



2026 Pfizer Retiree Benefits Brochure

For U.S. Retirees

As of October 2025



Non-Medicare Eligible

Medicare Eligible

The Pfizer Retiree Medical Plan provides medical coverage, including vision and prescription drug benefits, to eligible retirees both before and after they become eligible for Medicare.

Pfizer U.S. Retiree Benefits — Covering Your Dependents

Pfizer provides comprehensive benefits to retirees and their eligible dependents, including:

- Same- or opposite-sex spouse (including common-law spouse) or domestic partner (who meets the Pfizer eligibility requirements); and
- Dependent children up to age 26, or beyond age 26 for a disabled dependent (if they became disabled prior to turning age 26 and were already covered under the Plan).

Remember: If one or more of your dependents' Medicare eligibility status differs from your Medicare eligibility, you will need to enroll yourself and your eligible dependent(s) under separate options (refer to page 22). If your Medicare eligibility is the same as your covered dependents, they will be enrolled in the same option as you.

This brochure addresses retiree benefits, resources, and information to help you get the most from your benefits. Please reference this brochure throughout the year. Refer to the Plan's Summary Plan Description (SPD) in the *Reference Library* on netbenefits.com for details.

Moved or Changed Addresses Recently?

Update your address and/or telephone number information within 31 days of any change to ensure your Pfizer coverage is not interrupted or terminated. Contact Fidelity at the **Pfizer Benefits Center**:

Go to netbenefits.com or call **1-877-208-0950**.

Representatives are available Monday through Friday from 8:30 a.m. to midnight, Eastern Time.

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Information in this brochure, as well as on the Pfizer Plus website, does not apply to the following U.S. retiree groups: Aetna International, AH Robins, American Optical, Hospira Ashland Union, Warner Lambert retirees covered by the Enhanced Severance Plan (ESP), Warner Lambert Parke Davis Oil, Chemical and Atomic Workers (OCAW) Union, Warner Lambert colleagues who retired before January 1, 1992, or Wyeth retirees covered by the Change in Control (CIC) arrangement.

Non-Medicare Eligible (Under Age 65)

Pfizer offers medical, prescription drug, and vision coverage to retirees and their eligible dependents who are not yet eligible for Medicare (e.g., have not yet reached age 65).

Medical Plan Administrators: Horizon Blue Cross Blue Shield or UnitedHealthcare

Pfizer offers two administrators for medical insurance plans, including mental health and substance use coverage — you can choose Horizon Blue Cross Blue Shield (Horizon) or UnitedHealthcare (UHC)*.

These administrators typically differ in two ways:

- They each use a different network of providers; and
- The total cost a provider charges may differ based on their agreed-to network rate with the plan administrator (which affects how much you pay for services).

Regardless of the medical plan administrator you choose, you'll receive the same coverage and will pay the same contribution amount.

*Under UHC, Optum provides mental health and substance use coverage. Retirees enrolled in Horizon receive mental health and substance use coverage through Horizon.

Prescription Drug Coverage

Prescription drug coverage, administered through CVS Caremark®, is included with your retiree medical plan and covers medications dispensed through a pharmacy. Coverage varies based on your medical plan option. For details, see the chart on page 3.

Vision Coverage

Vision coverage, administered by EyeMed Vision Care (EyeMed), is included with your retiree medical plan. This coverage is the same, regardless of which coverage option or medical plan administrator selected. For more information, see page 8.



Medical Plan Options: Retiree PPO or HSA-Eligible PPO

There are two non-Medicare medical plan options — the **Retiree PPO** option and the **HSA-Eligible PPO** option. Both offer in-network coverage, preventive care, prescription drug, and vision coverage; however, the deductibles and other medical and prescription drug cost sharing is different between the two options. The two options also differ in how coverage for Pfizer medications (when no generic is available) works:

- **Retiree PPO:** Provides **100 percent coverage for Pfizer medications (when no generic is available)**. Pfizer medications that have a generic available (such as Accupril, Pristiq, Protonix, and others) are covered the same as any non-Pfizer medication — the Pfizer medication is covered, but you and Pfizer share in the cost;
- **HSA-Eligible PPO:** The deductible in this option is a combined medical and prescription drug deductible. This option will not pay for non-preventive medical and prescription drug services until you satisfy this combined annual deductible. In addition, you and Pfizer share the cost for **all** covered Pfizer and non-Pfizer medications. The HSA-Eligible PPO gives you the opportunity to contribute to a Health Savings Account (HSA) prior to your Medicare eligibility. An HSA is an individual savings and investment account that you (not Pfizer) can choose to contribute to (but you are not required to contribute to an HSA if you enroll). If you do not already have an HSA, contact your bank or another financial institution.

Advantages of an HSA

- You may contribute amounts, up to the annual IRS limits, to save and/or pay for your eligible out-of-pocket health care expenses each year;
 - Your contributions, any account investment earnings, and qualified distributions are federally (and in most states) tax-exempt when used for eligible health care expenses; and
- Your account rolls over from year to year, so you'll never forfeit the money; the balance is yours to keep, even if you decide to waive Pfizer retiree medical coverage in the future.

It Is Your Responsibility to Ensure You Meet the Eligibility Requirements to Contribute to an HSA

Generally, you're not eligible to contribute to an HSA if:

- You're someone's tax dependent;
- You're enrolled in non-HSA eligible health care coverage, such as Medicare, Tricare, or coverage through a spouse/partner or parent;
 - As you approach Medicare eligibility, you should plan to stop contributing to your HSA up to six months beforehand, as your Medicare Part A effective date will be retroactive by up to six months. Refer to page 9 for more information.
- You have access to a health care flexible spending account or a general purpose health care account (HCA), or have access to a health reimbursement account that covers pre-deductible medical expenses (these accounts could either be your own or your spouse's account).

Further restrictions may apply, for instance, if you are receiving medical benefits from the Indian Health Service or the U.S. Department of Veteran Affairs for non-service-related disability treatment. For more details about HSA eligibility, refer to the IRS website and **Publication 969**. If you have questions about your eligibility to contribute to an HSA, contact your tax advisor.

Medical Plan Options Comparison

Review the following charts for a comparison of the key provisions for the options available to non-Medicare eligible participants. The same vision coverage is included in both options (refer to page 8):

Feature	Retiree PPO		HSA-Eligible PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Coverage				
Annual Deductible (individual/family)	\$1,100/\$2,600	\$2,200/\$4,600	\$2,350/\$6,350 (combined medical and prescription ¹)	\$5,200/\$12,700 (combined medical and prescription ¹)
Annual Out-of-Pocket Maximum² (individual/family) (includes deductible)	\$5,000/\$8,200	\$8,300/\$15,900	\$7,200/\$14,200 (combined medical and prescription ³)	\$12,300/\$24,300 (combined medical and prescription ³)
Coinsurance (after deductible)	Plan pays 80% of contracted rate; you pay 20%	Plan pays 60% up to the Allowed Amount; you pay 40% ⁴	Plan pays 80% of contracted rate; you pay 20%	Plan pays 60% up to the Allowed Amount; you pay 40% ⁴
Preventive Care⁵ (deductible does not apply)	Plan pays 100%	Plan pays 100% up to the Allowed Amount	Plan pays 100%	Plan pays 100% up to the Allowed Amount
\$15 Virtual Visits⁶	\$15 copay Deductible does not apply	Not applicable	\$15 copay Deductible does not apply	Not applicable

¹ If you're covering dependents in the HSA-Eligible PPO, you must meet the full family deductible before the Plan begins to share the cost of non-preventive benefits.

