2017 Employee Benefits Handbook

For Abbott Employees

This Handbook describes the key features of major benefit programs offered to employees of Abbott and participating U.S. subsidiaries effective January 1, 2017. It describes only the highlights of the plans and does not attempt to cover all of their details. For additional information on your benefits go to: www.abbottbenefits.com for links to the Summary Plan Descriptions (SPD's) or connect through the HR Portal.

Benefits and services described in this Handbook apply only to those employees who are eligible under the individual plans, policies or programs. Nothing in this Handbook is intended to create or enlarge any contractual employment obligation between Abbott and its employees. This Handbook, in conjunction with the detailed medical plan booklets and SPD's as defined in the Employee Retirement Income Security Act of 1974 (ERISA) and supersedes all prior plan descriptions. Abbott reserves the right to change or end its benefit plans or programs at any time.

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Your Abbott Employee Benefit Programs

At Abbott, we help people unlock all that life has to offer through the power of health. And as an employer, Abbott recognizes that our ability to deliver on that promise starts with you. Your work enables us to create possibilities for the people we serve. And our employees are as important as our consumers

That's why Abbott offers innovative programs and solutions that deliver value both to the company and to our employees – programs that reward your efforts, recognize our rich diversity, promote healthy lifestyles, help you balance work and family needs and provide solid financial security. This Handbook is provided for your use as a reference. It is designed to provide you with an overview of our benefit plan and programs. Detailed descriptions for individual medical options are contained in the Summary Plan Descriptions (SPD's) and plan booklets provided are available online. Please refer to relevant sections whenever necessary. The Handbook also provides contact information to get you to the right resources whenever you have questions.

The information in this handbook is current as of January 1, 2017. Plan benefits, policies and programs may change from time to time. Changes are announced to you in writing as they occur. Abbott intends to update the online version of this Handbook and the accompanying medical booklets annually. These materials are available on the Benefits Web site at www.abbottbenefits.com and on Abbott's personalized HR portal.

Abbott Benefits Center and myHRTeam

The **Abbott Benefits Center** is ready to help with all your Benefit needs.

Phone: (**844) 30-MY-ABC (844-306-9222)** toll free, 7 a.m to 7 p.m., CST, Monday through Friday (outside of the United States use: +1-312-843-5221)
Online: **www.abbottbenefits.com**

myHRTeam is your resource for questions on vacation, sick time and employee relation issues.
Phone: (877)-228-4707

The chart below defines which team to contact:

Abbott Benefit Program	Abbott Benefits Center	MyHRTeam
Adoption Assistance		√
Accidental Death & Life Insurance	√	
Annuity Retirement Plan	√	
Business Travel Accident Plan	√	
Cash Profit Sharing		√
Commuter Benefits Program		√
Dental Coverage	√	
Employee Assistance Plan (EAP)	√	
Long-Term Disability (LTD)		√
Flexible Spending Accounts (FSA)	√	
Holiday Pay		√
Legal Referral Services	√	
Long-Term Care Insurance	√	
Medical Coverage	√	
Sick Pay		√
Stock Retirement Plan (SRP)	√	
Vacation Pay/Accrual		√
Vision Care (VSP)	√	
Workers Compensation		√
Work/Life Services	√	

LiveLifeWell

At Abbott, our core mission centers on enhancing life – by creating solutions that improve the lives of patients and by developing new ways for others to maintain and enhance their health. We're working to make the principle of enhancing life an integral part of your experience as an Abbott employee.

Abbott offers employee benefits that give you more convenience, more security, and a more healthy and active lifestyle. We encourage you to take advantage of these benefits to help you live life well.

Eligibility and Enrollment

If you are a regular employee of Abbott working a schedule of 20 or more hours per week, you are eligible for most plans and programs described in this Handbook. Part-time employees working a schedule of less than 20 hours per week and temporary employees are eligible for limited benefits (see chart below). Pay-related benefits are prorated based on scheduled hours.

Here's a summary of the eligibility requirements at most U.S. locations.

ABBOTT BENEFIT PROGRAM	WHO IS ELIGIBLE	
	Regular Employees	Temporary Employees
Adoption Assistance	Yes[1]	No
Accidental Death Insurance	Yes	No
Annuity Retirement Plan	Yes[2]	Yes[2]
Business Travel Accident Insurance	Yes	No
Cash Profit Sharing	Yes[3]	Yes[3]
Commuter Benefits Program	Yes[1]	No
Dental Coverage	Yes[1]	No
Employee Assistance Program	Yes	Yes
Long-term Disability Plan	Yes[1]	No
Flexible Spending Accounts (FSAs)[4]	Yes[1]	No
Life Insurance	Yes	No
Holiday Pay	Yes	Yes
Legal Referral Services	Yes	Yes
Long-Term Care Insurance	Yes[1]	No
Medical Coverage	Yes[1]	No
Sick Pay	Yes[1]	No
Stock Retirement Plan (SRP)	Yes	Yes[5]
Vacation Pay	Yes	No
Vision Care	Yes[1]	No
Workers' Compensation	Yes	Yes
Work/Life services	Yes	Yes

[1] Eligible if working a schedule of 20 or more hours per week
[2] Must be 21 years of age or older
[3] Eligible employees in participating divisions only; co-ops and interns are not eligible
[4] U.S. Global Assignees are not eligible to participate in dependent day care FSAs
[5] Seasonal employees and interns must have one year of service to be eligible

Individuals Who Are Not Eligible

The plans and programs described in this Handbook do not apply to individuals employed outside the U.S. or in Puerto Rico (except for certain designated transferred employees).

The Abbott Laboratories Annuity Retirement Plan (ARP) does not apply to employees who joined Abbott as a result of the BASF Pharma/Knoll or Solvay Pharmaceuticals acquisitions. Benefits for these employees are described in plan booklets available upon request from the Abbott Benefits Center**.**

You will be treated as an employee for purposes of these plans only if Abbott treats you as an employee for employment tax and wages withholding purposes, even if the U.S. Internal Revenue Service or other government agency later determines that you are a common law employee. Contract or leased employees are not eligible for Abbott benefit plans or programs.

Enrolling

At Hire

When you first become eligible for coverage, you will need to make the following decisions:

- Select the health care (medical, dental and vision) and life insurance options that best meet your needs
- Indicate your Health Savings Account pre-tax contribution amount and HSA bank for company funding if you elect the Health Investment Plan medical option
- Indicate health care and dependent day care flexible spending accounts pre-tax contribution amount for the current calendar year
- Designate beneficiaries for life insurance, accidental death and dismemberment insurance and business travel accident insurance

If you do not take action, you will automatically receive the following benefits:

- Medical coverage – UnitedHealthcare Health Investment Plan employee only coverage
- Dental – no coverage
- Vision – no coverage
- Flexible Spending Accounts – no coverage
- Life insurance – Basic coverage equal to one times your salary
- Accidental Death & Dismemberment (AD&D) – Basic AD&D of $10,000
- Annuity Retirement Plan – automatic participation

You will enroll in benefits online, via a secure website when you are first hired or during Open Enrollment. Complete all enrollments within 31 days after hire. For restrictions on making changes to your benefit elections after enrollment, refer to the Medical Plan SPD at www.abbottbenefits.com.

Annual Open Enrollment

An annual open enrollment period will be held each fall (usually in October). If you are a participant in the Abbott Laboratories Health Care Plan, you will be asked to make elections for the following calendar year for the following options:

- Your medical option and covered dependents
- Your dental option and covered dependents
- Your vision option and covered dependents
- Your pre-tax contributions to a Health Savings Account
- Your pre-tax contributions to health care and/or dependent day care flexible spending accounts (FSAs)

Abbott generally announces health care choices available for U.S. employees and the weekly cost for each option shortly before the annual enrollment begins.

You will receive an overview of plan changes and instructions on enrolling online. Annual enrollment options will be available at www.abbottbenefits.com on the first day of the open enrollment period. The enrollment deadline will be prominently displayed in your enrollment materials.

Any elections you make during the annual open enrollment are effective the following January 1.

If You Don't Reenroll

If your enrollment is not completed by the announced deadline, Abbott will default your medical, dental, and vision coverage for the upcoming calendar year and you will not be enrolled in either of the FSA's. If you elect coverage for a spouse or domestic partner, your spousal surcharge choice from your prior year election carries over to the next year.

The options that will be assigned to you if you don't reenroll are identified each year in your enrollment materials. These assigned benefits cannot be changed until the following annual open enrollment period.

Enrollment Changes

Once your health care elections have been recorded, you cannot change your elections during a calendar year unless you have certain family status, employment or residence changes.

Network Changes

It's important to note that hospitals, physicians and other health care providers may join or leave the plan's network throughout the year. These events are not considered qualified "status changes" under the Abbott Laboratories Health Care Plan and would not permit you to change to another medical option mid-year.

Changing Your Health Care Elections

Following is a list of events that allow you to make certain changes in your health care or flexible spending account (FSA) elections during a calendar year. You can change your contribution to the Health Savings Account at any time. This list reflects all circumstances where mid- year changes will be allowed under these plans. **All changes must be at www.abbottbenefits.com within 31 days after the event occurs.** You may need to provide proof of any change in eligibility.

Family Status Events

For medical, dental, and vision coverage and health care FSA changes, the following family status events will be recognized:

- A change in your marital status, including marriage, death of spouse, divorce, legal separation and annulment
- An event that changes your number of dependents, including birth, adoption, placement for adoption, or death
- Any of the following events that change your employment status or the employment status of your eligible dependents:
  - Termination or commencement of employment
  - Strike or lockout
  - Commencement of or return from an unpaid leave of absence
  - A change in work site that affects your eligibility for coverage under your current medical or dental option
  - Changes in eligibility conditions where you, your spouse, or your covered dependent become eligible or cease to be eligible for benefits under an employer-sponsored health plan or exhaust COBRA coverage.
- Your spouse's open enrollment window at his or her employer, and corresponding health care and FSA elections
- An event that causes your dependent to satisfy or cease to satisfy eligibility requirements for coverage
- A change in your place of residence or the residence of your spouse or eligible dependent that affects your eligibility for coverage under the plan
- A significant change in your spouse's health care coverage attributable to your spouse's employer

Some of these family status events will also be recognized as valid reasons to allow changes to your Dependent Day Care FSA.

Under federal income tax regulations, expenses incurred for your domestic partner or your domestic partner's children are not eligible for reimbursement from your FSAs. Therefore, status changes for domestic partners are not qualified events for mid-year changes to FSAs.

Any mid-year changes that you make to your health care or FSA elections must be consistent with the event that has occurred. For example, at the end of the month that your dependent turns 26 years of age, he or she will automatically be dropped from your healthcare coverage. You will not, however, be eligible to change your plan option or to drop other dependents from your coverage.

Alternately, if you move outside of the service area of an HMO, you may change your health care option but not your dependent coverage (who you are covering) as a result of that event. You may change your Dependent Day Care FSA election if this relocation also results in a change to your dependent day care costs.

Summary of Events Allowing Election Changes

The table below provides a quick reference to events that allow mid-year election changes:

PERMISSIBLE EVENT	MID-YEAR CHANGE ALLOWED TO:			
	Medical, Dental, Vision Option for Employee	Dependent Coverage	Health Care FSA	Dependent Day Care FSA
Marriage	No[6]	Yes	Yes	Yes
Divorce, legal separation or annulment	No[7]	Yes	Yes	Yes
Commencement or termination of domestic partnership	No	Yes	No	No
Birth, death or adoption of a child	No	Yes	Yes	Yes
Death of a spouse or domestic partner	No[6]	Yes	Yes	Yes
Spouse's loss of employment/loss of coverage	No[6]	Yes	Yes	Yes
Spouse's commencement of employment	No	Yes	Yes	Yes
Relocation resulting in loss of eligibility	Yes	Yes	Yes	Yes
Strike or lockout	Yes	Yes	Yes	Yes
Unpaid leave of absence	No[8]	No[8]	Yes	Yes
Dependent loses eligibility for coverage	No	Yes	Yes	No
Dependent becomes eligible for group coverage	No	Yes	Yes	No
Dependent exhausts eligibility for COBRA	No	Yes	Yes	No
Dependent becomes eligible for Medicare or Medicaid	No	No	Yes	No
Qualified Medical Child Support Order (QMSCO)	No	Yes	No	No

[6] You may drop coverage, but may not change your medical, dental or vision option.
[7] Unless you have waived coverage under the health care plan. In that event, you may elect any medical, dental or vision option.
[8] If you do not elect to continue coverage during an unpaid leave of absence, your participation will be suspended. Your current year election will be reinstated upon your return to work.

Health Care Plan

Medical, dental, and vision care benefits are provided for eligible employees under the Abbott Laboratories Health Care Plan. The plan provides benefits for a broad range of health care expenses for you and your covered family members. The medical options available to you are based on your geographic eligibility area.

Detailed information about medical options under the plan is provided in the individual booklet (summary plan description/SPD) for each option. Summary plan descriptions for Abbott's self-funded medical options are available at www.abbottbenefits.com or connecting through the **myHR** portal. Paper copies of plan booklets are available upon request. Summary plan descriptions for insured medical options are available from the insurer.

Employees and pre-65 retirees who are enrolled in the BlueCross BlueShield and United Healthcare plans are eligible to access the Abbott Care Coordinators. Abbott Care Coordinators by Quantum Health are an expert team of nurses, patient service representatives and benefits specialists, who are available to help you before, during and after any health event. The team will make sure you get the best possible care for you and your family. They can help you with claims, billing and benefit questions; finding network providers; reducing out-of-pocket costs; and anything that can make the healthcare process easier for you.

Eligibility

If you are a regular employee of Abbott working a schedule of at least 20 hours per week, you are eligible to participate in the Abbott Laboratories Health Care Plan.

People who are not eligible to participate in this plan include part-time employees working a schedule of less than 20 hours per week (unless specifically designated), temporary employees, and outside contract workers. Regular employees who convert to a schedule of less than 20 hours per week are not eligible for this plan.

Eligible Dependents

Eligible dependents include:

- Your spouse or eligible domestic partner, and
- Your biological and legally adopted children (including children of a domestic partner), foster children and stepchildren up to the end of the month in which they turn age 26.

Abbott provides health care coverage for your spouse or your domestic partner. If you and your same-sex partner are married, you are both eligible for Abbott health benefits on the same basis as other married couples. However, depending on state tax requirements, a same-sex spouse may be treated as a domestic partner for state income tax purposes.

Domestic Partner Coverage

To qualify for enrollment of a *domestic partner*, you and your partner must meet all of the following criteria:

- Have shared a continuous committed relationship for no less than six months,
- Are not legally married to another person and have no other such relationship with any other person,
- Reside in the same household and intend to do so indefinitely,
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under law,
- Are at least 18 years old and mentally competent to enter into contracts, and
- Complete the Affidavit process on www.abbottbenefits.com

You may enroll your domestic partner within 31 days after you first meet the above criteria or during the annual enrollment period. If you do not enroll your domestic partner when first eligible, you must wait until annual open enrollment to add him or her, unless your domestic partner has a qualified status change.

If you cover your domestic partner, you may also cover your domestic partner's children until the end of the month in which they turn age 26, as well as children placed with you or your domestic partner while adoption proceedings are pending.

Tax Considerations

Under federal income tax law, the cost of health care coverage provided to an employee's domestic partner and the domestic partner's dependent children (that is, the amount that Abbott pays to cover your domestic partner and/or your partner's children) will be treated as taxable compensation. This value is shown as imputed income on your pay stub and W-2 statement. You will be required to pay federal, state and/or local income taxes, FICA, and other applicable taxes on this amount. Details on imputed income amounts are available from the **Abbott Benefits Center.**

Special Circumstances

Legal Guardianship or Custody

If you have sole legal custody or guardianship (as evidenced by court documents) for any child, that child may be eligible for plan coverage. You must provide copies of sole legal guardianship or custody papers to the **Abbott Benefits Center** so that coverage can be approved.

Handicapped Dependents

An unmarried dependent child who is not capable of self-support due to a physical or mental condition that began before age 26 and who had Abbott health coverage before age 26 may be eligible for continued dependent coverage. A physician's statement documenting the condition is required before age 26 and may be required periodically thereafter for coverage to continue. The plan administrator determines eligibility for this coverage. If you drop coverage for a handicapped child after age 26, this coverage will not become available at a later date.

Qualified Medical Support Orders

Federal law requires the plan, under certain circumstances, to provide coverage for your children, provided you pay the required premiums. The process begins when the plan receives a qualified medical child support order (QMCSO).

This means any judgment, decree or order, including approval of a settlement agreement, which:

- Issues from a court of competent jurisdiction pursuant to a state's domestic relations law,
- Requires you to provide group health coverage available under the plan for your children – even though you no longer have custody, and
- Clearly specifies your name and address, the names and addresses of each child covered by the order, a reasonable description of the coverage to be provided, the length of time the order applies and the plan(s) affected by the order.

The Abbott Laboratories Health Care Plan will provide written notification to you and each identified child that it has received a court order requiring coverage. If the plan receives a QMCSO, it must permit immediate enrollment. This means the children identified will be included for coverage as your eligible dependents. The child's custodial parent, legal guardian or a state agency can apply for coverage, even if you don't apply for coverage.

Dependents Not Living With You

If you cover dependents living away from you, your dependents are subject to the terms and conditions of your plan and must satisfy the requirements described in your medical option booklet to receive coverage, including pre-certification requirements and use of network providers.

Dependents not eligible

Dependents who are not eligible for this coverage include children of a domestic partner if the domestic partner is not covered, grandchildren (unless you have legal custody or guardianship), and dependent parents or siblings.

Individuals covered as Abbott employees cannot also be covered as dependents. A child covered as the dependent of an employee under this plan may not also be covered as the dependent of another employee under the plan. Adult children enrolled for coverage as Abbott employees may not also be covered as dependents.

If you become legally separated from or divorce your spouse, or terminate a domestic partnership, your former spouse or partner is no longer an eligible dependent and must be removed from coverage within 31 days after your legal separation, divorce or termination of domestic partnership. If your former spouse or domestic partner is not dropped from your coverage, you will be required to reimburse the plan for any payments made for the ineligible dependent, at the plan administrator's discretion. Coverage for a former spouse or domestic partner may be continued for a limited period of time following your divorce or separation under the plan's continuation of coverage provisions (COBRA).

Your Contributions

Abbott pays the majority of the cost for your medical coverage. You pay your share through pre-tax payroll deductions. Employee contributions are reviewed annually and are subject to change annually.

Your contributions are based on the level of coverage you choose. The coverage levels are:

- Employee only
- Employee plus spouse/domestic partner[10]
- Employee plus child(ren)
- Family (employee plus spouse/domestic partner and child(ren)) [10]

If you elect coverage for your domestic partner, you are responsible for imputed income tax. This means that the company's contribution for your domestic partner and your domestic partner's dependents are added to your taxable income. Details on this imputed income are available from the **Abbott Benefits Center** and on the Benefits Web site at www.abbottbenefits.com.

You may be able to reduce your medical contributions by taking the LiveLifeWell health assessment.

Waiver of Coverage

If you waive Abbott medical coverage and you become ineligible for your primary group health coverage (for example, if your spouse's employment terminates, you and your spouse divorce, or your spouse dies), you may enroll yourself and your eligible dependents on a pre-tax basis in any available option within 31 days after the loss of coverage.

If You Are Married to an Abbott Employee

If you are an eligible, active employee you may elect coverage under any health care option available in your eligibility area or you may elect to be covered as a dependent of your Abbott-employed spouse. This election provides no coverage on its own, and there are no contributions or credits associated with this election. If your spouse's Abbott employment terminates, you and your spouse divorce or your spouse dies, you may enroll yourself and your eligible dependents on a pre-tax basis in any available option within 31 days after the loss of coverage.

[10] An annual surcharge will be applied for spouse/domestic partner coverage or family coverage if your spouse/partner has access to medical coverage through another employer or is self-employed and sponsoring a plan for his/her employees. The surcharge does not apply if your spouse/partner is also an Abbott employee or if the only other coverage available is Medicare, Medicaid, retiree coverage or military coverage.

When Coverage Begins

Employee Coverage

Your medical, dental, and vision coverage begins on the earliest of the following dates:

- Your first day of employment or eligibility, provided you elect coverage within 31 days of that date, or
- January 1 of the calendar year following the annual open enrollment period, provided your enrollment is recorded by the announced deadline.

Dependent Coverage

Medical, dental, and vision coverage for your eligible dependents begins on the earliest of the following dates:

- Your first day of employment or eligibility, provided you elect coverage within 31 days of that date, or
- January 1 of the calendar year following the date the dependent is added during an annual open enrollment period, provided your enrollment is recorded by the announced deadline.

