Abbott

2022
EMPLOYEE BENEFITS HANDBOOK
for Abbott Employees

March 2022

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Disclaimer

This Handbook describes the key features of major benefit programs offered to employees of Abbott and participating U.S. subsidiaries effective January 1, 2022. It describes only the highlights of the plans and does not attempt to cover all of their details. Formal legal documents govern the plans and policies described in this Handbook and the administration and payment of benefits. In case of a conflict between this Handbook and a plan's legal documents, the plan's legal documents control. For additional information on your benefits, go to the Abbott Benefits Center website at 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), supersedes all prior plan descriptions. Abbott reserves the right to change or end its benefit plans or programs at any time.

COVID-19 TEMPORARY RELIEF

Deadline Extensions

On May 4, 2020, the US Departments of Labor and the Treasury issued guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with certain elections, notifications, payments and claims/appeals. To protect individuals from losing benefits, the agencies are adjusting deadlines that may be missed during the "Outbreak Period," which is defined as the period beginning March 1, 2020 and ending 60 days after the of the federal National Emergency, which has yet to be announced.

If you or your dependent(s) are experiencing one of the following situations, the deadline will be recalculated to extend through the Outbreak Period (for up to one year), as described below.

To change your coverage due to a life change (e.g., loss of health coverage, qualified for Medicaid or the Children's Health Insurance Program (CHIP), gaining a dependent through marriage, birth or adoption, etc.):

You have 31 days from the date of your life change to make changes to your coverage. If your 31-day notification period falls within the Outbreak Period, you may have an additional 30 days past the end of the Outbreak Period, up to one year from your original deadline, to make coverage changes.

For life changes tied to financial assistance or loss of coverage under the Children's Health Insurance Program (CHIP) or Medicaid, the timing is based on a 60-day notification period, rather than 31 days.

Actions needed:

Call the Abbott Benefits Center at **844-306-9222** to process the change.

To complete notification for a COBRA-qualifying event (e.g., divorce or legal separation, change in child dependent eligibility or Social Security Administration disability determination):

If your 60-day notification deadline falls within the defined Outbreak Period above, you may have up to an additional 60 days past the end of the Outbreak Period, up to one year from your original deadline, to notify the plan.

Actions needed:

Call the Abbott Benefits Center at **844-306-9222** to process the change and/or complete enrollment.

If you have a disability extension and are later determined by the Social Security Administration to no longer be disabled, you must notify the Abbott Benefits Center within 30 days of the final determination.

To enroll in COBRA coverage:

If you become eligible for COBRA, you have a 60-day initial enrollment period. If your 60-day enrollment deadline falls within the defined Outbreak Period above, you may have up to an additional 60 days past the end of the Outbreak Period, up to one year from your original deadline, to enroll in COBRA.

Actions needed:

Call the Abbott Benefits Center at **844-306-9222** to complete enrollment.

To pay COBRA premiums:

If enrolled in COBRA, you have 45 days to submit payment for your initial bill and 30 days to submit payment for subsequent bills. For payment deadlines that fall within the defined Outbreak Period, you have at least 30 days past the end of the Outbreak Period (45 days past the end of the Outbreak period for the initial payment), up to one year from your original deadline, to submit your payments.

Actions needed:

Your payment options are as follows:

- Automatic monthly direct debit from your bank account
- Set up online at the Abbott Benefits Center website, accessible via **AbbottBenefits.com**, or call **844-306-9222** to request an authorization form.
- Online payments with Pay Now at the Abbott Benefits Center website
- Postal Mail
    1. Make check or money order payable to Abbott. (Don't send cash or foreign currency.)
    2. Include your account number on your check or money order.
    3. Enclose only the bottom portion of your bill with your payment in the envelope provided. Any other items will be discarded.

Please note: While an extended grace period will be allowed, the amount owed for applicable months of coverage will remain the same. If this full amount is not submitted by the extended deadline, coverage will be terminated retroactively to the last day of the month for which you have made payment.

Example: If you owe payment for March, April, May and June 2021 COBRA coverage, you have until 30 days after the end of the Outbreak Period to pay (but not later than March 30, 2022 to pay the March premium, April 30, 2022 to pay the April premium, etc.).

If you don't make payments by the extended deadline, your coverage will be terminated retroactive to February 28.

If you pay for March and April only by the extended deadline, your coverage will be terminated retroactive to your latest paid through date, April 30.

YOUR ABBOTT EMPLOYEE BENEFIT PROGRAMS

At Abbott, we help people unlock all that life has to offer through the power of health. 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.

Abbott offers innovative programs and solutions that deliver value 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 and designed to provide you with an overview of our benefit plans and programs. Detailed descriptions, summary plan descriptions (SPDs) and plan booklets for individual medical options are available online on the Abbott Benefits Center website via **AbbottBenefits.com**. Please refer to relevant sections whenever necessary. The handbook also provides contact information to get you to the right resources whenever you have questions.

SPDs for the Abbott Stock Retirement Plan (SRP), the Freedom 2 Save program and Annuity Retirement Plan (ARP) are available to eligible participants on the Abbott Benefits Center website. Those plans are not discussed in this handbook.

The information in this handbook is current as of January 1, 2022. 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. Materials are available on the Abbott Benefits Center website and on Abbott's internal HR portal.

ABBOTT BENEFITS CENTER AND HR SERVICE CENTER

The **Abbott Benefits Center** is ready to help with all your medical and retirement benefit needs. Call **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**). Or, visit the Abbott Benefits Center website via the link at **AbbottBenefits.com**.

The **HR Service Center** can help with vacation, sick time and employee relation issues. Call **877-228-4707** or visit the HR Service Center website, which is accessible from the internal HR portal on Abbott World.

The chart below shows who to contact for help with your various Abbott benefits.

PROGRAM	ABBOTT BENEFITS CENTER	HR SERVICE CENTER
Adoption Assistance		•
Accidental Death & Life Insurance	•	
Annuity Retirement Plan	•	
Business Travel Accident Plan	•	
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	•	
Workers Compensation		•
Work/Life Services	•	

LIVELIFEWELL

Abbott's 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 a broad range of well-being and work/life benefits that can help you eat better, reduce stress and become more active — and by doing so, even earn points that you can redeem for cash-value rewards. Visit **iLiveLifeWell.com** for more details.

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.

Eligibility for programs may vary depending on a variety of factors, including employer participation. Contact the Abbott Benefits Center or the HR Service Center to confirm your eligibility.

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
Business Travel Accident Plan	Yes	No
Commuter Benefits Program[2]	Yes[1]	No
Dental Coverage	Yes[1]	No
Employee Assistance Plan (EAP)	Yes	Yes
Long-Term Disability Plan	Yes[1]	No
Flexible Spending Accounts (FSA)[2]	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
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]U.S. global assignees are not eligible to participate in the Dependent Daycare FSA or Commuter Benefits Program

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).

You will be treated as an employee for purposes of these plans only if Abbott treats you as an employee for employment tax and wage-withholding purposes, even if the U.S. Internal Revenue Service or other government agencies later determine that you are a common law employee. Contract or leased employees are not eligible for Abbott beneit 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.
- Choose your Health Savings Account pre-tax contribution amount if you elect the Health Investment Plan (HIP) PPO medical option.
- Indicate your pre-tax health care and dependent care flexible spending account contributions for the current calendar year.
- Designate beneficiaries for life insurance, accidental death and dismemberment (AD&D) insurance and business travel accident insurance.

IF YOU DO NOT TAKE ACTION, YOU WILL AUTOMATICALLY RECEIVE THE FOLLOWING BENEFITS:

- Medical coverage (Employee only coverage in the UHC Health Investment Plan (HIP) PPO)
- No dental coverage
- No vision coverage
- No Health Savings Account
- No Flexible Spending Accounts
- Company-paid life insurance coverage equal to one times your salary
- Company-paid AD&D coverage of $10,000

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 rules on making changes to your benefit elections after enrollment, refer to the Medical Plan SPD available on the Abbott Benefits Center website, accessible via **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 daycare flexible spending accounts (FSAs)
- Your Vacation Buy Election (for participating entities)

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

Enrollment options will be available on the Abbott Benefits Center website 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 During Annual Open Enrollment

If your enrollment is not completed by the announced deadline, your medical, dental, vision and life coverage for the upcoming calendar year will default to your current year elections, but you will not be enrolled in either of the FSAs or Vacation Buy (if eligible). If you elect coverage for a spouse or domestic partner, you will have to make an election each year if the spousal surcharges should not apply. If no election is made the spousal surcharge will apply for the following year.

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

See the next page for 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 made on the Abbott Benefits Center website within 31 days after the event occurs. You may need to provide proof of any change in eligibility.