² Eligible expenses in a given calendar year for covered services, such as deductibles, copays, and coinsurance amounts, are applied toward the out-of-pocket maximum.

³ Eligible prescription drug expenses include both in- and out-of-network pharmacy expenses.

⁴ The Allowed Amount for out-of-network medical (including mental health) services is generally defined as 250 percent of the Medicare reimbursement rate. For certain other services and supplies where Medicare does not provide a reimbursable rate, the Allowed Amount for these out-of-network services will be determined based on the method utilized by your plan administrator. You may also be responsible for any non-covered services, or the difference between the billed charges and the allowance for out-of-network providers. Please contact your plan administrator if you are billed for amounts in excess of the Allowed Amount to determine if they can provide you with any balance billing support.

⁵ Includes annual physical and related preventive tests, such as a mammography or a colonoscopy. Contact your plan administrator for details. Preventive care must be coded as such to be covered at 100 percent (out-of-network services subject to Allowed Amount).

⁶ \$15 copay virtual medical visits through your medical plan administrator's virtual care provider — horizonblue.com/pfizer to access Horizon CareOnline for Horizon members, or myuhc.com/virtualvisits for UHC members. From migraines and sinus infections, flu or COVID-19 concerns, to skin rashes and more, get care 24/7 from a licensed provider. Excludes mental health and specialist visits. The \$15 copay does not apply for telehealth visits you have with regular providers; rather, these are considered office visits under the Plan.

Feature	Retiree PPO		HSA-Eligible PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Coverage				
Most Pfizer Medications (when no generic is available including Pfizer biosimilars)	Plan pays 100%		Plan pays 70%; you pay 30% after deductible Minimum: \$20 (or actual cost if lower) Maximum: \$300 Deductible doesn't apply if medication is on the HSA Preventive Drug List	
Retail Medications — Per 30-day Supply				
Non-Pfizer Medications + Pfizer Medications (when a generic is available)	Plan pays 80%; you pay 20% Minimum: \$15 (or actual cost if lower) Maximum: \$150		Plan pays 70%; you pay 30% after deductible (Minimum: \$20 (or actual cost if lower) Maximum: \$300) Deductible doesn't apply if medication is on the HSA Preventive Drug List	
Non-Pfizer Biosimilar Medications — 30-day Supply				
Non-Pfizer Biosimilar Medications ¹	You pay \$150 copay		You pay \$300 copay; Deductible doesn't apply if medication is on the HSA Preventive Drug List	
Maintenance Choice® Program — Up to a 90-day Supply Non-specialty maintenance medications when filled at a CVS Pharmacy® or through CVS Caremark Mail Service Pharmacy				
Most Pfizer Medications (when no generic is available including Pfizer biosimilars)	Plan pays 100%		Plan pays 70%; you pay 30% after deductible Minimum: \$50 (or actual cost if lower) Maximum: \$750 Deductible doesn't apply if medication is on the HSA Preventive Drug List	
Non-Pfizer Medications + Pfizer Medications (when a generic is available)	Plan pays 80%; you pay 20% (Minimum: \$37.50 (or actual cost if lower) Maximum: \$375)			
100% Coverage for Other Medications				
Certain Preventive Vaccines (deductible does not apply)	Plan pays 100% for certain preventive vaccines (e.g., flu shots) at a CVS Pharmacy or a pharmacy in CVS Caremark's Broader Vaccination Network. For more information, call CVS Caremark			
Certain Preventive Medications (deductible does not apply)	Plan pays 100% for certain medications on the Affordable Care Act (ACA) Drug List² . These include fluoride treatments, smoking-cessation treatments, oral contraceptives, colonoscopy prep medications, and low-dose generic statins, as well as certain over-the-counter products indicated for specific age and risk factors. For more information, call CVS Caremark			
Blood Glucose Testing Meters (deductible does not apply)	Plan pays 100% for certain blood glucose testing meters ³			
Certain Diabetic Supplies (deductible does not apply)	If you are enrolled in the TrestleTree coaching program, the Plan pays 100% for certain diabetic supplies dispensed through a pharmacy, including insulin needles and syringes, lancets, devices, and test strips. For more information and to enroll, call TrestleTree			
Annual Prescription Drug Deductible				
Individual/Family	N/A		Combined with Medical ⁴	
Annual Prescription Drug Out-of-Pocket Maximum				
Individual/Family	\$3,700/\$5,700		Combined with Medical ⁴	

¹ Prior authorization is required if the biosimilar's reference product (e.g. Humira or Stelara) is requested instead of the biosimilar; otherwise an additional fee of \$500 per 30-day supply will apply (this additional fee will not count toward your deductible or out-of-pocket maximum). Currently all available biosimilars available through pharmacy coverage are considered specialty medications and must be ordered through CVS Specialty.

² The **Prescription Drug ACA Drug List** can be found at [caremark.com](https://www.caremark.com) by going to *Plan & Benefits* and *Print Plan Forms*.

³ Blood glucose testing meters must be purchased through the Diabetic Meter Program. Contact **1-800-588-4456** for information. Choice of meter is subject to change.

⁴ If you're covering dependents in the HSA-Eligible PPO, you must meet the full family deductible before the Plan begins to share the cost of non-preventive benefits.



Things to Remember

\$15 Virtual Visits: Virtual visits are available to you and your covered dependents for non-emergency health conditions, such as a rash, the flu, or a sinus infection (excludes mental health and specialist visits). Access services through your medical plan administrator — visit horizonblue.com/pfizer and access Horizon CareOnline under the *Tools & Services* tab for Horizon members, or myuhc.com/virtualvisits for UHC members. You may also access these same services through the app for your medical plan administrator. Due to new legislation, if you are enrolled in the HSA-Eligible PPO option, your cost is not subject to the deductible. The \$15 copay does not apply for telehealth visits you have with regular providers; rather these are considered office visits under the Plan.

Pre-Authorization: Some medical services or prescription medications, including certain weight loss medications, require pre-authorization and verification that the service or treatment is medically necessary under the Retiree PPO or HSA-Eligible PPO options. Additionally, if you have a planned hospital stay coming up and are using an out-of-network provider, it is **your** responsibility to make sure your medical plan administrator is notified in advance, or the service may not be covered.

Experimental or Unproven Services or Treatments: As determined by your medical carrier or by the pharmacy benefit administrator, experimental or unproven services or treatments are not covered. Refer to the SPDs for additional information, available at netbenefits.com in the *Reference Library*. Find the *Health & Insurance* section on the home page, and then click *Quick Links* and *Reference Library*.

In-Network vs. Out-of-Network Providers: Each medical plan administrator offers in-network providers which provide greater benefits than out-of-network providers through:

- A lower in-network annual deductible; and
- A lower in-network rate for contracted services.

Go to page 26 to view the list of resources and websites that you can use to see if your medical providers are in-network, and determine which medical claim administrator's network better fits your needs.

Get Help with Disputing or Appealing a Claim: Participant Advocacy Services can guide you through issues you experience with your Pfizer health coverage, prior-authorizations, claims submissions, and appealing denied claims. Call Fidelity at the **Pfizer Benefits Center** and request to connect with a participant advocate by asking the representative to open a case with the Participant Advocacy Team. You will be asked to provide a brief overview of your concern, and a participant advocate case manager will call you back within three business days.