Coverage for new dependents begins on the following dates, provided the dependent change is received by the **Abbott Benefits Center** within 31 days after your family status change occurs:

- Biological children will be covered at birth
- Children for whom you have begun legal adoption proceedings will be covered on the date you assume and retain a legal obligation for total or partial support as evidenced by appropriate legal documents
- Other eligible children for whom you become legally responsible will be covered on the date you are granted legal custody or guardianship as evidenced by the appropriate legal documents
- A new spouse will be covered on the date of your marriage
- A spouse you did not previously elect to cover but whom you now elect to cover will be covered on the day after his or her employment terminates
- A domestic partner (and eligible domestic partner children) will be covered on the date your Affidavit of Domestic Partnership is signed

Changes Requested After 31 Days

To inquire about a change more than 31 days after the event date, please contact the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Coverage During a Leave of Absence

Your health plan coverage continues while you are on an approved leave of absence (LOA), provided you pay the required contributions for this coverage.

Your contributions during a family leave of absence (FLOA) or during the first six months of a medical leave of absence (MLOA) will be the same as the contributions paid by active employees for the same coverage.

If you are absent from work for more than 6 months, your employment with Abbott will terminate, except that a limited extension of leaves may be granted where necessitated by an employee's medical condition. If you are eligible to receive benefits under the Long-term Disability Plan, health care coverage for you and your covered eligible dependents is available under the Consolidated Omnibus Budget Reconciliation Act, called COBRA, for a limited time, provided you pay the required contributions. The contributions during the 18 month period will be the same contribution amounts as paid by active employees for the same coverage.

Dependent Coverage After Your Death

Limited survivor coverage

If you die while you are an active employee, have less than 15 years of service and are not eligible for any form of early retirement under an Abbott pension plan, medical, dental, and vision coverage will continue on your covered survivors for six months after your death at no cost to your dependents.

Your dependents may elect to continue coverage for up to 30 additional months under the plan's Continuation of Coverage provisions (COBRA).

Continuing survivor coverage

Continuing coverage under the Abbott Laboratories Retiree Health Care Plan will be available to your covered survivors if you die while active and have 15 or more years of Abbott service, or you are already eligible for any form of early retirement under an Abbott pension plan and you have at least three years of Abbott service [11].

[11] Eligibility requirements may differ for survivors of employees joining Abbott as a result of an acquisition or merger.

Coverage at Retirement

Coverage under the Abbott Laboratories Retiree Health Care Plan is available to eligible retirees with at least three years of Abbott service who are eligible to receive retirement benefits from an Abbott pension plan[12]. The Retiree Benefits Handbook describes Abbott retiree benefits, including health care. The Retiree Benefits Handbook is available from the **Abbott Benefits Center or on the benefits website at www.abbottbenefits.com.**

Retiree Medical — Your Cost

Under current rules, your share of retiree medical costs will be based on how many years of service you have at the time of retirement in accordance with the following schedule:

YEARS OF BENEFIT SERVICE	YOUR SHARE OF RETIREE MEDICAL COSTS
10	60.0%
11	58.0%
12	56.0%
13	54.0%
14	52.0%
15	50.0%
16	48.0%
17	46.0%
18	44.0%
19	42.0%
20	40.0%
21	38.7%
22	37.3%
23	36.0%
24	34.7%
25	33.3%
26	32.0%
27	30.7%
28	29.3%
29	28.0%
30	26.7%
31	25.3%
32	24.0%
33	22.7%
34	21.3%
35	20.0%

[12] Eligibility requirements and costs may differ for employees joining Abbott as a result of an acquisition or merger.

Retiree Dental

MetLife manages the retiree dental plan. Retirees can select from two options and establish payment plans directly with MetLife. Retirees pay the full cost of dental coverage, regardless of years of service.

Information about the dental options available to you will be sent to your home by MetLife within one month of your retirement. You will be able to enroll by contacting MetLife directly at 866-832-5756 or online at www.metlife.com/mybenefits.

When Active Coverage Ends

Employee Coverage

Your coverage will terminate on the earliest of the following dates:

- The date you fail to pay the required contributions,
- The date your employment terminates (for any reason other than retirement or your death).

Dependent Coverage

Your dependents' coverage will terminate on the earliest of the following dates:

- The date your coverage terminates (except in case of your death),
- The date they fail to qualify as eligible dependents under the plan, or
- The date you discontinue the required contributions for dependent coverage.

Suspension of Employment

The company reserves the right to suspend your participation in its health plans if your Abbott employment is suspended without pay.

Falsification of Information

If you knowingly submit false information on your enrollment data or claim form, or if you fail to notify the **Abbott Benefits Center** that an enrolled dependent is no longer eligible to participate in the plan, all participation may be immediately, permanently and retroactively cancelled. You may also be subject to disciplinary action, including termination of employment. You may be required to reimburse the plan for any payments made under false pretense or for ineligible dependents.

Patient Protection and Affordable Care Act of 2010

Before the Affordable Care Act, The Health Insurance Portability and Accountability Act (HIPAA) protected employees with preexisting conditions from losing coverage when they changed jobs. Employees received the protection by obtaining a “certificate of creditable coverage” from their employer.

Now, under the Affordable Care Act of 2010, effective for plan years starting on or after January 1, 2014, preexisting condition exclusions in plans are prohibited. In most cases, you will not need a certificate of creditable coverage if you change jobs. If, however, you do, you may obtain one by contacting the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Continuation of Coverage (COBRA)

Under certain conditions you, your spouse or other covered dependents may elect to continue health care coverage beyond the date it would otherwise stop — with the cost of coverage paid by you or your dependent. This continuation coverage, offered in compliance with the Consolidated Omnibus Budget Reconciliation Act, is commonly called COBRA.

This COBRA coverage is available to[13]:

- You and your dependents, if your coverage stops because of the termination of your employment (for reasons other than gross misconduct), military leave, or a change in your employment status which makes you ineligible for the plan
- Your spouse, upon your death, divorce or legal separation
- Your children, upon your death or when they no longer qualify as eligible dependents under the plan
- You and your dependents if you are approved for Long-term Disability benefits

If you or your dependent becomes eligible for coverage under this provision, the company will send a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage.

If You Are the Covered Spouse of an Abbott Employee

If you are the spouse of an employee covered by the plan, you have the right to choose continuation coverage under the plan for any of the following reasons:

- The death of your spouse
- Termination of your spouse's employment (for reasons other than gross misconduct) or a change in your spouse's employment status with Abbott that makes your spouse ineligible for coverage, or
- Divorce or legal separation from your spouse, or if your coverage is dropped during an annual open enrollment in anticipation of a divorce or legal separation

You or your spouse must notify the **Abbott Benefits Center** within 60 days after the loss of coverage to preserve your rights under COBRA.

[13] Continuation coverage equivalent to the COBRA coverage described in this section is available to your covered domestic partner and children of your covered domestic partner.

If You Are the Covered Child of an Abbott Employee

If you are the dependent child of an employee covered by the plan, you have the right to choose continuation coverage under the plan for any of the following reasons:

- The death of your Abbott-employed parent
- Termination of your Abbott-employed parent's employment (for reasons other than gross misconduct) or a change in his or her employment status with Abbott that makes you ineligible for coverage
- Your parents' divorce or legal separation
- You cease to be a "dependent child" under the terms of the plan

A child born to or placed for adoption with a COBRA participant during the period of continuation coverage is also eligible for coverage for the remainder of the continuation period as long as the COBRA Administrator is properly notified. You or your parent must notify the **Abbott Benefits Center within** 60 days after the loss of coverage to preserve your rights under COBRA.

What You Need to Do

You, your spouse or your child must notify the **Abbott Benefits Center** within 60 days after the loss of coverage (that is, within 60 days after the divorce date or the date a child's eligibility ends) to preserve your rights under COBRA. Upon notification, the plan administrator will send a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage. If the loss of coverage is due to termination of your employment or a reduction in hours, the plan administrator will automatically send you a notice upon receiving confirmation of your qualifying event.

You or your former dependent(s) must elect to continue coverage within 60 days after the notice of the right to continue coverage is sent (or after the date coverage terminates, if later). You have an additional 45 days to pay the back premium necessary to avoid a break in coverage. If coverage is not elected during this 45-day grace period, it is not offered again.

The cost of coverage is paid on an after-tax basis. As long as required premiums are paid, coverage can continue up to:

- 18 months after termination of your employment or a change in your employment status
- 24 months after your military leave of 31 or more days
- 30 months for dependents who wish to continue coverage after your death (in addition to the automatic six-month extension)
- 36 months if dependent coverage stops for any reason other than your death, termination of employment or a change in your employment status

An 18-month period of continuation coverage may be extended for up to 11 months (for a total of up to 29 months of continuation coverage) if you or your covered dependent is determined to be disabled for Social Security disability purposes at the time of the loss of coverage or within 60 days after that date. The Plan Administrator must be notified within 60 days after the determination of disability is made and before the end of the 29-month period.

COBRA coverage will stop earlier if:

- The required premiums are not paid in time
- You or your dependent becomes covered by another group plan. If, however, the group plan lawfully limits or excludes coverage for a preexisting condition, COBRA may be continued for that condition for the remainder of the eligibility period or until the limitation ends (whichever comes first)
- During a 29-month extension due to disability, there is a final determination that you are no longer disabled. The Plan Administrator must be notified within 30 days of any such determination
- The Abbott Laboratories Health Care Plan ends

Coverage Provided Under COBRA

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage provided under the plan to similarly situated employees or their family members. Like active employees, Abbott plan members with COBRA coverage receive annual open enrollment information each fall and have the same opportunities to change coverage for the following calendar year.

COBRA Coverage and Medicare

If you or your dependent becomes entitled to Medicare prior to electing COBRA coverage, you or your dependent may still elect COBRA coverage. Medicare is treated as the primary coverage and COBRA is treated as the secondary coverage, regardless of whether you or your dependent has enrolled in Medicare coverage. Because of this, it is important to enroll in Medicare benefits when the COBRA qualifying event occurs, if you or your dependent had not enrolled when first eligible.

If you or your dependent becomes entitled to Medicare after COBRA was elected, COBRA coverage ends.

Affordable Care Act

There may be other coverage options for you and your family. Under the Affordable Care Act, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace.

Medical Options

You and Abbott share the cost of your health care expenses when you participate in the Abbott Laboratories Health Care Plan. Medical options under the plan can help you with expenses for a broad range of hospital, surgical, medical and prescription drug expenses.

Each year, you can choose a medical option from among those offered within your eligibility area. If you do not want to have medical coverage under any of the options that are offered to you, you can waive benefits by electing no coverage.

You can confirm which medical option you have elected at any time by visiting the Benefits Web site at www.abbottbenefits.com.

Your Eligibility Area

The health care options available to you as an Abbott employee are based on the geographic eligibility area in which you reside, as determined by your home zip code.

When you are hired, and during each annual enrollment period, information about the plans offered within your eligibility area will be provided by the **Abbott Benefits Center**. You can also view your available medical options by accessing the Benefits Web site at www.abbottbenefits.com. Call the **Abbott Benefits Center** at **(844) 30-MY-ABC (844-306-9222)** to confirm availability of any medical or dental option.

If you have enrolled in a medical option specific to your eligibility area and you move outside that eligibility area, you will need to make a new election from among those offered within your new eligibility area.

Comparing Your Medical Options

When you are hired, and during each annual open enrollment period, information about the options offered within your eligibility area will be provided on the Benefits Web site at www.abbottbenefits.com.

If you have chronic conditions such as low back pain, heart disease or cancer, contact the Abbott Care Coordinators to learn about any special programs they may have to help you manage these conditions.

National Medical Options

Most employees are able to select from five national plans:

- BlueCross BlueShield Health Investment Plan (PPO HIP)
- BlueCross BlueShield PPO Plus (PPO)
- UnitedHealth care Health Investment Plan (PPO HIP)
- UnitedHealth care PPO Choice plus (PPO)

These plans are not available in Hawaii. The BlueCross BlueShield Health Investment Plan is the only national plan available in AltaVista, Virginia.

If you are enrolled in a Health Investment Plan (HIP) you are automatically eligible for the Health Savings Account (HSA). You can contribute to this account with pre-tax dollars to pay for future healthcare expenses, Abbott also makes an annual contribution to your HSA of: employee-only coverage $200.00, Family coverage $400.00.

Detailed information about these options, including plan booklets (summary plan descriptions), is available at the Benefits website at www.abbottbenefits.com and on the **myHR** portal. Paper copies of plan booklets are available upon request by calling the Abbott Benefits Center.

Employees and pre-65 retirees who are enrolled in the BlueCross BlueShield and UnitedHealth care plans are eligible to access the Abbott Care Coordinators. Abbott Care Coordinators by Quantum Health are an expert team of nurses, patient service representatives and benefits specialists, who are available to help you before, during and after any health event. The team will make sure you get the best possible care for you and your family. They can help you with claims, billing and benefit questions; finding network providers; reducing out-of-pocket costs; and anything that can make the health care process easier for you.

Regional Medical Options

Other plans are available in some areas. If you're eligible for one of more of these plans, you will see the detailed information online when you enroll.

- CIGNA Global – U.S. Global Assignees
- Kaiser HMO – Northern and Southern California
- Piedmont PPO – AltaVista, VA
- BCBS PPO Hawaii

Medical Coverage Options When You Turn Age 65

Active employees

If you continue to work beyond age 65, your medical coverage options are unchanged. If you retire at or after age 65, your Abbott health care options will change because Medicare will become your primary coverage.

Retirees

Abbott offers coverage in the Retiree Indemnity with Medicare option for Medicare-eligible retirees. This plan acts a secondary coverage to Medicare. UnitedHealthcare administers this option. When you switch to the Retiree Indemnity with Medicare option mid-year, your annual medical and prescription out-of-pocket maximums and deductibles will start over. If you or your dependents are enrolled in the Kaiser HMO and you or your dependents become Medicare eligible, the non-Medicare eligible retiree or dependent will be defaulted to the UnitedHealth Care Health Investment Plan (HIP). Split coverage is not allowed with the Kaiser HMO plan. Call the Abbott Benefits Center at (877) 30-MY-ABC (844-306-9222) for more details and to find out your options.

Covered Benefits and Exclusions

Detailed information about covered benefits and exclusions – what is not covered-is provided in the individual plan booklet (summary plan description) for each medical option. Summary plan descriptions for Abbott's self-funded medical options are available on the Benefits Web site at www.abbottbenefits.com and on the **myHR** portal. Paper copies of plan booklets are available upon request. Plan descriptions for insured medical options are available from the insurer.

Appeals

If you are notified that a claim has been denied in whole or in part, you may question that decision informally and/or formally by taking the steps described in the individual plan booklet for your medical option. Summary plan descriptions for Abbott's self-funded medical options are available on the Benefits Web site at www.abbottbenefits.com and on the **myHR** portal. Paper copies of plan booklets are available upon request. Plan descriptions for insured medical options are available from the insurer.

Dental Coverage

Abbott dental benefits are provided to help you pay for the costs of dental care for you and your eligible family members. Benefits are payable for a range of dental expenses, including preventive care, basic and major restorative services and orthodontics. Dental coverage is offered at all U.S. locations.

Metropolitan Life Insurance Company (MetLife) is the claims administrator for the dental plan. You can confirm your dental enrollment at any time by visiting the Benefits website at www.abbottbenefits.com**.**

U.S Global assignees are enrolled in the CIGNA option.

Highlights of Dental Coverage

- Preventive and Diagnostic Services
  - Exams, X-rays, Cleanings and Fluoride treatments
- Routine Services
  - Fillings, Oral Surgery, Root canals
- Major Services
  - Crowns, Dentures, Orthodontics
- TMJ treatment
- Removal of Impacted Teeth

Plan Benefits and Exclusions

Detailed information about covered benefits and plan exclusions – what is not covered - is provided in the individual plan booklet (summary plan description) for your elected dental coverage. A summary plan description for the MetLife dental plan is available on the Benefits website at www.abbottbenefits.com and on the **myHR** portal. Paper copies of plan booklets are available upon request. A plan description for the CIGNA Global dental option is available from the insurer.

Appeals

If you are notified that a claim has been denied in whole or in part, you may question that decision informally and/or formally by taking the steps described in the individual plan booklet (summary plan description) for your elected dental option. A summary plan description for MetLife dental options is available on the Benefits Web site at www.abbottbenefits.com and on the **myHR** portal. Paper copies of plan booklets are available upon request. A plan description for the CIGNA Global dental option is available from the insurer.

Vision Care

Abbott offers a vision care option under the Abbott Laboratories Health Care Plan. To receive vision care benefits, you must elect this option and pay the required employee contribution. Vision Service Plan (VSP) is the insurer for this option. VSP pays all claims for this option and benefits payable are determined by the insurance contract. Contact VSP Member Services at **(800) 877-7195** or visit their web site at www.vsp.com/go/abbott.

Highlights of VSP Coverage

- A preventive eye exam is covered in full after a $15 copayment once every calendar year; excluding contact lens fitting and evaluation
- Prescription eyeglass lenses (single vision, lined bifocal, or lined trifocal lenses) are covered after a $25 copayment once every calendar year
- Frames are covered up to $200 (or upto $250 for featured brand frames) after a $25 copayment once every other calendar year (when prescription eyeglass lenses and frames are covered in the same year, they must be purchased together and only one $25 copayment applies)
- Anti-reflective coating on lenses is available after a $25 copayment
  Contact lenses are covered up to $200 once every calendar year. The coverage limit applies to lenses, lens fitting, and evaluation
- Coverage is limited to contact lenses or eyeglass lenses every calendar year. Each year you choose one or the other.
- Coverage for frames is available every other calendar year, providing that you choose eyeglass lenses
- If you currently wear contacts, you may qualify for a special **VSP Contact Lens Care Program**[SM]. This program includes a contact lens exam and initial supply of contacts. Your VSP doctor will determine if you qualify for this program. Ask your doctor for more details.
- You can access hearing aid discounts though VSP

Additional requirements and limitations for this option are described in the program materials provided to eligible employees from the insurer and on the VSP web site at www.vsp.com/go/abbott.

VSP members are not required to complete any paperwork when services are received from a VSP network provider and VSP pays the provider directly.

A member's participation in a medical coverage option under the Abbott Laboratories Health Care Plan will not affect his or her eligibility for this option. VSP will not, however, duplicate benefits paid under a medical option of this Plan or other group medical coverage.

This option is subject to the continuation coverage provisions under the Consolidated Omnibus Budget Reconciliation Act (COBRA) applicable to the Abbott Laboratories Health Care Plan.

Long-Term Care Insurance

Abbott offers a Long-Term Care (LTC) insurance program under the Abbott Laboratories Health Care Plan. Benefits for this program are described in the Long-Term Care documents provided to eligible employees from the LTC insurer.

Active employees who work 20 or more hours per week, new hires age 66 and above retirees and their eligible dependents may electcoverage under this program with evidence of good health acceptable to the insurer.

Special provision for new employees: Coverage is available to eligible newly hired employees age 65 and under enrolling within 60 days after first becoming eligible for this benefit on a modified guaranteed acceptance basis (with short version evidence of good health).

Eligible dependents include:

- Your spouse or eligible domestic partner (age 18 or older)
- Your parents and parents-in-law
- Parents of your domestic partner
- Your grandparents and grandparents-in-law
- Your adult children (age 18 or older)
- Your spouse or domestic partner's adult children (age 18 or older)
- Siblings, stepsiblings, siblings-in-law
- Spouses of your eligible adult children (age 18 or older)

The insurer pays all claims for this program and benefits payable are determined by the insurance contract.

An employee's participation in a medical coverage option under the Abbott Laboratories Health Care Plan will not affect his or her eligibility for this program. LTC coverage will not, however, duplicate benefits paid under a medical option of this Plan or other group medical coverage.

This program is not subject to the continuation coverage provisions under the Consolidated Omnibus Budget Reconciliation Act (COBRA) applicable to the Abbott Laboratories Health Care Plan. However, this program offers guaranteed continuation of coverage to you if you pay monthly premiums directly to the insurer after you leave Abbott.

To learn more about the program, get a rate quote and enroll online, visit Genworth Life's website: www.genworth.com/abbott or call (800) 416-3624, Monday through Friday, 7 a.m.-7 p.m. CT

Privacy of Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the health plan's privacy notice, which is available at www.abbottbenefits.com or upon request by calling the Abbott Benefits Center (844) 30-MY-ABC (844-306-9222).

