



BlueCross BlueShield PPO Plus

Summary Plan Description effective January 1, 2010

For Abbott Laboratories Employees – Hawaii

This summary plan description (SPD) describes the key features of the BlueCross BlueShield (BCBS) PPO Plus for employees of Abbott Laboratories in the State of Hawaii. Benefits are offered under the Abbott Laboratories Health Care Plan effective January 1, 2010. This booklet describes only the highlights of the plan and does not attempt to cover all administrative details. Every attempt has been made to communicate this information clearly and in easily understandable terms.

Benefits are determined under the terms of the plan in effect at the time you become eligible for the Benefits in question. Benefits and services described here apply only to those employees and/or dependents enrolled in and eligible for Benefits under the plan. The company reserves the right to modify, suspend or terminate these Benefits at any time to the extent permitted by law. This SPD does not constitute a contract of employment or guarantee any particular benefit.

The Abbott Laboratories Health Care Plans are governed by formal legal documents and 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.

Este folleto contiene un resumen en Ingles de los derechos y beneficios del plan. Si tiene alguna dificultad en entender cualquier seccion de este folleto, puede comunicarse a nuestras oficinas de Beneficios (myHRTeam) al **(877) 228-4707** cualquier dia (Lunes a Viernes) dentro de 7 a.m. y 7 p.m. hora central.

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Introduction

BlueCross BlueShield PPO Plus (BCBS PPO Plus) Benefits are available to 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 options available to you are based on the eligibility area in which you reside.

This plan is a Participating Provider Option (PPO). Under a PPO plan, you have a Network of doctors that you can use. If you use a doctor in the Network, the charges are paid at the Network Benefit level. If you use a Provider that does not participate in the Network, the charges are paid at the Non-Network Benefit level.

You will need to satisfy the requirements described in this SPD to receive BCBS PPO Plus coverage.

Basic Plan Information	
Plan Type	Preferred Provider Organization (PPO)
Abbott Plan Code(s)	M80
Member Services	(800) 671-1210
Group Number	018046
Provider Network	PPO
Web Address	www.bcbsil.com/abbott

Definitions

Throughout this booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Benefits.

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

Ambulance Transportation: Local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

Ambulatory Surgical Facility: A facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services: The administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

Annual Maximum: The maximum amount the plan will pay for Covered Services during a calendar year. For example, the \$750 Annual Maximum on chiropractic services means the plan pays no more than \$750 in Benefits on chiropractic Claims for any Covered Person during a calendar year.

Behavioral Health Care: Treatment of mental or nervous disorders and substance abuse.

Benefits: Your right to payment for Covered Health Services available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the plan and applicable contracts.

Benefit Period: Your Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first Benefit Period begins on your Coverage Date and ends on the first December 31st following that date.

Certificate of Creditable Coverage: A certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

Certified Clinical Nurse Specialist: A nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications: i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and is a graduate of an advanced practice nursing program.

- A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.
- A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

Certified Nurse-Midwife: A nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications: is a graduate of an approved school of nursing and holds a current license as a registered nurse; and is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

- A “Participating Certified Nurse-Midwife” means a Certified Nurse Midwife who has a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.
- A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse Midwife who does not have a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

Certified Nurse Practitioner: A nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and Hospital referral and (c) meets the following qualifications: (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and (ii) is a graduate of an advanced practice nursing program.

- A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.
- A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

Chemotherapy: The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor: A duly licensed Chiropractor.

Claim: Notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claims Administrator may request in connection with services rendered to you.

Claims Administrator: The Claims Administrator for Medical Services is BlueCross BlueShield of Illinois. The Claims Administrator for Prescription Drugs is Caremark.

Claim Charge: The Provider's charge for services or supplies rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Claim Payment: The benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the Benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Clinical Laboratory: A laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

- A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.
- A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

COBRA: Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

Coinsurance: The percentage of Covered Health Services shared by you and your health plan. For example, if your Coinsurance is 20 percent, it means the plan pays 80 percent of the covered expense and you pay 20 percent.

Complications of Pregnancy: All physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

Congenital Anomaly: A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Coordinated Home Care Program: An organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and Speech Therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide Benefits for Private Duty Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

Contract Worker: An individual who performs work 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: A specified dollar amount you are required to pay toward a Covered Health Service.

Covered Health Services: Health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered Health Services are described on pages 40-57. Covered Health Services do not include any items specifically excluded on pages 65-72. Covered Health Services must be provided:

- When the Plan is in effect
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Covered Person: An employee or enrolled dependent while the person is enrolled under this plan. References to "you" and "your" throughout this booklet are references to a Covered Person.

CNRA: A Certified Registered Nurse Anesthetist, who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

- A "Participating CRNA" means a CRNA who has a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.
- A "Non-Participating CRNA" means a CRNA who does not have a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

Custodial Care Service: Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

Deductible: The amount of covered health care expenses that you must pay out of your own pocket before the plan begins paying Benefits. When a family Deductible limit is designated, combined Deductible expenses of all covered family members may be used to satisfy this family Deductible.

Dentist: A duly licensed Dentist.

Diagnostic Service: Tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Dialysis Facility: A facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Durable Medical Equipment (DME): Equipment that is used to serve a medical purpose due to illness or injury, is appropriate for use at home, is not disposable and can stand repeated use. Durable Medical Equipment is generally not useful to a person in the absence of a sickness or injury. Examples include crutches, wheelchairs, Hospital-style beds, oxygen and other respiratory equipment.

Durable Medical Equipment Provider: A duly licensed Durable Medical Equipment Provider.

- A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.
- A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

Eligible Charge (or Eligible Expense): In the case of a Provider other than a Professional Provider that has a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services. In the case of a Provider other than a Professional Provider which does not have a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of the Claims Administrator based on the following order:

- The charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claims Administrator, if available
- The amount that the Centers for Medicare & Medicaid Services ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or
- The charge which the particular Hospital or facility usually charges its patients for Covered Services.

Emergency Medical Care: Services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences. Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

Explanation of Benefits (EOB): When the Claims Administrator receives a Claim for you or your dependent, an Explanation of Benefits, or EOB, form is issued to you. This form explains what action was taken or what additional information is needed. If your Provider is paid directly, he or she also receives an EOB on the Claim. An EOB is issued to you each time a Claim is processed, whether or not a payment is made.

Home Infusion Therapy Provider: A duly licensed Home Infusion Therapy Provider.

- A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.
- A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claims Administrator or another BlueCross BlueShield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

Hospice Care Program Provider: An organization duly licensed to provide Hospice Care Program Service.

Hospice Care Program Service: A centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

Hospital: A duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

- A “Participating Hospital” means a Hospital that has an agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide Hospital services to participants in the Participating Provider Option program.
- A “Non-Participating Hospital” means a Hospital that does not meet the definition of a Participating Hospital

Infertility: For purposes of coverage under the Abbott Laboratories Health Care Plan, Infertility means the inability to conceive or maintain pregnancy after one year (six months for a female age 35 or older) of unprotected sex between a male and female.

Inpatient Stay: An uninterrupted confinement, following formal admission to a Hospital, skilled nursing facility or inpatient rehabilitation facility.

Investigational: Investigational services or supplies include procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you

Lifetime Benefit Maximum: The maximum amount a plan will pay for Covered Services during a Covered Person’s lifetime.

Maintenance Therapies: Maintenance Occupational Therapy, Maintenance Physical Therapy and/or Maintenance Speech Therapy are therapies administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maternity Service: Services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

Maximum Allowance: The amount determined by the Claims Administrator which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. The Claims Administrator may amend these amounts from time to time.

Medical Care: The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

Medically Necessary: A specific medical, health care or Hospital service is Medically Necessary when required, in the reasonable medical judgment of the Claims Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Medicare: The program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

Medicare Approved or Medicare Participating: A Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

Medicare Secondary Payer: Those provisions of the Social Security Act set forth in 42 U.S.C. W1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Naprapath: A duly licensed Naprapath.

Non-Participating Provider: An Administrator Hospital or Professional Provider which does not have a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claims Administrator as a Participating Provider.

Network Benefits: Benefits for Covered Health Services that are provided by a Participating Physician or other Participating Provider.

Non-Network Benefits: Benefits for Covered Health Services that are provided by a Physician or other health care Provider that does not have a participation agreement with the Claims Administrator. Benefits for Non-Participating Providers are generally paid at a lower level than Benefits for Participating Providers. Non-Network Benefits are also payable for Covered Health Services that are provided at Non-Network facilities.

Out-of-pocket (OOP) limit: Your payments toward Deductibles and Coinsurance are used to satisfy your out-of-pocket limits. If you or a covered family member reaches the individual Out-of-Pocket Limit during a calendar year, the plan will pay 100 percent of remaining covered expenses for that individual during the rest of the calendar year. Separate OOP limits may apply to specific expenses, such as Behavioral Health care or prescription drugs.

Participating Provider: An Administrator Hospital or Professional Provider which has a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claims Administrator as a Participating Provider.

Participating Provider Option: A program of health care Benefits designed to provide you with economic incentives for using designated Providers of Health Care Services.

Physical Therapist: A duly licensed Physical Therapist.

Physical Therapy: The treatment of a disease, injury or condition by physical means by a Physician or registered professional Physical Therapist under the supervision of a licensed Physician and which is designed and adapted to promote the restoration of a useful physical function.

Physician: A Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. A Podiatrist, Dentist, Psychologist, Chiropractor, Optometrist, or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a Provider as a Physician does not mean that Benefits for services will be payable.

Physician Assistant: A duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

Podiatrist: A duly licensed Podiatrist.

Private Duty Nursing Service: Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Plan Administrator: Abbott Laboratories or its designee as that term is defined under ERISA.

Provider: Any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

- An "Administrator Provider" means a Provider which has a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.
- A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.
- A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claims Administrator as a Participating Provider.

- A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claims Administrator as a Participating Provider.
- A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by the Claims Administrator or a BlueCross BlueShield Plan or Blue Cross Plan of another state.

Reconstructive Procedure: A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify Surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Regular Employee: This employment category describes an Abbott employee who is assigned to work an established weekly schedule for an indefinite period. You can verify your employment category (regular or temporary) with your manager.

Renal Dialysis Treatment: One unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

Respite Care: Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

Skilled Nursing Facility: An institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which has not been certified in accordance with the guidelines established by Medicare.

Skilled Nursing Services: Those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Speech Therapist: A duly licensed Speech Therapist.

Speech Therapy: The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Surgery: The performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

Temporomandibular Joint Dysfunction and Related Disorders: Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Temporary Employee: This employment category describes an Abbott employee hired to work for a temporary period of time. 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 your manager.

Urgent Care: Treatment of an unexpected sickness or injury that is not life threatening but requires outpatient Medical Care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center: A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

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 this plan on your hire date or the date of your conversion to an eligible status, if later. You can verify your employment status with your department manager or human resources office.

Employees who are not eligible

Employees who are not eligible for this option include those who live outside of this option's designated eligibility area, part-time employees working a schedule of less than 20 hours per week (unless specifically designated), Temporary Employees and Contract Workers. Eligible employees who convert to a schedule of less than 20 hours per week are no longer eligible for this plan, but may be eligible to continue coverage for a limited period of time under the plan's continuation of coverage provisions described on page 85-88.

Eligible Dependents

If you are an eligible employee and elect coverage under the BCBS PPO Plus, you may also cover certain dependents. You may only cover your dependents if you have also elected coverage for yourself.

Eligible dependents include your legal spouse or eligible domestic partner, and dependent children (including children of a domestic partner) under age 25. Your unmarried child may be covered until his or her 25th birthday if qualified as your dependent for federal income tax purposes¹.

Your spouse is the person to whom you are legally married (i.e., a legal union for purposes of all federal laws). **Your children** include your biological children and legally adopted children who are dependent on you for financial support (whether or not they live with you) and stepchildren who are dependent on you for financial support as long as they live with you at least 50 percent of the time.

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

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

If you cover your domestic partner, you may also cover your domestic partner's children who are dependent on you for financial support (as long as they live with you at least 50 percent of the time) and children placed with you or your domestic partner while adoption proceedings are pending.

Legal Guardianship or Custody

If you have 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 legal guardianship or custody papers to myHRTeam within the appropriate time frame before this coverage can be approved.