Paying for Your Prescription Medications: If you need assistance paying for your prescription medications, CVS Caremark offers an interest-free payment program for medications filled through either CVS Mail Order or CVS Specialty that costs you more than \$250 out-of-pocket. Contact CVS Caremark or CVS Specialty for details about their payment program.

Health Navigator (powered by PinnacleCare*) Expert Medical Opinion Service

The Retiree PPO and HSA-Eligible PPO options include access to a **no-cost** Expert Medical Opinion Service through Health Navigator for you and your covered non-Medicare eligible dependents. When dealing with a serious or complex health issue, such as cancer, substance use disorder or back surgery, a health navigator advisor will support and provide guidance to help you:

- Confirm your diagnosis;
- Evaluate available treatment options;
- Identify the most qualified provider or Center of Excellence (including those in-network with Horizon and UHC);
- Schedule appointments;
- Get answers to your health questions; and
- Connect you with other Pfizer-sponsored resources, such as the Cancer Support Program.

While this service does not replace your relationship with your physician or your ability to receive second opinions through your Pfizer medical coverage, it does offer additional resources and support to you and your treating physician. Alternatively, it can help you find a new physician if you prefer.

* Health Navigator is a Sun Life company.

Contact Health Navigator powered by PinnacleCare at:

sunlife.com/Pfizer
or by calling **1-877-280-7466**

Representatives are available Monday through Friday from 8 a.m. to 6 p.m., Eastern Time.

Healthy Weight Program for Weight Loss Medications

The Healthy Weight Program combines lifestyle changes supported through 1:1 Health Coach visits and doctor-prescribed medication to help you lose unhealthy weight, keep it off, and improve your overall health.

You partner with a personal Health Coach through TrestleTree to guide you on your weight loss journey and help you make changes to your lifestyle, including exercise, diet, and other activities to support your wellbeing.

If you are taking, or are considering taking, a weight loss medication (such as Wegovy, Saxenda, or Zepbound), you are required to enroll in this program

to have coverage under Pfizer's prescription drug benefit; additionally, your provider will be required to complete a prior authorization request with CVS Caremark.

For more information about the Healthy Weight Program, contact TrestleTree at:

1-866-237-0967

Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m., Eastern Time.

Specialty Medications

Specialty medications are injectable, infused, oral, topical, or inhaled requiring specialized delivery, handling, monitoring, or administration. They are offered as either a medical service or through a pharmacy:

- **Medical Service:** The specialty Pfizer or non-Pfizer/generic medications that are administered in your home, at a provider's office, or in a facility. Contact your medical plan administrator (Horizon or UHC) for coverage details and pre-authorization requirements;
- **Pharmacy:** The specialty Pfizer or non-Pfizer/generic medications that must only be obtained through CVS Specialty™.

For more information, including a list of CVS Specialty™ medications, go to:

cvsspecialty.com (*Resource Center* page), or call **1-800-237-2767**

Representatives are available Monday through Friday from 8:30 a.m. to 9 p.m. and Saturday from 9 a.m. to 4 p.m., Eastern Time.

Free Diabetic Supply Program

TrestleTree offers coaching for retirees and their covered dependents diagnosed with diabetes under the Retiree PPO and HSA-Eligible PPO options at no cost. **If you enroll with TrestleTree, certain diabetic supplies (dispensed through a pharmacy) are available at no cost, including insulin needles and syringes, lancets, devices, and test strips.** This list excludes supplies covered under your medical plan, such as pumps and pump supplies.

To enroll in coaching, contact TrestleTree at:

1-866-237-0967

Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m., Eastern Time.

Getting the Most from Your Prescription Drug Benefits

✓ Use Pfizer medications:

- **Retiree PPO:** When you use an in-network pharmacy, the plan covers 100 percent of the cost for Pfizer medications (when no generic is available). Out-of-network pharmacies may require a cost since out-of-network reimbursement is limited to the contracted rate. **Remember:** Pfizer medications (when a generic is available) — such as Accupril, Pristiq, Protonix, and others — are covered at the same cost sharing as non-Pfizer medications; you and Pfizer share in the cost;
- **HSA-Eligible PPO:** All Pfizer medications are covered at the same cost-sharing as non-Pfizer medications; you and Pfizer share in the cost.

✓ Understand the impact of requesting a non-Pfizer brand medication including those reference products with a biosimilar available.

In cases where a brand medication is prescribed and there is a generic available, the provider/prescriber must specify “dispense as written” on the prescription for you to receive the brand medication and avoid paying an additional cost. If your prescription does not include “dispense as written,” and you request the brand, you will pay the difference between the cost of the generic medication and the brand medication, **plus** your regular coinsurance amount. In the case of a reference product with a biosimilar available (such as Humira and Stelara), if you continue to fill the reference product without a prior authorization through CVS Caremark, you will be required to pay your regular cost share **plus** an additional fee of \$500 per 30-day supply (this additional fee **will not** count towards your deductible or out-of-pocket maximum).

✓ Know that, compared to the reference product, biosimilars have no clinically meaningful differences in terms of safety and efficacy and offer a cost-savings over the reference product.

Contact **CVS Specialty** for more information about biosimilars.

✓ Use a CVS Caremark network pharmacy.

Fill your prescriptions at a CVS Caremark network pharmacy. This includes CVS pharmacies and many local pharmacies and pharmacy chains (i.e., Walgreens), and retail store pharmacies (i.e., Walmart or Costco). Go to [caremark.com](https://www.caremark.com) to find a network pharmacy near you.

If you use an out-of-network pharmacy, you will pay the full cost of the prescription (for Pfizer, non-Pfizer, or generic). You will need to submit a reimbursement claim to CVS Caremark, which may reimburse less than what you paid if the amount is greater than the in-network CVS Caremark contracted rate. For more information, contact your local CVS Pharmacy, call CVS Caremark at **1-866-804-5881**, or go to [caremark.com](https://www.caremark.com).

✓ Use the Maintenance Choice® Program for maintenance medications.

If you regularly fill a non-specialty maintenance medication, request a 90-day prescription from your provider and use the Maintenance Choice Program to save money. You can fill a 90-day supply of your non-specialty maintenance medications via:

- a CVS Pharmacy; or
- the CVS Caremark Mail Service Pharmacy (free delivery to the location of your choice).

CVS Pharmacy and the CVS Caremark Mail Service Pharmacy offer preferred pricing. Talk with a CVS pharmacist for more information, go to [caremark.com](https://www.caremark.com), or call **1-866-804-5881**, 24 hours a day, seven days a week.

✓ Use CVS Specialty for specialty medications.

Specialty medications (Pfizer, non-Pfizer, or generic) dispensed through a pharmacy other than CVS Specialty **will not** be covered. Contact CVS Specialty at **1-800-237-2767** for more information.

Vision Coverage

Vision benefits are the same for the Retiree PPO and HSA-Eligible PPO medical options. Vision is administered by EyeMed Vision Care (EyeMed). EyeMed provides coverage for routine eye care expenses, including eye examinations and eyewear, through their **Insight network**, which includes a large network of independent and national retail providers, such as LensCrafters, Target Optical, and most Pearle Vision locations.

The following chart highlights key provisions under the Vision Plan. For more details, see the Benefits Summary available on netbenefits.com.