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, disclose protected health information to Abbott Laboratories, the Plan Sponsor, for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information.

You also have the right to file a complaint within the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please write to the Divisional Vice President, Employee Relations, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064.

Coordination of Benefits

Coordination of benefits between health plans is necessary when you have more than one insurance, so that the combined payments of all of the plans do not exceed the amount of the expense. When two group health plans cover someone, the plan that pays benefits first is called the primary plan and the other plan is called the secondary plan.

In general, the following rules apply:

- If your spouse or eligible domestic partner is covered by another group health plan as an employee or retiree and is a dependent on your Abbott plan, the Abbott plan coverage is secondary for your spouse or domestic partner's claims.
- If this plan and another group plan cover your dependent children, a "birthday rule" determines which plan is primary. Children's benefits are paid first by the plan of the parent whose birthday (month and day) falls earlier in the calendar year.

Non-duplication

The Abbott Laboratories Health Care Plan follows non-duplication of benefits when coordinating payments with other plans. In other words, the Abbott plan does not duplicate benefits payable under any other group health plan, or Medicare. When the Abbott plan is primary, it will pay its full benefits.

When the Abbott plan is secondary (that is, another health plan pays benefits on a claim first), your Abbott plan payments are offset by the other plan's benefits. As a result, for each secondary claim received:

- If the primary plan paid the same (or more than) the amount payable under the Abbott plan, the entire Abbott benefit is offset and no additional payment is made by Abbott, and
- If the primary plan paid less than the amount payable under this plan, the Abbott plan pays the difference between its usual benefit payment and the amount paid by the primary plan.

Coordination of benefits will not apply to individual insurance policies you purchase. Some insured plans will not coordinate benefits. Refer to your individual medical plan booklet for details.

If You Become Eligible for Medicare

Just before you reach age 65 or if you or a dependent becomes disabled, you should request information from your local Social Security Administration office regarding Medicare benefits and enrollment procedures. For more information about your Medicare benefits, please call the Social Security Administration at **(800) 772-1213**, or visit the Medicare website at www.medicare.gov.

Active Employees

If you or your dependent is entitled to Medicare benefits while you are covered by the Abbott Laboratories Health Care Plan for active employees, the Abbott plan will generally continue to be your primary coverage. The rules for determining whether Medicare is primary or secondary:

- If you continue to work beyond age 65, your medical coverage options are unchanged and the Abbott plan remains primary for you and your covered dependents. This plan is also primary for a dependent entitled to Medicare benefits. Claims must be sent to the Abbott claims administrator before they are sent to Medicare.

- This plan is also primary if you or your dependent is entitled to Medicare benefits because you need kidney dialysis for end-stage renal disease (ESRD) – a severe disorder of the kidneys. In most cases, if you are eligible for benefits due to ESRD, however, Medicare will become the primary payer after 30 months, even if you continue to be an active employee.

Retirees

Just before you reach age 65 or if you or a dependent becomes disabled, you should request information from your local Social Security Administration office regarding Medicare benefits and enrollment procedures. For more information about your Medicare benefits, please call the Social Security Administration at **(800) 772-1213**, or visit the Medicare Web site at www.medicare.gov.

Medicare is the primary payer on your medical claims after retirement. Non-duplication, as described on the preceding page, applies to any individual for whom Medicare is the primary payer, including those retirees and dependents under age 65 who are eligible for Medicare due to disability. All Abbott plan benefits will be offset by Medicare's payments.

If you or a dependent is eligible for Medicare, you are required to sign up for Parts A and B and notify the Abbott Benefits Center. If you elect Part B coverage when you are first eligible, a premium is deducted from your Social Security checks. The longer you wait to elect Part B, the higher your premium for that coverage will be. Further, if you (or a dependent) are entitled to benefits under Medicare Parts A and B, but have not applied for those benefits, the plan will determine its benefits as if you had. Call the **Abbott Benefits Center** at **(844) 30-MY-ABC (844-306-9222)** if you have any questions regarding Coordination of Benefits with Medicare.

Subrogation and Right of Recovery

Subrogation

When the Abbott Laboratories Health Care Plan (Plan) pays medical bills for you or your covered dependent, and another party or insurance company is responsible for those bills, the Abbott plan is entitled to recover its payments made to you or your dependent.

If a claim for expenses resulting from an accident is received, you will be asked to provide information about your insurance company and claim - including the claim number - to the Plan Administrator or its designee.

You may also be asked to provide information regarding treatment given to you or your dependent. If the accident is due to the negligence or wrongdoing of someone else or if benefits are covered by a liability or auto insurance policy, the plan will recover any monies it has paid from amounts you later receive from the other person, his or her insurance company or from any lawsuit.

You are responsible for taking any reasonable action necessary to protect the plan's right to recover. Any activity on your or your dependent's part that impedes this right to recovery could void benefits under the Abbott Laboratories Health Care Plan.

Right of Recovery

Abbott has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Paid in error
- Due to a mistake in fact, or due to a misrepresentation of facts
- Advanced during the time period of meeting a calendar year deductible or out-of-pocket limit

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will require that the overpayment be returned when requested, or reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Administrative Information

Plan Identification

The name of the plan is The Abbott Laboratories Health Care Plan. Abbott Laboratories is the plan sponsor. The Benefits Department of Abbott is the Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 501

Plan Funding

Benefits and premiums are paid from a combination of the Company's general assets and employee contributions.

Self-Insured Options

The options listed below are self-insured. That means that benefits are paid from a combination of the Company's general assets and employee contributions. A third party Claims Administrator provides administrative services only. Administrative services include claims processing (customer service and utilization review), network management and reporting services.

- BlueCross BlueShield PPO Plus (administered by Ameriben)
- BlueCross BlueShield Health Investment Plan (administered by Ameriben)
- BCBS PPO Hawaii
- Piedmont POS – Altavista, VA
- UnitedHealthcare Choice Plus (administered by UMR)
- UnitedHealthcare Health Investment Plan (administered by UMR)
- MetLife Dental

Fully Insured options

Abbott has arranged for benefits under certain options to be provided entirely through insurance. The insurer provides all administrative services for these options, including claims payment. The following options are fully insured:

- CIGNA Global Indemnity[15]
- Kaiser HMO – Northern and Southern California
- Vision Service Plan (VSP)
- John Hancock Long-Term Care (participants enrolled prior to December 21, 2011 only)
- Genworth Life Insurance Company Long-Term Care (effective June 11, 2012)
- Securian Life Insurance
- Chubb Business Travel Accident Insurance

Participating Employers

The Abbott Laboratories Health Care Plan applies to eligible employees of Abbott Laboratories and its subsidiaries.

Plan Changes

Abbott intends to continue the Abbott Laboratories Health Care Plan indefinitely, but reserves the right, by appropriate action by the Executive Vice President, Human Resources, to change it at any time, including:

- The right to change any amounts contributed by Abbott or its employees and other plan participants toward the cost of providing benefits
- The level of benefits provided
- The class or classes of employees eligible for plan benefits

Coverage under the plan is not a guarantee of employment, and Abbott reserves the sole right by appropriate action by its CEO to terminate the plan at any time, either in its entirety or with respect to any covered class or classes of employees.

If the plan is discontinued, benefits, if any, will be paid for all charges incurred for covered expenses before that date.

[15] U.S. Global Assignees are eligible for medical and dental coverage through this insured health care option.

Flexible Spending Accounts

Flexible spending accounts (FSAs) allow you to pay for certain expenses with tax-free dollars. If you elect to participate, you direct a part of your pay, on a pre-tax basis, into special accounts that can be used throughout the year to reimburse yourself for certain out-of-pocket health care or work-related dependent day care expenses. Because this money goes into your accounts before federal income taxes and Social Security taxes are withheld, you pay less in taxes and ultimately have more disposable income.

As you incur eligible expenses during the year and pay for them out of your own pocket, you reimburse yourself from your FSAs with tax-free money.

Abbott offers two FSAs for eligible employees:

- Health Care Flexible Spending Account (HCFSA)
- Dependent Day Care Flexible Spending Account (DCFSA)

You may elect to participate in either or both accounts. The health care and dependent day care spending accounts are completely separate programs, however, and money cannot be transferred between these accounts.

Internal Revenue Service regulations require that your contributions for any calendar year be used for eligible expenses incurred during that calendar year and grace period (for Abbott employees, through the following March 15) or they will be forfeited. It's advisable, therefore, to consider carefully what you expect your eligible expenses will be before making your FSA enrollment decisions.

Eligibility

If you are a regular employee of Abbott Laboratories and are working a schedule of 20 hours or more per week, you are eligible to participate in FSAs on your hire date or the date of your conversion to an eligible status, if later. U.S. Global Assignees are eligible to participate in health care FSAs only. You can verify your employment status with the **Abbott Benefits Center** by calling **(844) 30-MY-ABC (844-306-9222).**

If you and your spouse are both eligible employees of Abbott, each of you may join the plan and elect separate FSA accounts. Your combined contributions to dependent day care FSAs, however, may not be more than the annual IRS limit. This combined limitation also applies if your spouse works elsewhere and contributes to a dependent day care FSA through his or her employer.

Employees who are **not** eligible for FSAs include part-time employees working a schedule of less than 20 hours per week (unless specifically designated), temporary employees and contract workers. U.S. Global Assignees are not eligible to participate in DCFSA. Eligible employees who convert to a schedule of less than 20 hours per week are no longer eligible for FSAs, but may be eligible to continue health care FSA coverage for a limited period of time under the plan's continuation of coverage provisions (COBRA).

Enrollment

New Employees

You have 31 days from your date of hire to enroll in FSAs. To enroll, you must complete your election by logging on to the Benefits Web site at www.abbottbenefits.com.

Before you make this election, you will need to estimate the eligible expenses you are likely to have during the remainder of the current calendar year. Only those expenses incurred on or after the effective date of your enrollment will be eligible for reimbursement. Your election generally cannot be changed until the next open enrollment period.

Annual Enrollment

An annual open enrollment period will be held each fall (usually in October). The annual enrollment for active employees is conducted via the Benefits Web site. The enrollment deadline will be announced by the **Abbott Benefits** each year and will be prominently displayed in your enrollment materials. You must enroll by the deadline. Any elections you make during the annual open enrollment are effective the following January 1.

When Coverage Begins

Your pre-tax contributions begin with the first pay period following:

- Your first day of employment, if you elected coverage within 31 days of your hire date
- The date of your election, if you elected a contribution change within 31 days after a qualified status change
- January 1 following the date of your election if your enrollment is received during the annual enrollment period.

Your Contributions

Your health care and dependent day care FSAs are funded with your contributions, which are made through pre-tax payroll deductions — that is, deductions made before federal income and FICA taxes are determined. In most cases, your contributions are exempt from state and local taxes as well. Check with your tax advisor to find out if this tax exemption applies in your state of residence. Your contributions are made in equal increments per pay period over the course of the plan year. The Internal Revenue Service does not allow interest to be paid on FSA balances.

If you elect to participate, you may deposit from $52 to the IRS annual limits each calendar year.

Impact of Pre-tax Contributions

Your pre-tax contributions to this plan have no direct effect on your other Abbott benefits (such as retirement, medical leave pay, cash profit sharing and life insurance). These salary-related benefits will be based on your compensation before deduction of your pre-tax contributions.

Because you don't pay Social Security taxes on your FSA contributions, those benefits may be slightly less when you retire or if you become disabled. This potential reduction in benefits will depend on the length of time between your FSA contributions and the date when you begin receiving Social Security benefits. It will also depend on whether or not your taxable income exceeds the Social Security maximum wage level.

Contribution Changes

If you have a qualified life event, you can change your current FSA elections or enroll in coverage for the first time if you previously waived participation. A change in election due to a qualified life event must be consistent with the life event. The following is a list of common life events and changes that are allowed with the Healthcare Flexible Spending Account (HCFSA) and the Dependent Care Flexible Spending account (DCFSA):

Event Description	Enroll Mid-Year	Cancel Election	Increase Election	Decrease Election	Type of Account
Marriage	Yes	Yes	Yes	Yes	HCFSA
Marriage	Yes	Yes	Yes	Yes	DCFSA
Divorce/Legal Separation	Yes	Yes	Yes	Yes	HCFSA
Divorce/Legal Separation	Yes	Yes	Yes	Yes	DCFSA
Birth/Adoption	Yes	No	Yes	No	HCFSA
Birth/Adoption	Yes	No	Yes	Yes	DCFSA

For other qualified Life Events and associated changes that can be made to your FSA's please contact the **Abbott Benefits Center** at (844) 30-MY-ABC or (844-306-9222).

Under federal income tax regulations, expenses incurred for your domestic partner or your domestic partner's children are not eligible for reimbursement from your FSAs. Therefore, status changes for domestic partnerships are not recognized under this plan.

Most changes can be made online 24 hours a day by logging in to the Benefits Web site at www.abbottbenefits.com. Changes may be made within 31 days following a qualified life event. You may also be asked to provide legal documentation, an affidavit or other written evidence of your status change to the **Abbott Benefits Center.**

Please note that if you increase your FSA contributions due to a status change, your new election(s) are applicable for the remaining portion of the plan year only (i.e., from the date the change is effective forward). Expenses incurred before the effective date of the change will be reimbursed up to the previously elected amount(s) for that plan year, if any.

Unused Funds (Forfeitures)

Generally, contributions you elected to make to your FSAs during a calendar year are used for eligible expenses during that calendar year. Remaining funds must be forfeited. These forfeitures remain with the plan and are used to offset expenses related to FSA administration.

Abbott, however, has adopted the 2 ½ month grace period for incurring FSA claims allowed by the IRS. This means that you have until March 15 of the following calendar year to incur claims against your current calendar year FSA. Abbott adopted this amendment to reduce the chance that a participant in the FSA program will forfeit any funds.

The FSA Claims Administrator must still receive claims for expenses incurred during any calendar year by April 30 of the following calendar year. You are encouraged to submit your claims no later than April 15 to ensure that they will be complete by this deadline. After April 30, all unused FSA funds will be forfeited.

Health Care Flexible Spending Accounts (FSAs)

Although your Abbott health care plan offers you and your family considerable protection against the high cost of health care expenses, there may be a number of ordinary health care expenses — including deductibles, copayments and coinsurance amounts — that you will pay out of your pocket each year. Participating in a health care FSA can help you better manage these expenses while gaining real tax savings.

The amount credited to your health care FSA for any calendar year may be used toward the payment of eligible health care expenses incurred during that calendar year.

Eligible Expenses

Your health care FSA can be used to reimburse you for certain out-of-pocket health care expenses. Expenses that may be paid through your health care FSA are those that qualify as deductions for federal income tax purposes.

Account reimbursements may be made on behalf of the following dependents:

- Your spouse
- Children who are your eligible dependents for federal income tax purposes
- Other relatives, such as parents, who are your eligible dependents for federal income tax purposes

Under federal income tax regulations, expenses incurred for your domestic partner or your domestic partner's children are not eligible for reimbursement from your FSAs.

Any determination as to qualification of an expense under this plan is subject to the Internal Revenue Code, IRS regulations, and other guidance. Should the IRS take a position contrary to that of the Plan Administrator, the IRS position will govern.

Health Care FSA Considerations

Limited Purpose Flexible Spending Accounts

- Individuals enrolled in a Health Investment Plan (HIP PPO) medical option who also enroll in a HCFSA account will automatically be enrolled into a Limited Purpose Flexible Spending Account (LPFSA).
- The account will work the same as the other HCFSA account, except that you can only submit claims for eligible vision and dental expenses until the annual IRS deductible limit is met.
- The annual IRS deductible may be different than the annual health plan deductible.
- Once the annual IRS deductible limit is met, you can submit the HDHP Deductible Met form along with supporting documents.
- Once approved, the account will change to a standard HCFSA and funds can also be used for

eligible medical expenses.

- Only eligible medical expenses incurred after the IRS deductible limit is met are eligible. Same day expenses are not eligible.
- If you or your spouse has a health savings account (HSA), this may affect your FSA eligibility. Contact WageWorks at **(877) 924-3967** for more information.

Reimbursements from Your Health Care FSA

You will be reimbursed for eligible health care expenses up to the full amount of your annual contributions, regardless of the amount of money that has actually been deposited into your account to date. Eligible health care claims continue to be paid until your annual maximum is met.

An expense is incurred when the service is rendered. Your health care FSA contributions are credited to your account for the calendar year in which they are made. Reimbursements will be made only for expenses incurred during the same calendar year and FSA grace period.

HCFSA funds cannot be used for expenses incurred before your account participation begins, or after your participation has ended.

Your Health Care FSA Debit Card

Your FSA debit card is the easiest way to pay for eligible health care expenses without filing claims or waiting for reimbursement. The card draws directly from your FSA health care account and makes funds immediately available to you for payment of eligible medical services, goods and prescriptions at health care providers, pharmacies and drugstores.

The FSA debit card may only be used to purchase over- the-counter medications at the pharmacy counter with a prescription. A prescription number must be assigned as well as the name of the purchaser (or name of the person for whom the prescription applies) and the date and amount of the purchase.

Using your Debit Card

Whenever you have an eligible expense, simply present the card to your provider. Unlike other debit cards you may have, the FSA debit card does not require a PIN.

If you swipe your FSA debit card at a retail pharmacy (such as Walgreens), select “Credit” when prompted for type of card. If you enter “Debit”, the machine will prompt you for a PIN.

Save Your Receipts

You will need to save your receipts for all FSA purchases, in accordance with IRS rules. You may be asked to submit your receipts to WageWorks to verify the expense's FSA eligibility. If you pay for an ineligible expense with your debit card, you will be required to pay back your FSA. It is your responsibility to keep your receipts. If you don't have a receipt WageWorks requests, you will be asked to reimburse your FSA. If you do not respond to WageWorks' requests for verification or repayment within 90 days, your FSA debit card will be suspended

The surest way to use your debit card without the need to submit receipts is to shop at merchants and pharmacies that have the IRS-approved Inventory Information Approval System in place. For a list of IRS-approved merchants, please visit www.sigis.com. If WageWorks can not verify on their own using the methods mentioned above, they will ask you for receipts.

When Not to Use Your Debit Card

Before using your card, be sure that whatever you intend to pay for is an eligible health care expense under IRS regulations and Abbott's FSA program. You cannot use the FSA debit card for dependent day care expenses.

Additional Cards

You can order additional cards for your spouse or eligible dependents through www.wageworks.com. Click on the Card Center tab and select "Request Additional Card."

Pay My Provider Feature

You may elect to pay eligible health care expenses directly from your FSA account using the "Pay My Provider" feature. To elect this feature, log in to your account at www.wageworks.com, and click Claims & Activity.

Request "Pay My Provider" from the menu and follow the instructions.

- Enter the claim and provider information, and confirm
- Scan and upload the invoice or documentation (invoice or other documentation must include the dates of service, type of service, service provider, dependent's name, cost of service)

Once you have established a "Pay My Provider" arrangement, WageWorks will issue a check directly from your account to your provider. If you pay for eligible recurring expenses like orthodontia or chiropractic treatments, follow the online instructions to set up automatic monthly payments.

One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved. Health care payments may not be entered before the service start date.

Recurring health care payments will be mailed on the requested payment date. You are permitted to enter a requested payment date that is up to 10 calendar days prior to the due date shown on the contract, if required.

A one-time payment cannot be cancelled once it is submitted. A recurring payment, however, may be cancelled up to 10 days prior to the requested payment date.

In general, your detailed invoice or other appropriate documentation should include the following five pieces of information required by the IRS:

1. The patient's name or dependent under care
2. Service start and end date
3. Name of the service provider
4. A description of the service
5. The amount paid or owed.

Additional requirements apply for recurring dependent day care requests, recurring health care requests, and health care expenses that require a Letter of Medical Necessity.

Filing A Paper Claim (Pay Me Back Claim Form)

Call WageWorks at **(877) 924-3967** or visit the WageWorks web site at www.wageworks.com to obtain a Pay Me Back Form. Be sure to fill in all of the information requested on the form, attach your receipts, and sign the form.

Fax your completed claim form, along with copies of your receipts to: **(877) 353-9236** (toll-free). Or, if you prefer, you may submit your claims by mail to:

Claims Administrator
P.O. Box 14053
Lexington, KY 40511

Filing An Online Claim (Pay Me Back Claim Form)

To reimburse yourself for an eligible expense already paid, you can complete a Pay Me Back claim form online when you log on to your WageWorks account. Once the form is complete, you have two options:

1. Print the form and mail or fax it to WageWorks with the receipts.
2. Scan and upload the corresponding receipts to our system for faster processing.