¹ The Families Tax Relief Act of 2004 allows a person who is otherwise a "qualifying relative" to receive tax-favored coverage under an employer's health plan even if that person earns more than \$3,500 a year.

Handicapped Dependents

An unmarried dependent child who is not capable of self-support due to a physical or mental condition that began before age 25 may be eligible for dependent coverage. A physician's statement documenting the condition is required before age 25 and may be required periodically thereafter for coverage to continue. The plan administrator determines eligibility for this coverage. If you drop coverage for a handicapped child after age 25, 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 after you and your spouse divorce, 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 this SPD to receive coverage, including pre-certification requirements and use of Participating Providers. The BCBS PPO Plus offers Network-level Benefits if you use any Provider in the BCBS Choice Plus PPO Network nationwide. Your covered dependent may also use Non-Participating Providers and be reimbursed for services at the Non-Network level.

Dependents who are 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), dependent parents or siblings, stepchildren who do not live with you at least 50 percent of the time and foster children.

If you become legally separated from or divorce your spouse, he/she is no longer an eligible dependent and must be removed from coverage within 31 days after your legal separation or divorce. If your former spouse 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 your former spouse may be continued for a limited period of time following your divorce or separation under the plan's continuation of coverage provisions described on pages 85-88.

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

Your Contributions

Abbott pays the majority of the cost for your medical coverage. You pay your share through pretax payroll deductions. Employee contributions for the BCBS PPO Plus are reviewed annually and are subject to change each January 1. The Company announces changes during the annual enrollment period each fall.

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)
- Employee plus spouse/domestic partner and child(ren)

If you elect medical coverage for your domestic partner, you will be responsible for the imputed income tax. This means that the company's contribution for your domestic partner and your domestic partner's dependents will be added to your taxable income. Details on this imputed income are available from myHRTeam.

Enrollment

New Employees

You have 31 days from your date of hire to enroll in BCBS PPO Plus coverage for yourself and your eligible dependents. To enroll, you must complete your election by logging on to the Benefits Web Site at the web address noted in your offer letter. Your election generally cannot be changed until the next open enrollment period.

Annual Enrollment

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

Enrollment Changes

Once you have enrolled in this option you cannot change this election during a calendar year unless you move outside of the eligibility area for the BCBS PPO Plus.

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.

If You Move

If you relocate to a new geographic area, you may be able to make a new medical election. Changes must be made within 31 days after your relocation. The Company determines the plan options available to you based on the "eligibility area" for your home zip code. The BCBS PPO Plus may not be available in all eligibility areas. You can view the medical options available to you on the Benefits Web Site at www.Benefits.ehr.com. Call myHRTeam at **(877) 228-4707** if you have questions.

Changing Your Covered Dependents

You may change your dependent coverage during the year if you have a qualified life event change or other cause for a change in election. Otherwise, you may only make dependent changes during the annual enrollment period.

If you have a qualified life event, you can change your existing coverage or enroll in coverage for the first time if you previously waived medical coverage. A change in election due to a qualified life event must be consistent with the life event. The following is a list of life events that are considered to be qualified:

- Marriage,
- Divorce, annulment or legal separation,
- Birth, placement for adoption, change in custody, or legal guardianship of a child,
- Death of a dependent,
- Loss of dependent eligibility (i.e., your spouse or other covered dependent no longer qualifies for coverage under a group plan),
- A change in your spouse's employment status resulting in the commencement or loss of coverage,
- Commencement or termination of a domestic partner arrangement,
- Receipt of a qualified medical child support order (QMCSO).

You may be asked to provide legal documentation, an affidavit or other written evidence of your status change.

Most changes can be made online 24 hours a day by logging in to Benefits Web Site at www.Benefits.ehr.com. Select "Enroll" and follow the instructions for "Make a Family Status Change". Online changes may be made within 31 days following a qualified life event.

Changes Requested After 31 Days

Changes requested more than 31 days after an eligible event occurs may be provided only on a post-tax basis for the remainder of the calendar year. Post-tax changes cannot be made via the Benefits Web Site; you must contact myHRTeam at **(877) 228-4707** for assistance. If you do not make your change within 60 days after your eligible event occurs, you must wait until the next annual enrollment period.

When Coverage Begins

Employee Coverage

Your coverage begins on your first day of employment or eligibility, if you elect coverage within 31 days after you are first eligible.

If you previously waived medical coverage, your coverage is effective on the date your other health insurance ends (provided you elect this coverage within 31 days after losing your other health insurance).

Otherwise, your coverage will begin on January 1 following the date your enrollment is received, as long as your enrollment is received before the deadline specified during the annual enrollment period.

Dependent Coverage

Coverage for your eligible dependents will begin on the date your coverage begins, provided you elected dependent coverage on that date.

New dependents may be covered by the plan beginning on the following dates, provided your election is made within 31 days after a qualified life event:

- 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 elect to cover will be covered on the day after his or her employment terminates, and
- A domestic partner (and eligible domestic partner children) will be covered on the date your Affidavit of Domestic Partnership is signed and notarized.

Between 32-60 days from the date of any of these status change events, enrollment will be effective on the date the change notification is received by myHRTeam.

Deductions for late enrollments will be made on a post-tax basis for the remainder of the calendar year. After 60 days, enrollment is not allowed – you must wait until the next annual enrollment period.

About Your Coverage

Preferred Provider Organization (PPO) options offer the flexibility of direct access to specialty care and the cost advantages of Network discounts.

In a PPO, you have direct access to all covered Providers. You do not select a primary care Physician to coordinate your care. This means that you are responsible for managing your own care, including selection of Network or out-of-Participating Providers. Each time you need Medical Care you choose to either use a Participating Provider and receive higher coverage or go outside the Network and receive reduced Benefits.

Your Medical Identification Card

You and your covered dependents will receive a medical identification card from BlueCross and BlueShield about 10 business days after your initial enrollment (or in late December, if your initial election is during the annual enrollment period). You must show your medical identification card (ID card) each time you request health care services from a Participating Provider. If you do not show your ID card, Participating Providers have no way of knowing that you are enrolled under the plan. As a result, they may bill you for the entire cost of the services you receive.

Pre-certification phone numbers are shown on your medical identification card. Pre-certification is required for Hospital stays and is encouraged for certain medical services, as described on pages 30-34. All Infertility services and certain Behavioral Health care services, as described on page 62, must be pre-certified in order for the plan to pay Benefits. You are responsible for notifying the plan before you receive these services.

Your medical identification card is not a guarantee of coverage. Benefits are available only if the person who receives Covered Services meets all eligibility requirements and is a covered member at the time that services are received.

Eligible Expenses

The Benefits described in this SPD are payable for Eligible Expenses of Covered Providers. The Claims Administrator determines what charges are eligible for covered expenses based on reviews of actual fees charged by similar Providers in the same geographic area for the same procedure.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. Eligible Expenses do not include experimental, Investigational or unproven services or treatments, or other treatments, items or supplies listed in the "Exclusions" section of this SPD.

Plan Networks

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network-level Benefits are payable for Covered Health Services provided by a Network Physician or other Participating Provider and for emergency health services. Network-level Benefits may be paid for designated Non-Participating Providers (such as Chiropractors and optometrists) subject to the plan's stated limitations.

BlueCross and BlueShield Participating Providers

BlueCross and BlueShield of Illinois arranges for health care Providers to participate in the plan's medical Network. Participating Providers are independent practitioners. They are not employees of Abbott Laboratories or BlueCross BlueShield. It is your responsibility to select your medical Providers. The BCBS credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided.

Providers may join or leave the Network throughout the year. Before obtaining services you should always verify the Network status of a Provider. If a Provider leaves the Network or is otherwise not available to you, you must choose another Participating Provider to get Network level Benefits.

A Provider look-up feature can be found on the BCBS web site at www.bcbsil.com/abbott. You can also call BCBS Customer Service at **(800) 671-1210** for information on Participating Providers.

United Behavioral Health Network

United Behavioral Health (UBH) administers behavioral health care (mental health and substance abuse) benefits for members of the BCBS PPO Plus. United Behavioral Health maintains its own network of behavioral health providers. You must contact UBH by calling **(866) 808-5075** to pre-certify services before receiving most behavioral health care. In addition, you must use providers who participate in UBH's behavioral health care network to receive network-level benefits. A provider look-up feature can be found on the UBH web site at **www.liveandworkwell.com**.

Infertility Centers of Excellence

This plan uses Reproductive Resource Services (RRS) Infertility Centers of Excellence to manage Infertility treatment. Reproductive Resource Services and Infertility Centers of Excellence are not affiliated with BlueCross BlueShield of Illinois.

Any consultation with a reproductive endocrinologist and any infertility treatment services must be pre-certified in order for you to receive coverage. Contact RRS at **(866) 774-4626 or (800) 603-3813** to pre-certify before making an appointment. When you call to pre-certify, a reproductive nurse specialist will discuss your needs and share with you the Network facilities and Physicians participating in the Reproductive Resource Services program for infertility services. No plan benefits are payable for infertility treatment services that are not pre-certified. You must secure services from an approved RRS provider. There are no out of network benefits available for infertility services.

CVS Caremark Pharmacy Network

Caremark, Inc. administers prescription drug Benefits for members of the BCBS PPO Plus. Caremark is not affiliated with BlueCross BlueShield of Illinois. Caremark maintains its own pharmacy Network. A Provider lookup feature can be found on the CVS Caremark web site at **www.caremark.com**. You can also call Caremark Customer Care at **(866) 293-8009** for information on Participating Providers. More information about pharmacy Benefits can be found on page 58.

Pre-certification and Utilization Review

Pre-certification is designed assist you in determining the course of treatment that will maximize your Benefits under your health care plan. The BCBS PPO Plus requires a review of the following:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Services received in a Partial Hospitalization Treatment Program
- Private Duty Nursing Services
- Transplant Services
- Chemotherapy Treatment services
- Hospice Care
- Infertility Treatment services
- Blepharoplasty (Upper Eye Lid Surgery)
- Reconstructive Surgery
- Breast Reduction or Reconstruction (other than following Surgery for cancer)
- Durable Medical Equipment purchases over \$1,000

Failure to contact the appropriate Claims Administrator as required or to comply with the determinations of the Claims Administrator will result in a reduction in Benefits. Please read the provisions below very carefully.

The following information is required when you contact the Claims Administrator:

- The name of the attending and/or admitting Physician;
- The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
- The scheduled admission and/or service date; and
- A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claims Administrator:

- Will review the information provided and seek additional information as necessary.
- Will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
- Will provide notification of the determination to the Provider

Preadmission Review

Preadmission review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and other terms, conditions, limitations, and exclusions of the plan.

Inpatient Hospital Services – Medical

You, your Physician, a family member (or designated representative) or Hospital must call **(800) 671-1210** at least one business day before a scheduled non-emergency Hospital admission for Medical Care. In the event of an emergency admission, you or someone who calls on your behalf must notify the Claims Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum Benefits. There is a \$250 penalty for failure to pre-certify an inpatient Hospital stay.

If the Hospital stay is determined to be not Medically Necessary, some days, services, or the entire Hospitalization may be denied. The Claims Administrator will verbally advise the Hospital and your Physician of this determination.

Inpatient Hospital Services – Behavioral Health

Special rules regarding pre-certification of services apply to Behavioral Health care (mental health and substance abuse treatments). Pre-certification for Behavioral Health care services must be obtained through United Behavioral Health by calling **(866) 808-5075** before arranging services. In the event of an emergency admission, you or someone who calls on your behalf must notify the Claims Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum Benefits. There is a \$250 penalty for failure to pre-certify an inpatient Hospital stay.

If the Hospital stay is determined to be not Medically Necessary, some days, services, or the entire Hospitalization may be denied. The Claims Administrator will verbally advise the Hospital and your Physician of this determination.

Coordinated Home Care Program

Whenever your Physician recommends an admission to a Coordinated Home Care Program, you must call **(800) 671-1210** to receive maximum Benefits. This call must be made at least one business day prior to the scheduling of the admission. Benefits for home health care are limited to 60 visits per calendar year (network and non-network combined).