ELIGIBILITY AND ENROLLMENT (CONT.)

Family Status Events

For medical, dental, vision coverage and HCFSA 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.
- A benefits open enrollment period begins at your spouse or legal domestic partner's employer.
- 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.

Some of these family status events will also be recognized as valid reasons to allow changes to your DCFSA.

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 or HSA. 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 child 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 DCFSA election if this relocation also results in a change to your dependent 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[1]	Yes	Yes	Yes
Divorce, legal separation or annulment	No[2]	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[1]	Yes	Yes	Yes
Employee becomes eligible for Medicare or Medicaid	No[1]	No[1]	Yes	No
Spouse's loss of employment/loss of coverage	No[1]	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[3]	No[3]	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[1]	No[1]	Yes	Yes
Qualified Medical Child Support Order (QMSCO)	No	Yes	No	No

1 You may drop coverage, but may not change your medical, dental or vision option.

2 Unless you have waived coverage under the health care plan. In that event, you may elect any medical, dental or vision option.

3 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.

ELIGIBILITY AND ENROLLMENT (CONT.)

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 summary plan description (SPD) for each option. Summary plan descriptions for Abbott's self-funded medical options are available on the Abbott Benefits Center website, accessible via **AbbottBenefits.com**. 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 or UnitedHealthcare 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, find network providers, reduce out-of-pocket costs, and anything else 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:

- Legal spouse, defined as a person to whom you are legally married.
- Domestic partner, who may be qualified if you and your partner are either be registered with any state or local governmental domestic partner registry, or 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, and
  - Are at least 18 years old and mentally competent to enter into contracts.

When a person no longer meets the definition of domestic partner, that person no longer qualifies as your dependent.

- A dependent child until the child reaches the end of the month of their 26th birthday. The term "child" includes the following dependents:
  - A legally adopted child or a child legally placed for adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration (or a court of law if the child has not attained age 26 as of the date of such placement);
  - A child under your (or your spouse's or domestic partner's) sole legal guardianship as ordered by a court;
  - A child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - An alternate recipient (as defined in Section 609(a)(C) of ERISA under a court order if such order requires coverage under the Plan;
  - A child younger than age 26 for whom the eligible employee is legally responsible as evidenced by court documents awarding legal custody or sole guardianship;
  - An eligible employee's child of any age who is incapable of self-sustaining employment by reason of physical or intellectual disability and was so incapable prior to attainment of 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 either be registered with any state or local governmental domestic partner registry, or 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, and
- Are at least 18 years old and mentally competent to enter into contracts.

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. To enroll your domestic partner, you must complete the affidavit process on the Abbott Benefits Center website.

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.

Disabled Dependents

An unmarried dependent child who is not capable of self-support and is totally disabled due to a physical or intellectual disability that began before age 26 may be eligible for dependent coverage after age 26. To enroll your dependent child in this extended coverage, you will be required to provide a physician's statement documenting the disabling condition prior to age 26 upon enrollment and periodically thereafter. The plan administrator determines eligibility for this coverage.

To continue existing coverage for a disabled child beyond age 26, you must submit written proof of disability within 31 days after the day coverage for the dependent would normally end. Coverage for an adult disabled child may also be elected if you are enrolling yourself and your dependents within 31 days upon first becoming eligible for Abbott benefit coverage, within 31 days of a qualifying life event or during the annual open enrollment period for coverage effective January 1 of the following year. If coverage for your adult disabled child ends after age 26 for any reason, 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 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*
- Employee plus child(ren)
- Family (employee plus spouse/domestic partner and child(ren))*

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 imputed income are available from the Abbott Benefits Center and on the Abbott Benefits Center website, accessible via **AbbottBenefits.com**.

You may be able to reduce your medical contributions by taking the LiveLifeWell wellness 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. If you are a covered dependent of your spouse and their 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.

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 or prior health coverage terminates

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 **844-306-9222**.

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 six months, your employment with Abbott will terminate, unless a limited extension of leave is granted due to 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, while covered under the Long-Term Disability Plan, will be the same contribution amounts as paid by active employees for the same coverage.

* 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, COBRA, retiree coverage or military coverage.

Dependent Coverage After Your Death

Limited Survivor Coverage

If you die while you are an active employee, did not have 15 or more years of Abbott service, and you would not have met the eligibility requirements for coverage under the Abbott Laboratories Retiree Health Care Plan at the time of your death, medical, dental, and vision coverage may continue for your covered dependents through COBRA for six months after your death at no cost to your dependents. See "Coverage at Retirement" below for eligibility requirements.

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

If you die while you are an active employee and, at the time of your death, you either have 15 or more years of Abbott service or you would have otherwise met the eligibility requirements for coverage under the Abbott Laboratories Retiree Health Care Plan, continuing medical, dental and vision coverage under the Abbott Laboratories Retiree Health Care Plan will be available to your covered dependents. See the Section titled "Coverage at Retirement" below for eligibility requirements. Contact the Abbott Benefits Center for the cost of coverage for your covered dependents. "Abbott service" is earned only for service performed for Abbott Laboratories, or for an employer in Abbott's controlled group while that employer is an Abbott affiliate (i.e., Abbott service generally is not earned for time worked at a company prior to it being acquired by Abbott). If you worked for a company prior to it being acquired by Abbott, contact the Abbott Benefits Center for help in determining your years of Abbott service.

Coverage at Retirement

Coverage under the Abbott Laboratories Retiree Health Care Plan is available to former employees who are eligible to participate in the Abbott Laboratories Health Care Plan at their time of retirement, and who also meet the requirements to be an "eligible retiree". An "eligible retiree" is a former employee who at the time of termination is age 55 or older or is otherwise eligible to receive retirement benefits from the Abbott Laboratories Annuity Retirement Plan, and who (i) has at least ten years of Abbott service or (ii) is age 65 or older with at least three years of Abbott service. "Abbott service" is earned only for service performed for Abbott Laboratories, or for an employer in Abbott's controlled group while that employer is an Abbott affiliate (i.e., Abbott service generally is not earned for time worked at a company prior to it being acquired by Abbott.) Contact the Abbott Benefits Center for help in determining your years of Abbott service.

The Retirement Guide describes Abbott retiree benefits, including health care. The Retirement Guide is available on the Abbott Benefits Center website, accessible via **AbbottBenefits.com**.

Retiree Medical — Your Cost

Your share of retiree medical costs will be based on how many years of Abbott service you have at the time of your retirement, in accordance with the following schedule. Service is generally not earned for time worked at a company prior to it being acquired by Abbott. If you worked for a company prior to it being acquired by Abbott, you can contact the Abbott Benefits Center for help in determining your years of Abbott service.

YEARS OF ABBOTT 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%

Note that plan rules, and the above cost schedule, are subject to change.

Retiree Dental

MetLife manages the retiree dental plan. Eligible 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 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 **Metlife.com/mybenefits**.

Retiree Medical, Dental, and Life Insurance Benefits

This handbook is intended to provide general information about health care and life insurance benefits available to Abbott's eligible retirees as of January 1, 2022. Abbott retiree health care and life insurance benefits are governed by the relevant plan documents. If there is any inconsistency between the information provided in this handbook and the plan documents, the terms of the plan documents will control. These benefits are not vested and are subject to change. Abbott reserves the right to amend, change, or terminate benefit plans and programs at any time.

When Active Coverage Ends

Employee Coverage

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

- The date you fail to pay the required contributions, or
- The date your employment terminates. (Note: Full pay period contributions will be deducted from your final paycheck).

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), or
- 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 submit false information on your enrollment data or claim form, or if you fail to notify the Abbott Benefits Center that an enrolled spouse/domestic partner or dependent is no longer eligible to participate in the plan, all participation and coverage 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 an ineligible spouse/domestic partner or dependent.

Continuation of Coverage (COBRA)

Under certain conditions you, your spouse or domestic partner 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. The details of COBRA coverage are described in the individual plan booklet (summary plan description) for your medical option. Summary plan descriptions for Abbott's medical options are available on the Abbott Benefits Center website, accessible via **AbbottBenefits.com.** Paper copies of plan booklets are available upon request. Plan descriptions for insured medical options are also available from the insurer.

COBRA and the Affordable Care Act

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 Abbott Benefits Center website.

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 Abbott Benefits Center website. Call the Abbott Benefits Center at **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 in your eligibility area will be provided on the Abbott Benefits Center website.

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 four national plans:

- BlueCross BlueShield Health Investment Plan (HIP) PPO
- BlueCross BlueShield Traditional PPO
- UnitedHealthcare Health Investment Plan (HIP) PPO
- UnitedHealthcare Traditional PPO

These plans are not available in Hawaii.