Direct Deposit

If you would like your reimbursements for claims to be paid via direct deposit to your bank account, you will need to provide your bank information when you register your account on the WageWorks web site at www.wageworks.com.

Exclusions

Generally, services and products that are medically necessary to treat a specific condition are considered eligible health care expenses. Cosmetic or non-medical expenses are not eligible.

Expenses that are **not** eligible for reimbursement from your health care FSA include, but are not limited to:

- Adoption fees
-
- Child or newborn care instruction
- COBRA premiums
- Cord blood storage for undefined future use
- Cosmetic surgery
- CPR classes
- Dental insurance premiums
- Drugs for cosmetic purposes
- Experimental or imported drugs
- Educational classes or tuition
- Electrolysis or hair removal products/procedures
- Expenses eligible for reimbursement by your health plan
- Expenses incurred before your plan participation begins or after your plan participation ends
- Face lifts
- Fertility treatment for non-dependent surrogates
- Fitness programs
- Funeral expenses
- Hair growth or re-growth products (i.e., Rogaine, etc.), even if prescribed
- Hair transplants
- Hair treatments
- Health club dues
- Health insurance premiums
- Health savings account (HSA) contributions
- Household help
- Illegal operations or substances
- Late payment fees
- Long-term care premiums or services
- Marriage counseling
- Maternity clothes
- Medical literature, books, pamphlets or audio

- Medical savings account (MSA) contributions
- Medicare alternative insurance or plan premiums
- Medicare premiums
- Medicare supplement policy premiums
- No show fees charged by health care providers
- Over-the-counter medications without a physician's written prescription
- Physician retainer fees (for on-call or concierge services)
- Prescription insurance premiums
- Services for which you have no obligation to pay
- Student health fees
- Teeth bleaching or whitening
- Transgender treatments/surgery without a physician's written letter
- UV protection clothing
- Vision insurance premiums
- Weight loss foods
- Weight loss programs to improve or maintain general health

For a complete list of eligible expenses, visit:
https://www.wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table

About Your Participation

If You Leave the Company

If your employment terminates for any reason, including retirement, your FSA contributions will stop with your last paycheck. You may be reimbursed for eligible health care expenses incurred prior to your separation date as long as the FSA Administrator receives your claim by April 30 of the calendar year following your separation date.

Leave of Absence

Taking a leave of absence may affect your FSA participation. The impact depends on the type of leave that you take.

- **Medical Leave of Absence:** Your health care FSA participation continues during a paid medical leave. If your leave is unpaid, your health care FSA contributions are suspended automatically and you will need to reenroll after your leave. If you return to work in a different calendar year, you may make new FSA elections.
- **Family Leave of Absence:** Your health care FSA participation continues during a paid family leave. If your leave is unpaid, you may be direct billed for your FSA during your absence and will be collected upon your return to work. If you return to work in a different calendar year, you may make new FSA elections.

- **Personal Leave of Absence:** Your health care FSA participation ends. If you return to work in a different calendar year, you may make new FSA elections.
- **Military Leave of Absence:** Your health care FSA participation continues during a paid military leave. Your health care FSA participation ends during an unpaid military leave. If you return to work in a different calendar year, you may make new FSA elections.

Continuation of Coverage

Under certain conditions, you may elect to continue participation in your health care FSA beyond the date your contributions would otherwise stop — with your contributions made on an after-tax basis. There is a 2 percent administrative fee for this continuation coverage. Such coverage, offered in compliance with the Consolidated Omnibus Budget Reconciliation Act, is commonly called COBRA.

Electing COBRA FSA upon terminating from Abbott will allow you to incur eligible expenses after termination, while you are a COBRA FSA participant, in order to obtain reimbursement for your unused FSA dollars.

FSA COBRA coverage is available to you for up to 18 months if your participation stops because of the termination of your employment (for reasons other than gross misconduct) or a change in your employment status causes you to become ineligible for FSA benefits.

If you become eligible for FSA COBRA coverage, the company will send you a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage.

You must elect to continue coverage within 60 days after the notice of the right to continue coverage is received (or after the date the coverage terminated, if later). You will have an additional 45 days to pay the back premium necessary to avoid a break in coverage. If coverage is not elected during this 45-day grace period, it will not be offered again.

Your FSA COBRA coverage will stop when:
- You fail to make the required contributions
- You become covered under another FSA plan
- You reach the 18-month maximum, or
- The Abbott Laboratories Flexible Benefit Plan is terminated

Continuation coverage under COBRA does not apply to DCFSA.

Dependent Day Care Flexible Spending Accounts (FSAs)

A Dependent Day Care Flexible Spending Account (DCFSA) lets you set aside pre-tax dollars to cover qualified dependent day care expenses, such as child or elder care incurred in that calendar year. You may use DCFSA funds to help you pay for the care of any eligible dependents so that you (and your spouse, if you are married) can work. Reimbursement is also permitted if your spouse is a full- time student or is incapable of self-care.

Your eligible dependents include:

- Your dependent children under age 13
- A dependent child or adult living with you who is physically or mentally incapable of self-care and whom you claim as a dependent for federal income tax purposes

Limitations on Dependent Day Care FSA Contributions

- Expenses must be for DCFSA expenses that are necessary so that you (and your spouse, if you are married) can work
- If you are married and your spouse has no earned income during a calendar year, you cannot use the DCFSA unless your spouse is incapable of self-care or is a full-time student for at least five months during that year. If your spouse is a full-time student, annual contributions are limited.
- If you are a married employee filing a separate tax return, the maximum contribution you can make to your DCFSA is $2,500 per year
- If you and your spouse are both working, your combined annual contributions to a DCFSA cannot be more than $5,000 ($2,500 if filing separately) or the earned income of the lower-paid spouse, whichever is least
- Federal regulations require plan sponsors of DCFSA to conduct nondiscrimination tests to ensure the plan does not discriminate in favor of those employees with income over a certain level. If necessary during the plan year, Abbott will automatically decrease dependent day care FSA contributions of highly paid employees to ensure that the plan complies with these rules. Employees are notified individually when dependent day care cutbacks occur.

Eligible Expenses

The money set aside in your DCFSA can be used to reimburse you for care provided to your qualifying child under age 13 or other qualifying dependent, while you work or to enable you to work. Your provider must meet state and local laws, and provide a Social Security or Tax ID number. Check to be certain that this information is available to you before electing a DCFSA.

Eligible expenses include but are not limited to your out-of-pocket (unreimbursed) expenses for:

- Wages paid to a baby-sitter, au pair, nanny or companion in or outside your home, as long as the person providing care is not someone you claim as a dependent for federal income tax purposes
- Services of a day-care center or nursery school, as long as the center complies with all state and local laws
- Before and after school care
- Costs for care at facilities away from home, such as family dependent day care or adult dependent day care centers, as long as your adult dependent spends at least eight hours a day at home
- Wages paid to a housekeeper for providing care for an eligible dependent
- Day camp expenses for an eligible dependent as long as there are no significant educational services provided (all camp expenses, including non-refundable deposits, may be reimbursed only after the child has attended camp)

Any determination as to qualification of an expense under this plan is subject to the Internal Revenue Code, IRS regulations, and other guidance. Should the IRS take a position contrary to that of the Plan Administrator, the IRS position will govern.

Reimbursements from Your Dependent Day Care FSA

You will be reimbursed for eligible dependent day care expenses up to the amount of your account deposits on the date your claim is received. If your account deposits are not sufficient to cover your claim, a payment will be issued for your deposits to date and the balance will be held until further deposits are received. Additional claim payments will be issued regularly as additional deposits to your account are received, until the entire amount of the claim has been reimbursed or until your FSA contributions for the calendar year end — whichever comes first.

Only expenses that have been incurred qualify for reimbursement from your DCFSA. An expense is incurred when the service is rendered. Your FSA contributions are credited to your account for the calendar year in which they are made. Reimbursements will be made only for those expenses incurred during the same calendar year. DCFSA funds cannot be used for expenses incurred before your account participation begins.

Pay My Provider Feature

You may elect to pay eligible dependent care expenses directly from your FSA account using the "Pay My Provider" feature. To elect this feature, log in to your account at www.wageworks.com, and click Claims & Activity.

Request "Pay My Provider" from the menu and follow the instructions.

- Enter the claim and provider information, and confirm
- Scan and upload the invoice or documentation (invoice or other documentation must include the dates of service, type of service, service provider, dependent's name, cost of service)

Once you have established a "Pay My Provider" arrangement, WageWorks will issue a check directly from your account to your provider. If you pay for eligible recurring expenses like orthodontia or chiropractic treatments, follow the online instructions to set up automatic monthly payments.

One-time requests will be processed and distributed just a few days after the submitted invoice or documentation has been approved. Health care payments may not be entered before the service start date.

Recurring health care payments will be mailed on the requested payment date. You are permitted to enter a requested payment date that is up to 10 calendar days prior to the due date shown on the contract, if required.

One-time and recurring dependent care payments will be issued no sooner than the service end date. However dependent care payments may not be entered prior to the service start date.

A one-time payment cannot be cancelled once it is submitted. A recurring payment, however, may be cancelled up to 10 days prior to the requested payment date.

In general, your detailed invoice or other appropriate documentation should include the following five pieces of information required by the IRS:

1. The patient's name or dependent under care
2. Service start and end date
3. Name of the service provider
4. A description of the service
5. The amount paid or owed.

Additional requirements apply for recurring dependent day care requests, recurring health care requests, and health care expenses that require a Letter of Medical Necessity.

Filing A Claim (Pay Me Back Claim Form)

Call WageWorks at **(877) 924-3967** or visit the WageWorks website at www.wageworks.com to obtain a Pay Me Back Form.

Fax your completed claim form, along with copies of your receipts to: **(877) 353-9236** (toll-free). Or, if you prefer, you may submit your claims by mail to:

Claims Administrator
P.O. Box 14053
Lexington, KY 40511

Filing An Online Claim (Pay Me Back Claim Form)

To reimburse yourself for an eligible expense already paid, you can complete a Pay Me Back claim form online when you log on to your WageWorks account. Once the form is complete, you have two options:

1. Print the form and mail or fax it to WageWorks with the receipts.
2. Scan and upload the corresponding receipts to our system for faster processing.

Direct Deposit

If you would like your reimbursements to be paid via direct deposit to your bank account, you will need to provide your bank information when you register your account on the WageWorks web site at www.wageworks.com.

Exclusions

Expenses that are **not** eligible for reimbursement from your DCFSA include, but are not limited to:

- Activity Fees
- Babysitting or custodial elder care that is not work-related (i.e., for other purpose)
- Babysitting by your tax-qualified dependent (work-related or for other purpose)
- Custodial elder care (not work-related or for other purpose)
- Dance lessons
- Education, learning or study skills services
- Field trips
- Household services (housekeeper, maid, cook, etc.)
- Kindergarten tuition
- Language classes
- Late payment fees
- Meals, food or snack
- Medical care
- Music lessons
- Nursing home care
- Overnight camp
- Private school tuition (kindergarten and up)
- School tuition
- Transportation to and from eligible care
- Tutoring

For a complete list of eligible expenses, visit:
https://www.wageworks.com/employees/support-center/dcfsa-eligible-expenses-table

About Your Participation

If You Leave the Company

If your employment terminates for any reason, including retirement, your FSA contributions will stop with your last paycheck. You may be reimbursed for eligible dependent day care expenses incurred prior to your separation date as long as the FSA Administrator receives your claim by April 30 of the calendar year following your separation date.

Leave of Absence

Your participation in the DCFSA will be suspended automatically until you return from your leave. Internal Revenue Service rules do not allow you to receive reimbursements from your DCFSA for services provided while you are on a leave unless you are working at least part time When you return to work you must call the Abbott Benefits Center at 877-228-4707 to turn your DCFSA back on. Account reactivation is not automatic.

Right of Recovery

Abbott has the right to recover benefits it has paid that were:

- Paid in error
- Due to a mistake in fact, or due to a misrepresentation of facts

If the plan provides a benefit that is larger than the amount that should have been paid, the plan will require that the overpayment be returned when requested, or reduce a future benefit payment by the amount of the overpayment.

Appeals

If a claim for benefits is denied or reduced, you will be notified of the reason in writing for the denial within a maximum of 60 days. If you disagree with the decision or have additional information that may change the decision, you should contact WageWorks Customer Service at **(877) 924-3967** to discuss your concerns.

If you still have not received adequate explanation concerning the claim for reimbursement under the plan, you have the legal right to appeal the denial or partial denial of the claim.

You also have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your claim for benefits.

To Appeal a Denied Claim

To appeal the denial, you must send a written request to: WageWorks Claims Appeal Board
PO Box 991, Mequon, WI 53092-0991.

Your appeal must be in writing and must be received within 180 days of the date you received notice that your claim was denied. If your claim was never received, your appeal, with proof of timely claims submission, must be received by May 31 of the calendar year following the year in which the expense was incurred.

Your appeal should include a copy of the claim denial and any additional documentation that supports the approval of the claim. You are welcome to submit written comments, documents, records, a letter from your health care provider indicating medical necessity of the denied product or service, or any other information you feel will support your claim.

You can request copies of all documents and information related to your denied claim from WageWorks at no cost.

Appeal Review Process

Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was.

The review will take a fresh look at your claim and appeal without deference to the initial denial and will take into account all information submitted with your claim and/or appeal.

WageWorks will notify you of the decision regarding your appeal in writing within 30 days after receipt of your written appeal.

WageWorks will review your appeal on behalf of Abbott and issue you a final determination. In such cases, the denial of your claim will include details about appealing the denial to the Plan Administrator (Abbott). Level two appeals should be directed to:

Abbott Laboratories Attn: Abbott Benefits Practice Center (K.G) AP6 D0589, 100 Abbott Park Road, Abbott Park, IL 60064.

The Plan Administrator has full discretion and authority to make the final decision regarding all areas of plan interpretation and administration, including eligibility for benefits, level of benefits provided, interpretation of plan language or administrative procedures, including those described here.

The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the plan and, if challenged in court, the plan intends for the Plan Administrator's decision to be upheld, unless found by a court of competent jurisdiction to be arbitrary and capricious. Benefits will be paid under the plan only if the Plan Administrator determines, in its discretion, that the plan participant is entitled to them.

Administrative Information

Plan Identification

The name of the plan is the Abbott Laboratories Flexible Benefit Plan. Abbott is the Plan Sponsor. The Benefits Department of Abbott is the Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 570

Plan Funding

Spending accounts may be funded through employee contributions, Abbott contributions or both.

Participating Employers

The Abbott Laboratories Flexible Benefits Plan applies to eligible employees of Abbott Laboratories and its subsidiaries.

Claims Administration

WageWorks, Inc. is the third-party claims administrator for the Abbott Laboratories Health Care and Dependent Day Care Flexible Spending Accounts. WageWorks provides all administrative services, including claims processing, customer service, and reporting services.

Legal Service

Process can be served on the plan administrator by directing such legal service to the Divisional Vice President, Benefits, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064.

Plan Changes

Abbott Laboratories expects to continue this plan but reserves the right to change or end it at any time. The Company's decision to change or end a plan may be due to changes in federal or state laws, the requirements of the Internal Revenue Code or ERISA or any other reason.

If a plan is ended, you will have no further rights under the plan other than the payments of benefits accrued before the plan was terminated. The Company in accordance with any applicable legal requirements will determine the amount and form of any final benefit you may receive.

If you have any questions about this statement or about your rights under ERISA, contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington D.C. 20210.

Plan Documents

This booklet describes highlights of Flexible Spending Accounts for Abbott employees. It does not attempt to cover all details. Formal legal documents, rather than this summary, govern the plan in regard to administration and payment of all benefits. In case of a conflict between this summary and the plan's legal documents, the plan's legal documents control.

Privacy of Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the health plan's privacy notice, which is available on the Benefits Web site at www.abbottbenefits.com or upon request by calling the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, disclose protected health information to Abbott Laboratories, the Plan Sponsor, for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information.

You also have the right to file a complaint within the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you wish to file a complaint under HIPAA, please write to the Divisional Vice President, Employee Relations, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064.

Life Enrichment Programs

Achieving an appropriate balance between work and play can help you do both more effectively. Abbott offers you paid time off work so you can enjoy the things that interest you most. Other benefits to enrich your life and reward your efforts include adoption assistance, Legal Referral Services, an Employee Assistance Program, and the Abbott Laboratories Cash Profit Sharing Plan.

Holidays

There are generally 11 paid holidays each year, including scheduled Company holidays, Holiday Credits and Designated Holidays. These benefits may vary depending on your location and scheduled work hours.

Regular and temporary employees are eligible to receive full pay for company holidays and holiday credits. Seasonal employees and interns are eligible for holiday credits after six months of continuous service. You can find your current holiday schedule on **myHR**, a personalized portal accessible from Abbott Home.

Holiday Credits

Full-time employees at participating locations receive a holiday credit equal to four hours of holiday pay for each of the six months in which there are no regularly scheduled Company holidays — February, March, April, June, August and October — for a total of three eight-hour days each calendar year. Employees working less than full-time receive prorated holiday credits.

If you are eligible for holiday credits, you may use them earlier in the year than they are earned. Credits taken in advance will be deducted from your final pay if you leave Abbott before they are earned. Holiday credits must be taken during the calendar year in which they are earned and cannot be carried over into any subsequent year. If you convert from full-time to part-time, holiday credits taken in advance of being earned will be deducted from your remaining vacation time (or pay, if no vacation time remains).

Holiday credits generally may be used individually or may be added to scheduled Company holidays or vacations, provided the absence is approved in advance by your manager. At some locations, site management designates some or all of your days off for holiday credits. You can find your current holiday schedule on **myHR.**

Vacations

Vacation benefits provide employees with an opportunity to rest and relax. Vacations must be scheduled and taken in accordance with department guidelines and practices. Individual vacation schedules are subject to management approval.

Eligibility

Regular employees of Abbott are provided a vacation allowance at the beginning of each year based on years of Abbott service. Vacation allowances for part-time employees are prorated based on scheduled hours. Vacations are scheduled and taken in accordance with department guidelines and local practices. Individual schedules are subject to management approval.

Vacation Allowances

The following vacation allowances are provided for employees at most U.S. locations. Your current vacation benefits can be viewed on the **myHR** portal.

New Employees

After 30 days of employment new employees hired prior to October 1 in a calendar year are provided a vacation allowance for use in the calendar year of hire, in accordance with the schedule below.

- If you are hired on or before March 31, you will receive a vacation allowance of three weeks of vacation in your hire year following 30 days of employment
- If you are hired between April 1 and June 30, you will receive a vacation allowance of two weeks of vacation in your hire year following 30 days of employment
- If you are hired between July 1 and September 30, you will receive a vacation allowance of one week of vacation in your hire year following 30 days of employment
- If you are hired after September 30, you are not eligible for paid vacation until January 1 of the following calendar year.

Because this vacation allowance is granted as a lump sum amount in a “look forward” basis on the 31st day following the commencement of employment, employees do not earn vacation on a pro rata basis during the calendar year of initial hire or rehire, or thereafter. No vacation allowance will be paid at separation if the employee has completed less than 30 days of service.

All California employees and those hourly or non-exempt employees outside of California with unused vacation at the end of each calendar year will automatically be paid for the earned and unused vacation. Exempt employees outside of California will forfeit any unused vacation at the end of the year, unless prohibited by applicable state law. It is the responsibility of the department manager to ensure that the employee takes full vacation time off before the year-end.

Ongoing Vacation Benefits

Abbott provides vacation benefits to eligible employees on a “look forward” basis, meaning that, for eligible employees who are employed as of January 1 of a calendar year, Abbott provides those employees a lump sum allowance of vacation that the employee may use during that calendar year. All regular employees are eligible to receive and use vacation time according to the following schedule:

1 - 11 years	three weeks
12 - 24 years	four weeks
25 - 29 years	five weeks
30+ years	six weeks

Increases in the lump sum vacation allowances are granted at the beginning of the employee's anniversary. For example, under the policy, if a full-time employee was hired on March 1, 2004, the employee would receive an allowance of three weeks of vacation on January 1, 2015 as this would be considered the 11th calendar year of service. This employee would receive four weeks of vacation on January 1, 2016 as this would be considered the 12th calendar year of service, even though the employee would not have reached their 12th anniversary as of January 1, 2016.

Benefits for part-time employees are based on regularly scheduled hours as of January 1 of each year. You must be an active employee on January 1 to qualify for vacation during the calendar year, except as described in the next section.

