date with the acquired company, and regardless of whether such prior service is credited for other purposes.

Coverage Details

EPO Network Options—Pre-Medicare Eligible Retiree Options

The EPO network options offer access to physicians, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You must receive care from

network providers. If you or your dependents receive care from a provider who is not in the EPO network, benefits will not be paid unless due to a medical emergency.

The pre-Medicare eligible retiree medical options also include an annual deductible that must be satisfied before the option pays benefits for covered services. After you meet the annual deductible, you pay a portion of the cost – known as "coinsurance" or "copay". All out-of-network care will not be reimbursed unless due to a medical emergency. See ***Emergency Room Coverage*** section of this SPD for more details on out-of-network coverage.

If you meet the above conditions for premium or HRA-subsidized retiree coverage and want to continue health care coverage as a retiree, please note:

- **If both you and your covered spouse/domestic partner are not Medicare-eligible**, you and your eligible spouse/domestic partner and dependents may enroll in one of the medical/Rx, dental, and vision coverage options described in this SPD (subject to any variation in coverage that applies to retirees). If you opt out of coverage, you will have the opportunity to enroll in coverage during the next enrollment cycle.

  If you and your covered spouse/domestic partner are both Medicare-eligible, you will not be eligible for subsidized retiree medical/Rx, dental or vision coverage, and you and your eligible spouse/domestic partner may enroll in a Medicare plan with Alight's assistance through Alight Retiree Health Solutions. For questions about Alight Retiree Health Solutions, contact 1-844-779-9563.

- **If you have Medicare-eligible and non-Medicare-eligible family members** ("split family"):

  - Non-Medicare-eligible family members and dependents may enroll in one of the medical/Rx coverage options described in this SPD, as explained above.

  - Medicare-eligible family members may enroll in a Medicare plan with Alight's assistance through Alight Retiree Health Solutions, as described above.

Medicare-Eligible Retiree HRA.

Medicare-eligible retirees and their spouses/domestic partners who meet the premium-subsidized coverage requirements listed above and participate in Alight Retiree Health Solutions as described above will be eligible for a Health Reimbursement Arrangement (HRA) funded by Walgreens to help pay for the cost of medical coverage and other eligible healthcare expenses. This Medicare-Eligible Retiree HRA is separate from the other HRAs noted in this SPD (including the HRA noted above that applies to certain pre-Medicare eligible retirees). Information about this Medicare-Eligible Retiree HRA is communicated to you in a Medicare Eligible Retiree Guide and other communication materials provided to you upon becoming eligible for the Medicare-eligible retiree health plan. *Retirees eligible for HRA-subsidized pre-Medicare eligible coverage, as described above, are eligible only for a one-time annual credit to this Medicare-Eligible Retiree HRA (i.e., through age 66 for those who become Medicare-*

eligible at age 65), as communicated to eligible individuals at the end of September 2019. This HRA can continue to be used for reimbursement of eligible expenses until the end of the calendar year in which the two-year anniversary of the HRA funding end date occurs. The primary terms and conditions of this HRA are as follows:

- Walgreens will automatically fund an HRA for your use to pay for eligible healthcare expenses, including retiree medical plan premiums. You cannot contribute additional dollars, per IRS rules.
- Funds in your account may be used to pay for IRS-approved health care expenses. Any unused funds remaining in your HRA account at the end of the year automatically roll over to the following year and can be used for future eligible expenses.
- Funds are deposited by February each calendar year. You cannot use the funds until they are in your account.
- The amount Walgreens contributes depends on whether you have individual coverage, or you cover yourself plus spouse/domestic partner. The amount of the annual HRA credit is subject to change from year to year and is communicated to eligible retirees in enrollment materials.
- Retiree premiums may be reimbursed from this HRA (because paid after tax).
- If a participating retiree ceases to participate in Medicare eligible retiree health coverage through Alight Retiree Health Solutions, the HRA shall be discontinued at that time – subject to reimbursement of eligible expenses incurred prior to that time through the applicable claims filing deadline (i.e. June 30th of the following plan year), at which time any unused HRA balance is forfeited, and subject to resumption of HRA participation and credits if and when the retiree subsequently resumes participation in Medicare-eligible retiree health coverage through Alight Retiree Health Solutions.

NOTE: ***In order for the retiree's spouse or domestic partner to participate in the applicable coverage described above, the retiree must participate in whatever coverage is applicable to the retiree.***

Unsubsidized Retiree Health Plan Coverage

If you don't satisfy the subsidized retiree health coverage requirements and you are age 55 or older upon retirement, you and your eligible family members are eligible for unsubsidized retiree health coverage until you become Medicare eligible. This means that you will pay the full cost of the coverage to access the retiree health coverage. This unsubsidized retiree coverage may mirror the subsidized coverage or be provided via a separate offering.

NOTE: From a coordination of benefits standpoint, Medicare will be primary for anyone who is Medicare-eligible.

COBRA Coverage Alternative. Retirees and their family members who are eligible for retiree health care coverage are also eligible to choose COBRA coverage as an alternative. Retirees and their family members cannot have both retiree health care coverage and COBRA coverage at the same time. Therefore, any enrollment in retiree health care coverage will be an effective waiver by you (and any eligible family members on their behalf) of any rights under COBRA. See the ***Continuation Coverage Under COBRA*** section of this SPD for more details about COBRA coverage.

Retiree Health Plan Coverage – Puerto Rico

In Puerto Rico, active team members will receive $5,000 in life insurance coverage and subsidized pre-Medicare eligible retiree medical and prescription drug coverage if, after reaching age 55 with at least 25 years of service, they retire in good standing or otherwise cease to be eligible for active medical and prescription coverage under this Plan, and immediately prior to such retirement or eligibility change, they are enrolled in such coverage. In addition, these team members must have been hired before January 1, 1987.

Eligible Post-Medicare eligible Puerto Rico retirees receive a company subsidy and are enrolled in a Medicare supplemental plan through Triple -S.

The 2019 eligibility changes described above (i.e., must be at least age 64 with at least 24 years of service) and corresponding pre-Medicare eligible HRA subsidy described above for those in the U.S. Mainland also apply to Puerto Rico employees and retirees, as applicable.

Continuing Coverage

In certain situations, coverage may continue for you and your dependents when you are not at work, as long as you continue to pay any required premiums. Your payments will be made on an after-tax basis through direct-billing unless you are receiving your pay while you are on a paid leave from work, in which case your premium payments will continue to be deducted on a before-tax basis to the extent applicable. You will receive information from the Benefits Support Center describing the options available for paying your share of costs if you are taking an unpaid leave of absence, including personal, military or FMLA leave, or will be absent from work for an extended period of time. See your Disability SPD for further details.

Leaves of Absence

If You Are on a Company-Approved Disability Leave

You may continue coverage under the Plan for up to 12 months. While you are receiving disability pay, your premium will be deducted from your check. If you remain on an approved disability leave after all your Walgreens disability benefits are exhausted, your medical, dental and vision premiums will go into arrears, and will be deducted from your paycheck retroactively when you return to work or are otherwise subject to repayment if you do not return to work.

If your disability lasts 12 months (both paid and unpaid), your health care coverage will end. ***See the Continuation Coverage Under COBRA*** section of this SPD for information on how to continue your coverage for these benefits.

If You Are on an Unpaid Leave That Qualifies as a Family Medical Leave (under the rules of the Family and Medical Leave Act of 1993)

Your Plan coverage will continue during the leave. For an unpaid Family Leave you will continue to be responsible for the active employee premiums, which will be deducted from your

paycheck retroactively when you return to work. If you fail to return to work when your leave expires for reasons other than the continuation or recurrence of a serious health condition of you or your family member, as applicable, you may be required to pay both the employee and the employer portion of health insurance premiums incurred during your leave. See "Family and Medical Leave Act of 1993" below for more information.

If You or a Covered Dependent Are Hospitalized When Coverage Ends

Expenses for the balance of that confinement will be considered for payment.

Family and Medical Leave Act of 1993 ("FMLA" or "Act")

Health care coverage remains in effect while you are on FMLA leave. The FMLA, as amended, allows eligible team members to take leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care.
- You are needed to care for a family member (child, spouse, or parent) with a serious health condition, which includes a mental health condition.
- Your own serious health condition, including a mental health condition, makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that the team member's spouse, child, or parent is a covered member in the U.S. Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the U.S. Armed Forces with a serious injury or illness.

Uniformed Services Employment and Reemployment Rights Act ("USERRA")

Under USERRA, if you're absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you may elect to continue health care coverage for yourself and your eligible dependents under the provisions of USERRA and under Walgreens Military Leave Policy, which currently provides for continued medical and dental coverage at active-employee premiums during military leave. Contact the Benefits Support Center for more information on continuing your coverage under USERRA and Walgreens Military Leave Policy.