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: $200 for employee-only coverage, and $400 for all other coverage levels.

Detailed information about these options, including plan booklets (summary plan descriptions), are available on the Abbott Benefits Center website. 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 UnitedHealthcare 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. You may contact the Abbott Care Coordinators by calling **888-614-1011**.

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
- HMSA - 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.

Retirees

If you retire, are eligible for Abbott retiree health coverage, and are under age 65, your medical options are the same as your active coverage. If you are an eligible retiree and are at least age 65, or are eligible for Medicare due to disability, Abbott offers coverage in the Retiree Indemnity with Medicare option. This plan acts as 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 UnitedHealthcare Health Investment Plan (HIP) PPO. Split coverage is not allowed with the Kaiser HMO plan. Call the Abbott Benefits Center at **844-306-9222** for more details and to find out your options.

IMPORTANT NOTE: To complete your enrollment in the UHC Retiree Indemnity and Prescription plan, your Medicare number (MBI) must be on file with the Abbott Benefits Center one month prior to coverage eligibility to ensure that coverage is not interrupted for you or covered dependents (if applicable).

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 Abbott Benefits Center website. Paper copies of plan booklets are available upon request. Plan descriptions for insured medical options are available from the insurer.

Claims and Appeals

If your application for plan benefits is denied in whole or in part, you will receive written notification of the denial within a specified timeframe established by the Department of Labor, and you are entitled to appeal that decision informally and/or formally. The notification timelines and procedures for appeal are described in the individual plan booklet (summary plan description) for your medical option. Summary plan descriptions for Abbott's medical options are available on the Abbott Benefits Center website. Paper copies of plan booklets are available upon request. Plan descriptions for insured medical options are also 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.

Delta Dental of Illinois is the claims administrator for the dental plan. You can confirm your dental enrollment at any time by visiting the Abbott Benefits Center website.

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

U.S Global Assignees are enrolled in CIGNA. Plan description documents, coverage detail and appeal information are available directly from the insurer.

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 Delta Dental of Illinois dental plan is available on the Abbott Benefits Center website, accessible via **AbbottBenefits.com**. Paper copies of plan booklets are available upon request.

Claims and Appeals

If your application for plan benefits is denied in whole or in part, you will receive written notification of the denial within a specified timeframe established by the Department of Labor, and you are entitled to appeal that decision informally and/or formally. The notification timelines and procedures for appeal are described in the Delta Dental of Illinois and VSP program materials (summary plan description). Paper copies of program materials are available upon request.

Continuation of Coverage (COBRA)

Under certain conditions you, your spouse or domestic partner 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. The details of COBRA coverage are described in the individual plan booklet (summary plan description) for your dental option. A summary plan description for Delta Dental of Illinois dental options is available on the Abbott Benefits Center website.

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 **VSP.com**.

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 up to $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 ProgramSM. 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 **VSP.com**.

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.

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

Health & Wellness Resources

Your Abbott benefits can help maintain your physical and emotional well-being every day. These free resources are available to help you eat better, sleep better, lose weight, manage stress and bring more calmness into your life.

Bright Horizons

Provides access and discounts to care programs and resources for your family including child care, elder care, sitters, nannies, pet care, household help, learning support, and tutoring. Learn more by visiting **Clients.Brighthorizons.com/AbbottLaboratories**.

CarePartner

Helps you make decisions about a loved one's care. Specialists can help with finding services, navigating Medicare, resolving billing issues, and even coordinating family discussions. Learn more by visiting **Carepartner.com/abbott**.

Castlight

Provides you access to great programs to support your physical and emotional well-being, plus opportunities to earn rewards all year. Participation is 100% voluntary and 100% confidential. All U.S employees, regardless of medical coverage, and covered spouses/domestic partners enrolled in the Abbott medical plan are eligible to enroll. Learn more by visiting **iLiveLifewell.com/about-castlight**.

Hinge Health

Resource to manage muscle and joint pain without medication or surgery. Learn more in Castlight and take a short survey to determine if Hinge Health may be appropriate for you.

Kurbo

A 12-week health coaching program to help you eat healthier, exercise more and gain confidence. Plus, covered spouses/domestic partners and children ages 5-26 can enroll. Learn more in Castlight or visit **iLiveLifewell.com/kurbo.**

Lifeworks

The Employee Assistance Program (EAP) is available to all Abbott employees and their eligible family members. EAP counselors provide confidential assessment, support, and up to six free counseling sessions with a professional counselor. Learn more in Castlight or visit **iLiveLifewell.com/counseling-eap**.

meQuilibrium

To help you boost your resilience and reduce stress, meQuilibrium is a free personalized program available in your Castlight account. Learn more by visiting **iLiveLifewell.com/mequilibrium**.

Milk Stork

A free, convenient breast milk delivery service for Abbott moms traveling domestically or internationally on business. Learn more at **Milkstork.com/abbott**.

Omada

If you have been diagnosed with type 2 or type 1 diabetes, you may be eligible to work with a professional health coach trained in diabetes management. Omada offers personalized support to help you tackle sustainable lifestyle changes and achieve health goals. Learn more in your Castlight account or by visiting **iLiveLifewell.com/omada**.

Ovia

Whether you're preparing to start a family, expecting a bundle of joy or already have a little one at home, Ovia Health offers three unique programs for wherever you are on your parenting journey. These programs are accessible thorough your Castlight account. Learn more by visiting **iLiveLifewell.com/ovia** or contact Ovia Health at **support@oviahealth.com**.

Rx Savings Solutions

Get free, personalized prescription savings advise delivered directly to you for medications you are currently taking and any you are prescribed in the future. Register at **myrxss.com**.

Sleepio

A digital sleep improvement program accessed through your Castlight account. Learn more by visiting **iLiveLifewell.com/sleepio**.

Tobacco Cessation

A tobacco cessation health coach will help determine the best quit plan for you to kick your tobacco or nicotine habit. Learn more by visiting **iLiveLifewell.com/smoking-cessation** or speak to a Care Coordinator at **888-614-1011**.

Torchlight

If your child has special needs, Torchlight offers seminars, tools and guidance to support you. Learn more at **Child.torchlight.care**.

TutorMe

Receive three free hours of tutoring per week for yourself or your child, plus a discount on additional time. Learn more at **Tutorme.com**.

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.

Newly hired Abbott employees who are scheduled to work 20 or more hours a week can buy this coverage at a competitive group rate with no medical underwriting during the first 60 days of their employment. Active employees who are scheduled to work 20 or more hours per week and have been employed by the Company beyond 60 days may apply for this coverage. Applicants in this category are required to undergo medical underwriting to be considered for this coverage.

Abbott retirees, family members of Abbott retirees, and family members of Abbott employees (who are not Abbott employees) can also apply for coverage if they are age 18-79.

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)

Non-employee applicants will be asked to complete a health form and may be required to provide additional medical information to be considered for coverage. Applicants must be U.S. citizens or permanent resident aliens, have a valid social security number, and provide a U.S. mailing address. Global assignees into the U.S. are not eligible for LTC insurance.

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. LTC 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 at **Genworth.com/Abbott** or call **800-416-3624**.

Claims and Appeals

If your application for LTC benefits is denied in whole or in part, you will receive written notification of the denial within a specified timeframe established by the Department of Labor, and you are entitled to appeal that decision. The notification timelines and procedures for appeal are described in the Genworth Life program materials (summary plan description). Paper copies of program materials are available upon request.

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 the Abbott Benefits Center website, accessible via **AbbottBenefits.com**, or upon request by calling the Abbott Benefits Center **at 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, Global Privacy, 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.
- 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 **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 are as follows:

- 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, 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 website at **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 **844-306-9222** if you have any questions regarding coordination of benefits with Medicare.

Subrogation and Right of Recovery

Subrogation

When the Abbott Laboratories Health Care Plan 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 Traditional PPO (administered by Ameriben)
- BlueCross BlueShield Health Investment Plan (HIP) PPO (administered by Ameriben)
- UnitedHealthcare Traditional PPO (administered by UMR)
- UnitedHealthcare Health Investment Plan (HIP) PPO (administered by UMR)
- Delta Dental of Illinois

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*
- Kaiser HMO
- HMSA Hawaii
- Vision Service Plan (VSP)
- John Hancock Long-Term Care (participants enrolled prior to December 21, 2011 only)
- Genworth Life Insurance Company Long-Term Care

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.

*U.S. Global Assignees are eligible for coverage through this 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 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.