Special Provisions

Medical Leave of Absence (MLOA)

An approved MLOA will count as time worked for purposes of determining your vacation allowance. You will be eligible for your full vacation allowance in the calendar year following your leave provided that you return to an active employment status on or after January 1 of that year. If you do not return to work during the calendar year in which your leave begins, you will be paid for your unused vacation days. Payout for non-exempt employees is automatic and occurs in early January. For exempt employees, after six months of medical leave, Abbott will initiate the payout of unused vacation as appropriate.

Family Leave of Absence (FLOA)

You may request vacation before beginning an FLOA but are not required to do so. If you are a nonexempt employee and you do not return to work by December of the year in which your FLOA began, you will receive a cash payment for any unused vacation time for that year.

Military Leave of Absence and Reserve Duty

You will receive a cash payment for unused vacation in the year your military leave of absence begins. The period of your military leave of absence will count as time worked for purposes of determining your vacation allowance for the year in which you return to work at Abbott. If you are required to participate in annual military reserve duty, you will be granted time off for this duty in addition to your vacation. You cannot receive Abbott pay and reserve duty pay for the same period of absence.

Personal Leave of Absence (PLOA)

You are eligible for your regular vacation allowance in the calendar year your PLOA begins. It will be paid to you before your leave starts. If you return to work in a calendar year after the year in which your leave began, the vacation allowance for the calendar year is granted only after the 30th day after you return to work.

Changes in Scheduled Hours

Each year your vacation allowance is determined by your employment status and regular work schedule on January 1 of the current year. If your work schedule changes during the year, your vacation will not reflect this change until the following calendar year (assuming your regular work schedule remains changed as of January 1 of the following year). The following special provisions will, however, apply:

- If you convert from full-time to part-time status and have received a vacation allowance based on a full-time schedule as of January 1 of that year, your new schedule may not permit you to take the full amount of this vacation allowance. In that case, you will receive payment at the end of the year for any vacation allowance you are unable to take.
- If you convert from part-time to full-time status and have received a vacation allowance based on a part-time schedule as of January 1 of that calendar year, you will be given an option to take personal time (without pay) beyond the amount of the actual earned vacation allowance provided to you for that calendar year.

Changes in Your Employment Status

Temporary workers (non-Abbott employees) who are hired as Abbott employees may be entitled to vacation in the year in which they become Abbott employees.

Termination

If your employment terminates for any reason other than retirement, the unused amount of your vacation allowance for that calendar year will be paid to you in a lump sum. A new employee must work at least 30 days to receive payment for unused vacation, and no vacation is earned or accrued during the initial 30 days of employment.

Retirement

You will receive your full vacation allowance for the year of your retirement (based on your length of service as of January 1 of the year that you retire). You will receive payment for the balance of any unused vacation allowance when you retire.

Rehires

Former employees that are rehired are awarded vacation based on their new hire date. Past service does not count toward the vacation allowance calculation.

If Abbott rehires you in the same calendar year you terminated your employment with the company, you are not entitled to additional vacation for that year. If the vacation you would have received as a new employee is greater than the amount of vacation you used or received payment for, however, you may receive the difference. If you are not eligible for vacation in the year of your rehire, your manager may approve unpaid vacation.

Vacation Scheduling

You should schedule your vacation in advance with your department manager. You must use the full amount of your vacation allowance each year — it cannot be carried over into any other calendar year.

If a scheduled Company holiday falls during your vacation period, that day will not be charged against your vacation. If you become incapacitated during a scheduled vacation due to an illness or injury that requires a doctor's care, your manager may arrange to reschedule that portion of your vacation for later in the year. Vacation days may not be substituted for sick days if that substitution will result in eligibility for overtime.

Advance Vacation Pay

If you are a nonexempt employee and are taking at least one week of vacation, you may receive vacation pay before your vacation begins — provided your request is submitted to your payroll department at least two weeks in advance.

Funding and Payment of Benefits

Holiday and vacation benefits are funded by Abbott and are paid out of the Company's general assets. Vacation hours are paid at straight time equivalent wage or base salary.

Loss of Benefits

You must use your vacation allowance by the end of the calendar year. Vacation hours cannot be carried over into the following year.

Your participation in the Abbott Laboratories Vacation Program will be suspended in the event your employment with Abbott is suspended without pay.

Changes

Abbott intends to continue this vacation and holiday policies indefinitely, but necessarily reserves the right to change or end them at any time.

Adoption Assistance

The Abbott Laboratories Adoption Assistance Plan provides benefits for certain expenses you incur when adopting a child.

Eligibility

If you are a regular employee of Abbott and work a schedule of 20 or more hours per week, you are eligible for adoption assistance benefits. You must be an eligible employee at the time the expenses are incurred and when the adoption is final for eligible expenses to be reimbursed.

Benefit Amount

You may be reimbursed 100 percent up to a maximum of $20,000 in eligible expenses you incur for the adoption of an unrelated child under age 18 (for example, not a stepchild or grandchild). If you and your spouse both work at Abbott, either of you may submit expenses for reimbursement — up to a maximum of $20,000 per family per child. Benefits are payable when the adoption is final.

Eligible Expenses

The following expenses are eligible for reimbursement, up to a maximum of $20,000 per family, per child adopted:

- Public, private and foreign adoption agency fees
- Placement and home study fees
- Legal and court fees
- Temporary foster care charges
- Transportation, immigration and translation costs

Original receipts for each expense must be included with your reimbursement request. Requests must be filed within six months of the date the adoption is finalized. In addition, reimbursement requests must be filed within 30 days of when you no longer meet the plan's eligibility requirements.

Ineligible Expenses

The following expenses are **not** eligible for reimbursement from the plan:

- Expenses incurred in connection with the adoption of a child of a spouse
- Expenses incurred in violation of state or federal law
- Donations to adoption organizations
- Expenses related to surrogate parenting arrangements
- Expenses covered by any other benefit plan, policy or program maintained by Abbott
- Expenses for which you receive a tax deduction, tax credit or other funds under a local, state or federal program

Payment of Benefits

You need to file a claim for reimbursement of your eligible adoption expenses. Claim forms are available on the **myHR** Portal. Attach a copy of the adoption decree (with an English translation if it is in another language) and the original receipts for each eligible expense. Send the completed form and receipts to **myHRTeam**, Dept. 058E, BIdg. AP52, 200 Abbott Park Road, Abbott Park, IL, 60064-6222

Other Applicable Benefits

You may receive adoption leave benefits of up to two weeks paid time off. Your adoption leave benefit may be used before your adoption is finalized or within 15 weeks after your adoption is finalized for purposes of caring for your new child. The maximum adoption leave is 80 hours (prorated for part-time employees). To arrange for your time away from work, please contact your manager as far in advance as possible. Please also call Abbott's leave vendor at (877) 840-2128. This paid time off will apply toward any time that you take for family leave of absence.

Your adopted child is eligible for health care and dependent life insurance coverage on the date you assume and retain a legal obligation for total or partial support — if you are eligible for and have elected coverage under the plans. You must enroll your child within 31 days after he or she first becomes eligible. You may also begin or change contributions to appropriate flexible spending accounts within 60 days after your child becomes eligible. Claims incurred before you begin an account will not be reimbursed.

See Abbott's Human Resources Policy on Adoption Assistance for more information.

Plan Identification

The name of the plan is the Abbott Laboratories Adoption Assistance Plan. Abbott is the Plan Sponsor. The Benefits Department of Abbott is the Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 575

Plan Funding

Adoption Assistance Plan benefits are paid from the Company's general assets.

Participating Employers

The Abbott Laboratories Adoption Assistance Plan applies to eligible employees of Abbott Laboratories and its subsidiaries.

Changes

Abbott intends to continue the plan indefinitely, but reserves the right, by appropriate action by the Divisional Vice President, Compensation and Benefits, to change or end it at any time.

Employee Assistance Program (EAP)

Part of your well-being includes having peace of mind and support in areas that may go beyond physical health so Abbott offers an Employee Assistance Program (EAP) through LifeWorks.

Eligibility

All Abbott employees are eligible for assistance through the EAP. Your spouse, dependent children, and other household members may also contact the EAP for assistance.

How It Works

The EAP is a voluntary counseling and referral service. Counselors are available to help deal with personal issues that are affecting you. Services include information and referrals, short-term counseling (up to six sessions) and follow-up. You may contact the EAP by calling LifeWorks at **(800) 626-0738**; TDD **(800) 346-9185**. In emergencies, help is available 24 hours a day, 7 days a week. Or, visit the website at www.lifeworks.com (username: abbott, password: 1020) for general information. To talk to a Spanish-speaking consultant, call (888) 732-9020.

Counselors can provide assistance for a wide range of concerns. Some personal problems affect your health and general well-being — like emotional issues, or alcohol or substance abuse. Some are significant life traumas — like a serious illness, death of a loved one or a divorce. Others may be temporary — for example, stress, relationship or family conflicts, financial or legal difficulties.

In a private consultation, the EAP counselor will help you define your problem and explore various avenues available for help. Many issues may be resolved in short-term counseling with the EAP professional. If your issues are more complex or require specialized services, the EAP professional will refer you to a qualified treatment provider or program best suited to your needs in accordance with your health plan or community resources.

Your involvement in the EAP is confidential, as required by law, and will not affect your job in any way.

Your Costs

There is no cost to you for EAP services. If you are referred for continuing care, you should contact your health care plan to see how the charges will be covered.

When Coverage Ends

If your employment terminates for any reason other than early retirement, your participation in the EAP will end. Coverage may be continued for a limited period of time following your termination under the Continuation of Coverage provisions described below.

Continuation of Coverage

You may continue participation in the EAP beyond the date your eligibility would otherwise stop. Such coverage, offered in compliance with the Consolidated Omnibus Budget Reconciliation Act, is commonly called COBRA.

EAP COBRA coverage is available to you for up to 18 months if your participation stops because of the termination of your employment (for reasons other than gross misconduct).

Contact the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) within 60 days after the loss of coverage to preserve your rights under COBRA.

Work/Life Services

Managing your work and personal life may be challenging. LifeWorks can help you and your family with parenting and child care needs, elder care concerns, financial issues, educational resources and everyday issues.

Eligibility

Abbott provides LifeWorks services free of charge to Abbott employees and their family and household members.

How It Works

When you contact LifeWorks, a consultant will provide you with information and resources to assist you with a range of personal, work and family related issues. You also have access to:

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- A web site where you can download information, watch short videos, complete self-assessments, utilize interactive calculators and much more.

LifeWorks offers information on topics such as:

Parenting and Child Care

- Adoption, infertility and pregnancy
- Finding child care, summer care and back-up care
- Child development
- Parenting issues (single parenting, sibling rivalry, etc.)

Everyday Issues

- Consumer resources
- Home maintenance
- Real estate agents and apartment listings

Education

- K-12 education and special needs
- Colleges and universities
- Alternatives to college

Financial

- Budgeting
- Credit and collections
- Home buying and renting

Older Adults

- Retirement planning
- Senior health and living arrangements
- Caregiver resources
- Advocacy and rights

To contact LifeWorks, call **(800) 626-0738** or visit www.lifeworks.com (username: abbott; password: 1020). To talk to a Spanish-speaking consultant, call (888) 732-9020.

Your Costs

Consultation services and resource materials are available through this program at no cost to you. You will, however, need to pay for any child care, elder care or other service arrangements you make as a result of LifeWorks referrals.

Legal Referral Services

There may be a time when you or a family member needs legal services. Whether consultation is needed to buy a home, consolidate debt or plan for the future, LifeWorks offers resources that can help.

Eligibility

All Abbott employees are eligible for legal referral services. You may also seek legal advice and network services for your spouse, dependent children and other household members.

How It Works

To contact LifeWorks, call **(800) 626-0738** or visit www.lifeworks.com (username: abbott, password: 1020). To talk to a Spanish speaking consultant, call (888) 732-9020**.**

Services provided under **Legal Referral** are:

- One free office or telephone consultation of up to 30 minutes
- A 25 percent discount on attorney fees if the attorney is retained after the free legal consultation.

Covered Legal Issues

Covered legal and financial issues include the following:

- Adoptions and guardianships
- Civil/criminal disputes
- Collection matters
- Divorces, custody and support matters
- Document preparation
- Estate planning, wills and trusts
- Landlord/tenant issues
- Name changes
- Real estate sales or purchases
- Retirement planning
- Traffic violations
- Criminal misdemeanors

Legal referral services through this program are not available for criminal felony charges, employment or labor issues, or actions involving Abbott.

Commuter Benefit Program

If you commute to work using public transportation or vanpool, you may set aside money from your paycheck - on a pre-tax and post-tax basis - to pay for eligible transit expenses. Eligible parking expenses are also eligible for reimbursement.

Eligibility

Regular employees scheduled to work at least 20 hours per week are eligible to participate in the Abbott Commuter Benefit transit reimbursement program. Dependents are not eligible to participate in this program.

Enrollment

You can enroll, make changes, or cancel at any time at www.wageworks.com/mycommute. The enrollment deadline is the 10th of the month, for the upcoming benefit month.

How it Works

Orders are made online, the purchase price is deducted from your paycheck and your passes are mailed directly to your home. Passes can be ordered for any amount. The amount of the pass up to the statutory limit (see below) will be withheld from your paycheck pre-tax. Any orders beyond the pre-tax limit will be withheld from the paycheck on a post-tax basis.

When you make your online purchase you have the option to schedule it as an automatically recurring transaction. If you choose this option, your purchase will be automatically placed monthly. The only time you would need to go back online is to make a change or cancel your recurring purchase for a particular month. If you do not elect this option, then you would need to make your purchase each month.

IRS Monthly Limits

IRS monthly limits on eligible commuter benefits change annually. The current limits are available at www.wageworks.com/mycommute.

Eligible Expenses

Expenses for public transportation (trains, buses, etc.) and vanpools are eligible pre-tax expenses. In addition, parking at a location from where you commute to work by public transit or vanpool is also a qualified expense.

Ineligible Expenses

The law excludes personal transportation, mileage, tolls, fuel and carpooling expenses from this program. Business travel and other reimbursed travel expenses are also excluded from this benefit.

More Information

For more information, visit www.wageworks.com/mycommute, or call WageWorks at 877-WAGEWORKS (877-924-3967)

Changes

Abbott intends to continue this program, but necessarily reserves the right to change or end it at any time.

Cash Profit Sharing (CPS)

The Abbott Laboratories Cash Profit Sharing Plan (CPS) offers eligible U.S. employees the opportunity to share in Abbott's success. This plan has been providing an annual cash bonus to eligible employees since 1964. Across the U.S., many divisions and locations participate in CPS.

Eligibility

To be eligible for CPS, you must:

- Be a regular employee of a participating division who worked in the U.S.; ***and***
- Be actively employed or be on a medical, family, military, pay continuation, personal or educational leave of absence on November 15 of the plan year; ***and***
- Have had CPS eligible earnings during the plan year (Oct. 1 – Sept. 30).

Also eligible are:

- U.S. retirees of a participating division with CPS eligible earnings during the plan year (Oct. 1 – Sept. 30).

The following groups are not eligible for CPS:

- Participants in the Awards for Performance Excellence (APEX) program
- Employees of Abbott Diabetes Care, Abbott Electrophysiology, Abbott Point of Care, and Abbott Vascular divisions (these divisions have their own bonus programs)
- Interns
- Inpats (employees working in the U.S. on short- or long-term assignments whose home countries are outside the U.S.)
- Employees terminated during the plan year for reasons other than the expiration of medical leave (or ineligibility for medical leave)

In addition, some divisions have additional eligibility rules. Please contact myHRTeam at 877-228-4707 if you have questions about CPS eligibility.

CPS Plan Year

Your CPS bonus is based on Abbott's financial performance during the plan year. The CPS plan year begins on October 1 and ends on September 30.

Bonus Amount

The bonus amount is seven percent of eligible earnings unless, as of the end of the third quarter, it is determined that Abbott is not expected to achieve its full-year forecasted ongoing earnings per share (EPS). In that event, the bonus is five percent of eligible earnings, provided Abbott has been profitable through those three quarters.

Your CPS payout is subject to applicable federal, state and local income taxes.

Eligible Earnings

CPS eligible earnings include cash compensation received from Abbott during the CPS plan year (Oct. 1 – Sept. 30), ***excluding*** discretionary bonuses and payouts, special awards, family leave, pay continuation leave and last year's CPS payment.

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Payment of Benefits

CPS payments are distributed to eligible employees in early December of each plan year. However, if you are on personal or educational leave as of the annual plan eligibility date (Nov. 15), CPS payments are distributed three months after your return to work (or the duration of your personal leave, if it was less than three months).

Right of Recovery

Abbott has the right to recover benefits it has paid that were:

- Paid in error
- Due to a mistake in fact, or due to a misrepresentation of facts

If the plan provides a benefit that is larger than the amount that should have been paid, the plan will require that the overpayment be returned when requested, or reduce a future benefit payment by the amount of the overpayment.

Administrative Information

Plan Identification

The name of the plan is the Abbott Laboratories Cash Profit Sharing Plan. Abbott is the Plan Sponsor. The Executive Vice President, Human Resources of Abbott is the Plan Administrator.

Plan Funding

Cash Profit Sharing benefits are paid from the Company's general assets.

Plan Changes

Abbott Laboratories reserves the right to change or end the plan at any time.

Plan Documents

This booklet describes highlights of the Cash Profit Sharing Plan for Abbott employees. It does not attempt to cover all details. In case of a conflict between this summary and the plan's legal documents, the plan's legal documents control.

Other Policies, Services and Resources

There are human resources policies that may apply to you as an Abbott employee, as well as services and resources for Abbott employees that are beyond the employee benefits plans and programs described here. These policies and programs include, but are not limited to:

- Tuition Assistance
- Abbott Special Perks
- Child Care Resources
- Employee Referral Program
- Mothers at Work (lactation support)
- Occupational Health Services

Check with the appropriate program administrator or non-profit organization for information on eligibility and general rules. You are also encouraged to visit **myHR**.

Income Protection if You Can't Work

An unexpected illness or injury can happen to anyone. That's why Abbott offers medical leave programs that are designed to provide continuing income if you are unable to work due to illness, injury or pregnancy.

Hourly Sick Pay[17]

Regular non-exempt or hourly employees with less than 15 years of service who are working a schedule of 20 or more hours per week and are unable to work due to a non-work related illness or injury for less than 7 consecutive calendar days receive Hourly Sick Pay benefits equal to 75 percent of their current base rate of pay. Eligible non-exempt or hourly employees with 15 or more years of service receive Hourly Sick Pay benefits equal to 100 percent of their base pay.

Abbott provides 60 hours of Hourly Sick Pay benefits per payroll calendar year (beginning with pay period one). Hourly Sick Pay benefits for part-time employees are based on a pro rata percentage of 60 hours (that is, if your schedule is 20 hours per week, or 50 percent of a full-time schedule, the Hourly Sick Pay maximum is 30 hours).

Hourly Sick Pay may be used for your own illness or to care for an eligible family member who is ill. An eligible family member includes, a parent, spouse, child, step-child, grandparent, grandchild, parent-in-law, sibling, or registered domestic partner.

Should your illness exceed seven consecutive calendar days, you will transition to Abbott's Short-Term Medical Leave.

[17] Absences covered by Hourly Sick Pay may be subject to attendance and performance counseling. Additional information regarding job protection can be found in the Abbott HR Policy on Family Medical Leave of Absence, which is available on the myHR portal.

Short-Term Medical Leave Benefits[18]

Medical Leave and Weekly Sick

Abbott Short-Term Medical Leave benefits provide for continuation of all or part of your base pay while you are unable to work for medical reasons. Benefits are payable for absences due to illness, injury or pregnancy provided all of the following criteria are met:

- You have satisfied the waiting period
- You are under the care of a qualified treating provider
- Objective medical evidence is received by the Claims Administrator
- Your claim is approved

Short-Term Medical Leave benefits are payable for up to 26 weeks (130 work days or part-time equivalent) in any 52-week period.

Benefit Waiting Period

You need to satisfy a waiting period of consecutive lost time equal to your regularly scheduled workweek. This is normally seven calendar days, however, your schedule may differ. Please contact the Abbott claim administrator with questions regarding your applicable waiting period.

Non-exempt or hourly employees must use Hourly Sick Pay benefits, if available, to cover the waiting period. The amount of Hourly Sick time used during the waiting period is equivalent to your regularly scheduled work week (usually 40 hours within a seven-day calendar period). Your Hourly Sick time use may not exceed your regularly scheduled work week for each Short-Term Medical Leave claim filed. If you do not have any Hourly Sick Pay benefits remaining, you may request vacation pay to ensure continued income during the benefit waiting period. Vacation days may not be substituted for sick days if that substitution will result in eligibility for overtime. If you request vacation pay, it will not be reversed or credited back once issued, except as described in the *Injury or Illness During Vacation* section.