State Family and Medical Leave Laws

Walgreens must comply with any state law that provides greater family or medical leave benefits than those provided under the federal FMLA. If your leave qualifies under both the federal FMLA and under a state law, you will receive the greater benefit.

Contact the Benefits Support Center for additional information about leaves of absence.

Administrative Information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise. See the ***Your Rights Under ERISA*** section of this SPD for more information.

Plan Numbers and Employer Identification Numbers

The Employer Identification Number ("EIN") for the Plan is: 36-1924025

The Plan Number is: 501

Plan Documents

The governing instruments for the Plan consist of:

- The official Plan documents, if any.
- This SPD, including coverage summaries provided by insurance carriers, Claims Administrators and Walgreens.
- Applicable Summaries of Material Modifications ("SMMs") and other general communications identified as being part of the Plan.

Additional Plan Information

Plan Sponsor/Employer	Walgreen Co. 104 Wilmot Road Deerfield, IL 60015-5223
Plan Administrator	Walgreens Health & Welfare Committee* 104 Wilmot Road, MS 122H Deerfield, IL 60015-5143 The Plan Administrator has delegated certain day-to-day plan administrative functions to: Benefits Support Center DEPT 01040 P.O. Box 64116 The Woodlands TX 77387-4116 1-855-564-6153 * This Committee serves as the Plan Administrator for purposes of handling claims and appeals and other ministerial

	matters. All other Plan Administrator fiduciary functions are handled by the Plan Sponsor.
Enrollment and Eligibility Issues	**Enrollment and eligibility claims and appeals:** Benefits Support Center Claims and Appeals Management DEPT 01040 P.O. Box 64116 The Woodlands TX 77387-4116 Benefits Support Center 1-855-564-6153
Insurers/Claim Administrators	**Benefit claims and appeals:** **Medical/Prescription Drug** Blue Cross Blue Shield of Illinois Appeals P.O. Box 2401 Chicago, IL 60690 P: 1-800-458-6024 F: 1-888-235-2936 Blue Cross Blue Shield of Illinois Claim Review P.O. Box 805107 Chicago, IL 60680-4112 Dean /Prevea360 P.O. Box 56099 Madison, WI 53705 DHP.G.ATeam@deancare.com P: 800-649-0258 F: 608-252-0812 www.aon.deanhealthplan.com 1-877-232-9375 ELAN PO Box 2920 Clinton IA 52733 elanclaimteam@hlthben.comHMSA Hawaii Hawaii Medical Service Association P.O. Box 1958 Honolulu, HI 96805-1958 Phone: 1 808 948 6372 (from Oahu); 1 800 776 4672 (from Neighbor Islands)

	Kaiser Permanente (California) Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 12923 Oakland, CA 94604 Phone: 1-800-464-4000 Kaiser Permanente (Colorado) Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 Phone: 1-888-370-9858 or 1-303-338-3800 Fax: 1-866-466-4042 Kaiser Permanente (Georgia) Appeals Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736 Phone: 1-404-364-4862 Kaiser Permanente (Hawaii) National Claims Administration (NCA) HMO P.O. Box 378021, Denver CO 80237 Phone: 866-868-7220 Kaiser Permanente (Mid-Atlantic States) Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 Phone: 1-301-468-6000 Fax: 1-301-816-6192 Kaiser Permanente (Northwest) Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Phone: 1-503-813-2000 Fax: 1-503-813-3985 Kaiser Permanente (Washington) Kaiser Foundation Health Plan of Washington Options, Inc. P.O. Box 34593 Seattle, WA 98124-1593 Phone: 1-866-458-5479

	Fax: 1-206-901-7340 MCS (Puerto Rico) P.O. Box 9024200 San Juan Puerto Rico 00902-4200 1-888-758-1616; Rx 1-877-665-6609 www.mcs.com.pr Triple-S (Puerto Rico) Triple-S Salud, Inc. P.O. Box 363628 San Juan, Puerto Rico 00936-3628 1-787-749-4949 UnitedHealthcare (National) UnitedHealthcare Appeals P.O. Box 30573 Salt Lake City, UT 84130 UnitedHealthcare (National) UnitedHealthcare Claims P.O. Box 740800 Atlanta, GA 30374 Optum Rx Phone: 1-855-376-3214 **Health Savings Account (HSA)** Optum Bank www.optumbank.com 1-866-234-8913 **Dental** UnitedHealthcare Dental Attn: Claims Unit P.O. Box 30567 Salt Lake City, UT 84130 Phone: 1-866-660-7181 **Vision** FAA/EyeMed Vision Care Attn: Quality Assurance Dept. 4000 Luxottica Place

	Mason, OH 45040 F: 1-513-492-3259 **Flexible Spending Accounts and Health Reimbursement Arrangements (HRA)** Your Spending Account PO Box 64012 The Woodlands TX 77387-4012 Benefits Support Center Phone: 1-855-564-6153 Fax: 1-847-554-1869 **Employee Assistance Program** Curalinc www.walgreenslife365.com, Group code: life365 1-855-777-0078 TTY: 1-866-228-2809 MCS Solutions* 1-866-627-4327 INSPIRA (Triple-S) * 1-800-284-9515 EAP LatinA* www.eaplatina.com **EAP Provider options for Puerto Rico team members – in addition to Curalinc.* **Commuter Benefit Plan** Your Spending Account PO Box 64012 The Woodlands TX 77387-4116 Benefits Support Center Phone: 1-855-564-6153 Fax: 1-847-554-1869
Agent for Service of Legal Process	Walgreens Health & Welfare Committee* 104 Wilmot Road, MS 122H Deerfield, IL 60015-5143 Service of legal process may be made upon the above-mentioned Plan Administrator, or, for Fully Insured benefits, upon the Insurer.

	* This Committee serves as the Plan Administrator for purposes of handling claims and appeals and other ministerial matters. All other Plan Administrator fiduciary functions are handled by the Plan Sponsor.
Plan Year and Benefit Period	January 1 - December 31

Insurers/Claims Administrators

The Plan Administrator has the full discretionary authority to interpret the Benefit Programs in accordance with their terms and the provisions of ERISA and to resolve all disputed eligibility claims. In the case of Fully Insured benefits, the applicable Insurer has complete discretionary authority to determine eligibility for participation and benefit payment under its respective plan and in those cases, the applicable Insurer shall be the Claims Administrator.

The Plan Administrator has also delegated administrative duties to Claims Administrators who determine and pay claims for the Self-Insured benefits under the Plan. The Claims Administrators for Self-Insured benefits have:

- The authority to make determinations regarding eligibility and benefit claims under the Benefit Programs described in this SPD.

- Discretionary authority to:

  - Interpret the health and welfare plans based on provisions of the governing instruments and applicable law and make factual determinations about claims arising under such plans and programs.

  - Decide the amount, form, and timing of benefits.

  - Resolve any other matter raised by a claimant or that is identified by the Claims Administrator.

In case of an appeal, the decision of the applicable Claims Administrator or Plan Administrator will be final and binding on all parties to the full extent permitted under applicable law.

Payment of Benefits

Benefits will be payable to the covered participant, unless otherwise assigned, subject to the terms of the non-alienation provision, below. The Plan Administrator, in its discretion, may authorize payments to be issued to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Any benefit payments remaining unclaimed (e.g. uncashed checks) for more than one year after issuance of the corresponding payment or reimbursement check will be forfeited, and the

forfeited amounts will be used to offset Plan administrative expenses. Such amounts are considered plan assets under ERISA and, as such, are not subject to state escheatment laws.

No Guarantee of Tax Consequences

The Company is not liable for any taxes or other liability incurred by a participant or any individual claiming benefits through a participant by virtue of participation in the Plan. The Company does not represent or guarantee that amounts paid to or for the benefit of a participant will be excludable from the participant's gross income for federal, state, or local income tax purposes. It is the obligation of the participant to determine whether a payment is excludable from the participant's gross income for federal, state, or local income tax purposes and to notify the Plan Administrator if the participant has any reason to believe that any such payment is not so excludable.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order ("QMCSO"), National Medical Support Notice ("NMSN"), claims subject to the No Surprises Act or approved life insurance benefit assignment, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged, garnished or otherwise alienated and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered participant and shall not constitute an assignment of benefits under the Plan. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO or NMSN; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Limitations on Civil Actions

If you intend to bring a civil action against the Plan, the Plan Administrator, the Company, or any of its representatives for any reason, you must do so within two years of the date the cause of action occurs (i.e., within two years of the date the alleged action or inaction took place). This limitations period will be extended where required by federal law. This limitations period does not apply to any claim for benefits, which is governed by the limitations period described below under "Exhaustion Required."

Expenses

To the extent permitted by applicable law, all expenses incurred in connection with the administration of the Plan will be paid by the Plan except to the extent that the Company elects to pay such expenses.