Abbott offers two FSAs for eligible employees:

- Health Care Flexible Spending Account (HCFSA) is a spending account that allows you to use pretax dollars for qualifying medical, dental and/or vision expenses for you and your eligible dependents.
- Dependent Care Flexible Spending Account (DCFSA) is used to pay for childcare or adult dependent care expenses that are necessary to allow you and your spouse, if married, to work, look for work or attend school full time.

You may elect to participate in either or both spending accounts. However, these accounts are separate programs, and money cannot be transferred between these accounts.

Internal Revenue Service (IRS) regulations require that your contributions for any calendar year be used for eligible expenses incurred during that calendar year 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. Claims for current year funds need to be submitted by April 30th of the following year.

The HCFSA will automatically roll over balances of $550 or less into the next plan year for use. Any balance above $550 will be forfeited per IRS regulations. Restrictions for employees enrolled in the Health Investment Plan PPO apply.

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 the spending accounts 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 the HCFSA only. You can verify your employment status with the Abbott Benefits Center by calling **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 DCFSA, 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 care FSA through his or her employer. In addition, if you or your spouse has a health savings account (HSA), this may affect your HCFSA eligibility. Contact HealthEquity at **866-346-5800** for more information.

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 HCFSA 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 Abbott Benefits Center website, accessible via **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 Open Enrollment

An annual open enrollment period will be held each fall (usually in October). The annual enrollment for active employees is conducted via the Abbott Benefits Center website. The enrollment deadline will be announced by 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 January 1 of the following year.

When Spending Account Coverage Begins

Your pre-tax spending account 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 open enrollment period.

Your Contributions

Your HCFSA and DCFSA are funded with your pre-tax contributions. If you elect to participate, you may deposit a minimum of $52 or up to the IRS annual limits each calendar year. Your contributions are exempt from federal income taxes and in most cases 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 HCFSA and DCFSA balances.

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, life insurance, and any additional compensation plan programs if eligible). 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 health care and/or dependent care 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.

ALLOWED FSA UPDATES DUE TO LIFE CHANGES

Upon marriage, divorce or legal separation, you can:

- Enroll in the HCFSA/DCFSA
- Increase, decrease or cancel HCFSA/DCFSA elections

Upon the birth or adoption of a child, you can:

- Enroll in the HCFSA/DCFSA
- Increase HCFSA/DCFSA elections
- Decrease DCFSA elections

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 Abbott Benefits Center website, accessible via **AbbottBenefits.com**. Changes must 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. For qualified life events and associated changes that can be made to your FSAs, please contact the Abbott Benefits Center at 844-306-9222.

Please note that if you increase your FSA contributions due to a status change, your new election(s) are applicable from the date the change is effective. 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)

Contributions you elect 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.

For the HCFSA only, you are eligible to carry forward a maximum of $550 (20% of the IRS maximum contribution for HCFSA) to pay for eligible expenses incurred in a subsequent calendar year. No more than $550 of unused contributions may be carried forward from one year to the next. Any balance above $550 will be forfeited per IRS regulations. If you enroll in the Health Investment Plan (HIP) PPO in a subsequent year, the carryover balance will be carried forward into a Limited Purpose FSA.

Abbott has adopted the 2½ month grace period for the DCFSA 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 DCFSA.

The FSA Claims Administrator must still receive claims for expenses incurred during any calendar year by April 30 of the following calendar year. After April 30, all unused FSA funds will be forfeited (except for funds carried forward in the HCFSA).

Health Care Flexible Spending Accounts (HCFSAs)

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 (HCFSA) can help you better manage these expenses while gaining real tax savings.

The amount credited to your HCFSA for any calendar year may be used toward the payment of eligible health care expenses incurred during that calendar year (subject to the carryover rules).

Eligible Expenses

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

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

- Your spouse
- Children up to age 26
- 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.

FLEXIBLE SPENDING ACCOUNTS (CONT.)

For a list of eligible expenses and/or exclusions, please see IRS Publication 502 or visit **Learn.HealthEquity.com/Abbott.**

Limited Purpose Flexible Spending Accounts

- Individuals enrolled in the 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 medical deductible limit is met.
- The annual IRS medical deductible may be different than the annual health plan deductible.
- Once the annual IRS medical deductible limit is met, you can submit the HDHP Deductible Met form to HealthEquity 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 medical 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 HealthEquity at **866-346-5800** 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 been deposited into your account to date. Eligible health care claims continue to be paid until your annual maximum, plus any carryover amount from the prior year, is exhausted. If you do not use all of your annual contributions for expenses incurred in that calendar year, you may carry forward up to $550 (20% of the IRS contribution limit for HCFSA) in contributions to use for expenses incurred in subsequent calendar years until your termination of employment. See the section, "Continuation of Coverage," for how to use your contributions for expenses incurred following your termination of employment.

An expense is incurred when the service is rendered. Your HCFSA contributions are credited to your account for the calendar year in which they are made.

HCFSA funds cannot be used for expenses incurred before your account participation begins, or after your participation has ended, noted in the "Continuation of Coverage" section below.

Your Health Care FSA Debit Card

Your HCFSA 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 HCFSA and makes funds immediately available to you for payment of eligible medical services, goods, over-the-counter medications and prescriptions at health care providers, pharmacies and drugstores.

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 HCFSA debit card does not require a PIN.

If you swipe your HCFSA 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 HCFSA purchases, in accordance with IRS rules. You may be asked to submit your receipts to HealthEquity to verify the expense's HCFSA eligibility. If you pay for an ineligible expense with your debit card, you will be required to pay back your HCFSA. It is your responsibility to keep your receipts. If you don't have a receipt when requested, you will be asked to reimburse your HCFSA. If you do not respond to HealthEquity's requests for verification or repayment within 90 days, and you then submit for a Pay Me Back reimbursement, the unverified fund transactions will be subtracted from your request for reimbursement.

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 **Sigis.com**. If HealthEquity cannot 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 HCFSA debit card for dependent care expenses.

Additional Cards

You can order additional cards for your spouse or eligible dependents through **HealthEquity.com**. Click on the Manage Cards link and select "Order Dependent Card."

Pay My Provider Feature

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

Once you have established a "Pay My Provider" arrangement, HealthEquity 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.

FLEXIBLE SPENDING ACCOUNTS (CONT.)

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 name of the patient or the 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 health care expenses that require a Letter of Medical Necessity.

Filing A Paper Claim (Pay Me Back Claim Form)

Call HealthEquity at **866-346-5800** or visit the HealthEquity web site at **HealthEquity.com** to obtain a Pay Me Back form. Be sure to fill in all 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**. 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 HealthEquity account. Once the form is complete, you have two options:

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

Use the EZReceipts Mobile App

Download the EZReceipts mobile app available through Apple or Google and use your smartphone to file for reimbursements or pay providers.

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 HealthEquity website at **HealthEquity.com**.

If You Leave the Company

If your employment terminates for any reason, including retirement, your HCFSA contributions will stop with your last paycheck. You may be reimbursed for eligible health care expenses incurred prior to your separation date if 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 HCFSA participation. The impact depends on the type of leave that you take.

- *Medical Leave of Absence:* Your HCFSA participation continues during a paid medical leave. If your leave is unpaid, you will be direct billed for your HCFSA contributions. If you return to work in a different calendar year, you may make new HCFSA elections.
- *Family Leave of Absence:* Your HCFSA participation continues during a paid family leave. If your leave is unpaid, you will be direct billed for your FSA during your absence. If you return to work in a different calendar year, you may make new HCFSA elections.
- *Parental Leave of Absence:* Your HCFSA participation continues during a paid parental leave. If your leave is unpaid, you will be direct billed for your FSA during your absence. If you return to work in a different calendar year, you may make new HCFSA elections.
- *Bereavement Leave of Absence:* Your HCFSA participation continues during a paid bereavement leave. If your leave is unpaid, you will be direct billed for your HCFSA during your absence. If you return to work in a different calendar year, you may make new FSA elections.
- *Personal Leave of Absence:* Your HCFSA participation ends. If you return to work in the current calendar year, your HCFSA is reinstated, and your deductions are recalculated based on the year to date contributions and the remaining goal amount. If you return to work in a different calendar year, you may make new FSA elections.
- *Military Leave of Absence:* Your HCFSA participation continues during a paid military leave. Your HCFSA participation ends during an unpaid military leave. If you return to work in a different calendar year, you may make new HCFSA elections.

Continuation of Coverage

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

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

COBRA HCFSA coverage is available to you for the remainder of the calendar year in which your participation stops because of the termination of your employment or a change in your employment status causing you to become ineligible for FSA benefits. Following the end of the calendar year, you are eligible to carry over up to $550 (20% of the IRS contribution limit) of unused funds for reimbursement of expenses incurred for the maximum COBRA period following your termination of employment or change in employment status.