Partial Hospitalization

Whenever your Physician recommends an admission to a Partial Hospitalization Treatment Program for Medical Care, you must call **(800) 671-1210** to receive maximum Benefits. Pre-certification for Behavioral Health care services must be obtained through United Behavioral Health by calling **(866) 808-5075**. This call must be made at least one business day prior to the scheduling of the admission.

Private Duty Nursing Services

Whenever your Physician recommends Private Duty Nursing, you must call **(800) 671-1210** to receive maximum Benefits. This call must be made at least one business day prior to receiving services. Benefits for Private Duty Nursing Services are limited to 60 visits per calendar year (network and non-network combined).

Transplant Services

Whenever your Physician recommends an admission for Transplant Services, you must call **(800) 671-1210** to receive maximum Benefits. This call must be made at least one business day prior to the scheduling of the admission.

Hospice Care

Whenever your Physician recommends Hospice Care, you must call **(800) 671-1290** to receive maximum Benefits. This call must be made at least one business day prior to the scheduling of the admission.

Infertility Services

Any consultation with a reproductive endocrinologist and any Infertility treatment services must be pre-certified in order for you to receive coverage. Contact Reproductive Resource Services (RRS) at **(866) 774-4626** to pre-certify before making an appointment. When you call to pre-certify, a reproductive nurse specialist will discuss your needs and share with you the available Providers in your area. No plan Benefits are payable for Infertility treatment services that are not pre-certified. You must secure services from an approved Infertility Centers of Excellence Provider.

Behavioral Health Care

Special rules regarding pre-certification of services apply to Behavioral Health care (mental health and substance abuse treatments). Pre-certification for Behavioral Health care services must be obtained through United Behavioral Health (UBH). Call UBH at **(866) 80-5075** to pre-certify all inpatient services and alternatives to inpatient care. Plan benefits may be denied if services are not pre-certified. You must also pre-certify all Network outpatient services.

Case Management

Case management is a collaborative process that assists you with the coordination of complex care services. A BlueCross BlueShield case manager is available to you as an advocate for cost-effective interventions. Case managers are also available to you to provide assistance when you need alternative Benefits.

Alternative Benefits will be provided only so long as the Claims Administrator determines that the alternative services are both Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total Benefits for which you would otherwise be entitled under the Health Care Plan. Provision of alternative Benefits in one instance shall not result in an obligation to provide the same or similar Benefits in any other instance. In addition, the provision of alternative Benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

Length of Stay Review

Upon completion of the preadmission or emergency review, the Claims Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called BlueCross BlueShield and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding denial of payment for the extension.

Medically Necessary Determination

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claims Administrator. Should the Claims Administrator's Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit.

The Claims Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claims Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued Hospitalization or other health care service is a Covered Service under the plan.

In the event that the Claims Administrator determines that all or any portion of an Inpatient Hospitalization or other health care service is not Medically Necessary, the Claims Administrator will not be responsible for any related Hospital or other health care service charge incurred.

This plan does not cover the cost of Hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such Hospitalization, service or supply Medically Necessary. The plan will not pay for the Hospitalization, services or supplies unless the Claims Administrator determines it to be Medically Necessary and a Covered Service of the plan. Further, a determination that a Hospitalization, service or supply is Medically Necessary does not guarantee that Benefits are payable. For example, the plan may limit or exclude Benefits for that service, even if it is determined that the service is Medically Necessary.

Failure to Pre-Certify

The final decision regarding your course of treatment is solely your responsibility and the Claims Administrator will not interfere with your relationship with any Provider. However, the Claims Administrator has established the Precertification process for the specific purpose of assisting you in determining the course of treatment which will maximize your Benefits.

Should you fail to notify the Claims Administrator as required in the Preadmission Review section of this booklet, you will then be responsible for the first \$250 of the Hospital or facility charges for an eligible stay in addition to any Deductibles, Copayments and/or Coinsurance.

No plan Benefits are payable for Infertility services that are not pre-certified. No plan Benefits are payable for the following Behavioral Health Care services if not pre-certified: Autism treatment, Psychological testing, Biofeedback, Electroshock therapy and Hypnosis.

BLUE CARE CONNECTION

Blue Care Connection helps you optimize your health care Benefits and manage medical conditions by providing personalized attention, information and online resources.

Blue Care Connection offers members a 24/7 **Nurseline** staffed with nurses who can answer questions about minor illness or self-care. Blue Care Connection also provides personalized attention, support, and health advocacy through a Nurse Care Advisor. Nurse Case Advisors can help members find the right resources, optimize health care Benefits and manage chronic conditions, such as diabetes.

Blue Care Connection's suite of resources and support services provides personalized attention, health advocacy and health and condition-specific information. The Blue Care Advisor component of Blue Care Connection includes:

Personal Health Manager

This resource of online tools and information at www.bcbsil.com/abbott lets you:

- Complete a free health risk assessment to identify your possible health risks.
- Set up a personal health record to keep track of and manage your family's health information — within one secure location. As a Web based resource, you can access your personal health information to help facilitate care — anytime, and anywhere you have Internet access.
- With your permission, health care Providers and family members can access your records. When you grant access to your doctor on the personal health manager site, an automated e-mail is sent to your Physician with instructions on how to gain access and upload medical information.
- Ask registered nurses, your Nurse Care Advisors, health related questions online with the Ask A Nurse feature.
- Request nutrition, fitness and weight loss advice online from a team of personal trainers with Ask A Trainer.
- Access online health content. You'll find health and medication information, wellness tracking tools, videos and interactive tutorials, many personalized to your specific areas of interest.
- Receive targeted wellness and condition specific information via secured messaging to help you manage your health. You can receive alerts for screening tests and set up reminders for medical appointments and medication refills.

Go to the personal health manager from Blue Access for Members, our online secure service.

Click on the personal health manager icon. If you are new to Blue Access, just follow the easy login directions at www.bcbsil.com/abbott.

Healthy Expectations

If you are expecting, this program will help guide you through your pregnancy and postpartum care with educational materials and support, including access to a 24-hour, toll free BabyLine staffed by maternity nurses, and an online health information library.

Call **(800) 671-1210** to enroll.

Case Manager

If you have certain chronic health conditions or are at high risk for medical complications, a case management nurse may contact you. Our goal is to help you find the right resources, optimize your health care Benefits and help you better manage any medical conditions you may have.

Plan Benefits

The Benefits described in this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the Definitions, Eligibility and Exclusions sections of this booklet for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

In addition, the Benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

Deductibles

You must pay a Deductible amount each calendar year before the plan begins to pay Benefits for certain expenses:

- **Medical Services**
There is no annual Deductible for Network medical services. The annual Deductible for Non-Network medical services is \$300 per person or \$750 per family (\$600 if there are only two covered family members).
- **Prescription Drugs**
An annual Deductible of \$50 per person or \$100 per family applies to prescription drugs.

Copayments

A Copayment is a fixed dollar amount that you pay a Participating Provider at the time of service for specified services. Copayments most often apply to doctor's office visits, emergency room visits and Urgent Care centers. See pages 40-57 for Copayment amounts on Covered Services.

Coinsurance

Your Coinsurance is the share of covered expenses and is generally a percentage of Eligible Charges. For most Network medical services, your Coinsurance is 20 percent of Eligible Expenses and the plan pays the remaining 80 percent. For most Non-Network services, your Coinsurance is 30 percent after the annual out-of-Network Deductible. See pages 40-57 for Coinsurance amounts on specific services and supplies. Coinsurance amounts are always based on Eligible Expenses (see page 28 for a definition of Eligible Expenses).

Out-of-Pocket Limits

Your share of covered medical expenses is limited to \$3,000 per person each calendar year. Once an individual's out-of-pocket (OOP) limit is reached, the plan pays 100 percent of additional covered expenses for that person for the rest of the calendar year, except as described below. Your share of covered medical expenses for all covered family members is limited to \$7,500 each calendar year (\$6,000 for two family members), except as described below.

Prescription Drug Expenses

Your Deductibles and Coinsurance for prescription drugs will not apply to the medical out-of-pocket limits or Deductibles. There are separate annual Out-of-Pocket Limits of \$1,500 per person and \$3,000 per family for prescription drugs.

Expenses That Do Not Apply to Your Out-of-Pocket Limits

Your share of the following expenses will not apply toward your annual out-of-pocket limits, nor will these expenses be paid in full after your Out-of-Pocket Limits are reached:

- Your Copayments for Network office visits, emergency room visits and Urgent Care centers
- Penalties for failure to provide required prenotification or precertification
- Charges that are not covered by the plan
- Charges in excess of Eligible Expenses as described on page 28

Lifetime Benefit Maximum

There is no lifetime benefit maximum for this plan. Lifetime limits may apply to certain services.

Notice Regarding Provider Discounts

Please note that BlueCross BlueShield of Illinois has contracts with many health care Providers that provide for the Claims Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Participating Professional Providers have agreed to accept the Maximum Allowance (please refer to the definition of “Maximum Allowance”) with no additional billing after you have paid your Coinsurance and Deductible amount.

Limited Benefits for Non-Participating Providers (Non-Network)

You should be aware that when you elect to receive Covered Services from a Non-Participating Professional Provider in non-emergency situations, the amount of the benefit payment to such Non-Participating Professional Provider will be a reduced benefit payment that would have been made if services had been rendered by a Participating Professional Provider and not the actual billed charge. In certain cases, you can expect to pay in excess of 50% of the Non-Participating Professional Provider’s billed charge, even after the Claims Administrator has paid the Maximum Allowance under your coverage.

Covered Benefits

	YOUR PAYMENT	
	Network	Non-Network
<p>Acupuncture</p> <p>Acupuncture services for pain therapy are covered expenses for the treatment of nausea related to Chemotherapy, pregnancy-related and post-operative nausea or chronic pain when performed by a licensed Provider in the Provider's office and when another method of pain management has failed.</p>	\$20 Copayment per visit	Same as network
<p>Ambulance</p> <p>The plan covers emergency Ambulance Transportation (ground and air) by a licensed ambulance service to the nearest Hospital where emergency health services can be performed. Non-emergency ambulance services are covered when Medically Necessary and when authorized by the Behavioral Health administrator for facility-to-facility transfers for mental health/substance abuse inpatient services.</p>	20% of Eligible Expenses	Same as Network
<p>Ambulatory Surgical Facility</p> <p>Benefits are available for Covered Services rendered at a facility other than a Hospital whose primary function is the provision of surgical procedures on an ambulatory basis and which is licensed by the appropriate state and local authorities to provide such services. Covered ancillary services include room charges, drugs, surgical dressings and supplies.</p>	20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
<p>Audiology</p> <p>The plan covers charges by a licensed or certified audiologist for Physician-prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm organic hearing problems. Benefits are not payable for services relating to hearing aids.</p>	\$20 Copayment per visit	30% of Eligible Expenses after annual Non-Network Deductible
<p>Anesthesia Services</p> <p>Benefits are available for Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or ambulatory surgical facility or by a Physician other than the operating surgeon or by a CRNA. Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or ambulatory surgical facility if a medical condition requiring Hospitalization for dental care is present, or if required for a child age 6 or under.</p>	20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

YOUR PAYMENT

Autism Therapies

Benefits are available for outpatient treatment of autism including Applied Behavioral Analysis (ABA) that is pre-certified with the plan's Behavioral Health care administrator by calling UBH at 866-808-5075. Benefits cover treatment for psychiatric and/or behavioral services for Autism Spectrum Disorders that are provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider and/or Board Certified Behavior Analyst (BCBA).

Covered treatment is that which addresses the core behavioral problems addressed in the treatment plan and is individualized to meet the patient's condition. Covered treatments do not include special schools or educational programs provided by schools or other governmental agencies, biofeedback, unproven or experimental treatments. Residential treatment or partial hospitalization programs, vocational rehabilitation and sheltered workshops are also excluded. Treatment provided by the school system, such as consults, testing, assessments and school/home visits are not covered. Travel expenses, lodging, or meals for the trainers or participants are not covered.

Physical therapy, occupational therapy and speech therapy provided for the treatment of autism are covered under the plan's medical benefit for rehabilitation therapy.

Chiropractic Care

Benefits for spinal treatment include chiropractic and osteopathic manipulative therapy. Benefits include diagnosis and related services. Benefits are limited to a maximum of \$750 per covered person per calendar year.