Fraud

No payments will be made if you or your provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator or, for Fully Insured benefits, the Insurer, will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of facts has been made. The Plan

will have the right to recover any amounts, with interest, improperly paid by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Company, up to, and including, termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify each team member who acts in the capacity of an agent, delegate, or representative of the Plan ("Plan Administration Employee") against any and all losses, liabilities, costs, and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit, or other proceeding in which the Plan Administration Employee is involved by having been a Plan Administration Employee.

Nondiscrimination

In accordance with Code Section 125 and 105(h), the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416(i)(1)) or Highly Compensated Individuals as to eligibility to participate or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. If, in the operation of the Plan, more than the legally permitted nontaxable benefits are found to be provided to Key Employees, or the Plan discriminates in any other manner, then notwithstanding any other provision contained herein, the Plan Administrator shall reduce or adjust such contributions and/or benefits under the Plan as shall be necessary to ensure that the Plan will not discriminate. All rules, procedures, and decisions of the Plan Administrator shall be adopted, made, and applied in such fashion to not discriminate in favor of Highly Compensated Individuals, Highly Compensated Participants, or Key Employees.

The Company shall have no liability with respect to the income tax consequences that may be experienced by Highly Compensated Participants, Highly Compensated Individuals, or with respect to amounts re-characterized by reason of discrimination testing under the Plan.

Plan Funding and Type of Administration

Type of Administration	The Plan is administered by Walgreens through arrangements with the Insurers or other third-party administrators.
Funding	Walgreens and team members both contribute to the Plan. Funding for this Plan consists of an aggregation of the funding from team members and the Company for all benefits. For some Benefit Programs, benefits are paid solely by the Company; others are paid by a combination of Company and team member contributions. For Fully Insured benefits, Walgreens pays the Insurer a premium from Company general assets for providing coverage under the insured options.

Benefits are offered under the applicable insurance contracts. The Insurer or its delegate processes claims and makes all benefit determinations.

Any benefit funded by the purchase of insurance will be payable solely by the Insurer and the Company shall not have any further responsibility to pay such benefit.

For Self-Insured benefits, Walgreens pays fees to the third-party administrators to process claims for the Benefit Programs. Also, for Self-Insured benefits, any required employee contributions will be deemed to be applied to pay benefits under the Plan. Employer contributions pay the remaining cost of benefits and all administrative expenses under the Plan.

The Company has the right at any time to amend the funding arrangements for the Plan and to change Insurers, third-party administrators and/or Claims Administrators.

Right to Amend or Terminate

Although the Company presently intends to continue the Plan, it reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law.

The Company further reserves the right to change the amount of required participant contributions for coverage at any time, with or without advance notice to participants.

No Enlargement of Rights

All terms of the Plan are legally enforceable. However, this summary of benefits does not constitute a contract of employment nor does it interfere with the Company's right to terminate your employment, with or without cause.

Severability

If any provision of the Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the Plan will be construed and enforced as if such provision had not been included, and the remaining provisions shall continue to be fully effective.

Corporate Actions

As a matter of prudent business planning, the Company continually reviews and evaluates various proposals for changes in its Benefit Programs. Because of the need for confidentiality, such proposals are not evaluated below high levels of management. Team members below such levels do not know whether future changes will be made and/or new Benefit Programs adopted. Unless and until the Company formally announces such changes, no one is authorized to give assurances that such changes will or will not occur.

Claims Procedures

Types of Claims

This section describes the procedures under which you can make a claim for benefits under the Plan and appeal a denied claim. A "claim" is a request by you or your authorized representative for an eligibility determination or a Plan benefit. Any claim must be filed by you or your authorized representative. For benefits that rely on a provider network, when you use in-network health care providers, the initial claim will typically be submitted on your behalf by your provider as your authorized representative. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider defined below. A claim that does not relate to a specific benefit (for example, a claim regarding eligibility) must be filed initially with Claims and Appeals Management through Alight Solutions at the Benefits Support Center address shown under "Additional Plan Information" in the Administrative Information section of this SPD.

A request for prior approval of a benefit or service where prior approval is not required is not a claim under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid is not a claim, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received but there is not enough information to allow the Plan Administrator, Insurer and/or Claims Administrator to process the claim, you will have an opportunity to provide any missing information.

The Plan Administrator has delegated certain activities to Claims and Appeals Management, a shared service designed to serve Walgreens by conducting research and processing claims related to eligibility and enrollment for Self-Insured benefits, claims for your Healthcare FSA and Dependent Care FSA, and non-ERISA written inquiries. Claims and Appeals Management will additionally receive and track Fully Insured claim appeals for Walgreens.

Claims and Appeals Management also provides research for appeals related to eligibility and enrollment for group health and welfare plans.

To the extent that a group health and welfare plan claim or appeal does not relate to an eligibility or enrollment issue (such as a claim related to medical benefits under a plan), the Plan Administrator or the Claims Administrators have retained this responsibility as shown in the chart under "ERISA Benefits Claims" later in this section.

In addition to claims for eligibility, this section describes the procedures that pertain to those benefits under the Plan subject to ERISA. How and where you file your benefit claim is determined by whether the benefit is Self-Insured or Fully Insured. Under Department of Labor ("DOL") regulations, if you make a claim for a Plan benefit ("claimant"), you are entitled to a full and fair review of your claim. All claim procedures for ERISA benefits are intended to comply substantially with DOL regulations and the Affordable Care Act.

The following matrix shows the benefits covered by this SPD. It also shows which ERISA benefits are **Self-Insured or Fully Insured**. Depending on what type of claim you are submitting, your initial claim should be filed with the Claims Administrator identified below. When you use in-network providers, the initial claim will typically be submitted on your behalf by your provider. The initial claim and first appeal of a claim are referred to as the "internal" claims and appeals process. Your appeal should be filed with the applicable Claims Administrator using the contact information below. Unless otherwise stated in the insurance certificate, if applicable, or coverage summary for a particular benefit, the initial claim for benefits must be filed within six months after the end of the Plan Year in which the claim is incurred. For certain medical claims determined to be an adverse benefit determination, you may also have a right to request an external review by an independent review organization ("IRO"). The external appeal by the IRO is **voluntary.**

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
Medical Claims					
BCBS of Illinois (Copay and HSA plans)	Self-Insured	BCBSIL	BCBSIL	BCBSIL Appeals Review P.O. Box 2401 Chicago, IL 60690 Phone: 1-877-217-7986 Fax: 1-918-551-2011 Blue Cross Blue Shield of Illinois Claim Review P.O. Box 805107 Chicago, IL 60680-4112	BCBSIL
BCBSIL myVirtualCare Access	Self Insured	BCBSIL	BCBSIL	Appeals P.O. Box 25946 Overland Park, KS 66225 855-453-4747 BCBSIL Claims	BCBSIL

[2] The external appeal by the IRO is voluntary and only an option for adverse benefit determinations, medical claims or rescissions. See "External Review of Adverse Benefit Determinations" section of this SPD.

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
				P.O. Box 2920 Clinton IA, 52733 855-453-4747	
Dean / Prevea360	Fully-Insured	Dean / Prevea360	Dean / Prevea360	Dean Health 1277 Deming Way Madison, WI 53717 DHP.G & A Team@deancare.com P: 1-800-649-0258 F: 1-608-252-0812	Dean / Prevea360
HMSA	Fully Insured		HMSA	HMSA Medical Service Association P.O. Box 1958 Honolulu, HI 96805 1958 Phone:1-457-3277 on Oahu or 1-855-206-3277 from the Neighbor Islands 1-808-948-6372 (from Oahu) 1-800-776-4672 (from Neighborhood Islands)	HMSA
Kaiser Permanente (California)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (California) Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 Phone: 1-800-464-4000	Kaiser Permanente
Kaiser Permanente (Colorado)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Colorado) Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066 Phone: 1-888-370-9858 or 1-303-344-7933 Fax: 1-866-466-4042	Kaiser Permanente
Kaiser Permanente (Georgia)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Georgia) Appeals Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736	Kaiser Permanente

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
				Phone: 1-404-364-4862	
Kaiser Permanente (Hawaii)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Hawaii) National Claims Administration (NCA) HMO PO Box 378021, Denver CO 80237 Phone:1-866-868-7220	Kaiser Permanente
Kaiser Permanente (Mid-Atlantic)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Mid-Atlantic States) Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 Phone: 1-301-468-6000 Fax: 1-301-816-6192	Kaiser Permanente
Kaiser Permanente (Northwest)	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Northwest) Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Phone: 1-503-813-4480 Fax: 1-503-813-3985	Kaiser Permanente
Kaiser WA	Fully Insured	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente (Washington) Kaiser Foundation Health Plan of Washington Options, Inc. P.O. Box 34593 Seattle, WA 98124-1593 Phone: 1-866-458-5479 Fax: 1-206-901-7340	Kaiser Permanente
UnitedHealth Care	Self-Insured	UHC	UHC	UnitedHealthcare (National) UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130 UnitedHealthcare (National) UnitedHealthcare Claims P.O. Box 740800 Atlanta, GA 30374	UHC
Carrum* * See Carrum Coverage	Self-Insured	Carrum Health	First Level Carrum Health Appeals Committee	Initial Claim: Carrum Health 395 Oyster Point Blvd STE 211	N/A