Benefit ¹	In-Network	Out-of-Network Reimbursement ²
Annual Eye Exam	\$10 copay	Up to \$40
Lenses — Single Vision	\$20 copay	Up to \$40
Lenses — Bifocal	\$20 copay	Up to \$60
Lenses — Trifocal	\$20 copay	Up to \$80
Frames³ (any available frame at a provider location, once every 24 months)	\$0 copay, \$130 allowance; you receive a discount of 20% over the \$130 allowance	Up to \$50
Contact Lenses⁴ (disposable)	\$0 copay, \$150 allowance	Up to \$150
Contact Lenses⁴ (medically necessary)	\$0 copay, paid in full	Up to \$210
LASIK and PPK Procedures	Receive a discount at participating providers. Call 1-877-5LASER6 for more information	

¹ Except for frames, all benefit provisions (eye exams, lenses, contacts) shown are covered once every calendar year; however, you must select from either lenses or contacts.

² If you visit an out-of-network provider, be sure to obtain an itemized receipt to be reimbursed.

³ Frames are covered once every other calendar year.

⁴ Contact lens allowance includes materials only.

To find an in-network vision provider, go to eyemedvisioncare.com/pfizer and choose the Insight network, or call EyeMed at **1-855-629-5015**, Monday through Friday from 7:30 a.m. to 11 p.m., Saturday 8 a.m. to 11 p.m., and Sunday from 11 a.m. to 8 p.m., Eastern Time.

If You Wear Contact Lenses: You can fill your prescription at contactsdirect.com and receive in-network coverage.

Ongoing Vision Discounts

After you've used your in-network vision benefits, EyeMed offers access to ongoing discounts for prescription eyeglasses/sunglasses, contact lenses, and lens options not covered by the plan network providers (e.g., polycarbonate or anti-reflective coating). Visit eyemedvisioncare.com/pfizer and go to the *Special Offers* tab for the most up-to-date offers and discounts.

Turning Age 65 During the Year

If you (or your covered dependents) become eligible for Medicare (over age 65 or Medicare-disabled) during the year, to remain enrolled or eligible for coverage under Pfizer's retiree medical plan, you are **required** to enroll in Medicare Parts A and B. **Note:** Enrollment in Medicare Part D is not required. There are several things you or your eligible dependents will need to do in advance:

1. Six months before your 65th birthday, look for Medicare Parts A and B enrollment information via mail

You should receive information regarding the enrollment process directly from Medicare. If you do not, contact your local Social Security office. **Note:** both Pfizer's medical plans for active colleagues and the Pfizer non-Medicare eligible coverage under this retiree medical plan are both considered creditable coverage for CMS purposes;

2. Ninety days before you turn age 65 and become eligible for Medicare, enroll in Medicare Parts A and B

You will need to contact **Medicare and enroll in Medicare Part A and Part B**. Generally, you become eligible for Medicare on the first day of the month you turn 65. If your birthday occurs on the first of the month, you will become eligible for Medicare on the first of the month before your 65th birthday.

If you missed the deadline to enroll in Medicare, or otherwise need help enrolling in Medicare, Pfizer provides no-cost support through Allsup (**1-888-271-1173**) to assist with Medicare enrollment.

After you have enrolled in Medicare, the Social Security Administration will assign you a Medicare Beneficiary Identifier (MBI), which will be shown on your red, white, and blue Medicare ID card;

3. Ninety days before turning age 65, watch for a Personal Fact Sheet in the mail

The **Pfizer Benefits Center** will send you a letter and a **Personal Fact Sheet (PFS)** showing your available retiree coverage options and contributions, including the coverage you will have if no action is taken. Refer to the **What to Do When Turning Age 65 Tip Sheet** available on netbenefits.com for step-by-step enrollment instructions and more information about turning age 65; and

4. Contact Fidelity at the Pfizer Benefits Center before turning age 65

You must call the **Pfizer Benefits Center** to:

- Provide the MBI number on your Medicare ID card;
- Confirm your mailing address (this must be a street address and cannot be a P.O. Box); and
- Make your Medicare eligible coverage election based on the **PFS** you received from the **Pfizer Benefits Center** — and understand what happens if you do not enroll.

If you become Medicare eligible mid-year and elect coverage but were previously covered under Pfizer's non-Medicare eligible coverage, your **medical-related** deductible and out-of-pocket maximum amounts previously paid in the year **will not** count towards your Pfizer Medicare eligible coverage. Amounts accumulated toward your Pfizer prescription drug coverage may carryover to the Annual Individual Pfizer Maximum Out-of-Pocket (this only applies if you enroll in Rx Plus). See page 10 of this brochure for more information.

Enrolling in Pfizer's Medicare-Eligible Coverage for the First Time

Pfizer's Medicare-eligible retiree coverage requires CMS approval and this approval is generally effective the first of each month. If CMS has not approved your Medicare enrollment as of your coverage start date, or you are enrolling mid-month but your CMS has approved your enrollment for the first of the following month, you will be temporarily enrolled in a holding plan through UnitedHealthcare (UHC) with prescription drug coverage provided through CVS Caremark until the first of the month following CMS approval.

Here's how your coverage will work during this interim period:

- **For medical coverage:** You will receive a new medical ID card from UHC for this holding plan. Once your CMS enrollment is approved, you will receive a new ID card for Medicare Advantage coverage;
 - If you need medical services, you will pay the same copay or coinsurance percentage as under Pfizer's Medicare-Advantage Plan as long as you visit providers that haven't fully opted out of Medicare;
 - Amounts accumulated to your deductible and out-of-pocket maximum under the holding plan will NOT transfer to Pfizer's Medicare Advantage Plan through Humana;
 - You will not have access to the features and programs such as SilverSneakers, as described on page 15;
- **For prescription coverage:** If you need to fill a prescription for covered medications, you will continue to use your Caremark ID card at the pharmacy. Once your CMS enrollment is approved, you will receive new ID cards for your Silverscript coverage;
 - Amounts accumulated to your deductible will transfer over to your Silverscript coverage. If you are enrolled in Rx Plus, any amounts accumulated to your Annual Individual Pfizer Maximum Out-of-Pocket will transfer as well. If enrolling in either Rx Plus or Rx Base, these amounts **will not** transfer to your Annual Individual Medicare Out-of-Pocket maximum through SilverScript;
- **For vision coverage:** While covered under the UHC holding plan, a routine eye exam (including a glaucoma screening) will be covered at a \$0 copay. For a non-routine eye exam (eye exams for illness), you will need to pay a \$20 copay. For Medicare covered standard glasses or contacts following cataract surgery, you would have a \$0 copay after the deductible. You will not have coverage for regular frames, lenses and contacts while you are covered under the holding plan.

Didn't Sign Up for Medicare Parts A and B When Eligible?

If you missed enrolling in Medicare Part A and Part B when you were first eligible or during a Special Enrollment Period, Medicare will assess you a financial penalty in the form of a higher Medicare monthly premium for late enrollment. **This penalty will continue to apply for as long as you are enrolled in Medicare. You are responsible for paying this penalty.** If you missed the enrollment deadline, contact Allsup to request assistance in enrolling in Medicare. This service is provided at no cost (refer to the *Resources* section of this brochure).

Enrolled in the HSA-Eligible PPO and Contributing to a Health Savings Account (HSA)?

If you apply for Medicare prior to the month of your 65th birthday, you can contribute to your HSA up until the day before your Medicare effective date.

However, if you apply for Medicare after that time, you should plan to stop contributing to your HSA up to six months beforehand, as your Medicare Part A effective date will be retroactive by up to six months. This could cause you to face penalties if you continue to make HSA contributions after your retroactive Medicare Part A effective date.