If you become eligible for COBRA HCFSA 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 following your election to pay the back premium necessary to avoid a break in coverage. If coverage is not paid for during this 45-day grace period, it will not be offered again.

Your COBRA HCFSA coverage will stop when any of the following occur:

- You fail to make the required contributions.
- You become covered under another HCFSA plan.
- You reach the end of the calendar year in which coverage began (or, the end of the maximum COBRA period with respect to the carryover amount, if later).
- The Abbott Laboratories Flexible Benefit Plan is terminated.

Dependent Care Flexible Spending Accounts (DCFSA)

A Dependent Care Flexible Spending Account (DCFSA) lets you set aside pre-tax dollars to cover qualified dependent 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 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 less.
- 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 DCFSA contributions of highly-paid employees to ensure that the plan complies with these rules. Employees are notified individually when dependent 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 another 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, if 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, if 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 care or adult dependent care centers, if 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 if 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.

For a list of eligible expenses and/or exclusions, please see IRS Publication 503 or visit: **HealthEquity.com/employees/support-center/dcfsa-eligible-expenses-table.**

Reimbursements from Your Dependent Care FSA

You will be reimbursed for eligible dependent 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 or during the 2½-month grace period following the end of the 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 **HealthEquity.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. The invoice or other documentation must include the dates of service, type of service, service provider, dependent's name, and cost of service.

Once you have established a "Pay My Provider" arrangement, HealthEquity will issue a check directly from your account to your provider. If you pay for eligible recurring expenses like daycare, 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. One-time and recurring dependent care payments will be issued no sooner than the service end date. 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 name of the patient or the 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 care requests.

Filing a Claim (Pay Me Back Claim Form)

Call HealthEquity at **866-346-5800** or visit **HealthEquity.com** to obtain a Pay Me Back Form.

Fax your completed claim form, along with copies of your receipts to 8**77-353-9236**. 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 HealthEquity account. Once the form is complete, you have two options:

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

Use the EZReceipts App

Download the EZReceipts mobile app available through Apple or Google and use your smartphone to file for reimbursements or pay providers.

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 at **HealthEquity.com**.

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 care expenses incurred prior to your separation date if the FSA Administrator receives your claim by April 30 of the calendar year following your separation date. Continuation under COBRA does not apply to DCFSA.

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. If you return to work in the same calendar year, the DCFSA is automatically reinstated and your deductions are recalculated based on the estimated year to date contributions and your annual goal amount. If you are eligible to make a change due to a qualified life event, you must notify the Abbott Benefits Center at **844-306-9222** within 31 days of your return to work.

Right of Recovery

Abbott has the right to recover benefits it has paid that were paid in error or due to a mistake in fact or 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

Health Care FSA Appeals

If a claim for HCFSA benefits is denied or reduced, you will be notified of the reason in writing for the denial within 30 days. If it is necessary to extend the notification period beyond 30 days due to matters beyond the plan's control, the notification may be delayed for up to an additional 15 days, in which case you will be notified in advance. If such an extension is necessary due to your failure to submit the information necessary to

decide the claim, the extension notice will describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information. If you disagree with the decision or have additional information that may change the decision, you should contact HealthEquity at **866-346-5800** 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.

If your claim is denied, notification of the denial 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 final appeal. 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. In addition, you will be informed if the plan relied on any internal rule, guideline, protocol, or other similar criterion ("protocols"), and copies of such protocols will be provided free of charge if you request them.

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.

To Appeal a Denied HCFSA Claim

To appeal the denial, you must send a written request to:

Appeal Board
PO Box 14034
Lexington, KY 40512

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, even if the information was not submitted or considered in the initial claims review.

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

First Level Appeals

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 new 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. 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 nor that person's subordinate. The plan 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.

HealthEquity will review your appeal on behalf of Abbott and issue you a final determination in writing within 30 days after receipt of your written appeal. If your appeal is 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 to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, you will be informed if the plan relied on any internal rule, guideline, protocol, or other similar criterion ("protocols"), and copies of such protocols will be provided free of charge if you request them. If the denial is based on medical necessity, 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.

If your appeal is denied, the denial of your appeal will include details about appealing the denial to the Plan Administrator (Abbott). Your second level appeal must be in writing and must be received within 180 days of the date you received notice that your first level appeal was denied.

Second Level Appeals

Level two appeals should be directed to:

Abbott Benefits Practice Center
Building AP06B-2, Department 0589
100 Abbott Park Road
Abbott Park, IL 60064

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, and any other information you feel will support your claim, even if the information was not submitted or considered in the initial claims review or the first level of appeal. You can request copies of all documents and information relevant to your denied

claim from HealthEquity at no cost.

Your second level appeal will be reviewed by a person who was not involved with either prior claim denial and who is not a subordinate of any person who was.

The review will take a new look at your claim and appeal without deference to either prior denial and will take into account all information submitted with your claim and/or appeal. 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 an individual who was consulted in connection with either claim being appealed or his or her subordinate. The plan 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.

The Plan Administrator will issue you a final determination in writing within 30 days after receipt of your written appeal. If your appeal is denied, notification of the denial will include the specific reasons for the denial and specific references to the pertinent plan provisions on which the denial is based. 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. In addition, you will be informed if the plan relied on any protocols, and copies of such protocols will be provided free of charge if you request them. If the denial is based on medical necessity, 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. You will also be notified of your right to file a civil suit under section 502(a) of ERISA.

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. 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.

Dependent Care FSA Appeals

If a claim for DCFSA benefits is denied or reduced, you will be notified of the reason in writing for the denial within 30 days. If it is necessary to extend the notification period beyond 30 days due to matters beyond the plan's control, the notification may be delayed for up to an additional 15 days, in which case you will be notified in advance. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the extension notice will describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information. If you disagree with the decision or have additional information that may change the decision, you should contact HealthEquity at **866-346-5800** to discuss your concerns.

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

If your claim is denied, notification of the denial 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. 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:

Appeal Board
PO Box 14034
Lexington, KY 40512

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, even if the information was not submitted or considered in the initial claims review.

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

Appeal Review Process

HealthEquity will review your appeal on behalf of the Plan Administrator and issue you a final determination in writing within 30 days after receipt of your written appeal. The review will take a new 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. 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.

If your appeal is 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. 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.

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

HealthEquity, Inc. is the third-party claims administrator for the Abbott Laboratories Health Care and Dependent Care Flexible Spending Accounts. HealthEquity 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, Compensation and 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 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.

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 Abbott Benefits Center website, accessible via **AbbottBenefits.com,** or upon request by calling the Abbott Benefits Center at **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, Global Privacy, Abbott Laboratories, 100 Abbott Park Road, Abbott Park, IL 60064.

LIFE ENRICHMENT PROGRAMS

Abbott offers you paid time off work to help you balance your career and personal life. Other benefits to enrich your life and reward your efforts include adoption assistance, legal referral services, and an employee assistance program.

Holidays

Abbott typically provides 13 paid holidays each year, including scheduled company holidays, holiday credits and/or 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 the myHR portal, accessible from the Abbott intranet.

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, based on work location.

If an employee is eligible for holiday credits, they may use them before credits are earned in the year. Credits taken in advance will be deducted from the employee's final pay if they leave Abbott before the credits 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 an employee moves from full-time to part-time, holiday credits taken in advance of being earned will be deducted from their remaining vacation time (or pay, if no vacation time remains).

Holiday credits may be used individually or added to scheduled company holidays or vacations, based on advance manager approval. At some locations, site management designates some or all of an employee's days off for holiday credits.

Vacations

Vacation benefits are provided to all regular employees, with annual vacation amounts based on years of service at Abbott. Vacation for part-time employees is prorated based on scheduled hours. All vacations must be scheduled and taken in accordance with department guidelines and local practices; individual schedules also are subject to manager approval.

Vacation Allowances

Annual vacation allowances for regular employees are based on their years of Abbott service, as shown below. Vacation may be provided on either an accrual or lump-sum basis (see next section for details).

YEARS OF SERVICE	VACATION ALLOWANCE
1-6 years	3 weeks (120 hours)
7-16 years	4 weeks (160 hours)
17-29 years	5 weeks (200 hours)
30 or more years	6 weeks (240 hours)

Increases in vacation become effective January 1 of an employee's service year anniversary. For example, a full-time employee hired on August 1, 2022 would be eligible for four weeks of vacation on January 1, 2029, because 2029 is the employee's seventh year of service (even though the employee's actual anniversary is August 1).