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
Summary and below for additional information – including claims/appeals regarding exceptions to using the Carrum COE for mandated surgeries.			Second Level Carrum Health Appeals Committee Second Level Plan Administrator	South San Francisco, CA 94080 Phone: 1-888-855-7806 Carrum.me/walgreens 1st Level Appeal: Carrum Health Appeals Committee 640 N LaSalle Dr Suite 675 Chicago, IL 60654 2nd Level Appeal Plan Administrator Health and Welfare Committee 104 Wilmot Rd. MS# 122H Deerfield, IL 60015	
Rx Claims					
Optum Rx-Prior Authorization Appeals	Self-Insured	Optum Rx	Optum Rx	Optum Rx c/o Appeals Coordinator P.O. Box 2975 Mission, KS 66201Phone: 1-888-403-3398 Fax: 1-877-239-4565	Optum Rx
Optum Rx-Benefit Appeals	Self-Insured	Optum Rx	Optum Rx	Optum Rx Member Assistance P.O. Box 3410 Lisle, IL 60532-8410 Fax: 1-888-801-4745	Optum Rx
Dental Claims					
UnitedHealthCare	Fully Insured	UHC	UHC	UnitedHealthcare Dental Attn: Appeals P.O. Box 30569 Salt Lake City, UT 84130 Phone: 1-866-660-7181	N/A
Seguro De Servicio De Salud De Puerto Rico	Fully Insured	Seguro De Servicio De Salud De Puerto Rico	Seguro De Servicio De Salud De Puerto Rico	Medical Card System (MCS) www.mcs.com.pr Phone: 1-888-758-1616 Triple-S www.ssspr.com Phone: 1-787-774-6060 or 1-800-981-3241 (toll-free)	N/A

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
				Prescription Drug: www.optumrx.com/myCatamaranrx Phone: 1-855-376-3214	
ELAN	Fully Insured	ELAN	ELAN	ELAN Appeals Department PO BOX 16327 Lubbock, TX 79490	N/A
Vision Claims					
EyeMed	Fully Insured	EyeMed	EyeMed	FAA/EyeMed Vision Care Attn: Quality Assurance Dept 4000 Luxottica Place Mason, OH 45040 Fax: 1-513-492-3259	N/A
Healthcare Flexible Spending Accounts and HRAs					
Claims and Appeals Management	Fully Insured	YSA	YSA	Your Spending Account P.O. Box 1407 The Woodlands TX 77387-1407 Benefits Support Center Phone:1-855-564-6153 Fax: 1-847-554-1869	N/A
EAP					
Curalinc	Self-Insured	Curalinc	Curalinc	Curalinc www.walgreenslife365.com, Group code: life365Phone: 1-855-777-0078 TTY: 1-866-228-2809	N/A
MCS Solutions	Self-Insured	MCS Solutions	MCS Solutions	MCS Solutions Phone: 1-866-627-4327	N/A
INSPIRA (Triple S)	Self-Insured	INSPIRA (Triple S)	INSPIRA (Triple S)	INSPIRA (Triple S) Phone: 1-800-284-9515	N/A
EAP LatinA	Self-Insured	EAP LatinA	EAP LatinA	EAP LatinA www.eaplatina.com	N/A
Eligibility Claims, Commuter and Dependent Care FSA Claims					
Claims and Appeals Management		Benefits Support Center	Plan Administrator	Claims and Appeals Management P.O. Box 1407	N/A

WHERE TO FILE YOUR CLAIM					
Claims Administrator	**Funding**	**Initial Claim Determination**	**Appeal**	**Contact Information for Initial Claim and Appeal**	**Person to contact to facilitate the External IRO (Voluntary)[2]**
				The Woodlands TX 77387-1407 Benefits Support Center Phone: 1-855-564-6153	

ERISA Benefit Claims - Self-Insured Medical Benefits (Including Prescription Drug, Dental and Vision), Health Care Flexible Spending Account and Health Reimbursement Arrangement Benefits

Unless otherwise noted, the following claims procedures apply to self-insured medical benefits (including prescription drug, dental and vision), health reimbursement arrangement benefits, and health care flexible spending account benefits provided under the Plan. NOTE: Also see "Filing an FSA Claim" under the **Your Flexible Spending Accounts ("FSAs")** section of this SPD.

The complete claims procedure for Fully Insured Benefit Programs is contained in the respective coverage summaries that are provided to participants without charge as separate documents. You must fully comply with the Fully Insured Claim Administrator's claims and appeals procedure if your benefit claim is denied. You should refer to these documents for additional information about how and when to file an appeal. For group health care claims denied on appeal, the Fully Insured Claims Administrator will also provide you with information on its voluntary external review process by an independent review organization ("IRO")/external review organization ("ERO") or by the State Insurance Commissioner, if applicable. The Claims Administrator will describe the process to follow if you wish to pursue an external review of your claim.

There are several different types of health care claims that you may bring under the Plan. The Plan's procedures and timing for evaluating claims depend upon the type of claim filed. The Plan Administrator has delegated its authority to determine all health care claims to the applicable Claims Administrators.

The Claims Administrator, acting on behalf of the Plan Administrator, is authorized to make a final determination on appeals and interpret the terms of the Plan in its sole discretion. All decisions made by the Claims Administrator are final and binding on all parties.

Health care benefit claims and appeals are divided into four categories:

- **Post-service claim**
  A claim for reimbursement of benefits or services already received. This is the most common type of claim. Health care FSA and HRA claims are considered post-service claims.

- **Pre-service claim**
  A claim for a particular benefit that is conditioned upon your receiving prior approval in advance of receiving the benefit.

- **Concurrent care claim**
  A claim relating to the continuation or reduction of an ongoing course of treatment over a period of time. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment your therapist suggests ten treatments, your claim for the additional three treatments is a concurrent care claim. Some concurrent care claims also are urgent care claims.

- **Urgent care claim**
  A claim that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

Depending on the type of claim defined above, the table below identifies the time frames and communication methods permitted for the initial claim review and appeal of a denied claim for benefits; provided, however that the Claims Administrator may respond to different types of claims within different time periods as may be permitted or required by applicable law. The Claims Administrator may extend the time needed to make a decision or to review a claim denial upon appeal, if additional information is required from you.

	Urgent Care Claims	Concurrent Care Claims	Pre-Service Claims	Post-Service Claims
Plan Notice of Improper Claim	24 hours after receiving improper claim.[1]	24 hours after receiving improper claim if urgent concurrent claim.	5 days after receiving improper claim.[1]	Not applicable.
Plan Notice of Incomplete Claim	24 hours after receiving incomplete claim.	24 hours after receiving incomplete claim if urgent concurrent claim.	15 days after receiving the initial claim.	30 days after receiving the initial claim.

[1] Notice may be given orally unless you request written notification.

	Urgent Care Claims	Concurrent Care Claims	Pre-Service Claims	Post-Service Claims
Claimant Deadline to Complete Urgent Claim (after receiving notice of Incomplete/ Improper Claim)	48 hours after receiving notice.[3]	Not applicable.	Not applicable.	Not applicable.
Plan Notice of Initial Claim Denial Decision	72 hours[4],[5] after receiving the initial claim, if it was proper and complete. 48 hours[4] after receiving completed claim or after the 48-hour claim completion deadline, whichever is earlier.	For non-urgent concurrent care claims, determination will be made within time frame designated for type of claim (pre- or post- service) and prior to expiration of prescribed period of time/number of treatments. For urgent concurrent care claims, within 24 hours of receipt of claim if claim is submitted at least 24 hours prior to expiration of prescribed period of time/number of treatments. If not submitted within 24 hours prior to expiration, not later than 72 hours after receipt of claim.	15 days[6] after receiving the initial claim. 30 days[5] after receiving the claim if the Claims Administrator needs more information and if an extension notice is provided during the initial 15-day period.	30 days after receiving the initial claim. 45 days after receiving the claim if the Claims Administrator needs more information and if an extension notice is provided during the initial 30-day period.
Claimant Deadline to Complete Non-Urgent Claim	Not applicable.	Prior to benefit ending.	45 days after receiving extension notice.	45 days after receiving extension notice.
Claimant Deadline to Appeal Decision	180 days[5] after receiving claim denial.	Prior to benefit ending.	180 days after receiving claim denial.	180 days after receiving claim denial.
Extension Period[7]	Not applicable.	Not applicable.	Additional 15 days if more information is received by you and the extension notice is provided during the initial 15-day period.	Additional 15 days if more information is received by you and the extension notice is provided during the initial 30-day period.