This plan excludes therapies, services or supplies (including, but not limited to spinal manipulations) by a Chiropractor or other doctor for the treatment of a condition when it ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Dental Services

The plan does not cover charges for general dental services, except those required in conjunction with organ transplant preparation, initiation of immunosuppressives, or treatment of Congenital Anomaly. Benefits are also available for oral surgical services specified on page 48.

Network	Non-Network
20% of Eligible Expenses	30% of eligible medical expenses after annual Non-Network Deductible

<p>\$20 Copayment per visit; 20% of Eligible Expenses for chiropractic x-rays</p> <p>There is a combined benefit limit for all chiropractic services, including x-rays, of \$750 per person per calendar year (combined Network and Non-Network)</p> <p>A separate maximum of \$750 per person per year applies to Naprapaths</p>	<p>\$20 Copayment per visit; 20% of Eligible Expenses for chiropractic x-rays</p> <p>There is a combined benefit limit for all chiropractic services, including x-rays, of \$750 per person per calendar year (combined Network and Non-Network)</p> <p>A separate maximum of \$750 per person per year applies to Naprapaths</p>
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20% of Eligible Expenses	Same as Network
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YOUR PAYMENT

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
	Your share of Eligible Expenses for infant cranial headbands (DOC Bands®) for treatment of plagiocephaly is 20% whether Network or Non-Network

Durable Medical Equipment

Durable Medical Equipment (DME) must meet each of the following criteria:

- Ordered or provided by a Physician for outpatient use
- Used for medical purposes
- Not consumable or disposable (except for ostomy supplies)
- Not of use to a person in the absence of a disease or disability

If more than one piece of DME can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of DME include:

- Equipment to assist mobility, such as a standard wheelchair
- A standard Hospital bed
- Oxygen concentrator units and the rental of equipment to administer oxygen
- Delivery pumps for tube feedings
- Braces that stabilize an injured body part (including necessary adjustments to shoes to accommodate braces) and braces that straighten or change the shape of a body part
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions
- Medical compression hosiery; limit 6 pairs per calendar year
- Wigs, when appropriate following Chemotherapy or serious medical condition that results in hair loss (one per calendar year up to a lifetime maximum of \$1,000)

Benefits are available for a single unit of DME (example, one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of DME as often as medically appropriate for the condition.

Notify BCBS at **(800) 671-1210** before obtaining any item of Durable Medical Equipment (DME) that costs \$1,000 or more (either purchase price or cumulative rental of a single item). You must purchase or rent the equipment from a Participating Provider to receive Network-level Benefits.

YOUR PAYMENT

Emergency Room Services

Benefits are available for services in a Hospital emergency room that are required to stabilize or initiate emergency treatment.

Emergency treatment is covered for a sudden, serious injury or illness of unpredictable course that produces significant pain, loss of consciousness or excessive bleeding, or that poses an immediate threat to life or limb if untreated.

If you are confined in a Non-Network Hospital after you receive emergency health services, you must call **(800) 671-1210** within 48 hours after the admission.

If you choose to stay in a Non-Network Hospital beyond the date a transfer is medically appropriate, your expenses for the continued stay will be covered at the Non-Network level.

Urgent Care provided in a Non-Network Hospital emergency room will be reimbursed at the Non-Network benefit level. Urgent Care includes bruises, scrapes, wounds or cuts not requiring stitches, progressively worsening infections, earaches, fevers, headaches or flu. This type of care is not considered emergency care.

Hippotherapy

Benefits are available for services received for horseback riding therapy to benefit the treatment of Cerebral Palsy, Multiple Sclerosis, and other approved motor function disorders.

Home Health Care

Services received from a Home Health Agency that are ordered by a Physician and provided by or supervised by a registered nurse in the patient's home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled services are required.

Skilled home health care services include home nursing, teaching and rehabilitation services and Medically Necessary private duty nursing ordered by a Physician, which must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient. Such care requires clinical training to be delivered safely and effectively and is not delivered for the purpose of assisting with activities of daily living.

You must call **(800) 671-1210** before arranging for home care services. A service is not determined to be "skilled" simply because there is not an available caregiver.

Network

\$125 Copayment per visit; Copayment is waived if patient is admitted

20% of Eligible Expenses if provided for non-emergency

20% of Eligible Expenses

20% of Eligible Expenses

Effective January 1, 2010

Benefits for home health care and private duty nursing services are limited to 60 visits per calendar year (network and non-network combined)

Non-Network

Same as Network

30% of Eligible Expenses after annual Non-Network Deductible if provided for non-emergency

Same as Network

30% of Eligible Expenses after annual Non-Network Deductible

Effective January 1, 2010

Benefits for home health care and private duty nursing services are limited to 60 visits per calendar year (network and non-network combined)

YOUR PAYMENT

Hospice Care

Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when a Physician recommends hospice care and care is received from a licensed hospice agency.

You must call **(800) 671-1210** before arranging for services to ensure prompt and accurate payment of your Benefits.

Hospital – Inpatient Stay

Benefits are available for the following services and supplies received during an inpatient Hospital stay:

- Room and board in a Semi-private Room (a room with two or more beds).
- Intensive care or specialized care unit charges. Hospital ancillary services (other Hospital services and supplies required for patient care).

You, your Physician, a family member (or designated representative) or Hospital must call **(800) 671-1210** at least one business day before a scheduled non-emergency Hospital admission for Medical Care. In the event of an emergency admission, you or someone who calls on your behalf must notify the Claims Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum Benefits. There is a \$250 penalty for failure to pre-certify an inpatient Hospital stay.

Special rules regarding pre-certification of services apply to Behavioral Health care. Pre-certification for Behavioral Health care services must be obtained through United Behavioral Health by calling **(866) 808-5075** before arranging services.

If the Hospital stay is determined to be not Medically Necessary, some days, services, or the entire Hospitalization may be denied. The Claims Administrator will verbally advise the Hospital and your Physician of this determination.

Preadmission Testing - Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery, which you are scheduled to have as an Inpatient, provided that Benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Coordinated Home Care - Benefits will be provided for services under a Coordinated Home Care Program.

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

YOUR PAYMENT

Network

Non-Network

Infertility Services

The Plan pays Benefits for infertility services provided under the Reproductive Resource Services (RRS) program. You have access to a certain network of facilities and Physicians participating in the RRS program. For infertility services and supplies to be considered Covered Health Services, you must contact RRS and speak with a nurse consultant prior to receiving services. Contact RRS by calling toll-free at **(866) 774-4626**.

Covered services may include, but are not limited to:

- In vitro fertilization, gamete Intrafallopian transfer (GIFT) and zygote Intrafallopian transfer (ZIFT), and any related prescription medication treatment
- Embryo transport, donor eggs and semen and related costs, including collection and preparation
- Artificial insemination

For approved services (subject to the limitations described at right), the Plan pays Benefits as described under:

- Physician's Office Services
- Professional Fees for Surgical and Medical Services
- Hospital – Inpatient stay
- Outpatient Surgery, Diagnostic and Therapeutic Services

Benefits are payable if **all** of the following conditions are met:

- The covered member is unable to conceive or maintain pregnancy after one year (six months for a female age 35 or older) of unprotected sexual intercourse with a partner of the opposite sex*
- Pre-certification of services has been obtained through RRS
- The procedure is performed by an approved RRS provider

This plan **does not** cover:

- Infertility treatment occurring within 12 months (six months for a female age 35 or older) after the use of any form of birth control or reversal of an elective sterilization procedure, such as vasectomy or tubal ligation
- Surrogates and gestational carriers
- Donor search costs and donor reimbursement, fees or direct payment to a donor for sperm or egg donation
- Fees for maintenance or storage of frozen embryos
- In vitro genetic testing
- Services that are experimental or unproven, including IVIG therapy for the prevention of spontaneous abortion

* A woman without a male partner may be considered infertile if she is unable to conceive or maintain pregnancy after 12 cycles of donor insemination (six cycles if age 35 or older)

20% of eligible services if pre-certified and obtained from a designated RRS provider

There is a lifetime limit of \$35,000 for all infertility and related medical treatments and services (services received prior to January 1, 2007, and diagnosis services do not apply to the lifetime maximum)

Expenses incurred for prescription drug therapy in connection with infertility services are covered under the prescription drug benefit described on page 50. There is a lifetime limit of \$15,000 for infertility prescription drugs

You will pay the entire cost of services received from non-network providers.

There are no non-network benefits available for infertility services.

YOUR PAYMENT

Injections and Infusion Therapy

Benefits are available for injections and infusion therapies received in a Physician's office or other covered facility

Maternity Services

Benefits for pregnancy will be paid at the same level as for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The plan will pay Network-level Benefits for the services of a Certified Nurse Midwife if certified by the American College of Midwives and operating within the scope of this certification and applicable licensing. A birthing center may be covered if it is a licensed facility and meets the plan's requirements for accreditation.

There is a special prenatal program to help during pregnancy. It is completely voluntary and there is no extra cost for participating in the program. Call **(800) 671-1210** during the first trimester, but no later than one month prior to the anticipated childbirth to enroll. See page 36 for more information.

Hospital Stays for Childbirth: The plan will pay for an inpatient Hospital stay in connection with childbirth for mother or newborn child of at least 48 hours following a vaginal delivery and 96 hours following a cesarean section delivery. The mother and attending Provider may, however, decide upon earlier discharge.

You must call **(800) 671-1210** as soon as reasonably possible if an inpatient Hospital stay for the mother and/or the newborn will be more than the time frames described above. If you don't notify the Claims Administrator that the Inpatient Stay will be extended, your Benefits for the extended stay will be subject to a \$250 penalty.

Medical Foods

Charges for medical foods and enteral feedings are Covered Health Services when prescribed by a Physician due to diagnosed illness or injury if the patient is unable to meet nutritional requirements with a normal diet.

Network

20% of Eligible Expenses;
0% for allergy immunotherapy and childhood immunizations

A \$20 Copayment applies to the first Physician office visit for prenatal care. Thereafter, you pay 20% of Eligible Expenses for professional fees and outpatient diagnostic tests.

You pay 20% of Eligible Expenses for your Hospital stay.

Non-Network

30% of Eligible Expenses after annual Non-Network Deductible

30% of Eligible Expenses after annual Non-Network Deductible

Separate Deductibles apply to mother and baby

20% of Eligible Expenses

Same as Network

YOUR PAYMENT

Mental Health - Inpatient

Mental health benefits are provided through United Behavioral Health. All inpatient services and alternatives to inpatient care must be pre-certified. Call UBH at **(866) 808-5075** before arranging services. A call must be received within 48 hours after an emergency admission. A \$250 penalty will apply if pre-certification is not obtained for non-network inpatient (or alternative services)

Network	Non-Network
20% of eligible expenses if provider is in UBH network	30% of eligible expenses after annual non-network deductible
Services must meet criteria for medical necessity established by UBH	Services must meet criteria for medical necessity established by UBH

Mental Health - Outpatient

Mental health benefits are provided through United Behavioral Health. All network behavioral health care must have prior and ongoing approval. Call UBH at (866) 808-5075 before making an appointment for network outpatient behavioral health care. Benefits for network services are paid at the non-network level if pre-certification is not obtained.

\$20 copayment per visit if provider is in UBH network	30% of eligible expenses after annual non-network deductible
Services must meet criteria for medical necessity established by UBH	Services must meet criteria for medical necessity established by UBH

Non-network outpatient pre-certification is required for autism treatment, biofeedback, electroshock therapy, hypnosis and psychological testing received for network or non-network providers. A \$250 penalty will apply if pre-certification is not obtained.

YOUR PAYMENT

Nutritional Counseling

Benefits are available for services furnished by a provider (e.g., a registered dietician, licensed nutritionist or other qualified licensed health professional such as nurses who are trained in nutrition) recognized under the plan

Benefits are limited to three individual sessions per person per calendar year

Network	Non-Network
\$20 copayment per visit in office setting	30% of Eligible Expenses after annual Non-Network Deductible
20% of Eligible Expenses at other outpatient facility	

Obesity Surgery

Professional fees for obesity Surgery are covered if Body Mass Index (BMI) is 40 or greater (35 or greater with co-morbidities). Covered surgical expenses include surgeons' fees, consultation fees, anesthesia expenses and surgical dressings for outpatient use. Psychological testing prior to bariatric Surgery is covered as Behavioral Health care.