Abbott designates all time taken under an approved Short-Term Medical Leave as Family Leave of Absence (FLOA) in accordance with Federal and State Law. FLOA runs concurrent to all Short-Term Medical Leaves, if eligible.

[18] Sick pay benefits for employees in California, Hawaii, New Jersey, New York and Rhode Island differ slightly from those described in this booklet.

Recurring Illness

In the event you return to work full duty for 30 calendar days or less and again are unable to work due to the same illness or condition you will revert to your previous period of Short-Term Medical Leave and will not need to satisfy a new waiting period.

Any return to work greater than 30 days, regardless of condition, will be considered a new claim and will require a new waiting period.

Your Pay While on Medical Leave

Your Base Rate of Pay

Your base rate of pay is equivalent to your hourly rate of pay or base salary and does not include shift premiums (such as night, holiday or Sunday premiums), overtime, sales or marketing bonuses, cash awards, discretionary bonuses or payments from Abbott's Cash Profit Sharing (CPS) Plan. All authorized payroll deductions will be taken from your benefit payments. Weekly Sick Pay and Salary Continuation benefits will be offset by primary Social Security disability benefits payable to you for the same period.

Weekly Sick Pay and Salary Continuation Benefits

If you are a regular employee working a schedule of at least 20 hours per week, Weekly Sick Pay (for non-exempt employees) or Salary Continuation (for exempt employees) benefits are paid at 100 percent of your current base rate of pay for the first 7 weeks of approved absence and up to an additional 18 weeks at 70 percent of pay after satisfying the seven consecutive day waiting period.

Filing a Claim

A Short-Term Medical Leave claim must be filed with Abbott's Claims Administrator, in accordance with Abbott's Short-Term Medical Leave Policy, or benefits may be denied. The Short-Term Medical Leave policy can be found on the Abbott Corporate Policy Portal. You need to comply with Abbott's leave of absence procedures, including notifications and completion of all required paperwork. Failure to do so may result in loss of your leave benefits, including pay.

Benefits under Abbott's Short-Term Medical Leave program are payable for up to 26 weeks (130 work days or part-time equivalent, including the waiting period) in any 52-week period.

Planned absences may be filed up to 30 days in advance of the leave start date. Sick pay benefits may be suspended if the Claims Administrator does not receive all required documentation within 15 days from the first day of absence. Any claim filed beyond 30 days of first date of absence may be denied.

Benefits under this program are offset by benefits paid from any Abbott Voluntary Plan benefits, any state or other government programs and will be administered in compliance with applicable state requirements.

Failure to report leave of absence may lead to termination of employment.

Return to Work

You must contact the Abbott Claims Administrator as soon as you are released to return to work and provide written documentation of your work abilities. The Claims Administrator will work with Abbott to ensure a prompt and safe return. Failure to return on the confirmed return to work date, or failure to request an extension prior to the confirmed return to work date may result in suspension of pay and the absences may be considered unexcused until appropriate documentation is received.

If your release to return to work contains any restrictions or accommodations, the return must be coordinated through the Abbott Claims Administrator and your manager before you actually return. Details on the requirements for returning to work following a Short-Term Medical Leave can be found in the Short- Term Medical Leave policy on the Corporate Policy portal or by requesting a copy from **myHRTeam**.

If you are temporarily placed in a reduced work schedule, require temporary work restrictions or a temporary work accommodation during your recovery you are still considered on a medical leave of absence. Weekly Sick Pay benefits may be payable to supplement any difference between your regularly scheduled workday and the number of hours in your reduced work schedule.

While you are receiving Weekly Sick benefits and working a reduced work schedule you may not supplement pay with vacation or Hourly Sick benefits. If you elect to use vacation during a reduced work schedule, vacation must be taken in full day increments.

Injury or Illness During Scheduled Vacations or Plant Shut Downs

If you become ill, injured or have a baby during a pre-approved vacation period (or a scheduled plant shut down) for more than seven consecutive calendar days and require care from a health care provider, you may request a Short-Term Medical Leave of Absence. If the Short-Term Medical Leave is approved, any vacation time or pay for that period will be credited back to you and your Sick Pay benefits will be used.

At Retirement

If you become ill or suffer an injury before your scheduled retirement date, your retirement may be postponed until the earliest of the following dates:

- The date you are no longer medically incapacitated, or
- The date you have received benefits for 26 weeks (130 work days or part-time equivalent), unless you elect to apply for Long-term Disability Plan (LTD) benefits

Exclusions – What is not Covered

Weekly Sick Pay benefits are **not** payable for scheduled overtime periods. Weekly Sick Pay benefits are **not** payable for more than eight hours per day, or for any approved work-related illness or injury. Absences resulting from work-related illnesses or injuries may be eligible for benefits as described in the Workers' Compensation section of your Employee Benefits Handbook.

Absences not approved under Family Leave of Absence (FLOA), Short-Term Medical Leave (STML) or Workers' Compensation may be subject to attendance and performance counseling.

Loss of Short-Term Medical Leave Benefits

Short-Term Medical Leave benefits may be suspended in the event you fail to submit Objective Medical Evidence or necessary required documentation to Abbott or its Claims Administrator. Details on loss of benefits can be found in the Short-Term Medical Leave policy, on the Corporate Policy Portal or by requesting a copy of the policy from **myHRTeam**.

Termination of Coverage

Your participation in this plan will end on the date your employment with Abbott terminates for any reason. Any claim filed as a result of your termination will not alter the termination decision and if on approved leave, your position with Abbott will not be protected. Upon completion of your approved leave, your employment with Abbott will terminate. In the event of your death while receiving Hourly or Weekly Sick Pay or Salary Continuation, benefits through the date of your death will be payable to your authorized beneficiary or to your estate.

Right of Recovery

Abbott has the right to recover benefits it has paid on your behalf that were:

- Paid in error
- Due to a mistake in fact, or due to a misrepresentation of facts
- Advanced during the time period required to make a determination on your claim if your claim is not ultimately approved for payment
- Received under the Abbott Short-Term Medical Leave Policy and you then become entitled to claim benefit payments or reimbursement from a third party for an injury or illness that led to your eligibility for benefits under the Policy ("Proceeds"). This right may be through reimbursement by the employee or through subrogation to the employee's rights.

Abbott will require that any overpayment be returned when requested, or a reduction in future benefit payments will occur until the overpayment is recovered.

Administrative Information

Funding

Abbott pays Hourly and Weekly Sick Pay and Salary Continuation Benefits from its general assets.

Claims Administration

Matrix Absence Management, 9390 Research Blvd., Bldg. 1, Suite #220 Austin, TX 78759 (800) 663-8044

Plan Changes

Abbott has reserved the right to change its Sick Pay and Short-Term Medical Leave policies at any time by appropriate action by the Executive Vice President, Human Resources, including:

- The right to change any amounts contributed toward the cost of providing benefits by Abbott or its employees
- The level of benefits provided
- The class or classes of employees eligible for benefits

Long-term Disability Plan (LTD)

(Formerly known as the Extended Disability Plan (EDP))

The Abbott Laboratories Long-term Disability Plan (LTD) helps protect you against loss of income due to a serious health condition. Abbott pays the entire cost for these benefits.

Eligibility

The Abbott LTD plan automatically covers regular employees of Abbott who are working a schedule of 20 or more hours per week upon completing six months of continuous active service.

Active Service

Active service under the LTD plan is defined as performing your regular duties according to your established work schedule. It does not include absences due to illness or leave of absence. If you are absent from work on the date you become eligible for the plan, your coverage will begin on the day you return to active work. A medical absence of more than 7 consecutive days (or equivalent part-time work week) during your first six months of Abbott service will interrupt the completion of this eligibility waiting period. You will need to complete six months of continuous active service from the date you return to your regular duties according to your established work schedule. You may, however, substitute unused vacation and holiday credits for a medical absence that would interrupt completion of the eligibility waiting period.

Benefits under this plan are not automatic. You must apply for them, and you must be under the regular care of a legally qualified physician (who is not related to you).[19] You must also submit confirming documentation if requested by the Plan Administrator.

Plan Benefits

If you become eligible to receive benefits, the plan pays you 60 percent of your basic monthly earnings.

[19] Medical information submitted by a member of your family or household is not acceptable documentation under this plan.

Basic Monthly Earnings

Basic monthly earnings for purposes of determining your monthly LTD benefit are equal to your base rate of pay over your regularly scheduled workweeks — before reduction for any contributions you make under Abbott's pre-tax benefit plans. Your basic monthly earnings include sales bonuses — but do not include other bonuses, awards, shift differentials, overtime payments or other forms of income you may receive.

Benefit Reductions

Your monthly LTD benefits from Abbott are reduced by disability income benefits payable to you from other sources — including primary Social Security benefits, state or federal government programs or any plan or program toward which Abbott contributes or makes payroll deductions, including Workers' Compensation.

Any increases in Social Security disability benefits payable to you after your LTD benefits first become payable will not affect the amount you receive from the plan.

No more than 50 percent of a Workers' Compensation lump-sum settlement will be considered for the reduction under this provision.

Duration of Benefits

Plan benefits begin after you have been unable to work at your regular job for 26 weeks due to an illness or accidental bodily injury that prevents you from performing the duties of your normal job with Abbott. All plan benefits are subject to medical certification and must be approved by the Claims Administrator.

You may receive up to 24 months of LTD benefit payments provided you remain unable to perform the duties of your job at Abbott and comply with all other plan requirements.

At the end of 24 months, if you are physically unable to engage in any occupation for which you are qualified — or for which you may reasonably become qualified by training, education or experience — you may continue to receive monthly benefit payments from LTD until you recover or reach age 65, whichever occurs first.[20]

If you are disabled at age 61 or later, LTD payments may continue for the number of months indicated below:

AGE AT DISABLEMENT	MAXIMUM MONTHLY PAYMENTS
61	42
62	38
63	34
64	30
65	27
66	24
67	21
68	18
69	6

[20] See Exclusions section.

Rehabilitative Employment

You may continue to receive plan income if you enter into an Approved Rehabilitation Program. Only work that has received advance written approval by the Plan Administrator or Disability Claims Administrator will be considered an Approved Rehabilitation Program.

During the first 12-month period of an approved rehabilitation program, your rehabilitative earnings will not reduce your monthly LTD benefits unless your monthly earnings exceed 100 percent of your pre-disability monthly base earnings. During the second 12-month period of an approved rehabilitation program your monthly LTD benefit will be reduced by 70 percent of your monthly rehabilitative earnings.

Recurring Absences

If you begin receiving LTD benefits, return to work for *less than six consecutive months,* then again become unable to work due to the same or a related cause, your LTD benefits will resume without a 26-week waiting period.

If you return to work for *six months or more* or if you are unable to work because of a different medical condition, you will need to satisfy the 26-week waiting period again before LTD benefits begin.

Procedure to Obtain Benefits

To receive plan benefits you must complete the LTD application and return it to the Claims Administrator.

Payment of Benefits

Plan benefits are paid monthly.

Filing a Claim

When you have been absent from work for about four months, you will receive a notice of your eligibility to apply for LTD benefits, along with an LTD application. You and your treating provider(s) must complete the application and return it to the Claims Administrator. Claims must be filed promptly. To be eligible for plan payments, you must file an application for LTD benefits within 90 days after you receive notice of your eligibility, or before the date your employment with Abbott terminates, whichever is later. You may be required to submit a copy of your federal tax return for any year in which you receive plan benefits.

You must contact your local Social Security Administration office and apply for any Social Security disability benefits that may become payable to you. If the Social Security Administration denies your claim, you must participate in the appeal process and provide evidence that you have done so to the Claims Administrator.

Exclusions – What is not Covered

LTD benefits are **not** payable for absences:

- Due to mental illness or functional nervous disorder once benefits have been payable 24 months for that condition, unless you are continuously confined in a hospital or participating in a treatment program approved by the Claims Administrator for continuing LTD benefits or any period of disability caused or contributed to by chronic fatigue syndrome; fibromyalgia; or self-reported conditions after monthly benefits have been payable for 24 months for that disability
- Due to intentionally self-inflicted injuries
- Due to injuries sustained during your commission or attempted commission of a felony
- Due to war or any of act of war
- For which you are not under the care of a physician or for which you refuse to submit to a physical examination
- Beyond the date you begin gainful employment with any employer, including Abbott, other than in an approved rehabilitative program

Loss of Benefits

Benefits may be denied if you fail to submit medical certification acceptable to the Claims Administrator, or if you fail to submit to a medical examination or diagnostic testing requested by the Claims Administrator.

Benefits under the plan will automatically stop if you refuse or fail to participate in any rehabilitation or modified duty program when able to do so and requested to do so by Abbott or the Claims Administrator.

Benefits under the plan will stop if you become employed elsewhere or if Abbott offers you a job that makes reasonable accommodation for your medical condition but you refuse or fail to accept the job.

Termination of Coverage

Your LTD coverage will end on the earliest of the following dates:

- The date you are no longer considered an eligible employee
- The date your employment terminates unless you are eligible to receive LTD benefits)
- The date you retire under any pension or annuity plan maintained by Abbott.

Right of Recovery

Abbott has the right to recover benefits it has paid on your behalf that were:

- Paid in error
- Due to a mistake in fact, or due to a misrepresentation of facts
- Advanced during the time period required to make a determination on your claim if your claim is not ultimately approved for payment
- Received under the Abbott Long-term Disability Plan and you then become entitled to claim benefit payments or reimbursement from a third party for an injury or illness that led to your eligibility for benefits under the Plan ("Proceeds"). This right may be through reimbursement by the employee or through subrogation to the employee's rights.

If the plan provides a benefit for you that exceeds the amount that should have been paid, the plan will require that the overpayment be returned when requested, or reduce future benefit payments until the overpayment is recovered.

Claim Denial and Appeal Procedures

If your application for plan benefits (or "claim") is denied in whole or in part, you, your surviving spouse or beneficiary will receive written notification of the denial within 45 days of the filing of your claim. If it is necessary to extend the 45 days due to matters beyond the plan's control, the notification may be delayed for up to an additional 30 days, in which case you will be notified in advance. If it is necessary to extend the 75 days due to matters beyond the plan's control, the notification may be delayed for up to a second additional 30 days, in which case you will be notified of such extension during the initial 30-day period.

Any such extension notice will explain the circumstances requiring the extension, the date the plan expects to make a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If you have not submitted sufficient information to the Plan Administrator to process your claim, you will be notified of the incomplete claim and given 45 days to submit additional information. This will extend the time in which the Plan Administrator has to respond to your claim by the number of days from the date the notice of insufficient information is sent to you until the date you respond to the request. If you do not submit the requested missing information to the Plan Administrator within 45 days of the date of the request, your claim will be denied.

Notification of the determination of your claim will include the specific reasons for the denial; specific references to the pertinent plan provisions on which the denial is based; a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and an explanation of the plan's claim review procedures and its applicable time limits, including your right to file civil suit under the pertinent provision of ERISA if your claim is denied on appeal. Your denial notification will also state your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and

other information relevant to your claim. In addition, you will be informed of any internal rule, guideline, protocol, or other similar criterion, that the plan relied on, and a copy will be provided free of charge if you request it. If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, you will receive an explanation of the scientific or clinical judgment for that determination or a statement that such explanation will be provided free of charge if you request it.

Appeals

If you are notified that a claim has been denied in whole or in part, you may question that decision by taking the following steps.

How to Appeal a Claim Decision

There are two levels of appeal under the Abbott Laboratories Long-term Disability Plan. You must complete the Plan's appeal process before seeking legal action.

First Level Appeals

If your claim is denied and you disagree with this finding, you must first file a written appeal with the Claims Administrator within 180 days after the date you receive the written claim denial.

Your appeal must include the reason(s) why you feel your claim should not have been denied, and should include any documentation or basis for which you are seeking approval. You may also add copies of any other supporting documentation or records that you want considered for the appeal, even if the information was not submitted or considered in the initial claim review. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. The Claim's Administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

To file an appeal with the Claim's Administrator, you, your surviving spouse or beneficiary or your duly authorized representative must submit a written request for appeal of the claim to Matrix Absence Management, PO Box 11035, San Jose CA 95103 Attn: Quality Review Unit.

In any case, the appropriate reviewer of your appeal will not be the same person who made the initial decision to deny your claim or his or her subordinate. In deciding an appeal that is based in whole or in part on medical judgment (including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), such reviewer will consult with a health care professional with appropriate training and experience in the field involved in the medical judgment. Such health care professional will neither be the individual who was consulted in connection with the initial claim denial being appealed or his or her subordinate. The Claim Administrator will provide for identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claim denial, whether or not the advice was relied upon in making the decision.

Normally, you will receive a final decision within 45 days of the date your request for review is received. In special circumstances requiring a delay, you will be notified of the need for an extension

and will receive notice of the final decision within 90 days. If such an extension is needed, you will be notified in writing before the end of the 45-day period. In reviewing your appeal, the Claim's Administrator will not give any deference to the initial decision denying your claim. The Claims Administrator will take into account all comments, documents, records, and other information that you, your surviving spouse or beneficiary or your duly authorized representative submitted with your appeal, whether or not such information was submitted or considered in the initial determination.

The final written decision will include specific reasons for the decision, with specific reference to the plan provision on which that decision is based. It will also notify you of your right to file a civil suit under section 502(a) of ERISA, which suit must be filed before the earlier date of (a) ninety days after the date of the final written decision or (b) three years after the date on which you claim you first became disabled. It will also notify you 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.

In addition, you will be informed of any internal rule, guideline, protocol, or other similar criterion, that the plan relied on, and a copy will be provided free of charge if you request it. If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, you will receive an explanation of the scientific or clinical judgment for that determination or a statement that such explanation will be provided free of charge if you request it.

Second Level Appeals

If your appeal to the Claims Administrator is denied and you disagree with the findings, you may file an appeal with the Plan Administrator. Your appeals must be in writing and must be filed with the Claims Administrator within 180 days after the date you receive the written notice of claim denial. The Claims Administrator will submit the second level appeal for Abbott review.

Documents or records supporting the appeal should accompany your request. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also submit written comments, records, documents and other information relevant to your appeal, whether or not such documents were submitted in connection with the initial claim.

In deciding an appeal that is based in whole or in part on medical judgment (including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), such reviewer will consult with a health care professional with appropriate training and experience in the field involved in the medical judgment. Such health care professional will neither be the individual who was consulted in connection with the initial claim denial being appealed or his or her subordinate. The Plan Administrator will provide for identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claim denial, whether or not the advice was relied upon in making the decision.

Normally, you will receive a final decision within 45 days of the date your request for review is received. In special circumstances requiring a delay, you will be notified of the need for an extension and will receive notice of the final decision within 90 days. If such an extension is needed, you will be notified in writing before the end of the 45-day period.

In reviewing your appeal, the Plan Administrator will not give any deference to the initial decision denying your claim. He or she will take into account all comments, documents, records, and other information that you, your surviving spouse or beneficiary or your duly authorized representative submitted with your appeal, whether or not such information was submitted or considered in the initial determination.

The final written decision will include specific reasons for the decision, with specific reference to the plan provision on which that decision is based. It will also include your right to file a civil suit under the pertinent provision of ERISA and the applicable time limits for filing a civil suit. It will also provide notification 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.

In addition, you will be informed of any internal rule, guideline, protocol, or other similar criterion, that the plan relied on, and a copy will be provided free of charge if you request it. If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, you will receive an explanation of the scientific or clinical judgment for that determination or a statement that such explanation will be provided free of charge if you request it.

The Plan Administrator has full discretion and authority to make the final decision regarding all areas of plan interpretation and administration, including eligibility for benefits, level of benefits provided, interpretation of plan language (including this summary plan description) or administrative procedures.

Benefits will be paid under the plan only if the Plan Administrator, or his delegate, determines in his discretion that the claimant is entitled to them.

Administrative Information

Plan Identification

The name of the plan is the Abbott Laboratories Long-term Disability Plan. Abbott is the Plan Sponsor. The Divisional Vice President, Compensation and Benefits is the Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following numbers:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 504

Plan Funding

Abbott pays all plan benefits from its general assets.

Participating Employers

The Abbott Laboratories Long-term Disability Plan applies to eligible employees of Abbott Laboratories and its subsidiaries.