Abbott service is earned only for service performed for Abbott Laboratories. If you worked for a company prior to it being acquired by Abbott, contact the Abbott Benefit Center to determine whether you are entitled to Abbott service for such employment.

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

How Vacation is Granted/Earned

Abbott provides vacation benefits to eligible employees via two methods:

1) On an "earn as you go"/Accrual method, under which eligible employees earn a determined amount of vacation while actively working during the calendar year. Vacation is accrued and earned on a biweekly basis up to the full amount per year. Employees who accrue vacation may use up to 40 hours of vacation before it is earned.
2) On a "lump sum"/Look-Forward method, under which eligible employees who are employed as of January 1 of a calendar year will receive a lump sum allowance of vacation that may be used during that calendar year.

Your method of earning vacation is based on your date of hire and Abbott division. To see your available vacation for the year, visit the myHR portal. All employees hired on or after January 1, 2022 receive vacation on an accrual basis.

Unused Vacation

At Abbott, vacation is intended to be used each year; it doesn't roll over to the following year. All salaried (exempt) employees with earned but unused vacation at the end of the year will forfeit that unused time, except in states where payment is required by law. All hourly (non-exempt) employees with unused vacation at the end of each calendar year will automatically be paid for the earned but unused vacation.

Vacation and Leaves of Absence

For employees who accrue vacation, accruals are allowed only while they are actively at work—which means that accruals cease during all leaves of absence. The accruals will begin upon return to work.

Please see below for how different types of leave may impact vacation benefits.

Medical Leave of Absence (MLOA)

For employees who receive vacation under the Look-Forward method, an approved MLOA will count as time worked for purposes of determining vacation allowance. The employee will be eligible for their full vacation allowance in the calendar year following their leave if they return to an active employment status on or after January 1 of that year. Under both the Accrual and Look-Forward methods, if the employee does not return to work during the calendar year in which their leave begins, they will be paid for their unused vacation days. Payout for non-exempt employees is automatic and occurs in early January. For exempt (salaried) employees, after six months of medical leave, Abbott will initiate the payout of unused vacation, as appropriate.

Family Leave of Absence (FLOA)

Although an employee may request vacation before beginning an FLOA, they are not required to do so. If the employee is a nonexempt (hourly) employee and they do not return to work by December of the year in which their FLOA began, they will receive a cash payment for any unused vacation time for that year.

Military Leave of Absence and Reserve Duty

Employees will receive a cash payment for unused vacation in the year their military leave of absence begins. If their military leave extends beyond the year in which it originated, the period of their military leave of absence will count as time worked for purposes of determining their vacation allowance for the year in which they are reinstated to work at Abbott. Under both the Accrual and Look Forward methods, if the employee is required to participate in annual military reserve duty, the employee will be granted time off for this duty in addition to their vacation. (Note: An employee cannot receive Abbott pay and reserve duty pay for the same period of absence.)

Personal Leave of Absence (PLOA)

An employee is eligible for their regular vacation allowance and/or year to date accrued vacation in the calendar year their PLOA begins. It will be paid to the employee before their leave starts or shortly thereafter.

- Under the Look-Forward method, if the employee returns to work in a calendar year after the year in which their leave began, the vacation allowance for the calendar year is granted only after the 30th day after they return to work.
- Under the Accrual method, if the employee returns to work in a calendar year after the year in which their leave began, the bi-weekly vacation accrual will begin upon their reinstatement to work.

Vacation and Changes in Scheduled Hours

Under the Accrual method, if an employee's scheduled hours change during the year, their vacation accrual will change on the effective date of the schedule change (assuming you remain eligible for vacation benefits under your new work schedule).

Under the Look-Forward method, if an employee's schedule changes, their vacation allowance will not be updated until the following calendar year. The following special provisions apply:

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

Changes in Employment Status

Temporary employees (Abbott employees who are hired to work for a temporary period) are not eligible for time off under Abbott's Vacation Policy. If a temporary employee is later hired by Abbott as a regular employee, they may be entitled to vacation in the year in which they become an Abbott employee. Calculation of vacation allowance for that year will be based on the employee's Abbott hire date as a regular employee and the employee will accrue vacation at the same level as a new regular employee.

Termination

If an employee's employment terminates for any reason other than retirement, the unused amount of their vacation allowance for that calendar year or their year-to-date earned vacation accrual will be paid to the employee in a lump sum.

Retirement

Retiring employees will receive a payout of their unused vacation balance the year of their retirement. Use of vacation prior to your retirement does not extend your service with Abbott.

Rehires

Former employees that are rehired on or after January 1, 2022, are awarded vacation based on their new hire date and they will receive vacation under the Accrual method. Past service does not count toward the vacation allowance calculation.

Vacation Scheduling

If a scheduled company holiday falls during an employee's vacation period, that day will not be charged against the employee's vacation. If the employee becomes incapacitated during a scheduled vacation due to an illness or injury that requires a doctor's care, their manager may arrange to reschedule that portion of the employee's 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 a nonexempt employee is taking at least one week of vacation, they may receive vacation pay before their vacation begins — provided their request is submitted to their payroll department at least two weeks in advance. Under the Accrual method, employees are eligible to "go negative" up to 40 hours, meaning they may use up to 40 hours of vacation before it is earned throughout the year.

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

An employee's participation in the Abbott Laboratories Vacation Program will be suspended in the event their employment with Abbott is suspended without pay.

Changes

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

Vacation Buy Program

During Abbott's annual open enrollment period, eligible employees can purchase additional days of vacation for use in the subsequent year. From one to five additional days may be purchased, up to a maximum of six weeks total vacation counting both normal and purchased vacation. This benefit is available to active U.S. employees regularly scheduled to work 20 hours or more per week, excluding employees in Abbott Rapid Diagnostics.

Enrollment in the Vacation Buy Program is normally allowed only during the annual open enrollment period, but may also be open to employees returning from a leave of absence and/or global assignment.

All employees who elect to participate in the program are required to discuss the election with their manager. Following the election period, employees should provide a confirmation of the program election to their manager.

Payroll Deductions

An employee's purchased vacation will be deducted from their pay on an after-tax basis over the subsequent year. Deductions will be in equal increments each pay cycle over the course of the year. The amount deducted will be 75% of the employee's rate of pay for the number of days elected.

Deductions will be based on the employee's annual base pay rate as of December 15 of the year in which the elections were made. Abbott will not make deduction adjustments based on annual merit increases. Participants who have an employment change during the year (e.g., from full-time to part-time, part-time to full-time, exempt to non-exempt, etc.) will maintain the elected number of days and hours purchased through the program. Payroll deduction amounts will not be adjusted.

However, if an employee goes out on an unpaid leave of absence, upon return to active status their deductions will be increased for the remaining pay periods in order to meet the annual deduction amount.

Unused Vacation

Purchased vacation is required to be used in the year for which it is purchased. Unused vacation does not carry over to the subsequent year and will be forfeited, unless mandated by state law.

Employees who terminate their Abbott employment will be reimbursed for any unused purchased vacation for the calendar year in which they terminate, to the extent the unused purchased vacation has been already paid for at the time of termination.

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%, 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 embryo adoption 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 Abbott 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 HR Service Center, Dept. 058E, Bldg. AP52, 200 Abbott Park Road, Abbott Park, IL, 60064-6222.

Other Applicable Benefits

You may receive parental leave benefits of up to eight weeks paid time off. Your parental leave benefit may be used when your adoption is finalized. The maximum adoption leave is 320 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.

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 or domestic partner, 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 LifeWorks at (800) 626-0738; TDD (800) 346-9185 24 hours a day, 7 days a week. You may visit the website at abbott.lifeworks.com (username: abbott, password: 1020) for general information, listen to podcasts, complete self-assessment and much more. 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 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 time following your termination under the Continuation of Coverage provisions described below.

Continuation of Coverage

You may be able to 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 generally 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 **844-306-9222** 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, legal and financial issues, educational resources and everyday issues.

Eligibility

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

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 may contact LifeWorks at **(800) 626-0738**; TDD **(800) 346-9185** 24 hours a day, 7 days a week. You may visit the website at abbott.lifeworks.com (**username:** abbott, **password:** 1020) for general information, to listen to podcasts, complete a self-assessment and much more. To talk to a Spanish-speaking consultant, call **(888) 732-9020**.

Your Costs

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

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 **HealthEquity.com**. 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 **HealthEquity.com**.

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 **HealthEquity.com** or call **866-346-5800**.

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
- 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 the myHR portal.

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*

Regular non-exempt or hourly employees 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 100% 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% 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.

Short-Term Medical Leave Benefits

Medical Leave and Weekly Sick Pay

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; and
- 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.