You must call **(800) 671-1210** at least five business days before an elective Hospital admission and within one business day of a non-elective admission.

20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
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Oral Surgery

Benefits are available for services provided by a licensed Dentist or oral surgeon for treatment of fractures or dislocations of the jaw, removal of cysts or tumors in the mouth, surgical incisions to remove foreign bodies from mucosa, skin or subcutaneous alveolar tissue. Covered surgical expenses include surgeons' fees, consultation fees, anesthesia expenses and surgical dressings for outpatient use.

You must call **(800) 671-1210** at least five business days before an elective Hospital admission and within one business day of a non-elective admission.

20% of Eligible Expenses	Same as Network
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YOUR PAYMENT

Outpatient Services

Covered diagnostic and therapeutic services received on an outpatient basis at a Hospital or alternate facility include:

- Surgery and related services.
- Laboratory and radiology/X-ray.
- Other diagnostic tests and therapeutic treatments including:
 - Cancer Chemotherapy
 - Intravenous infusion therapy
 - Radon, radium, radioactive isotope, cobalt and radiation
 - Kidney dialysis

Covered Services include the facility charge and charges for required services supplies and equipment.

Benefits for professional fees related to outpatient Surgery, diagnostic and therapeutic services are described under Professional Fees on page 52.

Benefits for professional fees related to outpatient Surgery, diagnostic and therapeutic services performed in a Physician's office are described under Physician's Office Services below.

Physician's Office Services

Covered Services received in a Physician's office include routine examinations, treatment of sickness or injury, voluntary family planning, and minor surgical procedures.

Benefits for preventive Medical Care are described on 51.

Podiatrist Care

Covered Services include treatment for illnesses and injuries of the foot, including appropriate surgeries, by a licensed Podiatrist. Routine foot care provided in a Podiatrist's office may be covered when necessary for severe systemic disease.

Benefits for Podiatrist services related to Surgery in a Hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility are described under Professional Fees on page 52.

You must call **(800) 671-1210** at least one business day before a Hospital admission.

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

\$20 copayment per visit	30% of Eligible Expenses after annual Non-Network Deductible
You pay 20% of Eligible Expenses for in-office lab work and x-rays	

\$20 copayment per visit for in-office care	Same as Network
There is a benefit limit of \$750 per year for non-surgical podiatry care (combined Network/non-Network)	There is a benefit limit of \$750 per year for non-surgical podiatry care (combined Network/Non-Network)
20% of Eligible Expenses for surgical care in a Hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility	

YOUR PAYMENT

Prescription Drugs

Prescription drug benefits are provided through CVS Caremark. Covered products and services are described in the brochure provided with your member ID card and may be reviewed on the CVS Caremark member web site at www.caremark.com.

Benefits are available for retail pharmacy purchases up to 30 days supply. Can purchase up to 90 days supply at CVS pharmacy. Mail service benefits are available for purchases up to 90 days supply. Specialty Pharmacy available. See pages 43-46 for more information on prescription drug benefits.

Diabetes Pilot Program (Current Participants Only)

Employees, covered spouses and covered adult dependents (age 18 or older) who are actively participating in the Abbott Diabetes Pilot Program and who satisfied all program requirements prior to January 31, 2009 are eligible for no-cost prescriptions for diabetes medications and supplies (insulin, oral diabetes medication, meters and strips) and designated medications for heart disease, high cholesterol, high blood pressure and depression. Call OptumHealth at **(888) 206-0355** for details.

This is a three-year pilot program. Plan members who did not complete the program eligibility requirements prior to January 31, 2009 are not eligible for this no-cost prescription drug benefit. Participants must continue to meet pilot requirements for continued enrollment.

Network

0% for Abbott prescription drugs and diabetic supplies; deductible does not apply

For all other prescription drugs and diabetic supplies, an annual prescription drug deductible of \$50 per person; \$100 per family applies

Retail: 25% of eligible expense with minimum copayment of \$5 per generic prescription and \$15 per brand prescription (or actual cost, if less). Limited to 30 day supply.

CVS Pharmacy: 25% of eligible expense with minimum copayment of \$5 per generic prescription and \$15 per brand prescription (or actual cost, if less). \$10 copayment for each generic prescription on the Value Generic Drug List. Up to 90 day supply.

Mail Services and Specialty Pharmacy: 20% of eligible expense with minimum copayment of \$15 per generic/\$35 per brand prescription (or actual cost, if less). \$10 copayment for each generic prescription on the Value Generic Drug List. Up to 90 day supply.

Non-Network

Same as Network

YOUR PAYMENT

Network	Non-Network
Covered in full	30% of Eligible Expenses after annual Non-Network Deductible

Preventive Services

In general, this plan pays preventive care Benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and American Academy of Pediatrics.

Annual adult physical and related testing and screenings, including cholesterol, glucose, hearing, blood pressure, and sexually transmitted disease screenings are covered under the plan's preventive care benefit. Screenings for vision and skin cancer are covered when performed during an annual physical.

Preventive care Benefits include:

- Adult immunizations based on industry standards
- Annual prostate cancer check for men age 40 and older
- Annual well-woman exam and related testing
- Annual mammogram for women age 35 and older
- Bone density testing (age 65+)
- Colorectal cancer screening, including but not limited to blood testing and colonoscopy for members age 40 and older

Well-baby and well-child visits up to age 18, including testing and immunizations, in accordance with pediatric guidelines are covered under this preventive care benefit.

Covered childhood immunizations generally include:

- Diphtheria-tetanus-pertussis (DTP)
- Oral poliovirus (OPV)
- Measles-mumps-rubella (MMR)
- Conjugate haemophilus influenzae type B
- Hepatitis B
- Varicella (Chicken Pox)
- Human papilloma virus (HPV) vaccine limited to one complete dosage per lifetime

Note: Preventive Benefits must be billed by your health care Provider using appropriate "v" codes and preventive codes

Covered Services for preventive care that exceed the recommended limits or intervals or are received from Non-Participating Providers will not be paid at 100%.

Services excluded from this 100% preventive care benefit, but covered under regular plan provisions if ordered by your doctor include but are not limited to: EKGs, chest x-rays, stress tests and bone density screenings under age 65.

YOUR PAYMENT

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

Professional Fees

Professional fees include surgeon' Medical Care received in a Hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility.

Covered surgical expenses include surgeons' fees, consultation fees, anesthesia expenses and surgical dressings for outpatient use. Surgical assistant fees are Covered when performed by a Physician, Dentist or Podiatrist who assist the operating surgeon in performing Covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, surgical assistant Benefits are available for a Physician Assistant or registered nurse practitioner assisting a Covered Surgery under the direct supervision of a Physician, Dentist or Podiatrist.

Benefits for professional fees related to outpatient Surgery, diagnostic and therapeutic services performed in a Physician's office are described under Physician's Office Services.

You must call **(800) 671-1210** at least one business day before any Hospital admission. For emergency admissions, call within two business days.

Prosthetic Devices

Benefits are available for prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet the patient's functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by or under the direction of a Physician. Benefits are available for a single purchase, including repairs of a type of prosthetic device and for the replacement of each type of prosthetic device due to normal growth process.

Call **(800) 671-1210** before obtaining any prosthetic device that costs \$1,000 or more. You must obtain the prosthetic from a Participating Provider to receive Network-level Benefits.

20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
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YOUR PAYMENT

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

Reconstructive and Plastic Surgery

Benefits are available for Reconstructive Procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better.

The plan does not provide Benefits for cosmetic procedures. Services are considered cosmetic when they improve appearance without making an organ or body part work better.

Breast Reconstruction Following Mastectomy: Breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry are covered reconstruction services and are not classified as cosmetic.

You must call **(800) 671-1210** before receiving services. When you pre-certify services, you can verify that the service is a Reconstructive Procedure rather than a cosmetic procedure.

Rehabilitation Services

Short-term outpatient Benefits are available for:

- Physical and occupational therapy.
- Speech Therapy, when speech impediment or dysfunction results from injury, stroke or Congenital Anomaly or is required following the placement of a cochlear implant.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy. Benefits are limited to 72 visits Network/Non-Network for Phases I and II combined.

A licensed therapy Provider must perform adult rehabilitation services under the direction of a Physician. Benefits are available only for services expected to result in significant improvement in the patient's condition within two months of the start of treatment.

Rehabilitation services/therapies for children are not limited for the treatment of autism, cerebral palsy and coordination disorder, developmental delay, hearing loss, tongue disorders, congenital abnormalities, and chromosomal abnormalities.

20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
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YOUR PAYMENT

Skilled Nursing Facility

In general, the intent of skilled nursing is to provide Benefits for covered members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. Benefits are available when the patient is expected to improve to a predictable level of recovery and skilled nursing and/or rehabilitation services are needed on a daily basis.

Benefits are not available when these services are required intermittently (such as Physical Therapy three times a week) or for custodial, domiciliary or maintenance care, even if ordered by a Physician.

Call **(800) 671-1210** at least one business day prior to admission..

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible

Sterilization Procedures

The plan covers expenses associated with elective tubal ligation or vasectomy, and reversals.

Covered surgical expenses include surgeons' fees, consultation fees, anesthesia expenses and surgical dressings for outpatient use.

Benefits for professional fees related to outpatient Surgery performed in a Physician's office are described under Physician's Office Services on page 49.

20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
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YOUR PAYMENT

Substance Abuse Treatment - Inpatient

Benefits for substance abuse treatment are provided through United Behavioral Health (UBH). All inpatient services and alternatives to inpatient care must be pre-certified. Call UBH at **(866) 808-5075** before arranging services. A call must be received within 48 hours after an emergency admission. A \$250 penalty will apply if pre-certification is not obtained for non-network inpatient (or alternative services)

Network	Non-Network
20% of eligible expenses if provider is in UBH network	30% of eligible expenses after annual non-network deductible
Services must meet criteria for medical necessity established by UBH	Services must meet criteria for medical necessity established by UBH

Substance Abuse Treatment - Outpatient

Benefits for substance abuse treatment are provided through United Behavioral Health (UBH). All network behavioral health care must have prior and ongoing approval. Call UBH at **(866) 808-5075** before making an appointment for network outpatient behavioral health care. Benefits for network services are paid at the non-network level if pre-certification is not obtained.

\$25 copayment per visit if provider is in UBH network	30% of eligible expenses after annual non-network deductible
Services must meet criteria for medical necessity established by UBH	Services must meet criteria for medical necessity established by UBH

TMJ Treatments

The plan provides coverage for surgical treatment of conditions affecting the temporomandibular joint (including orthognathic Surgery) when provided by or under the direction of a Physician. Coverage includes treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Covered Services do not include dental services or oral appliances. Coverage for TMJ exams, x-rays and appliances may be available under your company-sponsored dental program, if elected.

\$20 copayment for in-office Diagnostic Services	30% of Eligible Expenses after annual Non-Network Deductible
20% of Eligible Expenses for treatment	

YOUR PAYMENT

Transplant Services

Your Benefits for certain human organ transplants are the same as your Benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants.

Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their Benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the Benefits described in this booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your Benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the Benefits described in this booklet will be provided for you. However, no Benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery
- The evaluation, preparation and delivery of the donor organ
- The removal of the organ from the donor
- The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the U.S. or Canada.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact BCBS Customer Service at **(800) 671-1210** before your transplant Surgery has been scheduled. You will be furnished with the names of Hospitals which have Human Organ Transplant Programs approved by the plan. Benefits will NOT be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at a Hospital that does not have a Human Organ Transplant Program that has been approved by the plan.

(Continued on next page)

Network	Non-Network
20% of Eligible Expenses	30% of Eligible Expenses after annual Non-Network Deductible
Benefits for transportation, lodging and meals are limited to a lifetime maximum of \$10,000.	Please note that Benefits will NOT be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at a Hospital that does not have a Human Organ Transplant Program that has been approved by the plan.