Claims Administration

Matrix Absence Management, 9390 Research Blvd., Bldg. 1, Suite #220 Austin, TX 78759
(800) 663-8044

Plan Changes

Abbott intends to continue the plan indefinitely, but reserves the right, by appropriate action by the Executive Vice President, Human Resources, to change it at any time, including:

- The right to change any amounts contributed by Abbott or its employees toward the cost of providing benefits
- The level of benefits provided
- The class or classes of employees eligible for plan benefits.

Coverage under the plan is not a guarantee of employment, and Abbott reserves the sole right by appropriate action by its board of directors or the Executive Vice President, Human Resources to terminate the plan at any time, either in its entirety or with respect to any covered class or classes of employees.

Workers' Compensation

If you have a work-related injury or illness, regardless of severity, you must report it immediately to your supervisor or manager. Take this step even if you do not think you need medical care. Your supervisor or manager will arrange for a medical evaluation or emergency first aid treatment. If an Occupational Health Services office is available at your location, they may provide an initial medical evaluation and/or refer you to an outside physician or hospital.

Sales Employees: Call **(877) 840-2128** if you suffer an injury on the job, unless you live in Nevada, North Dakota or Washington. In those states, call the state Workers' Compensation office. You should also contact your manager and division safety coordinator.

When you report your injury promptly, you not only help protect your rights under Workers' Compensation law; you greatly increase the speed and efficiency of your claim handling.

Workers' Compensation in Florida: If you live in the state of Florida, you are covered by the Florida Workers' Compensation Managed Care Act. This Act requires that you receive treatment for work-related conditions only from approved providers. If you are injured while working in the state of Florida, call Matrix immediately at **(877) 840-2128** for guidance. It is important to remember that medical services from unauthorized providers may be at your own expense.

Work-related Absences

If it is determined that you are unable to perform the duties of your regular job with Abbott because of a work-related illness or injury, your compensation for time lost will be coordinated through the medical leave administrator in accordance with the medical leave policies for your location.

Payment of insured compensation will be in accordance with appropriate state law. There is generally a waiting period of three to seven days before insured benefits begin.

Abbott Sick Pay and LTD benefits are offset by benefits you receive for Workers' Compensation.

Abbott Transitional Pay Plan

Abbott's policy is to take reasonable actions to avoid reductions in force — including finding other jobs, where practical, for affected employees. Abbott has adopted the Abbott Laboratories Transitional Pay Plan to set conditions under which benefits may be granted to Abbott employees who are terminated due to a reduction in force.

Eligibility

Benefits may be paid to Abbott U.S. employees as designated by the Divisional Vice President, Compensation and Benefits, at the sole and absolute discretion of Abbott. As a condition of receiving benefits under this plan, the employee must sign a release form designated by Abbott. Plan payments cannot be contingent on the employee retiring.

This plan does not apply to voluntary terminations, terminations for cause or terminations for performance reasons — even if those terminations occur at the same time as a reduction in force. This plan does not apply to any termination if the employee is offered another job with Abbott or its affiliates.

The granting of benefits in any particular situation or to any particular group of employees does not require that similar benefits, or any plan benefits, be granted to other employees in the same or similar situations. Abbott reserves the right to change or end this plan at any time.

Plan Benefits

The Divisional Vice President, Compensation and Benefits will determine the amount of benefits payable to any employee, at his or her sole discretion.

Funding

Abbott pays all plan benefits from its general assets.

Plan Identification

The name of the plan is the Abbott Laboratories Transitional Pay Plan. Abbott is the Plan Sponsor and Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following numbers:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 560

Protecting Your Family

Abbott life insurance benefits are designed to help you provide financial security for your survivors in case of your death. You also have options for dependent life insurance coverage for your spouse and eligible children.

Life Insurance

Life insurance under the Abbott Laboratories Life Accident Plan provides benefits to your beneficiary if you die while covered by the plan.

Eligibility

You are eligible for coverage under the Abbott Laboratories Life Accident Plan on your first day of work as a regular employee of Abbott.

Enrollment

When you first become eligible, the basic life insurance portion of this plan automatically covers you at one times your base pay. You will need to name your beneficiary and indicate if you want to elect supplemental life insurance coverage. To designate your beneficiaries and/or enroll for supplemental life insurance, you must log on to the Benefits Web site at www.abbottbenefits.com and follow the instructions provided.

No medical examination is required for basic life insurance coverage or for supplemental life insurance coverage under this plan if you enroll within 31 days after you first become eligible, unless your total coverage elected exceeds 5 times your basic annual earnings or $2.8 million. Elections over the limits require evidence of your insurability satisfactory to the insurance company before your coverage can become effective.

Evidence of Insurability

If you enroll for supplemental life insurance coverage more than 31 days after you are first eligible, you will be required to submit evidence of your insurability satisfactory to the insurance company before your coverage can become effective. On-screen instructions for submitting evidence of insurability are included in the online Enrollment tool.

Basic Insurance

Your basic life coverage is equal to your basic annual earnings rounded to the next higher $1,000 (if not an even multiple of $1,000).

There is a minimum basic benefit of $15,000. Abbott provides this basic life insurance coverage at no cost to you.

Basic Annual Earnings

For purposes of determining your life insurance amounts, your basic annual earnings equal:

- Your hourly rate of pay times 2,080 if you are a nonexempt employee[20]
- Your monthly salary times 12 if you are an exempt employee

Basic annual earnings do not include overtime pay, shift differentials, bonuses (other than sales bonuses) or any other form of extra compensation.

Imputed Income

Under federal income tax regulations, you could realize some additional taxable income on basic life insurance coverage provided by Abbott. The amount of your life insurance coverage determines whether you are subject to this imputed income. If this tax provision affects you, the additional taxable income will be reflected on your pay stub and will appear on your W-2 statement from Abbott each January.

Supplemental Insurance

If you are eligible for basic life insurance under this plan, you are also eligible to elect supplemental life insurance. Supplemental life is in addition to your basic life insurance coverage. You can confirm your current coverage at any time by visiting the Benefits Web site at www.abbottbenefits.com.

Supplemental Life Insurance Options

There are seven supplemental life insurance options available, (elections over 500 percent of basic annual earnings will always be subject to evidence of insurability).:

- 100 percent of your basic annual earnings
- 200 percent of your basic annual earnings
- 300 percent of your basic annual earnings
- 400 percent of your basic annual earnings
- 500 percent of your basic annual earnings
- 600 percent of your basic annual earnings
- 700 percent of your basic annual earnings

[20] For employees working less than full-time, life insurance amounts are based on scheduled hours

Supplemental life premium rates are based on your age as of January 1 of each calendar year.

Your supplemental life insurance benefit will be rounded to the next higher $1,000 (if not an even multiple of $1,000). The maximum amount of life insurance under the group plan is $7.3 million basic and supplemental life combined.

Your Contributions

There is no employee contribution for basic life insurance. Your contribution for supplemental life insurance is based on the amount of life insurance in effect, your age tier and whether or not you are a non-smoker. Rates are subject to revision annually. You can view your current life insurance coverage and costs at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

Non-smoker Elections

A non-smoker is defined as someone who has been tobacco and nicotine free for at least 12 months. This includes cigarettes, cigars, pipes, chewing tobacco, nicotine gums, patches and nicotine delivery systems. At the time of your life insurance election, you will select either a smoker or non-smoker contribution amount. By selecting a non-smoker contribution amount, you are certifying that you do not use any form of tobacco. If you are certified as a non- smoker and you later begin or resume smoking, you are no longer eligible for the non-smoker discount and must change your contribution amount accordingly.

If an employee dies of a cause shown to be directly related to smoking (for example, lung cancer), and a non-smoker discount is in effect, an investigation may be performed to determine if he or she was a smoker by the above definition on or after the date of such certification. If so, the supplemental life insurance claim may be denied and all premiums refunded to the named beneficiary.

Changes in Your Life Insurance Amounts

Automatic Adjustments

As your eligible earnings increase or decrease, your basic and supplemental life insurance coverage amounts are automatically adjusted up to the plan maximum of $7.3 million. Your contributions for supplemental coverage (if elected) are also automatically adjusted. If you are absent from work due to illness or injury on the date your insurance amount is scheduled to increase, the increase will not become effective until you return to work.

Reduced Coverage after Age 65

If you continue working past your 65th birthday, your basic and supplemental life insurance coverage are reduced to 60 percent of the amount in effect during the month in which your 65th birthday occurs. This reduction becomes effective as of the first day of the month following your 65th birthday and continues in effect until the end of the month in which you retire. Your contributions will not decrease.

Election Changes

You may request an increase to your supplemental life insurance percentage (up to 700 percent of your basic group life insurance) at any time by logging on to the Benefits Web site at www.abbottbenefits.com and following the on-screen instructions. If your request is submitted more than 31 days after you are first eligible for coverage, or if your total coverage amount elected within 31 days of when you are first eligible exceeds $2.8 million, you will be required to provide Evidence of Insurability (EOI). The amount and cost of your life insurance coverage will automatically default to the highest level of coverage available without EOI until approved by the insurer. If your request is approved, the increase will be effective on the date approved by the insurer.[22]

You may reduce your supplemental life insurance election at any time by logging on to the Benefits Web site at www.abbottbenefits.com and following the on-screen instructions. The reduction will be effective on the date you submit your request.

[22] If requested during the annual open enrollment and approved before December 31, your increase will become effective January 1 of the following year.

Your Beneficiary Designations

When you first enroll, you will be asked to name primary and contingent beneficiaries for your life insurance benefits. The primary beneficiary is the person, persons, trust or organization that you wish to receive payment of your death benefits under this plan. The contingent beneficiary is your "back-up" and would receive benefits only if your primary beneficiary cannot receive benefits (for example, if your primary beneficiary dies before you).

You can name anyone as a beneficiary and you can change a beneficiary at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

If your designation of beneficiary provides for payment to a trustee under a trust agreement, the Plan shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of the Plan to the extent of such payment.

If your beneficiary is a minor child (i.e., under age 18 at the time of your death), benefit payments will be held by the insurer until the child reaches 18 years of age. If you have questions about naming a minor child as a beneficiary, consult a legal advisor.

When Coverage Begins

Your basic life insurance coverage begins on your first day of employment or eligibility.

Your supplemental life insurance coverage begins:

- On your first day of employment or eligibility, if you enroll within 31 days of when you first become eligible, or
- On the date your Evidence of Insurability application is approved

If you are not actively at work on the day coverage would otherwise begin, your coverage will begin on the day you return to active work on your regular schedule.

Coverage During a Leave of Absence

Your group life insurance coverage may be continued for a limited period while on a medical, personal or family leave of absence, subject to payment of any required contributions. For more information about extended coverage under these circumstances call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Filing a Claim

Your beneficiary must file a claim with the insurance company to receive any life insurance benefits that may become payable under this plan. Your beneficiary may obtain the necessary forms and instructions for filing the claim by calling the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Accelerated Benefit Claims

Your life insurance benefit contains an accelerated benefits provision. This means that all or a portion of the coverage amount may be paid to you if you have a terminal condition caused by sickness or an accident which directly results in a life expectancy of 24 months or less. You may choose to receive a partial accelerated benefit. You may request early payment of up to 100 percent of your life insurance amount (Basic and Supplemental Life coverages combined), up to a maximum of $1,000,000. More details are available from the **Abbott Benefits Center**. Generally, the Claims Administrator will request medical records that the medical directors at the insurance company will review to confirm your medical condition and life expectancy.

Contestability

The insurance company reserves the right to contest a claim based upon new or increased insurance coverage if the increase occurs within two years of death and there is reason to question the validity of statements made in the application for the increase.

When Coverage Ends

Your supplemental life insurance will terminate if you fail to pay the required contributions for this coverage.

At Termination

Basic and supplemental coverage under this plan will terminate when your employment terminates for any reason. Within 31 days after your employment or LTD cumulative 18 month waiver of premium eligibility ends, you may convert or "port" your life insurance coverage to an individual policy as described below. If you should die within the 31-day period after your Abbott group life insurance coverage terminates, benefits will be paid as though you had elected a conversion policy for the full amount available.

Termination of Employment Due to Total Disability

If your employment terminates due to a total disability for which you are eligible to receive benefits from the Abbott Laboratories Long-term Disability Plan (LTD), the full amount of your active Abbott basic life insurance benefits is provided on an equivalent level under the Abbott Laboratories Life Accident Plan. These benefits are maintained at no cost to you until you are no longer considered disabled under the LTD, retire or are age 65, whichever occurs first.

Your supplemental life coverage remains in effect at no cost to you for a total of 18 cumulative months of LTD status. At the end of a cumulative 18 months of LTD your employer sponsored coverage will end and you will be offered the opportunity to convert your supplemental and dependent life insurance to individual policies

At Retirement

Your eligibility in the Abbott Laboratories Life Accident Plan ends on your retirement date. You may be eligible for benefits under the Abbott Laboratories Retiree Life Insurance Plan. The Abbott Retiree Benefits Handbook contains details about retiree life insurance coverage.

Portability

The portability option allows you to continue your group term life insurance coverage for a specified period of time if your employment terminates or you retire. You may elect to "port" coverage at group rates that are higher than those for your active group term coverage, but usually lower than the premium rates for individual conversion policies. Ported group term life insurance may be subject to age-based reductions. Application forms must be submitted to the insurance company. If you wish to "port" your coverage, please call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for guidance.

Conversion Privileges

Within 31 days after your employment or LTD life insurance eligibility ends, you may convert all or part of your group life insurance coverage to an individual policy — without taking a medical examination. The cost for individual coverage is based on the insurance company's regular premium rates for the type and amount of insurance available to you through the conversion privilege, and on your age when you apply for the individual policy. To convert to individual coverage, the appropriate forms must be submitted to the insurance company. If you wish to convert your coverage, please call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for guidance.

Accidental Death and Dismemberment Insurance

Accidental death and dismemberment insurance (AD&D) pays benefits to you or to your named beneficiary for loss of life or limb due to an accident that occurs while you are covered by the plan. Benefits may also be payable for rehabilitative therapy or medical coverage for your surviving family members following a covered accident.

Basic Insurance

Your basic AD&D insurance coverage is $10,000. Abbott provides this basic coverage at no cost to you.

Supplemental Insurance

Employee Coverage

If you are eligible for basic AD&D insurance under this plan, you are also eligible to elect supplemental AD&D insurance in multiples of $10,000, up to a maximum benefit of 10 times your basic annual earnings, or $500,000, whichever is less. You can confirm your current coverage at any time by visiting the Benefits Web site at www.abbottbenefits.com.

Spouse's Coverage

If you elect supplemental AD&D insurance on yourself, you may also elect coverage for your spouse or eligible domestic partner[23] in multiples of $10,000, up to a maximum benefit of $100,000 or the amount of your own supplemental AD&D coverage, whichever is less.

Ancillary Benefit Provisions

The following ancillary AD&D benefits became effective May 1, 1999.

- **Rehabilitation benefit:** This benefit reimburses expenses for rehabilitative therapy (up to 20 percent of your total AD&D coverage or $10,000 per accident, whichever is less) if you receive a dismemberment benefit under this plan as a result of a covered accident.
- **COBRA benefit:** This benefit reimburses your family's actual costs to continue medical coverage under the Abbott Laboratories Health Care Plan's Continuation Coverage Provision (COBRA) for up to three years following your death due to a covered accident. The maximum annual amount payable under this benefit is 3 percent of your total AD&D coverage or $3,000, whichever is less.

[23] If you and your spouse or domestic partner are both eligible active employees of Abbott, you both may select employee coverage for supplemental AD&D insurance, but neither of you may be covered as a spouse under this plan.

Seat Belt Incentive

If you are killed or receive a dismemberment benefit as a result of a covered motor vehicle accident, the plan will pay an additional 10 percent of your total AD&D coverage, up to $25,000, if at the time of the accident:

- You are wearing a properly fastened seat belt
- You are driving a vehicle with a driver-side air bag or riding as a passenger in a seat protected by an air bag, and
- The driver of your vehicle is neither intoxicated nor under the influence of drugs (unless taken as prescribed by a physician).

Your Contributions

There is no employee contribution for basic AD&D insurance.

If you enroll in supplemental AD&D insurance, your contribution is based on the amount of AD&D coverage you select for yourself and for your spouse, if any. Rates are subject to revision annually. You can view current costs for AD&D coverage at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

Changes in Your Supplemental AD&D Coverage

You may increase or decrease your supplemental AD&D insurance coverage at any time by logging on to the Benefits Web site at www.abbottbenefits.com and following the on-screen instructions.

Your change will be effective on the date you submit your request, and benefits will be payable for covered accidents that occur after that date. If, however, you are absent from work due to a medical leave on the date your own insurance amount is scheduled to change, your new insurance amount will not become effective until you return to work.

Your Beneficiary Designations

You are the beneficiary for benefits payable under this plan due to your accidental dismemberment. If you elect supplemental AD&D coverage on your spouse or domestic partner, you are automatically named as the beneficiary for these benefits.

When you are first eligible for coverage, you will be asked to name primary and contingent beneficiaries for AD&D benefits payable due to your accidental death. The primary beneficiary is the person, persons, trust or organization that you wish to receive payment of your death benefits under this plan. The contingent beneficiary is your "back-up" and would receive benefits only if your primary beneficiary cannot receive benefits.

You can name anyone as a beneficiary for AD&D benefits payable as a result of your accidental death and you can change a beneficiary at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

If you live in a community property state, your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. In light of significant differences in law among community property states, you should consult a legal advisor if you live in a community property state and wish to name someone other than your spouse or domestic partner as a beneficiary

If your beneficiary is a minor child (i.e., under age 18 at the time of your death), benefit payments will be held by the insurer until the child reaches 18 years of age. If you have questions about naming a minor child as a beneficiary, consult a legal advisor.

When Coverage Begins

Your basic AD&D insurance coverage begins on your first day of employment or eligibility. Your supplemental AD&D insurance coverage begins on the day you apply. If you are not actively at work on the day coverage would otherwise begin, your coverage will begin on the day you return to active work on your regular schedule.

Coverage during a Leave of Absence

Your basic AD&D coverage may be continued for a limited period if you are absent from work due to a leave of absence, subject to payment of the required contributions. For more information about extended coverage under these circumstances call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Filing a Claim

You or your beneficiary must file a claim with the insurance company to receive any AD&D insurance benefits that may become payable under this plan. You or your beneficiary may obtain the necessary forms and instructions by contacting the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Payment of Death Benefits

Basic AD&D

If you die because of and within 180 days after an accident that occurs while basic AD&D insurance coverage is in effect, the full amount of your basic AD&D insurance ($10,000) will be paid to your beneficiary. This death benefit is payable in addition to any benefits payable under your basic and supplemental group life insurance.

Supplemental AD&D

If you die as a result of and within 180 days after a covered accident that occurs while supplemental AD&D insurance coverage is in effect, the full amount of your supplemental AD&D insurance will be paid to the AD&D beneficiary. A spouse/partner's accidental death benefit will be paid to you, if living, otherwise to your estate.

These death benefits are payable in addition to any benefits payable under your basic and supplemental group life insurance. Your spouse/partner's death benefit is payable in addition to any dependent life insurance benefit which may become payable in case of his or her death.

Payment of Dismemberment Benefits

If you sustain bodily injuries that result in your death or dismemberment within 180 days of a covered accident, your AD&D coverage in effect on the date of the accident (basic and supplemental, if elected) will be paid in a lump sum as follows:

TYPE OF LOSS	BENEFIT PAYABLE
Loss of hearing	50% of benefit amount
Loss of Life	Full benefit amount
Loss of one member (hand, foot or eye)	50% of benefit amount
Loss of speech	50% of benefit amount
Loss of speech and hearing	Full benefit amount
Loss of thumb and index finger of same hand	25% of benefit amount
Loss of two or more members (hand, foot or eye)	Full benefit amount

No more than 100 percent of a covered person's AD&D insurance (not including ancillary benefits) will be paid for all losses sustained as result of the same accident.

Exclusions

Abbott Laboratories AD&D insurance benefits are **not** payable for losses caused by the following:

- Suicide or attempted suicide, whether sane or insane
- Intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane
- The insured's participation in or attempt to commit a crime, assault or felony
- Bodily or mental infirmity, illness or disease
- Medical or surgical treatment, including diagnostic procedures
- Alcohol, drugs, poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected
- Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury
- Travel or flight in or on any vehicle (other than an Abbott-owned aircraft or an aircraft being used in place of an Abbott-owned aircraft) used for aerial navigation including getting in, out, on, or off such vehicle, if the insured is:
  - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers,
  - Acting as a pilot or a crew member of any aircraft, unless riding as a passenger
  - Riding as a passenger in a non-chartered aircraft which is owned, leased, operated, or controlled by the eligible employee's employer
  - A student taking a flying lesson, unless riding as a passenger,
  - Hang gliding
  - Parachuting, except when the insured has to make a parachute jump for self-preservation
- War or any act of war, whether declared or undeclared
- Riot or civil insurrection
- Service in the military of any nation

When Coverage Ends

Your coverage under this plan terminates when your employment terminates for any reason. Supplemental AD&D insurance also terminates if you fail to pay the required contributions for this coverage.