Medicare Eligible (Age 65 or Above)

Overview

Medical coverage under the Pfizer Medicare Advantage Plan is administered through Humana and replaces Medicare Parts A and B coverage. Please note, however, that you must continue to pay your Part A (if applicable) and Part B premiums to Medicare. **Failure to enroll in both Medicare Parts A and B will affect your eligibility to elect coverage under the Pfizer Medicare Advantage Plan.**

The Pfizer Medicare Advantage Plan includes prescription drug coverage (see page 16), so you should not enroll in another Part D prescription drug plan. Enrolling in another Part D plan will cause your Pfizer coverage to be dropped. If you are required to pay an additional high earner Medicare premiums for Parts B and/or D (referred to as IRMAA), you must continue to pay those additional premiums; failure to do so will impact your Pfizer coverage.

If you and your dependents differ in Medicare eligibility (e.g., one or more of you are non-Medicare eligible and the rest are Medicare eligible), you will need to enroll yourself and your eligible dependent(s) separately in the Retiree Medical Plan based on each individual's Medicare eligibility; this is referred to as "Split Family" coverage. (Refer to page 22 to learn more.)



Medical Plan Options

Pfizer offers **medical (including vision) and prescription drug** coverage for retirees and/or dependents who are eligible for Medicare (i.e., have reached age 65 or are disabled and eligible for Medicare).

If you and/or your eligible dependent(s) are eligible for Medicare, you can choose from one of the following coverage options:

- Medicare Advantage with Rx Plus;
- Medicare Advantage with Rx Base;
- Rx Plus Only; or
- Rx Base Only.

The Rx Plus Only and the Rx Base Only options do not include coverage for any medical services (including mental health and vision). Refer to page 13 for more information on your coverage if you enroll in either of these options.

You may not elect Pfizer's Medicare Advantage coverage without electing prescription drug coverage through Pfizer.

We recognize your health care needs may change, and you may choose to remain in medical coverage either directly through Medicare or a supplemental Medicare program. With this in mind, consider the following key features of Pfizer's Medicare eligible coverage:

Pfizer Medicare Advantage Plan Highlights	Pfizer Prescription Drug Plan Highlights
Any U.S. provider or hospital who participates in (accepts payment from) Medicare is covered by the Plan. This includes providers who accept assignment from Medicare. Pfizer's Plan only excludes those providers who have fully opted out of Medicare. Your coverage is the same whether you visit a network provider or a provider who does not participate in Humana's network (as long as they participate in Medicare.)	Coverage for eligible Pfizer medications at any U.S. pharmacy, including Mail Service through SilverScript: Under Rx Plus, Pfizer medications (when no generic is available) are covered at no cost to you; under Rx Base, these medications are covered at the same cost sharing as any non-Pfizer brand medication. Under both Rx options, Pfizer medications (when a generic is available) are covered at the same cost sharing percentage as any other non-Pfizer medication. For Rx Base, however, coverage for these medications is only available if they are covered under the SilverScript Platinum formulary.
Only the Pfizer plan deductible applies; you do not have to pay the Medicare Parts A & B deductible. The Pfizer annual plan out-of-pocket maximum applies; you are not subject to the unlimited coinsurance under Medicare Part B. Also, unlike Medicare, the Pfizer Plan provides for emergency care incurred while travelling outside the U.S.	Under Rx Plus, access SilverScript's broadest formulary (Bronze) as permitted under Medicare PLUS additional coverage for many medications not covered by Medicare (e.g., weight loss medications such as Wegovy, Saxenda, or Zepbound, eligible erectile dysfunction medications, and prescription cough and cold medications). Also, under Rx Plus there is no cost for certain preventive medications, such as for colonoscopy prep, low-dose generic statins, and tobacco cessation. Under Rx Base, access SilverScript's broad formulary (Platinum). There is no additional coverage for medications not covered by Medicare.
Coverage for medical services not covered by Medicare, including private duty nursing, vision (eyeglasses and contacts), and hearing aids.	Though the plan does have some medical necessity review, such as for human growth hormones and eligible weight loss medications (Rx Plus only), overall there is easier access to covered medications with limited pharmacy management restrictions to better support your relationship with your provider.
Access additional services and programs at no cost, including virtual medical and mental health care through MD Live, wellness incentives, gym membership benefits, and post-discharge care including transportation and meals after a hospital stay.	Access to additional resources and programs at no cost, including personalized nurse support for conditions requiring specialty medications such as rheumatoid arthritis.

Pfizer Medicare Advantage Plan Features

See the chart below for the key provisions of the Pfizer Medicare Advantage Plan for 2026. These provisions apply regardless of whether you enroll in the Medicare Advantage with Rx Plus option or the Medicare Advantage with Rx Base option:

Feature	Pfizer Medicare Advantage Plan via Humana ¹
Annual Individual Deductible	\$150
Annual Individual Plan Out-of-Pocket Maximum	\$3,500
Preventive Care	Plan pays 100% ² (deductible does not apply)
Primary Care Office Visit	You pay \$25 copay
Specialist Office Visit	You pay \$40 copay
Outpatient Mental Health and Substance Use Visit	You pay \$25 copay
Lab	You pay \$25 per visit
X-ray	You pay \$25 copay
Magnetic Resonance Imaging (MRI)	You pay \$25 copay
PT/OT/Speech Therapy Visit	You pay \$25 copay
Inpatient Hospital Stay	You pay \$500 per admission
Outpatient Surgery	You pay \$350 copay
Routine Acupuncture	You pay \$20 copay; maximum of 20 visits per year (deductible does not apply)
Routine Chiropractic Visits	You pay \$20 copay; maximum of 20 visits per year (deductible does not apply)
Emergency Room Visit	You pay \$125 copay (deductible does not apply)
Urgent Care Visit	You pay \$50 copay (deductible does not apply)
Durable Medical Equipment	You pay 20%; Plan pays 80% ³
Diabetic Supplies	Plan pays 100% for meters and test strips marketed by Roche (e.g., Accu-Chek Aviva Plus, Accu-Chek Guide, Accu-Chek Guide Me) or Trividia Health (e.g. TrueMetrix, TrueTrack) ⁴ (deductible does not apply)
Private Duty Nursing (requiring skilled care)	\$1,500 allowance per year (deductible does not apply)
Medicare Part B Prescription Drugs (including eligible Pfizer medications covered under medical)	You pay 20%; Plan pays 80%
Additional Features and Programs (including vision, hearing aids, meal delivery, and more)	Refer to page 15 for more details
Prescription Drug Coverage	Choose from the Rx Plus and Rx Base options outlined in the chart on page 16

¹ Unless otherwise noted, copays and/or coinsurance will apply after deductible is met.