[2] Information may be provided by telephone, fax, or similar method.

[4] Notice may be provided orally if written or electronic notice is provided within 3 days of notification.

[5] Notice applies to claim approvals as well as claim denials.

[6] Additional information may be provided on appeal by telephone, fax, or similar method.

[7] Whenever an extension is required, you must be notified before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

	Urgent Care Claims	Concurrent Care Claims	Pre-Service Claims	Post-Service Claims
Plan Notice of Appeal Decision	72 hours after receiving appeal.	In time to submit and receive determination before benefit ends.	30 days after receiving the appeal. 15 days after receiving an appeal if the benefit offers two levels of appeal.[8]	60 days after receiving the appeal. 30 days after receiving the appeal if the benefit offers two levels of appeals.[7]

Notice of Decision

The written or electronic notification of the denial of a health care claim will be written in a manner calculated to be understood by you or your authorized representative and will include: (a) the specific reason(s) for denial with reference to those specific Plan provisions on which the denial is based; (b) a description of any additional material or information necessary for you or your authorized representative to perfect the claim and an explanation of why that information is necessary; (c) a description of the Plan's appeal procedures and time frames, including a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse decision on appeal; (d) any internal rule, guideline, checklist, protocol, or similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, checklist, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; (e) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning; and (f) if the denial was based on medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request. For urgent care claims, you will also be provided with a description of the expedited review process.

How to Appeal a Claim Determination

You or your authorized representative may appeal a denied claim for benefits within 180 days after receipt of a notice of denial. You will have the right to submit for review written comments, documents, records, and other information related to the claim and to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The Plan Administrator or its designee or the Claims Administrator, as applicable, reviewing your appeal of the denial of a health care claim will:

- Provide a review that does not afford deference to the initial denial or your claim and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual

[7] Both levels of appeal must be completed within the deadline that applies as if there were only one level of appeal.

who made the adverse decision that is the subject of your appeal nor the subordinate of that individual;

- Provide that, in deciding an appeal of an adverse decision that was based in whole or in part on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither the individual who consulted in connection with the adverse decision that is the subject of your appeal nor the subordinate of that individual; and

- Provide for the identification of the medical experts whose advice was obtained on behalf of the Plan in connection with the adverse decision on your claim, without regard to whether the advice was relied on in making the decision on your claim.

The Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied on or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with your claim. The evidence will be provided as soon as possible and sufficiently in advance of the date the Claims Administrator must provide notice of its decision on the appeal in order to allow you time to respond. In addition, before the Claims Administrator can issue an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date the Claims Administrator must provide notice of its decision on the appeal in order to allow you time to respond.

The written or electronic notification of the denial of an appeal of a health care claim will include: (a) a statement of the specific reason(s) for denial with reference to those specific Plan provisions on which the denial is based; (b) a statement that you or your authorized representative is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (c) a description of the Plan's appeal procedures and time frames, including a statement of your right to bring a civil action under ERISA Section 502(a); (d) any internal rule, guideline, checklist, protocol, or similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, checklist, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; (e) if the denial was based on medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request; and (f) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

The notification of denial of an appeal of a claim for health care benefits will be written in a culturally and linguistically appropriate manner and will also include: (a) information sufficient to identify the claim involved (including the date of service, health care provider, and claim amount, if applicable); (b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(c) the denial code and its corresponding meaning, and a description of the health plan's standard, if any, that was applied in denying your claim; (d) a statement of your right to an internal appeal (when an additional level of internal review is offered) and an external review of your claim for benefits by an independent review organization ("IRO"), including information about how to initiate such an internal or external review; and (e) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeals and with the external review process. The notice of denial after the final internal appeal will also include a discussion of the decision.

External Review of Adverse Benefit Determinations

If your claim involving medical judgment or involving a rescission of coverage is denied, you can request an external review. In the case of an urgent care claim, you can file a request for an expedited external review at the same time you file an internal appeal.

You must file your request for an external review with the Claims Administrator within four months after the date you received the final internal appeal denial.

This section describes the external review procedures for Self-Insured benefits. Fully-Insured benefits will either adhere to these claims or to the claims procedures outlined in the applicable insurance certificate.

Preliminary Review

Within five business days of receipt of your request, the Claims Administrator will complete a preliminary review to determine that:

- You were covered by the Plan at the time the service was requested or provided;
- The adverse claim determination was not related to your failure to meet the plan's eligibility requirements;
- You had exhausted the Plan's internal appeals process, if required under law; and
- You had provided all of the necessary information and forms to process an external review.

Within one business day after completing the preliminary review, the Claims Administrator will contact you in writing. If your request was complete but not eligible for an external review, the notice will tell you why and provide you with the contact information for the Employee Benefits Security Administration. If your request is incomplete, the notice will describe what information is needed to perfect your review request. You have 48 hours from receipt of this notice, or up to the original four-month external appeal filing deadline, to provide the requested information.

Referral to Independent Review Organization

If your claim qualified, the Claims Administrator will assign your review request to an accredited Independent Review Organization ("IRO") that will conduct the external review. The Claims Administrator will provide the IRO with the documents and any information considered in previously denying your claim.

The IRO will notify you in writing of your eligibility and acceptance for external review. The notice will inform you of your right to submit additional information for review in writing to the IRO within 10 business days following receipt of the notice.

Within one business day of receiving any additional information from you, the IRO will forward that information to the Claims Administrator. The Claims Administrator may then reconsider its benefits denial. If the Claims Administrator decides to reverse its previous denial, the external review will be terminated, and you will receive a written notice of the Claims Administrator's decision within one business day.

The IRO will review your claim without regard to any previous decision or conclusions reached during the internal claims and appeals processes. You will receive written notice of the IRO's decision within 45 days after the IRO received your review request.

If the IRO reverses the Plan's adverse benefit decision, your claim will be immediately paid or coverage must be immediately provided (whichever applies to your claim).

The written decision of the IRO will include the following:

- A general description of the reason for the external review request, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), notice regarding the availability of the diagnosis code and its corresponding meaning and/or the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Claim Administrator or you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

For Urgent Care Claims and appeals, there is an expedited external appeal process. In such a case, the Claims Administrator will immediately determine if the claim is eligible for an external review and provide all documents and information to the IRO electronically or by phone or fax to expedite the process. The IRO will make a decision on your claim within 72 hours of receiving it.

The decision of the IRO is binding upon all parties, however you still have the right to bring an action under Section 502(a) of ERISA.

Other Claims (Eligibility, Dependent Care FSA and Commuter Benefit Plan Claims)

This section applies to eligibility claims, non-health related Self-Insured benefit claims and claims for benefits under the programs that are not covered by ERISA. The processes laid out below mirror the ERISA rules and are intended to be followed for consistency purposes, but they generally are not prescribed by or enforced under ERISA. It explains the steps you or your authorized representative is required to take to file a claim or appeal. A benefit claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

For purposes of this section, an eligibility claim is a claim to participate in a Benefit Program or plan option or to change an election to participate during the Plan Year.

To submit a claim that falls in this category, contact the Benefits Support Center at 1-855-564-6153, except for EAP claims, as described below**.**

Your eligibility claims under the EAP will be reviewed by the third-party administrator (the "Claims Administrator"), which will make its decision based on the information submitted by you, your EAP counselor or by Walgreens.

	Eligibility and non-ERISA Benefit Claims Procedure
How to file a claim:	To file an eligibility or a non-ERISA **non-health care benefit** claim, you (or your authorized representative) should contact the Benefits Support Center at **1-855-564-6153** and then submit your claim to: **Claims and Appeals Management** **DEPT 01040** **P.O. Box 64116** **The Woodlands, TX 77387-4116** Or, if the claim relates to the EAP, contact the EAP Claims Administrator as follows **Curalinc Healthcare** Attn: Claims Department 314 W Superior St, Suite 601 Chicago, IL 60654 For all claims, you must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.