Your spouse's AD&D coverage, if any, terminates on the earliest of the following dates:

- The date your employment terminates
- The date your spouse or domestic partner no longer qualifies as your dependent
- The date you fail to pay the required contribution for this coverage.

Abbott AD&D insurance coverage is not portable and cannot be converted to an individual policy.

Termination of Employment Due to Total Disability

Your basic and supplemental accidental death & dismemberment life insurance remains in effect at no cost to you for a total of 18 cumulative months of LTD status. At the end of a cumulative 18 months of LTD your employer sponsored coverage will end and you will be offered the opportunity to convert your life insurance to individual policies.

Business Travel Accident Insurance

Eligibility

All regular employees of Abbott are automatically covered by travel accident insurance when traveling on Abbott business anywhere in the world. Spouses/domestic partners and dependent children are covered when traveling with an eligible employee for company business or relocation.

Insurance Amount

Your travel accident insurance amount is equal to five times your basic annual earnings. There is a minimum coverage amount of $100,000 and a maximum of $1 million. This coverage is provided at no cost to you.

The travel accident insurance amount for eligible spouses or domestic partners is $100,000 and for eligible children is $25,000.

Your Beneficiary Designations

When you first enroll, you will be asked to name primary and contingent beneficiaries for your group life insurance benefits. You can name anyone as a beneficiary and you can change a beneficiary at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

If your designation of beneficiary provides for payment to a trustee under a trust agreement, the Plan shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of the Plan to the extent of such payment.

If you live in a community property state, your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. In light of significant differences in law among community property states, you should consult a legal advisor if you live in a community property state and wish to name someone other than your spouse or domestic partner as a beneficiary

If your beneficiary is a minor child (i.e., under age 18 at the time of your death), benefit payments will be held by the insurer until the child reaches 18 years of age. If you have questions about naming a minor child as a beneficiary, consult a legal advisor.

Filing a Claim

You or your beneficiary must file a claim with the insurance company to receive travel accident insurance benefits. You or your beneficiary may obtain the necessary forms and instructions for filing the claim by calling the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Payment of Benefits

Death Benefit

If you die because of and within 365 days after an accident that occurs while you are traveling on Abbott business, the full amount of your travel accident insurance benefit will be paid to your named beneficiary in a lump sum. This death benefit is payable in addition to any benefits payable under your basic and supplemental group life insurance and AD&D coverage.

Dismemberment Benefits

If you lose sight, speech, hearing or limb as the result of and within 365 days after an accident that occurs while you are traveling on Abbott business, your benefit will be paid to you in a lump sum, as follows:

- Thumb and Index Finger of the Same Hand: 25 percent of your travel accident insurance amount
- Loss of one hand, one foot, sight in one eye, speech or hearing: 50 percent of your travel accident amount
- For any two or more of these losses: 100 percent of your travel accident insurance amount.

Loss of Use Benefit

Benefits are payable for loss of use as follows:

- Both arms and both legs: 150 percent of your travel accident insurance amount
- Any two of an arm or leg: 66 $^{2}/_{3}$ percent of your travel accident amount
- Three limbs: 75 percent of your travel accident amount
- An arm or leg: 50 percent of your travel accident amount

Your travel accident insurance benefits for loss of life, sight or limb are payable in addition to benefits payable under your Abbott Laboratories Life Accident Plan for the same accident.

Coma

Benefits payable for coma resulting from an eligible accidental injury are one percent of your travel accident insurance amount for 100 months

Rehabilitation/Retraining

Benefits payable for rehabilitation/retraining necessitated by an eligible accidental injury are an additional five percent of your travel accident insurance amount to a maximum of $20,000.

Home Alteration/Vehicle Modification

Benefits payable for home alteration or vehicle modification necessitated by an eligible accidental injury are an additional five percent of your travel accident insurance amount to a maximum of $25,000

Psychological Therapy Benefit

Psychological therapy benefits for an eligible accidental injury are an additional five percent of your travel accident insurance amount to a maximum of $20,000

Benefit Limits

No more than 150 percent of your travel accident insurance amount will be paid for all losses sustained because of the same accident. If you suffer more than one loss as a result of the same accident, only the largest benefit will be paid. If more than one insured employee is injured in the same commercial aircraft accident, a maximum benefit of $25 million is payable for all covered losses resulting from that accident. There is a $10 million sub-limit applicable to Bomb Scare only.

Exclusions

Business travel accident benefits are **not** payable for losses caused by the following:

- Illness, disease, infections, pregnancy or childbirth
- Infirmity of body or mental infirmity
- Suicide or attempted suicide or other self-inflicted injuries
- War or any act of war, declared or undeclared
- An insured involvement in any type of active military service
- Other non-accidental causes, or
- Accidents that occur when you are not on Abbott business

When Coverage Ends

Your travel accident insurance terminates when your employment terminates and cannot be converted to an individual policy.

Life Insurance on Dependents

If you are eligible for coverage under the Abbott Laboratories Life Accident Plan, you may also elect dependent life insurance on your eligible dependents. Dependent life insurance pays a specified benefit amount to you if your dependent dies for any reason while covered by this plan. You can confirm your current coverage at any time by visiting the Benefits Web site at www.abbottbenefits.com**.**

Dependent Life Insurance Amounts

You may make separate life insurance elections for your spouse/domestic partner and your eligible children.

There are four spouse/domestic partner life insurance options available:

- $10,000
- $25,000
- $50,000
- $100,000

There are three eligible dependent children life insurance options available:

- $5,000
- $10,000
- $25,000

Your Contributions

Your contributions for coverage are based on the option you elect. Rates are subject to revision annually. You can view current costs for dependent life insurance at any time by logging on to the Benefits Web site at www.abbottbenefits.com.

Eligible Dependents

Eligible dependents include your spouse or domestic partner, and dependent children (including children of a domestic partner) under age 26. Eligible dependents are the same as defined for the Health Care Plan.

Ineligible spouses/domestic partners

If both you and your spouse or domestic partner are eligible for life insurance benefits as Abbott employees, neither of you may be covered as a spouse for dependent life insurance. Only one parent may enroll dependent children in Abbott life benefits. The life insurance will only pay benefits to one parent upon the death of a child. This applies even if the parents are divorced.

If your spouse or domestic partner is receiving benefits under the Long-term Disability Plan and is eligible for equivalent life insurance provided by the Abbott Laboratories Retiree Life Insurance Plan, you may not cover him or her as your dependent under this plan.

Dependents on active military duty are not eligible for coverage.

Enrolling

At Hire

To enroll for dependent life insurance, you must log on to the Benefits Web site at www.abbottbenefits.com and follow the instructions provided. If elected, you are authorizing deductions for this coverage. You must list your eligible dependents.

You may elect up to $50,000 in spouse/domestic partner and $25,000 in eligible child(ren) dependent life benefits without evidence of insurability within 31 days after you become eligible for such coverage (for example, upon hire, marriage, birth or adoption of a child).

Enrollment Changes

If you enroll for dependent life insurance coverage more than 31 days after you are first eligible or more than 31 days after you acquire a newly eligible dependent, you will be required to provide evidence of each dependent's insurability that is satisfactory to the insurance company before coverage can become effective. **Evidence of insurability** includes an Evidence of Insurability application, showing your dependent is in good health.

Payment of Benefits

You are automatically the beneficiary for any death benefits payable on behalf of each of your insured dependents. If a covered dependent dies from any cause, at any time or place, while plan coverage is in effect, the full amount of the dependent's life insurance benefits is paid in a lump sum.

Filing a Claim

To receive dependent life insurance benefits, you must submit a certified copy of your covered dependent's death certificate along with a completed claim form to the insurer. Please contact the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for assistance.

Termination of Coverage

Dependent life insurance coverage under this plan terminates on the earliest of the following dates:

- The date your employment terminates for any reason
- The date a dependent no longer qualifies as an eligible dependent
- The date you fail to pay the required contribution for this coverage.

Termination of Employment Due to Total Disability

If your employment terminates due to a total disability for which you are eligible to receive benefits from the Abbott Laboratories Long-term Disability Plan (LTD), your dependent life coverage remains in effect at no cost to you for a total of 18 cumulative months of LTD status. At the end of a cumulative 18 months of LTD your employer sponsored coverage will end and you will be offered the opportunity to convert your life insurance to an individual policy.

Portability

The portability option allows your dependent to continue group term life insurance coverage for a specified period of time if it ends because he or she no longer qualifies as an eligible dependent, or because your employment terminates or you retire. Your dependent may elect to "port" coverage at group rates that are higher than those for your active dependent coverage, but usually lower than the premium rates for individual conversion policies. Ported group term life insurance may be subject to age-based reductions. Application forms must be submitted to the insurance company. Call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for guidance.

Conversion Privilege

Within 31 days after a dependent's coverage ends because he or she no longer qualifies as an eligible dependent, or because your employment terminates or you retire, your dependent may convert dependent life insurance coverage to an individual whole life policy — without taking a medical examination. The cost for individual coverage is based on the insurance company's regular premium rates for the type and amount of insurance available through the conversion privilege, and

on your dependent's age at the time he or she applies for the individual policy. Application forms must be submitted to the insurance company to convert to individual coverage. Call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for guidance.

If your dependent dies within the 31-day period after dependent life insurance coverage terminates, benefits will be paid as though he or she had elected a conversion policy for the full amount available.

Administrative Information

Plan Identification

The name of the plan is the Abbott Laboratories Life Accident Plan. Abbott is the Plan Sponsor. The Benefits Department of Abbott is the Plan Administrator. Plan records are kept on a calendar-year basis starting on January 1 and ending on December 31.

This plan is considered a welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is identified under Internal Revenue Service (IRS) rules by the following numbers:

- Employer Identification Number (EIN) assigned by the IRS: 36-0698440
- Plan Number assigned by Abbott: 551

Plan Insurers

The Plan Insurers pay all benefits. Minnesota Life Insurance, St. Paul, MN insures all group life insurance, dependent life insurance and accidental death and dismemberment insurance for the plan.

Zurich American Insurance Company, Schaumburg, IL provides business travel accident insurance.

Plan Funding

Benefits under the plan are provided through insurance. The plan is funded through employee contributions as well as company contributions. Abbott pays the premiums for basic group life, basic accidental death and travel accident insurance to the Plan Insurers.

Employee contributions for supplemental life, dependent life and supplemental accidental death and dismemberment insurance are deposited in the Abbott Laboratories Employees Insurance Trust, and the trust pays the premiums for these coverages to the plan insurer.

Plan Trustees

The Trustees of this trust are: Stephen Fussell, Karen Peterson and Brian Yoor, all of whom are located at Abbott, Abbott Park, IL 60064.

Participating Employers

The Abbott Laboratories Life Accident Plan applies to eligible employees of Abbott Laboratories and its subsidiaries.

Plan Changes

Abbott intends to continue the Abbott Laboratories Life Accident Plan indefinitely, but reserves the right, by appropriate action by the Executive Vice President, Human Resources, to change it at any time, including:

- The right to change any amounts contributed by Abbott or its employees toward the cost of providing benefits
- The level of benefits provided
- The class or classes of employees eligible for plan benefits

Coverage under the plan is not a guarantee of employment, and Abbott reserves the sole right to amend or terminate the plan at any time. If the plan is discontinued, benefits, if any, will be paid for all charges incurred for covered expenses before that date.

Plan Documents

The Abbott Laboratories Life Accident Plan is governed by formal legal documents, including insurance contracts, for administration and payment of all benefits. In case of a conflict between this summary and those legal documents, the plans' legal documents will control.

Right of Recovery

Abbott has the right to recover Benefits it has paid that were made in error, due to a mistake in fact, or due to a misrepresentation of facts by an employee or beneficiary. If the plan provides a benefit that is larger than the amount that should have been paid, the plan will require that the overpayment be returned when requested.

Legal Service

Process can be served on the plan administrator by directing such legal service to the Divisional Vice President, Benefits, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064.

Building for the Future

Your Abbott retirement programs help you build financial security and can provide you with a continuing income after you retire. These plans work together, along with Social Security and your personal savings, to help you reach your financial goals.

- Abbott Laboratories Annuity Retirement Plan
- Abbott Laboratories Stock Retirement Plan

Please visit www.abbottbenefits to learn more about your retirement benefits.

Your Rights under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) was created to help protect the rights of employees who participate in employer-sponsored benefit programs. The provisions of ERISA that apply to this plan cover you. Among other things, this law allows you to:

- Examine, without charge, at Abbott Benefits, all documents filed by Abbott with the U.S. Department of Labor or Internal Revenue Service for the plan.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. Copies will be furnished at a nominal cost.
- Receive a summary of the annual financial reports for these plans. The plan administrator is required by law to furnish each participant with a copy of this summary annual report each year.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate the plans (called "fiduciaries") have an obligation to do so prudently and in the interests of plan participants.

No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If plan fiduciaries misuse a plan's money or if you are discriminated against for asserting your rights, you may file suit in a federal court or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney fees. But if you lose because, for example, the case is considered frivolous, you may have to pay all of these costs and fees.

Under ERISA, there are steps you, your surviving spouse or your beneficiary can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file a suit in a federal court. The court may require the plan administrator to provide the materials and pay you up to $110 for each day's delay until the materials are received, unless they were not sent because of matters beyond the control of the administrator.

Claim Denial and Appeal Procedures

If your application for plan benefits is denied in whole or in part, you, your surviving spouse or beneficiary will receive written notification of the denial within 90 days of the filing of your claim. In special circumstances, the notification may be delayed for up to an additional 90 days, in which case you will be notified of such extension during the initial 90-day period. Any such extension notice will indicate the special circumstances requiring the extension and the date the plan expects to make a decision.

Your notification will include the specific reasons for the denial; specific references to the pertinent plan provisions on which the denial is based; a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and an explanation of the plan's claim review procedures and its applicable time limits, including your right to file civil suit under the pertinent provision of ERISA if your claim is denied on appeal. Your denial notification will also state your rights to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.

Problem Solving

You are encouraged to resolve individual complaints by contacting the Abbott Benefits Center for verbal resolution. If these discussions do not resolve your question, you may request an additional verbal review of your claim by Abbott Care Coordinators at (888) 614-1011. Please see the Summary Plan Description Booklet (SPD) for the formal appeal process.

Appeals for the Retirement Plans

If you disagree with a claim denial, you may file an appeal with the Plan Administrator. Appeals must be in writing and must be filed within 60 days after you receive the written claim denial described above.

To file an appeal with the Plan Administrator, you, your surviving spouse or beneficiary or your duly authorized representative must submit a written request for appeal of the claim to the Divisional Vice President, Compensation and Benefits, Abbott, 100 Abbott Park Road, Abbott Park, IL 60064-6112. Documents or records supporting the appeal should accompany your request.

The Plan Administrator or his representative will review your appeal and will notify you, your beneficiary or your duly authorized representative of the decision. Normally, you will receive a final decision within 60 days of the date your request for review is received. In special circumstances requiring a delay, you will be notified of the need for an extension during the initial 60-day period. If an extension is needed, you will receive notice of the final decision within 120 days.

In reviewing your appeal, the Plan Administrator will take into account all comments, documents, records, and other information that you, your surviving spouse or beneficiary or your duly authorized representative submitted with your appeal, whether or not such information was submitted or

considered in the initial determination.

The final written decision will include specific reasons for the decision, with specific reference to the plan provisions on which that decision is based. It will also include your right to file a civil suit under ERISA and the applicable time limits for filing a civil suit. The final decision will also provide notification 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.

The Plan Administrator has full discretion and authority to make the final decision regarding all areas of plan interpretation and administration, including eligibility for benefits, level of benefits provided, interpretation of plan language (including this summary plan description) or administrative procedures. The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the plans, and, if challenged in court, the plan intends for the Plan Administrator's decision to be upheld, unless found by a court of competent jurisdiction to be arbitrary and capricious. Benefits will be paid under the plans only if the only if the Plan Administrator, or his delegate, determines in his discretion that the claimant is entitled to them.

Definitions

Some terms used in this Handbook may not be familiar to you. If so, the following definitions may be helpful. If you need more information about terms or policies described in this Handbook, call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222)**.**

Abbott: Abbott Laboratories and its participating subsidiaries (the "Company").

Accidental death and dismemberment insurance (AD&D): An insurance policy that pays benefits in the event a covered person dies, becomes an amputee or is blinded as a result of a covered accident). An AD&D policy does not pay benefits for losses resulting from illness, surgery or disease or from losses due to intentional causes (i.e., suicide or attempted suicide, or acts of war).

Annual maximum: The maximum amount the plan will pay for covered services in a calendar year.

Beneficiary: The person or persons to receive the value of your life insurance or other specified benefits, in the event of your death. You name your plan beneficiaries by completing the appropriate forms.

Certain and life annuity: An annuity guaranteeing payment of a certain number of monthly payments — regardless of whether the retiree lives or dies. The payments are guaranteed to be the greater of: 1) the participant's lifetime or 2) the "certain" period.

Coinsurance: Your share of the costs of a covered service. For example, if your coinsurance is 80%/20%, the plan pays 80 percent of the expense and you pay 20 percent.

Contract worker: A "contract" worker performs work for Abbott under direct Abbott supervision but is employed by and looks to another company to fulfill the terms and conditions of employment. An independent contractor or consultant contracts directly with Abbott to perform certain work on or off the premises and meets certain additional requirements of the Department of Labor and the Internal Revenue Service regarding "leased" service. Contract or leased workers and consultants are not eligible for Abbott Laboratories employee benefit plans.

Copayment: The fixed dollar amount (for example $25) you pay for covered health care, usually when you receive the service.

Cosmetic: Services provided by physicians, surgeons, dentists or vision care providers that are not deemed medically necessary and are performed primarily to improve appearance.

Deductible: An annual deductible is the amount you must pay for all costs of services under a plan before the plan begins to pay for services.

Health maintenance organization (HMO): In an HMO plan, members usually agree to receive all health care services from providers within the HMO network. HMOs often require a member to select a Primary Care Physician to oversee care and to provide referrals to specialty care.

Joint and survivor annuity: An annuity guaranteeing payments for the longer of two people's lifetimes (for example, a retiree and his or her spouse). Depending on the option elected, the monthly amount payable may decrease when the retiree dies.

Out-of-pocket (OOP) limit: The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. Separate OOP limits may apply to specific expenses, such as prescription drugs.

Preferred provider organization (PPO): A PPO allows you to choose providers from the plan's network *or* to choose providers who do not participate in this network. You make this choice each time you need care. When you use network providers, you generally receive a higher level of benefits.

Reasonable charges: These are dollar limits on what the plan will pay for covered services and supplies. The claims administrator determines reasonable charges for covered expenses. Guidelines for reasonable charges are updated regularly and are based on reviews of actual fees charged by similar providers in the same geographic area. Reasonable charges may also be based on rates the claims administrator has negotiated with network providers for similar services, a fee schedule, or other criteria.

Regular employee: This employment category describes an Abbott employee who is assigned to work an established weekly schedule for an indefinite period. Regular employees may be assigned to work a full-time or part-time schedule. Regular employees must be available for work on any schedule or shift and to work on an overtime basis as required. You can verify your employment category (regular or temporary) with the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Retiree: A former Abbott employee, who qualifies for retirement, retires from employment with Abbott and at the time of such retirement is eligible to receive a pension under the Abbott Laboratories Annuity Retirement Plan.

Single life annuity: An annuity guaranteeing payments for the participant's lifetime. There are no payments (except to recover participant contributions, if applicable) to a beneficiary or survivor(s).

Temporary employee: This category describes an Abbott employee hired to work for a temporary period of time, which is specified at the time of hire. The schedule and duration of a temporary assignment may be altered or terminated at any time. You can verify your employment category (regular or temporary) with the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222).

Additional Information

This Handbook describes only the highlights of the Abbott employee benefit plans, programs and policies — and does not attempt to cover all of their details. Formal legal documents, rather than this summary, govern the plans and policies described in this Handbook for administration and payment of all benefits. In case of a conflict between this summary and the plan's legal documents, the plan's legal documents control.

Benefits and services described in this Handbook apply only to those employees eligible for benefits under the plan, policy or program. Nothing in this Handbook is intended to create or enlarge any contractual employment obligation between Abbott and its employees.