YOUR PAYMENT

Transplant Services (continued from previous page)

If you are the recipient of the transplant, Benefits will be provided for transportation, lodging and meals for you and a companion. If the recipient of the transplant is a dependent child, Benefits for transportation, lodging and meals will be provided for the transplant recipient and two companions. For Benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed. You and your companion are each entitled to Benefits for lodging and meals up to a combined maximum of \$200 per day.

In addition to the other exclusions of this benefit booklet, Benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery
- Travel time and related expenses required by a Provider
- Drugs which do not have FDA approval
- Storage fees
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision

Urgent Care Centers

The plan provides coverage for services received at a freestanding Urgent Care center. An Urgent Care Center is a facility other than a Hospital that provides care and treatment required to prevent serious deterioration of an individual's health as a result of unforeseen sickness, injury or the onset of acute or severe symptoms. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Office Services on page 49.

Vision Care

You may self-refer to any licensed optometrist or ophthalmologist once per calendar year for a routine vision exam.

Expenses incurred for refractive Surgery, lenses, frames or fittings are not covered under this plan, except as noted at right. Coverage for these expenses may be available under your company-sponsored vision service plan, if elected.

Network

20% of Eligible Expenses

Benefits for transportation, lodging and meals are limited to a lifetime maximum of \$10,000.

\$50 Copayment per visit

\$25 Copayment for one routine exam per calendar year; eyewear not covered; hardware discounts are available; call Davis Vision at (877) 393-8844 for details; combined network/non-network benefit

Non-Network

30% of Eligible Expenses after annual Non-Network Deductible

Please note that Benefits will NOT be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at a Hospital that does not have a Human Organ Transplant Program that has been approved by the plan.

\$50 Copayment per visit

Same as Network

Prescription Drug Benefits

CVS Caremark, one of the nation's leading pharmacy benefit managers, administers prescription drug benefits in the BCBS PPO Plus. CVS Caremark is not affiliated with BCBS.

Benefits are provided for insulin and diabetic supplies (except for continuous glucose monitors and insulin pumps and supplies, which are provided under medical benefits) and contraceptives or other drugs for which a physician's written prescription is required by federal or state law.

CVS Caremark Pharmacy Network

CVS Caremark's retail network includes thousands of pharmacies throughout the U.S. Participating pharmacies provide plan members with preferred pricing. When you use network providers, you pay only your deductible and/or coinsurance amount. There is no need to file a claim form.

You can purchase a prescription at a non-network pharmacy without a reduction in your benefit level. If you purchase a prescription at a non-network pharmacy, you must pay the total cost of your prescription at the time of purchase and must file a claim for reimbursement from the claims administrator as described on page 57.

To view a list of network providers go to CVS Caremark's member web site at www.caremark.com. You may also request information about pharmacy providers in your geographic area from Caremark Customer Care by calling **(866) 293-8009**.

CVS Caremark ID Card

A separate prescription drug card will be provided to you from CVS Caremark. You should use this prescription drug card each time you make a retail purchase from a participating pharmacy. Participating pharmacies provide Abbott members with preferred pricing. When you use network providers, you pay only your deductible and/or coinsurance amount. There is no need to file a claim form.

Coverage for Abbott Prescription Drugs

This plan covers Abbott drugs and diabetic supplies at 100 percent with no deductible. This special Abbott prescription drug benefit includes but is not limited to:

Abbott Prescription Drugs

Advicor®	Kaletra®	Simcor®
Biaxin®*	Lupron®	Synthroid®*
Biaxin XL®*	Lupron Depot®	Tarka®
Cardizem® LA	Mavik®*	Teveten®
Depakote®*	Meridia®	Teveten® HCT
Depakote® ER*	Niaspan®	TriCor®
Gengraf®	Norvir®	Trilipix®
Humira®	Omnicef®*	Zemplar®

Abbott Diabetes Supplies

FreeStyle Lite® Blood Glucose Monitoring System
FreeStyle Navigator® Continuous Glucose Monitoring System (Navigator®)**
FreeStyle Freedom Lite® Blood Glucose Monitoring System
FreeStyle Lite® Test Strips
FreeStyle® Test Strips
Precision Xtra® Blood Glucose and Ketone Monitoring System
Precision Xtra Test Strips (blood glucose and ketone test strips)
Precision Sure-Dose® Syringes
FreeStyle® Lancets

* Has a generic substitute. Generic substitutes are not covered at 100%

** Type 1 diabetes only. Covered as durable medical equipment. To initiate the coverage process, patients must complete an enrollment packet, which is available online at www.freestylenavigator.com or by contacting the Abbott Diabetes Care (ADC) Resource Center at (877) 423-2463.

When you use a participating CVS Caremark pharmacy, you should not have to make any payment for an Abbott product when making a retail purchase. If you are asked to pay upfront, it is most likely because you are getting a generic substitute for an Abbott drug and are being charged the generic Coinsurance amount. If you are charged for a prescription you believe to be an Abbott drug, check with the pharmacist before you leave the pharmacy counter. Once you leave the counter, you won't be able to exchange the generic prescription for the Abbott drug.

Be aware that for some older Abbott drugs, the pharmacy may not stock the Abbott brand. Contact your pharmacy ahead of time to ensure they will have the Abbott brand available when you have a prescription. If you accept the generic, you will be charged the generic Coinsurance amount.

Pharmacy Benefits

Annual Deductible

You must pay a prescription drug deductible of \$50 per person or \$100 per family each calendar year before the plan begins to pay benefits for retail and/or mail service and specialty prescription drugs. This deductible is separate from and cannot be used to satisfy annual deductibles for other covered health care expenses.

Prescription Drug Out-of-Pocket Limit

There are annual out-of-pocket limits of \$1,500 per person and \$3,000 per family for prescription drugs. Once your out-of-pocket limit is met, the plan will pay 100 percent of charges for eligible prescription drugs for the remainder of the calendar year. Copayments, deductibles and coinsurance for other covered health services do not apply toward your prescription drug out-of-pocket limit.

Retail Purchases

Retail purchases are limited to a 30-day supply. Once your annual deductible has been satisfied, you pay 25 percent of eligible expenses for covered prescription drugs purchased at a retail pharmacy. You pay a minimum amount of \$5 per generic prescription and \$15 per brand prescription (or the actual cost of the product, whichever is less).

CVS Caremark Mail Service

Mail Service delivery is available for maintenance or long-term prescriptions. You may order up to a 90-day supply of your medications. When you use the mail service service you pay only 20 percent of eligible charges after your annual prescription drug deductible (you will pay a minimum of \$15 for each generic prescription and \$35 for each brand-name prescription - or the actual cost of the product, if less) for covered medications.

Effective January 1, 2010 you and your family will be expected to use mail service for all of your maintenance drugs, unless you opted-out when you enrolled online (when you first became eligible for coverage or during the 2010 benefit enrollment period). You will be able to get a 30-day maintenance drug prescription filled twice at a retail pharmacy before you are required to transfer that prescription to mail service (or pay the full cost out of your own pocket).

You can order refills by Internet, phone or mail. The information included with your last order will show the date you can request a refill and the number of refills you have left.

- **Online at www.caremark.com.** This is the most convenient way to order refills and inquire about the status of your order day or night. You will need to register and log in to access service.
- **By phone.** Call Customer Care at (866) 293-8009 for fully automated refill service. Have your ID number ready.
- **By mail.** Attach the refill label provided with your last order to a mail service form. Enclose payment with your order, if your plan requires a payment. Forms for mail service are also available at www.caremark.com. Send your completed mail service form along with your original 90-day prescription and appropriate payment to: Caremark, P.O. Box 94467, Palatine, IL 60094-4467

You can expect to receive your prescription 7-10 days from the date Caremark receives your order. Once you have received a prescription through Caremark, you may obtain refills for that prescription online or by calling Caremark. Order your prescription three weeks before your current supply of medication runs out. Suggested refill dates will be included on your prescription label.

Transferring Prescriptions to Mail Service

Transferring your maintenance or long-term prescriptions to mail service is simple and convenient. Call Caremark at **(800) 875-0867**. Caremark will work with your doctor and place the order for you. No paper forms or extra trips to the doctor are needed to get a written prescription!

90-Day Purchases at CVS or Longs Pharmacies

The best way to reduce your out-of-pocket prescription drug costs is to use mail service. Another way to save is to get a 90-day supply of maintenance drugs at any CVS or Longs pharmacy. You'll still pay the same share of the cost as if you purchased a 30-supply at retail (i.e., 25%) but you will benefit from volume discounts and the convenience of a 90-day supply. Visit www.caremark.com/abbott or call **(866) 293-8009** for details.

\$10 Generic Drugs

Effective January 1, 2010, you can get a 90-day supply of over 350 select generic medications for just \$10 if you order through CVS Caremark Mail Service or at a CVS or Longs pharmacy. Visit www.caremark.com/abbott or call **(866) 293-8009** for details.

Specialty Pharmacy and Services

CVS Caremark Specialty Pharmacy provides access to specialized medications not generally available through retail pharmacies. When you use this program you pay only 20 percent of eligible charges after your annual prescription drug deductible.

Specialty medications are used to manage long-term (chronic), rare and complex conditions or genetic disorders. These include rheumatoid arthritis, cancer, multiple sclerosis, growth hormone disorders, immune deficiencies, and more. The medications are often injectable or intravenously (IV) infused, but may also be in oral or inhaled form. These medications typically have special storage and handling needs and cost more than other drugs because of the way the drugs are made. CVS Caremark provides special support for these patients, including 24-hour access to pharmacy services and emergency pharmacist consultation, as well as ongoing support and counseling.

Learn more about the CVS Caremark Specialty Pharmacy at www.caremark.com/specialty or call **(800) 237-2767** to speak with a Caremark Specialty Pharmacy Services representative.

Customer Care Resources

CVS Caremark members may register at www.caremark.com for access to Caremark's online self-service tools and health information, including a directory of network providers. Or, if you prefer, contact Caremark Customer Care at **(866) 293-8009** (toll-free).

Behavioral Health Care Services

You and your covered dependents have access to a wide range of quality mental health and substance abuse benefits. In 2009, behavioral health care services are administered by Magellan Behavioral Health. Effective January 1, 2010, behavioral health care services are administered by United Behavioral Health (UBH).

This program is designed to provide personalized care for behavioral health needs. Members can get help for alcohol and drug abuse, along with a variety of mental health concerns, including depression and anxiety. Services include:

- Outpatient assessment and treatment
- Individual and group treatment
- Alternatives to inpatient care (partial hospitalization, intensive outpatient or residential treatment)
- Crisis intervention
- Inpatient assessment and treatment
- Treatment follow-up and aftercare

Pre-certification Requirements

Call UHB at **(866) 808-5075** to pre-certify services. You must call to pre-certify:

- **All inpatient services and alternatives to inpatient care.** Call at least five business days prior to a scheduled admission. A call must be received within 48 hours after an emergency admission. A \$250 penalty will apply if pre-certification is not obtained for non-network inpatient (or alternative) services. Plan benefits may be denied if services are not precertified.
- **All network outpatient services.** Benefits for these services will be paid at the non-network benefit level if not pre-certified.
- **The following outpatient services.** Abbott requires network and non network precertification of Psychological Testing, Electroshock Therapy, Biofeedback, Hypnosis and Autism. Biofeedback is not a covered treatment for ADHD, ADD and Autism.

Behavioral Health Network

Effective January 1, 2010, United Behavioral Health (UBH) administers behavioral health care (mental health and substance abuse) benefits for members of the BCBS PPO Plus. United Behavioral Health maintains its own network of behavioral health providers.

To qualify for inclusion in the behavioral health care network, providers must meet a variety of rigorous quality standards. These standards include professional degrees and licenses as well as a minimum length of time in practice.

Network providers include psychiatrists, psychologists, social workers and clinical counselors. The network also includes hospitals, community mental health centers and other treatment facilities. Network providers are independent practitioners. They are not employees of the behavioral health care administrator, Abbott Laboratories or BlueCross BlueShield.

When you call to pre-certify care, a representative can assist you in finding an experienced network provider in your geographic area. However, it is ultimately your responsibility to select your provider.

Plan Benefits

To receive network-level benefits for behavioral health care services, you must use the plan's designated behavioral health network providers and must pre-certify services before receiving care.