	Eligibility and non-ERISA Benefit Claims Procedure
When you will be notified of the claims decision or your failure to provide sufficient information:	You will be notified of the decision within 90 days of receipt of your claim form (180 days when special circumstances apply) by the applicable Claims Administrator. If special circumstances require the extension of time for processing your claim, you will be provided written notice of the extension prior to the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring the extension and the date by which the Plan expects to provide its benefit determination. You will also be notified of the deadline to submit additional information, if applicable.
If your claim is denied:	The Claims Administrator will notify you in writing if your claim is approved. If your claim is **denied**, in whole or in part, your written denial notice will set forth: • The specific reason(s) for the denial. • The Plan provisions (or reference to such specific provisions) on which the denial was based. • A description of any additional material or information you may need to submit to complete the claim and an explanation of why such material or information is necessary. • A description of the Plan's appeal procedures and the time limits applicable to such procedures.
About your appeal:	Before you can bring any action at law or in equity to recover benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained, and the appeal must be finally decided by the Plan Administrator or its designee. The Plan Administrator or its designee is authorized to finally determine eligibility appeals, non-ERISA benefit appeals, and to interpret the terms of the Plan in its sole discretion. All decisions by the Plan Administrator or its designee are final and binding on all parties.
How to file an appeal:	If your claim is denied and you want to appeal it, you must file your appeal within 60 days from the date you receive written notice of your denied claim. You may request, free of charge, access to and copies of documents, records, and other information relating to your claim. To file your appeal, write to the applicable Claims Administrator and include: • A copy of your claim denial notice. • The reason(s) for the appeal. • Other written comments, documents, records, or information relating to your claim.

	Eligibility and non-ERISA Benefit Claims Procedure
If your appeal is denied:	The Claims Administrator will notify you in writing if your appeal is approved. If your appeal is **denied**, in whole or in part, your written denial notice will set forth: • The specific reason(s) for the denial. • The Plan provisions (or reference to such specific provisions) on which the denial was based. • A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits • Your right to file a civil action under ERISA Section 502 (if applicable) and any time limits on filing such an action.

General Claims/Appeals Information

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

The authority granted to the Claims Administrator and the Plan Administrator or its designee to construe and interpret the program 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 program will be paid or provided to you or your dependents only if the Claims Administrator, the Plan Administrator, or its designee, as the case may be, decides in their 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 or its designee.

Exhaustion Required

You must first utilize the claim and 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.

The decision of the applicable Self-Insured or Fully Insured Claims Administrator and/or the Walgreens Health & Welfare Committee shall be final and conclusive on all persons claiming benefits under the plans, subject to applicable law.

No action at law or in equity in the courts of the United States may be brought by any person to recover benefits claimed unless and until an appeal for such denied benefit has been brought and

denied (or is deemed denied) in accordance with all applicable claims and appeals procedures. For any denial considered an "adverse benefit determination" (generally, denials under the medical or prescription drug Benefit Programs), if a Claims Administrator or the Walgreens Health & Welfare Committee does not fully comply with all claims and appeals requirements, subject to the *de minimis* rules, you are considered to have exhausted the Plan's appeal requirements ("deemed exhaustion") and you may proceed with an external review (if available), or you may pursue any remedies available under federal or state law, as applicable.

For any type of claim, no legal action may be commenced more than one year, or later if required by state or federal law, after the earliest of the following (i) the date you are informed of the decision on the final level of appeal you choose to pursue, (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, or (iii) the deadline for filing a claim for benefits.

The Advocacy Program

Walgreens offers a confidential Advocacy Program administered by Alight Solutions.

The Advocacy Program can help you (and your family members) with the complex rules and administration of benefits, specifically with claim processing. If you have problems resolving an issue directly with the Claims Administrator, having a helpful third-party advocate who can perform research and speak with the Claims Administrator directly can be beneficial in bringing an issue to resolution.

The objectives of the Advocacy Program are:

- Assisting in the resolution of issues not related to eligibility with plans;
- Acting as a participant liaison and advocate while providing education through the resolution process;
- Initiating corrective and/or proactive action as appropriate to resolve or avoid issues;
- Documenting and tracking issues for trend analysis; and
- Partnering with Walgreens and the plans to address trends.

The Advocacy Program can assist you with issues relating to the Walgreen Health and Welfare Plan as well as other benefits not covered in this SPD.

Before contacting Advocacy, you must make one attempt to contact the Claims Administrator directly. Call the Benefits Support Center at 1-855-564-6153 and ask to speak with an Advocacy team member. The Advocacy Program cannot make exceptions or guarantee claim payment.

Continuation Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, is a federal law that allows continuation of your health care coverage under certain circumstances.

This section provides an overview of COBRA continuation coverage which will be provided by the Plan Administrator (or its designee) to the extent required by law. It includes important information about your right to COBRA continuation coverage and when it may become available. It also describes what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under this Plan and under federal law, contact the Benefits Support Center.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What COBRA Continuation Coverage Is

COBRA coverage is a temporary continuation of health plan coverage when it otherwise would end because of a life event, known as a "qualifying event." (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if you are covered under a health plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

COBRA Qualified Beneficiaries

- **Team Member**. You become a COBRA qualified beneficiary if you lose your coverage under the health plans because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason.
- **Your Spouse**. Your spouse becomes a COBRA qualified beneficiary if he or she loses coverage under the health plans because of one of the following qualifying events:

  - You die.
  - Your hours of employment are reduced.
  - Your employment ends for any reason.
  - You become divorced or legally separated from your spouse.
  - You enroll in Medicare benefits (under Part A, Part B, or both).

- **Your Dependent Children**. Dependent children become COBRA qualified beneficiaries if they lose coverage under the health plans because of one of the following qualifying events:
  - You die.
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You become divorced or legally separated.
  - Your child loses eligibility for coverage as a "dependent child."
  - You enroll in Medicare benefits (under Part A, Part B, or both).

The following individuals are not qualified beneficiaries for purposes of COBRA continuation:

- Domestic partners.
  - A child of a domestic partner is a qualified beneficiary if he or she is your IRS tax dependent.

Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your domestic partner or children of a domestic partner even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA coverage terminates. Under "How Long COBRA Coverage Lasts with Respect to Medical/Prescription Drug, Dental, and Vision Benefits" later in this section, please note that the two bullets regarding "Disability extension of 18-month period of continuation coverage" and "Second qualifying event extension of 18-month period of continuation coverage" are not applicable to these individuals.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Walgreens, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving

spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When COBRA Coverage Is Available

The health plans offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. (See the ***Administrative Information*** section of this SPD for contact information.)

Notification of Qualifying Events

When the qualifying event is the end of employment or reduction in hours of employment or death of the team member, **the employer must notify** the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation of the team member and spouse or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, **you or the qualified beneficiary must notify** the Company within 60 days after the later of the date the qualifying event occurs or the day you lose coverage on account of the qualifying event by contacting the Benefits Support Center. If you or the qualified beneficiary fails to notify the Company within 60 days after the qualifying event, your dependent will not be entitled to elect COBRA continuation coverage.

How COBRA Coverage Is Offered

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

Information is sent to the COBRA claims administrator via the Benefits Support Center. The claims administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event. You may also elect to receive notices electronically via the secure private mailbox on the Benefits Support Center. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Covered team members may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address on file to ensure that you receive a COBRA enrollment notice following a qualifying event.

Your eligible dependents have 60 days from the day coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If your eligible dependent fails to elect COBRA coverage within the applicable time frame, such individual will lose the opportunity to continue coverage under COBRA.

How Long COBRA Coverage Lasts with Respect to Medical/Prescription Drug, Dental, and Vision Benefits

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

Your death.

Your divorce.

A dependent child losing eligibility as a dependent child.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of continuation coverage**. If a qualified beneficiary covered under the health plans is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

  – Your COBRA qualifying event was a termination of employment or reduction in hours.

  – The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

  – A copy of the Notice of Award from the Social Security Administration is provided to the Benefits Support Center within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.

- **Second qualifying event extension of 18-month period of continuation coverage**. If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the health plan (as described under "Notification of Qualifying Events" above).

  This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, get divorced, or if your dependent child is no longer eligible under the health plans as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the health plans had the first qualifying event not occurred.

COBRA Qualifying Events

Qualifying Event	Maximum Continuation Period (months) for:		
	You	Spouse	Covered child
You lose coverage because of reduced work hours or taking unpaid leave, other than leave under the FMLA	18	18	18
You terminate employment for any reason	18	18	18
You or your dependent is disabled—as defined by the Social Security Act—at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)	29 (Initial 18 months, plus additional 11 months)
Your covered child no longer qualifies as a dependent	N/A	N/A	36
You die	N/A	36	36
You and your spouse divorce or legally separate	N/A	36	36

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

How Long COBRA Coverage Lasts with Respect to the Healthcare FSA and EAP

You and your eligible dependents may be eligible to continue participation in the Healthcare FSA **for the remainder of the calendar year** in which participation otherwise would end due to a COBRA qualifying event. You will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA coverage will be available to you only if you have a positive Healthcare FSA balance at the time you become eligible for COBRA (taking into account all claims submitted by you before the date of the qualifying event). Coverage will cease at the end of the calendar year and will not be continued for the next year. The contributions you make under COBRA for the Healthcare FSA will be made on an after-tax basis.