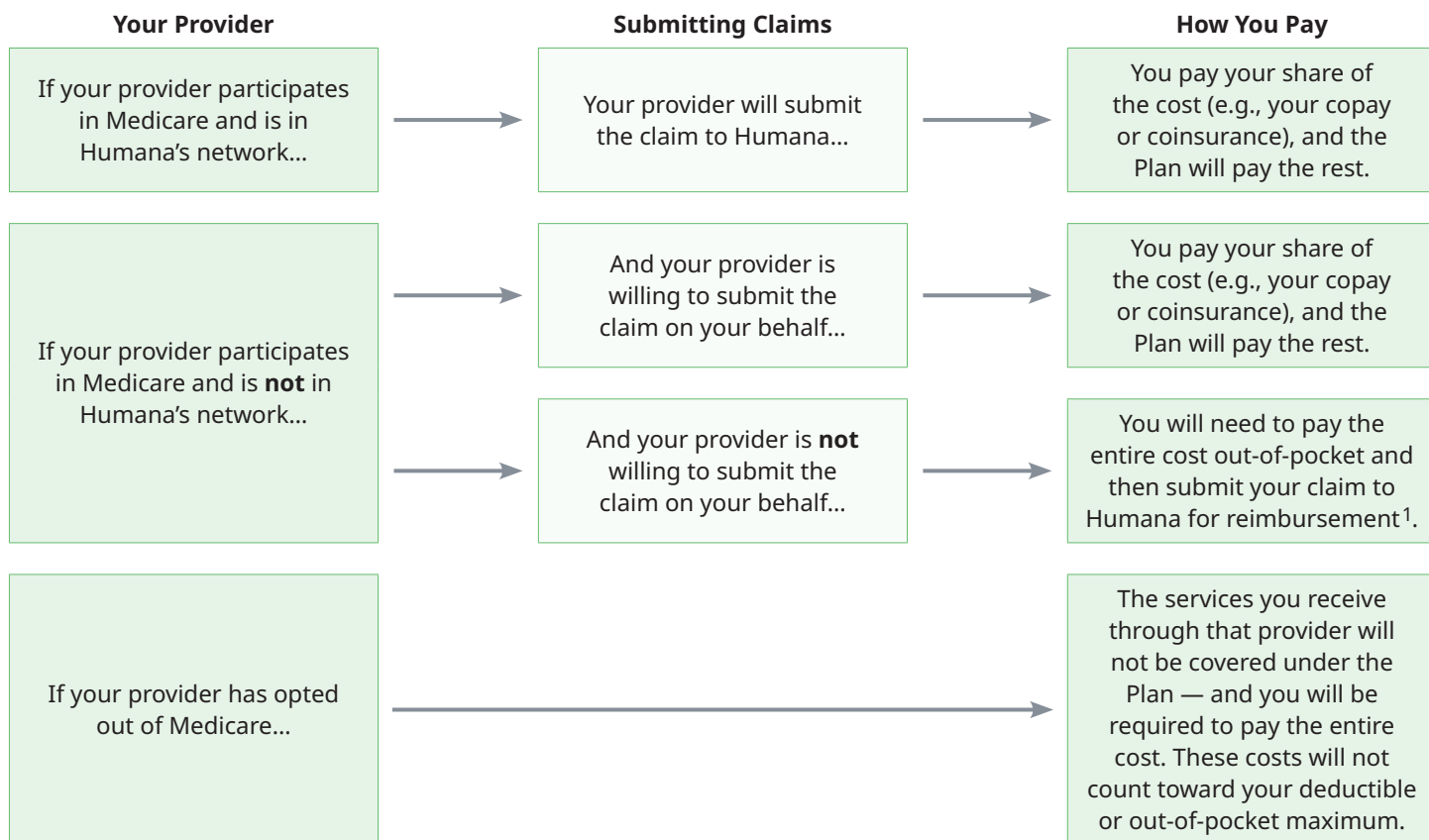
² Includes annual physical and related preventive tests, as well as preventive screenings such as a mammography or a colonoscopy. Contact Humana for details. Preventive care must be coded as such to be covered at 100 percent.

³ Medicare participating providers must be used. Providers who participate in Humana's network will be reimbursed at the contracted rate. Providers who participate with Medicare but do not participate with Humana will be reimbursed based on the Medicare fee schedule.

⁴ Blood glucose testing meters are provided by Roche (e.g., Accu-Chek Aviva Plus, Accu-Chek Guide, Accu-Chek Guide Me) or Trividia Health (e.g. TrueMetrix, TrueTrack) and require a prescription from your doctor. To learn more about this benefit, call Humana at **1-800-654-1092**, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.

Submitting Claims

The Pfizer Medicare Advantage Plan provides the flexibility to see any provider who has not opted out of Medicare. The chart below shows how you submit claims and pay for care based on your provider:



¹ **Note:** This occurs infrequently, but if it does, contact Humana to understand how they may be able to support you with the claim filing process.

To Find Medicare Participating Providers:

Visit [medicare.gov/care-compare](https://www.medicare.gov/care-compare).

To Find Providers Who Have Opted Out of Medicare:

Visit <https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool>.

Submitting Claims for Reimbursement

- Go to <https://www.humana.com/member/documents-and-forms> and select "Health Benefits Claim Form" to download, print, and complete a **Reimbursement Form**.
- Call Humana at **1-800-654-1092**, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.

Reminder: Pfizer's Medicare Advantage Plan is a national, employer group-based PPO plan and reimburses providers who participate in Medicare but do not participate in Humana's network based on Medicare's fee schedule; you pay the same copay or coinsurance percentage as if you had visited a network provider. Contact Humana if your non-network Medicare participating provider has questions about the Plan and how it works or refer to the "Member to Provider" flyer located in your **Welcome Kit** from Humana.

Medicare Advantage Plan Features and Programs

Humana offers a variety of programs as part of your Medicare Advantage Plan coverage at no cost to help support you. For more information, go to <https://your.humana.com/pfizer>, or call Humana at **1-800-654-1092**, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.

Humana Programs	Contact Information
Telehealth through MDLive	- Free eVisits: No copay (deductible does not apply) when you use MDLive. Speak to participating providers anytime, anywhere, via computer or mobile device (including tablets and smartphones): For a non-emergency health condition: You can schedule a visit with MDLive at 1-888-673-1992 or at https://members.mdlive.com/humanamedicare/landing_home. Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time if you have any questions.
Health and Well-Being Assessments (HWA)	- An annual visit to your home by a licensed health care practitioner to review your health history and medication, identify health risks, perform a physical evaluation, and provide education information at no additional cost. Results of the visit are sent to your doctor. - Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.
SilverSneakers	- SilverSneakers® is a no cost, fitness program. You have access to thousands of fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. - Go to SilverSneakers.com/StartHere to activate your free online account. Log in to view your member ID number and take that to a participating location. - Access online education on SilverSneakers.com, watch workout videos on SilverSneakers On-Demand™ or download the SilverSneakers GO™ fitness app, for additional workout ideas.
TruHearing	- Choose from a selection of hearing aid devices through TruHearing. \$0 copay on routine hearing exams, up to 1 per year. \$1,500 allowance amount for hearing aid(s) up to 2 aids every 3 years, through in-network providers. Includes 80 batteries per aid and a 3 year warranty. Contact TruHearing at 1-888-939-3635 to schedule an appointment.
Transportation for Medical-Related Trips	Routine Transportation — Up to 12 one-way, no cost rides for routine transportation services to medically related appointments, up to 50 miles each way. Post-Discharge Transportation — Up to 12 one-way, no cost rides per event after an inpatient stay in the hospital or a skilled nursing facility, you are eligible for transportation to plan-approved locations by car, van or wheelchair accessible vehicle for each qualifying post-discharge event. Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.
In-Home Meal Delivery	Receive 2 meals per day for 14 days delivered to your home, at no cost to you after your inpatient stay in either a hospital or skilled nursing facility. Meals can be ordered by your care manager or may be ordered directly from the meal order vendor. The request must be completed within 30 days of your inpatient stay.
In-Home Caregiving Support	- With the Personal Home Care (PHC) benefit, receive in-home care services for a minimum of 4 hours per day up to a maximum of 8 hours per discharge from an inpatient hospitalization or skilled nursing facility stay. - PHC includes certain in-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs). Personal home care services must be initiated within 30 days of the discharge event and utilized within 60 days of discharge. Prior authorization rules may apply. Care may be received in your home or the home of your caregiver. - Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.
Personal Emergency Response (PERS) Device	- The Personal Emergency Response System by Lifeline provides help in emergency situations. Access includes one device plus monthly monitoring services at no cost. The Go Mobility personal help button device functions both in and out of the house and offers fall detection. - Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.