Network Services

Outpatient services

You pay a \$20 copayment for each outpatient visit to a UBH network provider. Services must meet criteria for medical necessity as determined by UBH.

Inpatient services

You pay 20 percent of approved charges for inpatient behavioral health care provided at a UBH network facility. Services must meet criteria for medical necessity as determined by UBH. There is no separate out-of-pocket limit for behavioral health care services.

Non-Network Services

Outpatient services

The plan pays 70 percent of reasonable charges after the annual non-network deductible for visits to a non-network provider. Services must meet criteria for medical necessity as determined by UBH.

Inpatient services

The plan pays 70 percent of reasonable charges after the non-network deductible for approved stays at non-network facilities. Services must meet criteria for medical necessity as determined by UBH.

Special Provisions

Psychological testing

Psychological testing is a covered benefit only when determined to be medically necessary and conducted for the purpose of a diagnosis of a mental health/substance abuse condition, including psychological testing for bariatric surgery and prior to insertion of pain management devices. Pre-certification is required for both the in and out of network benefit.

Autism

Benefits are available for outpatient treatment of autism including Applied Behavioral Analysis (ABA) that is precertified with the plan's behavioral health administrator. Benefits cover treatment for psychiatric and/or behavioral services for Autism Spectrum Disorders that are provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider and/or Board Certified Behavior Analyst (BCBA).

Covered treatment is that which addresses the core behavioral problems addressed in the treatment plan and is individualized to meet the patient's condition. Covered treatments do not include special schools or educational programs provided by schools or other governmental agencies, biofeedback, unproven or experimental treatments. Residential treatment or partial Hospitalization programs, vocational rehabilitation and sheltered workshops are also excluded. Treatment provided by the school system, such as consults, testing, assessments and school/home visits are not covered. Travel expenses, lodging, or meals for the trainers or participants are not covered.

Physician therapy, occupational therapy and Speech Therapy provided for the treatment of autism are covered under the plan's medical benefit for rehabilitation therapy.

Claims

Behavioral health claims for network services are handled between your network provider and the claims administrator. This allows you to concentrate on getting the care you need instead of dealing with paperwork.

Claims for services received on or ***before December 31, 2009*** should be submitted to:
Blue Cross and Blue Shield of Illinois, P. O. Box 805107, Chicago, Illinois 60680-4112

Claims for services received on ***January 1, 2010 or later*** should be submitted to: UBH, P.O. Box 30755, Salt Lake City, UT 84130-0755. Claims can also be submitted online at www.liveandworkwell.com.

Exclusions – What is not covered

The plan does not cover every health care expense you may have. In addition to the limitations described elsewhere in this booklet, plan Benefits are not payable for the treatments, items or supplies described in this section even when recommended or prescribed by a Physician or when it is the only available treatment for your condition.

Services Not Medically Necessary

No Benefits will be provided for services that are not, in the reasonable judgment of the Claims Administrator, Medically Necessary. Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claims Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or other setting without adversely affecting the patient's condition.

Examples of Hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory or pathological services or machine diagnostic tests) that could have been provided safely and adequately in another setting, e.g., Outpatient facility or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of Hospitalizations or other services and supplies that are not Medically Necessary. The Claims Administrator will make the decision whether Hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Health Care Plan. In most instances this decision is made by the Claims Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view Hospitalization or other health care services and supplies as Medically Necessary does not make the Hospitalization, services or supplies Medically Necessary and does not mean that the Claims Administrator will pay the cost of the Hospitalization, services or supplies.

Plan Exclusions

Claims for the following services will not be paid by any of the plan's Claims Administrators .

Alternative Treatments

- Acupressure
- Aromatherapy
- Holistic or homeopathic care
- Massage Therapy, unless performed by a covered Provider
- Naturopaths and naturalists
- Rolfing
- Other forms of alternative treatment (except for Naprapaths) as defined by the Office of Alternative Medicine of the National Institutes of Health

Comfort or Convenience Items

- Telephone or television, beauty/barber services or guest services
- Supplies, equipment or incidental services for personal comfort, including but not limited to: air conditioners, purifiers and filters; batteries and battery chargers; dehumidifiers and humidifiers; home remodeling to accommodate a health need (such as, ramps and swimming pools) or adjustable chairs and beds

Dental Care (except as described on pages 41 and 48)

Drugs

- Non-injectable medications given in a Physician's office, except as required in an emergency
- Over-the-counter drugs and treatments

Experimental or Investigational Services or Unproven Services

Experimental, Investigational or unproven services are excluded. Benefits are not payable even if a service, treatment, device or drug regimen is the only available treatment for a particular condition if the procedure is considered to be experimental or Investigational or if it is unproven in the treatment of that condition.

Foot Care

- Routine foot care, nail trimming or cutting, except when needed for severe systemic disease
- Hygienic and preventive foot care or other services performed when there is no localized illness, injury or symptom involving the foot
- Treatment of flat feet

Ineligible Providers

- Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with your same legal residence

- Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other Provider, including services that are self-directed to such diagnostic facility or services ordered by a Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, if that Physician or other Provider has not been actively involved in your Medical Care prior to ordering the service, or is not actively involved in your Medical Care after the service is received. Note: This exclusion does not apply to mammography or other preventive testing as part of an Abbott-sponsored wellness initiative

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities.
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Elastic stockings in excess of 6 pair per calendar year
 - Ace bandages, gauze and dressings
 - Tubings, nasal cannulas, connectors and masks are not covered except when used with covered Durable Medical Equipment described on page 42

Mental Health/Substance Abuse

- Any court-ordered diagnosis and/or treatment, including any diagnosis or treatment ordered as a condition of parole, probation, custody and/or visitation evaluation, except when determined by the Claims Administrator to be Medically Necessary
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless treatment is determined by the Claims Administrator to be Medically Necessary
- Sex therapy, treatment for sexual deviance, or diagnosis or treatment in conjunction with sexual reassignment procedures (including psychological testing prior to sexual reassignment procedures)
- Alternative treatments including, but not limited to the following:
 - Primal therapy
 - Psychodrama
 - Bioenergetic therapy
 - Vision perception training
 - Carbon dioxide therapy
 - Aversion therapy
- Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services
- EEG/neurofeedback or biofeedback treatment for ADHD, ADD and Autism
- Malingering (V code 65.2) and non-compliance with treatment (V code 15.81)
- Diagnosis and treatment for organic, congenital and developmental disorders other than autism, except for stabilization of an acute episode of such disorder, or management of medication
- Services, treatment or supplies primarily for rest, custodial, domiciliary or convalescent care
- Wilderness therapy programs, therapeutic boarding schools or independent living facilities
- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings

- Services, treatment or supplies requiring pre-certification for which pre-certification was not obtained
- Treatment of obesity or weight reduction, or for the cessation of smoking, including supplies, except for psychological testing prior to covered bariatric surgery
- Treatment by a provider who has less than a Master's degree and is not licensed at the highest level as a Mental Health Provider in the state in which care is to be given

Nutrition

- Megavitamin and nutrition-based therapy
- Enteral feedings and other nutritional and electrolyte supplements, including donor breast milk, diets for weight control or treatment of obesity (including liquid diets or food), oral vitamins, and oral minerals except as described on page 46

Physical Appearance

Cosmetic treatments, including:

- Pharmacological regimens, nutritional procedures or treatments
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
- Skin abrasion procedures performed as a treatment for acne
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility or general motivation and services of a personal trainer
- Weight loss programs, including supplies, office visits and testing, whether or not they are under medical supervision
- Liposuction
- Botox except when approved in advance by the Claims Administrator

Reproduction

- Surrogates and gestational carriers
- Fees or direct payment to a donor for sperm or ovum donations
- Donor search fees
- Fees for maintenance and/or storage of frozen embryos
- In vitro genetic testing
- Services that are experimental or unproven
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes

Services Covered by another plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements (This includes but is not limited to coverage required by workers' compensation, no-fault auto insurance, or similar legislation.)
- Hospital confinement in a Hospital operated by the U.S. government or its agency unless required by law
- Health services while on active military duty.
- Charges for a dependent entitled to Benefits as an employee or former employee of Abbott

Transplants

- Health services for organ and tissue transplants and multiple organ transplants other than those designated as Covered Health Services on page 56
- Health services for transplants involving mechanical or animal organs

Travel

Travel or transportation expenses, even if prescribed by a Physician. Some travel expenses related to covered transplants or approved Centers of Excellence programs may be reimbursed at the discretion of the Plan Administrator.

Vision and Hearing

- Charges for eyeglasses, contact lenses, or hearing aids (except for the first pair of either glasses or contact lenses after cataract Surgery and contact lens and related charges for the diagnosis of Aphakia)
- Fitting charges for hearing aids, eyeglasses or contact lenses
- Eye exercise therapy (except orthoptic therapy for cross-eyed or convergence insufficiency) Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye Surgery.

Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Health Service as defined on pages 40-57
- Full body scans and other care that is deemed experimental and/or not yet proven effective
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education, sports, camp, travel, employment, insurance, marriage or adoption
 - Related to judicial or administrative proceedings or orders
 - Conducted for purposes of medical research
 - Required to obtain or maintain a license of any type
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the plan ends
- Services for which you have no legal responsibility to pay

- Services for which a charge would not ordinarily be made in the absence of coverage under the Plan
- When a Provider waives Copayments, Coinsurance or Deductibles for a health service, no Benefits are provided for that health service
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- Penalties for failure to provide the required prenotification for Hospital admissions to the Claims Administrator
- Infertility services, treatment or supplies requiring precertification when precertification was not received
- Infertility services provided at a Provider other than a designated RRS Center of Excellence Provider
- Speech Therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or Congenital Anomaly
- Non-surgical treatment of obesity, including morbid obesity
- Sex transformation (change) operations
- Private duty nursing received on an inpatient basis.
- Respite Care or rest cures
- Psychosurgery
- Chelation therapy (except to treat heavy metal poisoning)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, time spent on the completion of forms, finance charges or record processing
- Any charges higher than the actual charge; the actual charge is defined as the Provider's lowest routine charge for the service, supply or equipment
- Any charge for services, supplies or equipment advertised by the Provider as free
- Any charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency or who is not licensed in the state in which care is given
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Any additional charges submitted after payment has been made and your account balance is zero.
- Any outpatient facility charges in excess of payable amounts under Medicare
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services

How to File a Claim

Network Expenses

There are no Claim forms for you to complete when you use Network services. Your Participating Provider files required Claims on your behalf.

Non-Network Expenses

Whenever you use Non-Participating Providers, you must submit a Claim form to the Claims Administrator. It is your responsibility to submit any Claims for reimbursement. When you request payment of Benefits, you must provide the Claims Administrator with all of the following information:

- A. Employee's name and address
- B. The patient's name, age and relationship to the Employee
- C. The member or subscriber number stated on your ID card
- D. An itemized bill from your Provider that includes the following:
 - Patient diagnosis
 - Date(s) of service
 - Procedure code(s) and descriptions of service(s) rendered
 - Charge for each service rendered
 - Provider of service Name, Address and Tax Identification Number
- E. The date the Injury or Sickness began
- F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program; if you are enrolled for other coverage you must include the name of the other carrier(s)

Claim forms are available from myHRTeam, on the Benefits Web Site or from the plan's member services office. File a completed Claim form, along with itemized bills and receipts, whenever you incur a covered expense, even if all of your expenses will apply to your Deductible and no plan payments are due. Claims must be received by the end of the calendar year following the year in which the expense is incurred. Claims received after this deadline will be denied.

Send Non-Network **Medical Claims** to:

Blue Cross and Blue Shield of Illinois, P. O. Box 805107, Chicago, Illinois 60680-4112

Send Non-Network **Prescription Drug Claims** to:

CVS Caremark, P.O. Box 52196, Phoenix, AZ 85072-2196

Send non-network **behavioral health claims** *through December 31, 2009* to:

Blue Cross and Blue Shield of Illinois, P. O. Box 805107, Chicago, Illinois 60680-4112

Effective January 1, 2010 send non-network **behavioral health claims** to:

UBH, P.O. Box 30755, Salt Lake City, UT 84130-0755. Claims can also be submitted online at www.liveandworkwell.com.

Payment of Benefits

Benefits will be paid to you unless the Provider notifies the Claims Administrator that your signature is on file, assigning Benefits directly to that Provider or you make a written request for the Provider to be paid directly at the time you submit your Claim.