Continuation of benefit coverage for EAP under COBRA automatically begins when your employment ends. COBRA coverage for purposes of the EAP will continue for 18 months after your termination date, at no cost to you.

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single team member.

Payment is due at enrollment, but there is a 45-day grace period from the date of your enrollment election to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the first of each month, but there is a 60-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by July 31).

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of coverage you had as an active team member or choose a lower level of coverage.
- Your or your dependent's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 65-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
  - During your Open Enrollment period.
  - If you have a qualifying life event.
  - If you have a change in circumstance recognized by the IRS and Walgreens.
- You may enroll any newly eligible spouse or child under Plan rules.

What to Consider When Deciding Whether to Elect COBRA

When considering whether to elect COBRA continuation coverage, consider the following:

- **Special Enrollment Into Other Group Health Coverage**: Within 30 days after your group health coverage ends because of a qualifying event, you may qualify for special enrollment (enroll without waiting until the next Open Enrollment) in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). This same special enrollment right applies at the end of COBRA continuation coverage if coverage is continuous for the maximum time available.
- **Health Insurance Marketplace and Medicaid**: There may be other coverage options available for you and your family instead of enrolling in COBRA continuation coverage. You

may want to buy coverage through the Health Insurance Marketplace or obtain coverage through Medicaid. For more information, visit **www.healthcare.gov**.

- **Eligibility for Medicare**: Individuals who are eligible for but do not enroll in Medicare when first eligible, may be subject to a penalty from Medicare if they delay Medicare enrollment. Coverage as an active employee or covered dependent may nullify any Medicare penalty for late enrollment; however, COBRA coverage does not generally count to negate Medicare penalties for late enrollment.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another health plan.
- You or your covered dependent fails to make contributions by the due date as required.
- Walgreens stops providing health benefits to any team member.

Continuation coverage also may be terminated for any reason the health plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 ("ERISA"), including COBRA, the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at **www.dol.gov/ebsa**.

Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit **www.healthcare.gov**.

Your Rights Under ERISA

As a participant in one of the ERISA-covered plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and 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 contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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, 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.

If your claim for a 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 it within 31 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

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

Assistance with Your Questions

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

If you have any questions about 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 write to:

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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **1-866-444-3272**.

HIPAA Privacy

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Under Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations in 45 CFR Parts 160 through 164 ("HIPAA"), certain group health plans are required to protect the confidentiality of your Protected Health Information ("PHI"). PHI is information created or received by the Plan that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual.

The Plan will not use or disclose PHI except as necessary for treatment, payment, health care operations and plan administration functions, or as otherwise permitted or required by law, without your written authorization. The Plan has required all of its Business Associates with respect to any underlying Plan which is a health plan to comply with HIPAA's privacy rules.

Before the Plan will disclose, or permit one of its agents or contractors to disclose, PHI to the Plan Sponsor (including any committee of the Plan Sponsor that is the Plan Administrator), the Plan will require the Plan Sponsor to (i) certify that the information is necessary in connection with plan administration functions or other permitted functions performed or to be performed by the Plan Sponsor; (ii) amend the Plan documents and provide certification of amendment to give assurances that the Plan Sponsor will use and disclose the information solely in connection with such plan administration or other permitted functions; and (iii) not use or further disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor without the participant's authorization.

Under HIPAA, you have certain rights with respect to your PHI, including the right to inspect and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information and request confidential communications. To exercise any of these rights, contact the applicable Claims Administrator for the underlying plan involved and follow the procedures outlined by the Claims Administrator. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a Notice of Privacy Practices with respect to any underlying Plan that is a group health plan under HIPAA, which provides a complete description of your rights under HIPAA's privacy rule. You may request a copy of this Notice of Privacy Practices at any time by contacting the Plan's Benefits Support Center at www.benefitssupportcenter.com; or for any underlying applicable insured benefits you should contact the applicable insurer for a copy of its notice of privacy practices. If you have questions about the privacy of your health information, please contact the Plan's Privacy Officer at the address listed in the Notice of Privacy Practices.

Certain Notices and Affordable Care Act Disclosures

Your Maternity Rights (Newborns' and Mothers' Health Protection Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Compliance

The medical benefits under the Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder, referred to as Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Lifetime or Annual Dollar Limits. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

- *Financial Requirement or Treatment Limitations*. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or non-quantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

- *Criteria for medical necessity determinations*. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

Walgreens monitors its plan designs with respect to mental health parity guidance through:

- *Financial and quantitative testing*. Walgreens conducts periodic financial and quantitative testing to ensure that each medical plan option's cost sharing and treatment limits for mental health and substance use disorder benefits within each MHPAEA classification meet the substantially all and predominant tests of the law.

- *Non-quantitative treatment limitation (NQTL) analysis*. Walgreens works with its claim administrators to ensure that they have conducted NQTL analysis to confirm that each medical plan option, including the prescription drug benefit, is in parity. To comply with MHPAEA, each medical plan option must be able to demonstrate that under the terms of the plan as written and *in operation*, the processes, strategies, evidentiary standards, or other factors used to apply an NQTL to mental health/substance use disorder benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits in the same classification. Examples of NQTLs include, but are not limited to, medial management standards, prior authorization, formulary designs for prescription drugs, "fail-first" provisions, and exclusions of specific treatments for certain conditions.

Patient Protection and Affordable Care Act Compliance

- *No Lifetime or Annual Limits.* The Plan does not impose a lifetime or annual limit on the dollar value of Essential Health Benefits provided under the Plan. Essential Health Benefits are health-related items and services that fall into the following ten categories, as defined in Affordable Care Act §1302 and further determined by the Secretary of Health and Human Services:

  - Ambulatory patient services;
  - Emergency services;
  - Hospitalization;
  - Maternity and newborn care;
  - Mental health and substance use disorder services, including behavioral health treatment;
  - Prescription drugs;
  - Rehabilitative and habilitative services and devices;
  - Laboratory services;
  - Preventive and wellness services and chronic disease management; and
  - Pediatric services, including oral and vision care.

  For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits (see below) under the Affordable Care Act, the Plan has chosen the State of Utah as its benchmark state.

- *No Pre-Existing Condition Exclusion.* The Plan will not impose a pre-existing condition exclusion on medical benefits.

- *No Cost Sharing on Recommended Preventive Care.* The medical benefits under the Plan will not require participant cost-sharing (co-payments, deductibles or coinsurance) on recommended preventive care provided by in-network providers. Preventive care services covered in-network at 100% have been defined to include the following as will be reviewed annually:

  – Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;

  – Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  – Evidence-informed preventive care and screening provided for in the comprehensive guidelines support by the Health Resource and Services Administration (HRSA) for infants, children, and adolescents; and
  – Other evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA for women.

  In-network preventive care items and services with no cost sharing include a number of screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations (including COVID-19 immunizations), counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as a specialist consultation, bowel preparation medications, anesthesia, polyp testing, and certain follow-up procedures[9]), and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.

  For women, the Plan's medical options also will cover in-network, with no cost sharing, an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods,[10] items and services as well as counseling as prescribed for women; breastfeeding support (including lactation counseling services), equipment and supplies, and counseling; and screening and counseling for interpersonal and domestic violence.

  In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be

[9] Beginning in 2023, this includes coverage for a follow-up colonoscopy after a patient has received a positive screening test or direct visualization test.

[10] As clarified by the federal government in July 2022, this includes items and services that are integral to the furnishing of birth control, regardless of whether the items or services are billed separately. For example, coverage for anesthesia for a tubal ligation procedure and pregnancy tests administered prior to providing an intrauterine device. Beginning in 2023, male condoms must be covered at no cost in-network with a prescription.

eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact the Claims Administrator to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.

NOTE:

The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. The federal government recently clarified that with respect to contraception, it will scrutinize medical management techniques such as denial of coverage of all or a particular brand name contraceptive, fail-first policies, or age-based restrictions. The Plan will defer to a medical necessity determination given by your physician. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

If you have any questions regarding whether a particular preventive care item or service will be offered with no cost sharing, please contact the applicable Claims Administrator (for example, UnitedHealthcare, BCBS of Illinois, Kaiser, or Optum Rx).

- *Coverage of Clinical Trials.* The Plan shall not deny participation in an approved clinical trial for which a covered person is a "qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A covered person participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms "qualified individual," "life threatening disease or condition," approved clinical trial" and "routine patient costs" shall have the same meaning as found in Section 2709 of the Public Health Services Act.

- *Cost Sharing Limits.* The Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the Affordable Care Act. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-pays or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

- *Medical Loss Ratio Rebates*. With respect to any insurance company rebate received by the Company that are subject to the Medical Loss Ratio ("MLR") provisions of the ACA, if any, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts

will be used by the Plan or applied to the benefit of participants; which participants need not be the same participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated as the Company in its sole discretion determines appropriate.