Short-term medical leave benefits for employees of the Abbott Rapid Diagnostics division, Alere, Inc. and its subsidiaries are not described in this booklet. Contact your HR representative for information on these benefits.

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 claims 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.

Recurring Illness

In the event you return to work full duty for 30 calendar days or less and become 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 (if eligible). 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% of your current base rate of pay for the first 7 weeks of approved absence and up to an additional 18 weeks at 70% of pay after satisfying the seven consecutive day waiting period.

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* 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.

Sick pay benefits for employees in Michigan, Arizona, Colorado, Massachusetts, Oregon, Nevada, California, Hawaii, New Jersey, New York, Washington and Rhode Island may differ from those described in this booklet.

INCOME PROTECTION IF YOU CAN'T WORK (CONT.)

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 myHR 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 (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 federal or state statutory benefits, social security disability income benefits, or workers' compensation or similar benefits in connection with a work-related injury or illness. These offsets apply whether or not the employee applies for such benefits.

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 my HR portal or by requesting a copy from the Abbott HR Service Center.

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 Shutdowns

If you become ill, injured or have a baby during a pre-approved vacation period (or a scheduled plant shutdown) 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 (or part-time equivalent), unless you elect to apply for Long-Term disability plan (LTD) benefits.

Exclusions

Weekly sick pay benefits are not payable for scheduled overtime periods, 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 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 my HR portal or by requesting a copy from the Abbott HR Service Center.

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 Abbott's short-term medical leave policy, after which you 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

For claims inquiries, call Matrix Absence Management at **800-663-8044**, or write to:

Matrix Absence Management
9390 Research Blvd., Bldg. 1,
Suite #220 Austin, TX 78759

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. These changes may include any amounts contributed toward the cost of providing benefits by Abbott or its employees, the level of benefits provided, and/or the class or classes of employees eligible for benefits.

Long-Term Disability Plan

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.* 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% of your basic monthly earnings.

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 work weeks — 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% of a workers' compensation lump-sum settlement will be considered for the reduction under this provision.

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

INCOME PROTECTION IF YOU CAN'T WORK (CONT.)

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.

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

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% 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% 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

LTD plan benefits are paid monthly.

Filing a Claim

When you have been absent from work for approximately 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. 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

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); or
- 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 if the plan relied on any internal rule, guideline, protocol, or other similar criterion ("protocols"), and copies of such protocols will be provided free of charge if you request them. Otherwise, you will receive a statement explaining that the plan did not rely on any such protocols. 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.

If you filed your claim after April 1, 2018, the notification of the denial of your claim will also include, if applicable, an explanation of the basis for disagreeing with, or not following: (1) the views of medical and/or vocational professionals who evaluated you, if any, that you submitted; (2) the views of any medical or vocational experts obtained by the plan, whether or not the plan relied on such views in denying your claim; and/or (3) a disability determination made by the Social Security Administration, if you submitted one.

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.

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 Claims Administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

To file an appeal with the Claims 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
Attn: Quality Review Unit
PO Box 11035
San Jose, CA 95103

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 nor his or her subordinate. The Claims 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 Claims 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.

If the Claims Administrator denies your appeal, 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 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 if the plan relied on any protocols, and copies of such protocols will be provided free of charge if you request them. Otherwise, you will receive a statement explaining that the plan did not rely on any such protocols. 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. If the denial is based on any new or additional evidence or rationale, the Claims Administrator must provide such evidence or rationale to you sufficiently in advance of the denial in order to give you a reasonable opportunity to respond.

If you filed your claim after April 1, 2018 and your appeal is denied, the notification of the denial will also include, if applicable, an explanation of the basis for disagreeing with, or not following: (1) the views of medical and/or vocational professionals who evaluated you, if any, that you submitted; (2) the views of any medical or vocational experts obtained by the plan, whether or not the plan relied on such views in denying your claim; and/or (3) a disability determination made by the Social Security Administration, if you submitted one.

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 or the first level of appeal. The Plan Administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

In any case, the appropriate reviewer of your appeal will not be the same person who made either prior 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 an individual who was consulted in connection with either claim denial being appealed nor 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. If the denial is based on any new or additional evidence or rationale, the Plan Administrator must provide such evidence or rationale to you sufficiently in advance of the denial in order to give you a reasonable opportunity to respond.

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 prior decisions 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 a prior determination.

If the Plan Administrator denies your appeal, 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 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 if the plan relied on any protocols, and copies of such protocols will be provided free of charge if you request them. Otherwise, you will receive a statement explaining that the plan did not rely on any such protocols. 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.

If you filed your claim after April 1, 2018 and your appeal is denied, the notification of the denial will also include, if applicable, an explanation of the basis for disagreeing with, or not following: (1) the views of medical and/or vocational professionals who evaluated you that you submitted; (2) the views of medical or vocational experts obtained by the plan, whether or not the plan relied on such views in denying your claim; and/or (3) a disability determination made by the Social Security Administration.

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

For claims inquiries, call Matrix Absence Management at **800- 663-8044**, or write to:

Matrix Absence Management
9390 Research Blvd., Bldg. 1,
Suite #220 Austin, TX 78759

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 or would have received if you had applied for such benefits in connection with a work-related injury or illness.

Other Paid Leaves of Absence

Parental Leave

Regular employees scheduled to work a regular weekly schedule of 20 hours or more are eligible for parental leave. Parental leave helps new adoptive and/or birth parents by providing eight weeks (320 work hours or an equivalent part-time workweek) paid time away, for purposes of bonding, at a rate of 100% base pay.

Voting Time

Voting is a right and a responsibility. To ensure you can vote in federal primary and general elections, we are providing up to four hours of 100% paid time to vote. Again, this is for federal elections only.

Bereavement Leave

Regular employees scheduled to work a regular weekly schedule of 20 hours or more are eligible for bereavement leave. In order to prevent the loss of income and allow the necessary time to manage your affairs after the death of a loved one, you are eligible to receive 100% paid time away. Loss of a dependent child (under age 26) or spouse/domestic partner qualifies for 80 hours (or two-week part-time equivalent) of paid time. The loss of close family members such as an adult child (26 and older), parent, grandparent, sibling, grandchild, in-laws, and/or step relatives qualifies for 40 hours (or one-week part-time equivalent) of paid time.

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, Employee Relations, 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 plan also does not apply to an employee who would otherwise be entitled to both plan benefits and a severance benefit under an employment agreement.

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.

Claims and Appeals

If your application for plan benefits is denied in whole or in part, you will receive written notification of the denial within a specified timeframe established by the Department of Labor, and you are entitled to appeal that decision informally and/or formally. The notification timelines and procedures for appeal are described in the claim's procedures for the plan, which are available upon request to the Divisional Vice President, Employee Relations of Abbott.

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

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 or domestic partner and your eligible children.

Group 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 time 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 Abbott Benefits Center website, accessible via **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*
- 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.

* For employees working less than full-time, life insurance amounts are based on scheduled hours.

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 Abbott Benefits Center website.

Supplemental Life Insurance Options

Supplemental life insurance options are available, ranging from 100% to 700% of your basic annual earnings (selectable in 100% increments). Elections over 500% of basic annual earnings will always be subject to evidence of insurability.

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 the Abbott Benefits Center website.

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, such as e-cigarettes or vaping. 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.

Election Changes

You may request an increase to your supplemental life insurance percentage (up to 700% of your basic group life insurance) at any time by logging on to the Abbott Benefits Center website, accessible via **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.*

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

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 Abbott Benefits Center website.

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 **844-306-9222**.

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 **844-306-9222**.

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% 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 reviewed by medical directors at the insurance company 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.

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

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. (Note: Full pay period contributions will be deducted from your final paycheck).

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 Retirement Guide 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. Application forms must be submitted to the insurance company within 31 days of termination or retirement. If you wish to "port" your coverage, please call the Abbott Benefits Center at **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 **844-306-9222** 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.

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

Supplemental Coverage

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. 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 Abbott Benefits Center website, accessible via **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* 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

- *Rehabilitation benefit:* This benefit reimburses expenses for rehabilitative therapy (up to 20% 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% of your total AD&D coverage or $3,000, whichever is less.

* 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% 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).

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 Abbott Benefits Center website and following the 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. You can change a beneficiary at any time on the Abbott Benefits Center website.

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 **844-306-9222**.

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 **844-306-9222**.

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/domestic partner 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/domestic 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% 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
- Intentionally self-inflicted injury or any attempt at self-inflicted injury,
- 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 AD&D 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 AD&D insurance to individual policies.

Business Travel Accident and Out of Country Travel Medical Insurance

Insurance coverage is provided to support Abbott employees while traveling on Abbott business. Coverage includes up to 14 days of leisure travel, when attached to an approved business trip. This coverage is provided at no cost to employees.