Benefit Determinations

Urgent Care Claims

Urgent Care Claims are those Claims that require notification or approval before receiving Medical Care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition could cause severe pain.

In these situations you will receive notice of the benefit determination in writing or orally within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If you filed an urgent Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent Claim was received. If additional information is needed to process the Claim, the Claims Administrator will notify you of the information needed within 24 hours after the Claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the Claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as previously defined, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new Claim and decided according to post-service or pre-service time frames, whichever applies.

Pre-Service Claims

Pre-service Claims are those Claims that require notification or approval prior to receiving Medical Care. If your Claim was a pre-service Claim, and was submitted properly with all needed information, you will receive written notice of the Claim decision from the Claims Administrator within 15 days of receipt of the Claim.

If you filed a pre-service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service Claim was received. If additional information is needed to process the pre-service Claim, the Claims Administrator will notify you of the information needed within 15 days after the Claim was received, and may request a one-time extension not longer than 15 days and pend your Claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your Claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide you with the Claim appeal procedures.

Post-Service Claims

Post-Service Claims are those Claims that are filed for payment of Benefits after Medical Care has been received.

If your post-service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the Claim, as long as all needed information was provided with the Claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the Claim, and may request a one-time extension not longer than 15 days and pend your Claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the Claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your Claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide you with the Claim appeal procedures.

Appeals

If you are notified that a Claim has been denied in whole or in part, you may question that decision informally and/or formally by taking the following steps.

What to Do First

If your question or concern is about a benefit determination, you may informally contact the appropriate Customer Service department before requesting a formal appeal. All of the Customer Service telephone numbers shown below are toll-free.

- For **medical** Claims, contact BCBS Member Services at **(800) 603-3813**
- For **prescription drug** claims, contact Caremark Customer Care at **(866) 293-8009**
- For **behavioral Health** claims contact United Behavioral Health at **(866) 808-5075**

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may request a formal appeal.

Designating a Representative

If you wish, you may authorize a representative to act on your behalf. You can inform the Plan Administrator of this either orally or in writing.

In the case of an Urgent Care Claim appeal, a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law who has knowledge of your medical condition shall be permitted to act as your authorized representative and can be designated orally.

How to Appeal a Claim Decision

The Abbott Laboratories Health Care Plan provides for two levels of appeal. You must complete the plan's appeal process before seeking legal action.

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. (However, you, your Physician or your authorized representative may request an Urgent Care Claim appeal orally or in writing, provided it meets the definition as described on page 74).

Your appeal must include the name of the plan participant, the medical condition and treatment, service or basis for which you are asking 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.

The plan's procedures for reviewing Claims and appeals vary depending on whether requests for Benefits are Urgent Care, concurrent, pre-service or post-service Claims as described on pages 75 and 76. You or your authorized representative may initiate any of these Claims appeals.

Urgent Care Appeals

If you submit your appeal in a timely manner, the administrator responsible for issuing a decision will provide you with a final decision as soon as possible, taking into account the medical emergency, but not later than 72 hours after the receipt of your appeal. The decision will be transmitted to you or your authorized representative by telephone, facsimile any other agreed upon method. If the administrator notifies you of a decision orally, you will be provided a follow-up written notice within 3 days of the initial notification.

Level Two Appeals

If your appeal to the Claims Administrator is denied and you disagree with their findings, you may file an appeal with the Plan Administrator. Appeals must be in writing and must be filed within 60 days after the date you receive the written appeal denial from your Claims Administrator.

Your appeal must include the name of the plan participant, the medical condition and the treatment, service or basis for which you are asking approval. You must also include a copy of the appeal denial from the Claims administrator. 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.

The charts on the following page summarize information about how appeals are handled and contact information for the different Claims Administrators and types of Claims. In certain situations, the time frames may be extended.

Appeals on Medical Claims and Behavioral Health Claims incurred prior to January 1, 2010

Medical Director, Health Care Service Corporation, P. O. Box A3957, Chicago, Illinois 60601

Phone: **(800) 603-3813** Fax number can be provided to you by Member Services.

Type of Claim	Level One Appeal	Level Two Appeal
Urgent Care or Concurrent	BlueCross BlueShield Final decision within 72 hours	Abbott Laboratories*
Pre-service	BlueCross BlueShield Response within 15 days	Abbott Laboratories* Final decision within 15 days
Post-service	BlueCross BlueShield Response within 30 days	Abbott Laboratories* Final decision within 30 days

Appeals on Behavioral Health Claims incurred January 1, 2010 or later

United Behavioral Health Appeals, P.O. Box 30755, Salt Lake City, Utah 84130-0755

Phone: **(866) 808-5075** Fax number can be provided to you by Customer Service.

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care or Concurrent	Behavioral Health Administrator Final decision within 72 hours	Abbott Laboratories*
Pre-service	Behavioral Health Administrator Response within 15 days	Abbott Laboratories* Final decision within 15 days
Post-service	Behavioral Health Administrator Response within 30 days	Abbott Laboratories* Final decision within 30 days

Appeals on Prescription Drug Claims (Caremark)

Caremark Inc. Appeals Department, P.O. Box 52084, Phoenix, AZ 85072-2084

Phone: **(866) 293-8009** Fax number: **(866) 689-3092**

Type of Claim	Level One Appeal	Level Two Appeal
Urgent Care or Concurrent	Caremark Final decision within 72 hours	Abbott Laboratories*
Pre-service	Caremark Response within 15 days	Abbott Laboratories* Final decision within 15 days
Post-service	Caremark Response within 30 days	Abbott Laboratories* Final decision within 30 days

*** Direct Level Two appeals to:**

myHRTeam D589 AP51, 200 Abbott Park Road, Abbott Park, IL 60064-6222

Phone: **(877) 228-4707** Fax: **(866) 649-3764**

Appeal Determinations

The administrator responsible for reviewing your appeal will not give any deference to the initial decision denying your Claim and will take into account all comments, documents and information you submitted with your appeal, even if you did not submit such documents or information with your initial Claim.

If your appeal is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, Investigational or not medically necessary or appropriate, the Claims Administrator will consult with an independent third party review professional with the appropriate training and experience in the medical field pertaining to the services you are requesting for review. Such professional will not be the one who was consulted for the initial Claim denial or his or her subordinate.

Notice of Appeal Approval

Notification of the approval of your appeal will include any terms, conditions or guidelines applicable to the approval.

Notice of Appeal Denial

Notification of a denial of your appeal will include:

1. The specific reason(s) for the decision;
2. The specific references to the pertinent plan provisions on which the decision is based;
3. Information regarding any internal rule, guideline, protocol or other similar criterion, that the administrator relied on to make the decision (and a copy will be provided free of charge if you request it).
4. If the decision is based on medical necessity, or experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for that determination;
5. A statement explaining your right to file a civil suit under the pertinent provision of ERISA and the applicable time limits for filing a civil suit; and
6. A statement explaining 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.
7. If your Claim is denied, the administrator will, upon request, identify the medical or vocational expert whose advice was obtained on the plan's behalf in connection with the Claim denial.

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.

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 BCBS PPO Plus coverage is secondary for your spouse or domestic partner's Claims.
- If this plan and another group plan cover your dependent children, a "birthday rule" determines which plan is primary. Children's Benefits are paid first by the plan of the parent whose birthday (month and day) falls earlier in the calendar year.

Non-duplication

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

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

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

Coordination of Benefits will not apply to individual insurance policies you purchase or to prescription drug Claims through Caremark. Caremark does not coordinate Benefits on prescription drug purchases.

If You Become Eligible for Medicare

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

Active Employees

If you or your dependent is entitled to Medicare Benefits while still covered by the Abbott Laboratories Health Care Plan for active employees, the rules for determining whether Medicare is primary or secondary are shown below:

This plan is primary for a dependent entitled to Medicare Benefits because of a total disability qualifying for Social Security Benefits. This means that your Claims must be sent to the Abbott Claims Administrator (BCBS, UBH or Caremark) 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

Medicare is the primary payer on your medical Claims after retirement. Non-duplication, as described above, 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 are a dependent are eligible for Medicare, it is important that you sign up for Parts A and B. 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.

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.

Subrogation and Right of Recovery

Subrogation

When the Abbott Laboratories Health Care Plan pays medical bills for you or your covered dependent through the BCBS PPO Plus, and another party or insurance company is responsible for those bills, the Abbott plan is entitled to recover its payments on your behalf.

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.

Continuation of Coverage (COBRA)

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

This COBRA coverage is available to:

- You and your eligible dependents, if your coverage stops because of the termination of your employment (for reasons other than gross misconduct) or a change in your employment status which makes you ineligible for Benefits under the Abbott Laboratories Health Care Plan
- Your spouse, upon your death, divorce or separation.
- Your children, upon your death or when they no longer qualify as eligible dependents under the Abbott Laboratories Health Care Plan

If you or your dependent becomes eligible for coverage under this provision, 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.

Domestic partners and their children are not eligible for COBRA coverage.

If You Are the Covered Spouse of an Abbott Employee

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

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

You or your spouse must notify myHRTeam, in writing, within 60 days after the loss of coverage to preserve your rights under COBRA.

If You Are the Covered Child of an Abbott Employee

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

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

A child born to or placed for adoption with a COBRA participant during the period of continuation coverage is also eligible for coverage for the remainder of the continuation period as long as the COBRA Administrator is properly notified.

You or your parent must notify myHRTeam, in writing, within 60 days after the loss of coverage to preserve your rights under COBRA.

What You Need to Do

You, your spouse or your child must notify myHRTeam within 60 days after the loss of coverage (that is, within 60 days after the divorce date or the date a child's eligibility ends) to preserve your rights under COBRA. Upon notification, the COBRA administrator designated by the company will send a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage.

If the loss of coverage is due to termination of your employment or a reduction in hours, the administrator will automatically send you a notice upon receiving confirmation of your qualifying event.

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

Your costs for this coverage will be on an after-tax basis. As long as premiums are paid, coverage can continue up to:

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

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

COBRA coverage will stop earlier if:

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

Coverage Provided Under COBRA

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

COBRA Coverage and Medicare

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

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

Administrative Information

Plan Identification

The BCBS PPO Plus option is offered under the Abbott Laboratories Health Care Plan. Abbott Laboratories 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:

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

Plan Funding

The plan is a self-insured plan. That means that benefits are paid from a combination of the Company's general assets and employee contributions.

Claims Administration

BlueCross BlueShield (BCBS) of Illinois is the third-party Claims Administrator for the BCBS PPO Plus. BCBS provides administrative services, including Claims processing, customer service, and Network management and reporting services for health care expenses.

CVS Caremark is the third party claims administrator for pharmacy benefits. Caremark provides administrative services, including claims processing, customer service, and network management and reporting services.

United Behavioral Health is the third party claims administrator for behavioral health care benefits. United Behavioral Health provides administrative services, including claims processing, customer service, and network management and reporting services.

Legal Service

Process can be served on the Plan Administrator by directing such legal service to the Divisional Vice President, Benefits, Abbott Laboratories, 200 Abbott Park Road, Abbott Park, IL 60064-6222.

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 the BCBS PPO Plus. It does not attempt to cover all details. Its formal legal documents, rather than this summary, govern the plan in regard to administration and payment of all Benefits. In case of a conflict between this summary and the plan's legal documents, the plan's legal documents control.

Privacy of Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the health plan's privacy notice, which was distributed to you in April 2003 (or upon enrollment) and is available on the Abbott Wide Web and upon request by calling myHRTeam at **(877) 228-4707**.

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

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

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

If you wish to file a complaint under HIPAA, please write to the Divisional Vice President, Employee Relations, Abbott Laboratories, 200 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. You are covered by the provisions of ERISA that apply to this plan. Among other things, this law allows you to:

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate the plans (called “fiduciaries”) have an obligation to do so prudently and in the interests of plan participants. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If plan fiduciaries misuse a plan’s money or if you are discriminated against for asserting your rights, you may file suit in a federal court or request assistance from the U.S. Department of Labor.

If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney fees. But if you lose because, for example, the case is considered frivolous, you may have to pay all of these costs and fees.

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