Prescription Drug Coverage

If you are enrolling in the Pfizer Medicare Advantage Plan, you must elect either the Rx Plus or Rx Base option. Alternatively, you may elect Rx Plus Only or Rx Base Only. If you elect Rx Only coverage, you will have no medical or vision coverage.

The prescription drug coverage for Medicare eligible participants is administered by SilverScript® Insurance Company (affiliated with CVS Caremark). The SilverScript options are Pfizer-sponsored Medicare Part D prescription drug plans covering pharmaceutical medications dispensed through a pharmacy.

SilverScript offers a standard Medicare Part D Plan — which aligns to how the standard Medicare Part D Plan works.

- **Rx Plus** covers most Pfizer medications (when no generic is available) dispensed through a pharmacy at no cost to you; and provides **additional coverage** for medications not covered by Medicare (as well as broad coverage for Medicare Part D medications that are not covered by most standard Part D plans);
- **Rx Base** provides coverage for most Pfizer medications (when no generic is available) dispensed through a pharmacy at the same cost-sharing as non-Pfizer medications. Pfizer medications with a generic available are only covered if they are a Medicare Part D medication and on SilverScript's Platinum formulary. To understand if your Pfizer medication with a generic available is covered, see page 19.

The chart below outlines both prescription drug coverage options:

	Rx Plus ¹	Rx Base ¹
Covered List of Medications	Bronze formulary	Platinum formulary
Annual Individual Deductible	\$615; does not apply to Pfizer medications (when no generic is available)	\$615; applies to all covered medications

Prescription Drug Annual Out-of-Pocket Maximums

Annual Individual Medicare Out-of-Pocket Maximum²	\$2,100	\$2,100
Annual Individual Pfizer Maximum Out-of-Pocket²	\$3,500	Not applicable — no additional coverage beyond formulary

Most Pfizer Medications

Most Pfizer Medications (when no generic is available)	Plan pays 100%	Plan pays 75%; you pay 25%
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Retail Medications — Per 30-day Supply

Non-Pfizer Medications + Pfizer Medications (when a generic is available)	Plan pays 75%; you pay 25%	Plan pays 75%; you pay 25%
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Maintenance Choice Program Medications³ — Up to a 90-Day Supply

Non-specialty maintenance medications when filled at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy.

Non-Pfizer Medications + Pfizer Medications (when a generic is available)	Plan pays 75%; you pay 25%	Plan pays 75%; you pay 25%
Non-Medicare Part D Medications (e.g., weight loss, erectile dysfunction, and prescription cold and cough)	Covered	Not covered

	Rx Plus ¹	Rx Base ¹
100% Coverage for Other Medications		
Certain ACA Preventive Medications (deductible does not apply)	Plan pays 100% for certain medications considered preventive by the Affordable Care Act (ACA) ⁴ . These include fluoride treatments, smoking-cessation treatments, oral contraceptives, colonoscopy prep medications, and low-dose generic statins. It also includes certain over-the-counter products for specific age and risk factors. For more information, call SilverScript.	Not applicable; however, medication may be covered if on the SilverScript Platinum formulary but you pay the applicable cost share based on the type of medication

¹ Interest-free payment plan available for Medicare Part D medications where you have a cost. Details about how the payment plan works will be provided by SilverScript in the **Annual Notices of Changes**. For more information, call SilverScript.

² **For Rx Plus**, medications covered by Medicare Part D generally accumulate toward both the Annual Individual Medicare Out-of-Pocket Maximum and the Annual Individual Pfizer Maximum Out-of-Pocket; additionally, under Rx Plus, Pfizer medications when no generic is available do not accumulate to the Annual Individual Pfizer Maximum Out-of-Pocket as these medications are covered at no cost but, due to CMS rules, estimated amounts do count toward the Annual Individual Medicare Out-of-Pocket Maximum. For medications not covered by Medicare Part D but covered under the additional coverage through Pfizer, applicable amounts for those medications will only accumulate toward the Annual Individual Pfizer Maximum Out-of-Pocket. **For Rx Base**, only medications covered by the SilverScript Platinum formulary are covered. There is no additional coverage, therefore amounts only accumulate toward the Annual Individual Medicare Out-of-Pocket Maximum and there is no Pfizer Maximum Out-of-Pocket.

³ The Maintenance Choice Program is referred to in SilverScript materials as Preferred Network Pharmacy.

⁴ The **Prescription Drug Coverage ACA Drug List** can be found at [caremark.com](https://www.caremark.com).

Note: The cost for select insulin products under Medicare Part D plans, such as this SilverScript Plan, are capped at \$35 for a 30-day supply.

Understanding Which Medications are Covered by Medicare Part D

Medications Covered by Medicare Part D:

- **Rx Plus (Bronze formulary):** Almost all Medicare Part D medications will be included under the Pfizer Retiree Medical Plan's prescription coverage;
- **Rx Base (Platinum formulary):** Provides access to a broad range of medications covered under Part D;

Review the applicable SilverScript formulary to find whether your medications are covered under the \$2,100 Annual Individual Medicare Out-of-Pocket Maximum or call SilverScript with any questions;

Once you reach the \$2,100 Annual Individual Medicare Out-of-Pocket Maximum, the Plan will pay 100 percent for all eligible Medicare Part D medications.

Medications Not Covered by Medicare Part D (e.g., Weight loss medications such as Wegovy, Saxenda, or Zepbound, erectile dysfunction medications, and prescription cough and cold medications):

- **Rx Plus:** These medications are not covered by Medicare Part D, but are generally covered under Rx Plus; in some cases, prior authorization may be required;
 - Due to CMS rules, your eligible out-of-pocket amounts for these medications only count toward the Annual Individual Pfizer Maximum Out-of-Pocket;
 - The Annual Individual Pfizer Maximum Out-of-Pocket includes your costs for medications covered by Medicare Part D **and** these medications that are covered by your additional coverage through Pfizer;
 - Once you reach the Annual Individual Pfizer Maximum Out-of-Pocket, the Plan will pay 100 percent for all eligible medications;
- **Rx Base: Medications not covered by Medicare Part D are not covered under Rx Base.**

Examples: Understanding How Your Medicare Prescription Coverage Works

Note: Actual costs may vary, for illustrative purposes only.

Non-Part D Medication under Rx Plus After Deductible is Met

 Zepbound Pen 2.5 mg Non-Part D medication 30-day supply (2 pens) Rx Plus Option (not covered in Rx Base)	Total Rx cost	\$876
	Applied to deductible	Met
	You pay (25%)	\$219
	Pfizer pays (75%)	\$657
	Applied to Medicare out-of-pocket	N/A
	Applied to Pfizer out-of-pocket	\$219

Lower Cost Medication Before the Deductible is Met:

 Entresto 24mg – 26mg Part D non-Pfizer medication 30-day supply (30 tablets) Rx Plus and Rx Base Option	Total Rx cost	\$330
	Applied to deductible	\$330
	You pay	\$330
	Pfizer Pays	\$0
	Applied to Medicare out-of-pocket	\$330
	Applied to Pfizer out-of-pocket	\$330

Pfizer Medication Under Rx Plus and Rx Base After Deductible is Met:

 Eliquis Tab 2.5 mg Part D Pfizer medication (when no generic is available) 30-day supply (30 tablets)	Rx Plus		Rx Base	
	Total Rx cost	\$288	Total Rx cost	\$288
	Applied to deductible	N/A	Applied to deductible	Met
	You pay	\$0	You pay (25%)	\$72
	Pfizer pays	\$288	Pfizer pays (75%)	\$216
	Applied to Medicare out-of-pocket	\$72	Applied to Medicare out-of-pocket	\$72
	Applied to Pfizer out-of-pocket	\$0	Applied to Pfizer out-of-pocket	\$72

Things to Remember

Diabetic supplies, including continuous glucose monitors, are only covered under the Pfizer Medicare Advantage Plan and are not covered under your Pfizer prescription drug coverage through SilverScript. If you enroll in the Rx Plus Only or Rx Base Only option, you will only have diabetic supply coverage through your Medicare Part B coverage.