Eligibility

All regular employees of Abbott are automatically covered for business travel accident and out of country medical insurance while traveling on Abbott business.

Spouses/domestic partners and dependent children are covered when traveling with an eligible employee for company business or relocation.

Business Travel Accident Insurance Benefits

Provides a defined benefit in the event of death, dismemberment or other covered incidents which occur anywhere in the world.

Principal Sum

The principal sum is the base benefit upon which all covered benefits are based. The employee's principal sum is equal to five times basic annual earnings, with a minimum amount of $100,000 and a maximum of $1,000,000.

The principal sum for eligible spouses or domestic partners is 50% of the insured employee's principal sum, subject to a maximum of $250,000, and a minimum of $100,000. The

principal sum for eligible children is 25% of the insured employee's principal sum, subject to a maximum of $50,000, and a minimum of $25,000.

Death Benefit

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

Dismemberment or Loss-of-Use Benefit

If, within 365 days of a covered accident which occurs while a covered person is traveling on Abbott business, injury results and there is a loss of sight, speech, hearing, limb, or function, a benefit will be paid to the employee in a lump sum, at the corresponding benefit percentage shown in the policy document.

This dismemberment or loss of use benefit is payable in addition to benefits payable under Abbott Laboratories' Life Accident Plan for the same accident.

Benefit Limits

No more than 150%f 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
- Accidents that occur when you are not on Abbott business

The above list is not exhaustive. For a complete list of exclusions, please refer to the full policy document.

Out-of-Country Business Travel Medical Insurance Benefits

Provides benefits for sick, urgent and emergency care while traveling outside of home country or country of permanent residence.

Primary Benefits

The plan will pay up to $1,000,000 for medically necessary expenses incurred for hospital and medical care, treatment or services within 30 days of a covered accident or sickness.

Exclusions

Out of Country Business travel medical benefits are not payable for losses caused by the following:

- Routine physicals
- Routine dental care and treatment
- Cosmetic surgery
- Eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and hearing aids
- Services, supplies, or treatment including any period of hospital confinement which is not recommended, approved, and certified as medically necessary and reasonable by a doctor, or expenses which are non-medical in nature
- Treatment or service provided by a private duty nurse
- Treatment by any immediate family member or member of the insured's household
- Accidents that occur when you are not on Abbott business

The above list is not exhaustive. For a complete list of exclusions, please refer to the full policy document.

Additional Benefits

Emergency Medical, Emergency Evacuation, Repatriation of Remains, Lost Baggage, Personal Property & Financial Instrument Reimbursement, Trip Interruption

Please refer to the fully policy document for more information.

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 Abbott Benefits Center website, accessible via **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

For any type of medical attention or an accident while traveling on business, immediately contact International SOS (iSOS) at **1-215-942-8226**. iSOS will coordinate the submission of claims directly to the insurance company for payment.

When Coverage Ends

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

Dependent Life Insurance

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 Abbott Benefits Center website.

Dependent Life Insurance Amounts

Separate life insurance elections are allowed for your spouse/domestic partner and your eligible children. Spouse/domestic partner coverage may be elected in the amount of $10,000, $25,000, $50,000 or $100,000. Dependent children coverage may be elected in the amount of $5,000, $10,000 or $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 Abbott Benefits Center website.

Eligible Dependents

Eligible dependents include your spouse/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 and children

If both you and your spouse/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/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.

If your spouse or domestic partner is receiving benefits under the Retiree Basic Life Insurance, you may still elect Spouse Life Insurance.

Enrollment

To enroll for dependent life insurance, you must log on to the Abbott Benefits Center website, accessible via **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 for spouse/domestic partner 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 **844-306-9222** 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; or
- The date you fail to pay the required contribution for this coverage.

Note that if your employment terminates, full pay period contributions will be deducted from your paycheck.

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 within 31 days of termination or retirement to the insurance company. Call the Abbott Benefits Center at **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 **844-306-9222** 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. Securian Life Insurance, St. Paul, MN ("Securian") insures all group life insurance, dependent life insurance and accidental death and dismemberment insurance for the plan. Chubb Group 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.

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.

Administrative Information

Claim Denial and Appeal Procedures

Group Life, Dependent Life and Accidental Death and Dismemberment Insurance Only

Contact the plan administrator if you have any questions or to initiate a claim. You may also contact Securian directly to initiate a claim. Upon the receipt of notification of a claim Securian will provide claim forms and claim forms may be obtained by contacting Securian. Read the instructions on those forms carefully and be sure all the questions are answered and that you include any required attachments. Completed forms must be sent to Claims, PO Box 64114, St. Paul, MN 55164-0114. After your claim has been processed by Securian, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

You will be notified of a decision within 90 days of receiving your claim for benefits. If special circumstances require more time, the review period may be extended up to an additional 90 days. You will be notified in writing of this extension within the original review period.

The notice of extension will explain the circumstances requiring the extension and indicate the date by which the plan expects to render the benefit determination.

Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for Benefits will consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure, including your right to bring a civil action in Federal court if your claim is denied upon review.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for Benefits by filing a written request for a full and fair review to Securian, at Claims PO Box 64114, St. Paul, MN 55164-0114. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure, if you submit written proof of the representation to Securian. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. Before Securian can deny a claim on appeal, Securian shall provide you with any new evidence considered, relied upon, or generated during the appeal, as well as any new rationale for the decision. Any new evidence or rationale will be provided to you free of charge, as soon as possible before the date by which the appeal is to be decided, so that the claimant may respond to the evidence or rationale before that date. The full and fair review will be held, and a decision rendered by Securian, no later than 60 days after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days. You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of any missing information and shall specify and indicate the date by which Securian expects to render the benefit determination. The notice of extension will specify a timeframe, no less than 180 days, in which any necessary missing information must be provided. Where the timeframe to process an appeal is extended because additional information to render an appeal decision is needed, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 180 days of the date on the notice, Securian may close the appeal and no further consideration will take place.

If your appeal is denied, the written notification will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent Plan provisions on which the denial was based;
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents; and
- A statement of your right to sue in federal court.

During all steps of the claims appeal procedure, you can write or call Securian and ask to see all documents relevant to your claim. In addition, you may have an attorney or other representative write letters or otherwise act on your behalf, but you may need to provide written proof of designation of the representative.

Legal Action

You may not initiate any lawsuit to recover benefits under the Plan until you have exhausted the claims and appeals procedures applicable to the Plan. After exhaustion of the claims and appeals procedures, any further legal action taken against the Plan, Abbott, or any of the Plan fiduciaries, if any, must be filed in a federal court no later than the earliest of the following: (a) 90 days after the plan administrator's (or claims administrator's, as applicable) final decision regarding the claim; (b) three years after the date when you submitted an authorization to commence payment of the Benefits at issue in the judicial proceeding, if applicable; or (c) the statutory deadline for filing a claim or lawsuit with respect to the Benefits at issue in the judicial proceeding. In no case may a suit or legal action be brought if the claim for Benefits was not made within the time period specified in the claims and appeals procedures. This limitation on suits for Benefits applies in any forum where you initiate a suit or legal action. If you pursue legal action for Benefits, the evidence that may be presented in such legal action will be strictly limited to the documents, information and other evidence timely presented to the plan administrator and/or claims administrator during the claim and appeal procedures. All decisions and communications related to claims, denials of claims or a claim appeals must be held strictly confidential by Abbott, the plan administrator, and/or the claims administrator, as applicable, and you at all times after your claim is submitted.

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

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. ERISA applies to the Health Care Plan, the Health Care Flexible Spending Accounts, the Employee Assistance Program, the Long-Term Disability Plan, the Transitional Pay Plan, Life Insurance, Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance.

The provisions of ERISA that apply to these plans 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 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.

Problem Solving

You are encouraged to resolve individual complaints by contacting the Abbott Benefits Center or the HR Service Center, as applicable, for verbal resolution.

Additional Information

A misstatement or other mistake of fact will be corrected when it becomes known, and the Plan Administrator will make such adjustment as it considers equitable and practicable. For example, if you receive a payment from a plan that is greater than the payment that should have been made, or if a person receives an erroneous payment from a plan, the Plan Administrator has the right to recover the excess amount from you or erroneous payment from the applicable individual, including earnings.

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, and 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 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 **844-306-9222**.

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.

Coinsurance:

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

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.

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.

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 **844-306-9222**.

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 **844-306-9222**.

ADDITIONAL INFORMATION

This Handbook describes only the highlights of the Abbott employee benefit plans, programs and policies — and does not attempt to cover all 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.