- *No Discrimination Based on a Health Factor.* The Plan does not discriminate against participants and beneficiaries based on a health factor.

- *No Waiting Period Exceeding 90 Days.* The Plan's waiting period does not exceed 90 days. See the Enrollment section of this SPD for more details.

- *No Provider Discrimination.* The medical and prescription drug options offered under the Plan will not discriminate against an eligible healthcare provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical plan options to accept all types of providers into a network.

- *Transparency and Internet-Based Self-Service Tool.* Beginning in 2023, the Affordable Care Act transparency provisions will give Plan participants access to an internet-based price comparison tool to compare prices for up to 500 items and services designated by the government. In 2024, this requirement will apply to all items and services covered by the Plan. Upon request, this information may be provided in paper without a fee, subject to certain limits.

Reimbursement and Subrogation

General Principle

When you or your dependent receive benefits under the Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plans' right to subrogation or reimbursement will not be affected or reduced by the "Make Whole" Doctrine, the "fund" doctrine, the "Common Fund" Doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from Walgreens.

If the Plan should become aware that you or your dependent has received a third party payment, amount or recovery and not reported and/or repaid such amount, the Plan, in its sole discretion, may (i) suspend all further benefit payments related to you or any of your dependents until the reimbursable portion is returned to the Plan; (ii) offset against amounts that would otherwise be paid to or on behalf of you or your dependents; or (iii) terminate coverage under the Plan for you and your dependents.

Participant Duties and Actions

By participating in the Plan, you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Plan. At that time, you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from Walgreens.

Any funds received by or on behalf of a participant or dependent will be treated as being held in a constructive trust on behalf of the Plan. You and your dependent may not receive any of the funds until you have paid the Plan's claims for subrogation/reimbursement.

Terms to Know

Below are common terms used in this SPD. Be sure to consult the coverage summaries for definitions specific to your Benefit Programs. If there is a conflict between a defined term in this SPD and a coverage summary, the coverage summary controls.

Affordable Care Act ("ACA")

In March 2010, Congress passed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. These new laws are commonly referred to as "Health Care Reform." For purposes of this SPD, they are collectively referred to as the "Affordable Care Act."

After-Tax Dollars

These dollars are deducted from your pay after taxes are withheld.

Air Ambulance

Medical transport by rotary wing (helicopter) or fixed wing (airplane) air ambulance as defined by federal law.

Ancillary Services

Items and services provided by out-of-network providers at in-network facilities that are defined by federal law, including:

- Those related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, intensivists, and other specialty practitioners;
- Diagnostic services, including radiology and laboratory services;
- Provided by an out-of-network physician when no in-network physician is available.

Before-Tax Dollars (Pretax)

These dollars are deducted from your pay, in equal amounts throughout the year, before taxes are withheld. Paying for coverage with before-tax dollars reduces your taxable income for federal, Social Security, and, in most cases, state income taxes.

Claim

An acceptable notice to the Claims Administrator that a service has been provided to you. The notice must include full details of the service received, including your name, age, sex, plan ID number, the name and address of the provider, an itemized statement of the service rendered or

furnished, date of service, diagnosis, service charge, and any other information that the Claims Administrator may request in connection with services provided to you.

Claims Administrator

The third-party administrator designated by Walgreens to handle claims processing and certain day-to-day administration of each benefit option under the Plan.

Clinical Trial

A scientific study designed to identify new health services that improve health outcomes. In a clinical trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance

A percentage of eligible expenses that you are required to pay toward a covered service.

Copay

A flat dollar predetermined portion of covered medical expenses paid by you or Walgreens. Your copay varies depending on the type of service provided and whether or not you take advantage of the Plan's cost-saving features, when appropriate.

Deductible

The dollar amount of covered expenses you have to pay before the Plan begins to pay. Each year, you must pay the deductible amount before the Plan will begin to pay for most covered expenses. Generally, a deductible is an amount you must pay before the Plan pays benefits.

Doctor or Physician

A doctor or physician duly licensed to practice medicine in all of its branches. A doctor is a person who performs tasks that are within the limits of his or her medical license and who:

- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery;
- Has a doctoral degree in psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- Is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

The Plan will not recognize any relative, including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you submit.

Domestic Partner

Your Domestic Partner is an individual who meets all of the requirements listed below for a minimum of six months:

- Neither your domestic partner nor you are married, legally separated, or involved in another domestic partnership;
- You and your domestic partner share the same principal address;
- You and your domestic partner both reside in the United States;
- You and your domestic partner maintain an intimate, committed relationship of mutual caring and support;
- You and your domestic partner agree to share, and are both responsible for, basic living expenses (e.g. medical care, rent or mortgage, utility bills) during your domestic partnership and will permit anyone who is owed these expenses to collect from either partner; and
- You and your domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage under applicable law in effect in the state where you legally reside.

Eligible Charges (for Out-of-Network Dental Providers)

Refer to the coverage summary or insurance policy for the applicable Benefit Program for information on how Eligible Charges are determined for out-of-network care. To the extent that the amount billed by the provider is in excess of the Eligible Charge for such care, you will be responsible for the excess amount.

Eligible Team Member (Employee)

An individual who works in a common-law employee-employer relationship with the Company and who meets the eligibility requirements for medical, dental and vision coverage, as described in the Eligibility section of this SPD.

Emergency Medical Care (Emergency Services)

Services that a medical practitioner, exercising prudent clinical judgment, would provide to an individual experiencing an emergency medical condition, including:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

- Within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, such further medical examination and

treatment as required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Medical Condition

A medical condition (including a mental health condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Fully Insured

In a fully insured health plan:

- The Company pays a premium to the Insurer.
- The Insurer collects the premiums and pays the health care claims based on the coverage benefits outlined in the purchased plan.
- You are responsible to pay any deductible amounts or copays required for covered services.
- Certain benefit options under the Plan are Fully Insured.

Health Reimbursement Arrangement ("HRA")

An account funded solely by an employer used to reimburse team members for qualified medical expenses up to a maximum dollar amount for a coverage period. The contribution cannot be paid through a voluntary salary reduction agreement on the part of a team member. An HRA may be offered with other health plans, including Flexible Spending Accounts.

Illness

A bodily disorder or disease, including a mental health disorder or substance abuse.

Injury

An accidental physical injury to the body caused by unexpected external means.

Insurer

Any insurance carrier that insures, or partially insures, any benefit provided by this Plan.

Medically Necessary

See the coverage summary prepared by your Claims Administrator or Insurer for the applicable definition of Medically Necessary.

Medicare

The program established by Title XVIII of the Social Security Act.

Mental Illness (Mental Health Condition)

Illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, which is current as of the date services are rendered to a patient.

See the coverage summaries for specific coverages.

Qualified Medical Child Support Order ("QMCSO") or National Medical Support Notice ("NMSN")

A QMCSO or NMSN is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide health care coverage for a dependent child under the Plan (medical, prescription drug, dental, and/or vision coverage).

You may obtain a copy of the QMCSO administrative procedures, free of charge, from the Benefits Support Center. To be qualified, the medical child support order must meet the requirements of Section 609 of ERISA, including:

- The name and last known mailing address of the participant and the name and mailing address of each alternative recipient (dependent child subject to the order);
- A description of the coverage type to be provided by the Plan to each alternative recipient (e.g., medical, prescription drug, dental, and/or vision); and
- The period to which the order applies.

In any case, if subject to an order, you and each child will be notified about further procedures. You should notify the Plan Administrator if you are subject to a QMCSO or NMSN.

Participant

Any team member or beneficiary who is eligible for and elects to participate in a benefit under the Plan.

Provider (Healthcare Provider)

A doctor or physician, registered nurse, or facility (such as a hospital), that provides healthcare services. Includes a state-licensed or state-certified psychologist, psychiatrist, social worker, psychiatric nurse, counselor, therapist, or facility that provides mental health and substance abuse treatment.

Self-Insured

In a self-insured plan, the Company acts as its own insurer. That is, the Company uses the money it would have paid the insurance company and instead directly pays health care claims to providers.

Certain benefit options under the Plan are Self-Insured.

Spouse

The person to whom you are legally married under the laws of any state or foreign jurisdiction. This includes civil unions where applicable under state law.

Summary of Benefits and Coverage ("SBC")

A concise statement of your coverage that will be provided at the time of the Company's Open Enrollment each year. It details, in plain language, simple and consistent information about your health care options and coverage. The SBC is designed to help you better understand the coverage you have and to allow you to easily compare your coverage with other coverage options you may have. It summarizes key features of the coverage, including cost-sharing provisions, coverage examples, and limitations and exceptions that may apply. The SBCs can be accessed at the Benefits Support Center. You may also request a copy, at no cost to you, from the Benefits Support Center.