Note: Diabetic medications, such as insulin, are covered under your Pfizer prescription drug coverage.

Infused Medications

Medications that are infused or administered in your home or at a provider's office or facility (including any Pfizer medications) are generally covered as a medical service under the Pfizer Medicare Advantage Plan. Please contact Humana for coverage details, including pre-authorization requirements.

Prescription Drug Only Options (Rx Plus Only or Rx Base Only)

If you have medical coverage elsewhere (e.g., you are enrolled in a Medigap plan or a Medicare Supplemental plan), or you would like to keep Medicare for your medical coverage, you can elect prescription drug coverage through Pfizer — either Rx Plus Only or Rx Base Only.

Eligibility Requirements for Rx Only Coverage

You may only enroll in the Pfizer Medicare Advantage Plan if you meet the CMS requirements that you:

- Are enrolled (and remain enrolled) in Medicare Parts A and B; enrollment in Medicare Part D is not required;
- Provide Fidelity at the **Pfizer Benefits Center** with your Medicare Beneficiary Identifier (MBI) shown on your red, white and blue Medicare ID card as your “Medicare Number;”
- Have a permanent U.S. street address (not P.O. Box)* on file; or
- Are not within the 30-month coordination period for end-stage renal disease.

* You can keep your P.O. Box address as your primary mailing address; we will only use your street address for purposes of Medicare eligibility.

How to Maximize Your Prescription Drug Benefits

- **Use Pfizer medications:** Under **Rx Plus**, when you visit an in-network pharmacy, the Plan covers 100 percent of the cost for Pfizer medications (when no generic is available). Out-of-network pharmacies may require a cost since out-of-network reimbursement is limited to the contracted rate. Also, Pfizer medications (when a generic is available) — such as Accupril, Pristiq, Protonix, and others — are covered at the same cost-sharing as non-Pfizer medications; you and Pfizer share in the cost. **Note:** Under **Rx Base**, Pfizer medications on the SilverScript Platinum formulary are covered at the same cost-share as non-Pfizer medications;

- **Use a SilverScript network pharmacy:** Fill your prescriptions at a network pharmacy to receive the maximum Plan benefit. You can find network pharmacies near you on the SilverScript website. See the *Resources* section on page 26 for details and contact information;

If you use an out-of-network pharmacy, you may be required to pay the full cost of the prescription (including a Pfizer medication covered at no cost based on your coverage option). You will also need to submit a reimbursement request along with your receipt for payment to SilverScript. Reimbursement will be provided up to the SilverScript contracted rate, which may be lower than the amount you paid;

- **Use the Maintenance Choice Program* for maintenance medications (90-day supply):** With this program, you can fill up to a 90-day supply of your non-specialty maintenance medications at either a CVS Pharmacy or through the CVS Caremark Mail Service Pharmacy and receive preferred pricing. Maintenance medications are typically taken on a regular basis for long term or chronic conditions (i.e., diabetes, high blood pressure, and high cholesterol).

For more information, call SilverScript at **1-844-774-2273** or go to pfizer.silverscript.com. You can view a full list of non-specialty maintenance medications by logging on to caremark.com, access the *Plan & Benefits* tab and then click on *Print Plan Forms*;

- **Talk to your provider about biosimilar medication:** These are available to treat conditions such as Crohn’s disease, ulcerative colitis, and rheumatoid arthritis. Compared to the reference product (e.g., Humira or Stelara), biosimilars have no clinically meaningful differences in terms of safety and efficacy, and offer a cost-savings over the reference product. Contact SilverScript for more information about biosimilar medications.

* Referred to in SilverScript materials as Preferred Network Pharmacy.

Vision Coverage

Vision benefits are administered by Humana and accessed through EyeMed for Medicare eligible retirees covered under the Pfizer Medicare Advantage Plan. This coverage includes routine eye care including eye examinations and eyewear. Coverage is through EyeMed’s Insight network (the same network used by Pfizer’s vision coverage for Non-Medicare Eligible retirees). Show your **Humana ID card** to an EyeMed participating provider.

Note: Vision coverage is not included with Pfizer’s prescription drug-only coverage.

The chart below highlights key vision benefits. The Plan deductible does not apply to these benefits:

Benefit Coverage (every 12 months)	In-Network (Insight network)	Out of Network Maximum Reimbursement*
Routine Eye Exam with Vision Test	\$0 copay	Up to \$175 maximum benefit
Frames and Lenses	\$400 coverage	\$400
Contacts (in lieu of frames and lenses)	\$150 coverage	\$150

*Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

For questions or more information about your vision coverage including how to locate an EyeMed Insight network provider, visit <https://findcare.humana.com> or call Humana at **1-800-654-1092**, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.



Dental Coverage for Non-Medicare Eligible and Medicare Eligible Retirees

When you retire, you have the option to choose from two dental plan providers:

MetLife

Through MetLife, you have a one-time opportunity when you retire to elect retiree dental coverage at group rates. There is no waiting period for coverage to start. For more information, call **1-800-GET-MET-8 (1-800-438-6388)**, Monday through Friday from 8 a.m. to 8 p.m., Eastern Time. Summary details are also posted to the Reference Library on netbenefits.com.

Delta Dental

Through Delta Dental, you have the option to enroll in retiree dental coverage at any time; however, waiting periods for certain non-preventive dental services may apply. Delta Dental offers you the option to enroll in their Smile On* program, which is available in select states. If the Smile On program is not available in your area, coverage through an individual policy may be available. Visit deltadentalins.com/SmileOn or call **1-888-216-9662**, Monday through Friday from 8 a.m. to 8 p.m., Eastern Time.

*Smile On Dental Plan options are currently available in AL, CA, DE, FL, GA, LA, MD, MS, MT, NV, NY, PA, TX, UT, WV and DC. Plan options for most other states are available at pooled rates through Delta Dental. Smile On representatives will help connect you to your options. Plans purchased through this coverage are considered new coverage and not a continuation of any plan you may currently have. Waiting periods may apply. Any applicable deductibles and maximums will reset. Limitations and exclusions apply. See Delta Dental's plan documents for details.

Enrolling in Dental Coverage

You will receive information about electing coverage from each provider approximately four weeks after you become eligible for coverage (which is generally your termination date or end of active benefit continuation under a Pfizer separation plan, if later).

Regardless of whether you select coverage through MetLife or Delta Dental, you pay the full cost of any coverage elected. Contributions vary based on the level of coverage selected, the family members you enroll, and your geographic location.

In addition to these dental options, remember when your active Pfizer dental coverage ends (such as when you terminate or your active benefits continuation coverage ends), you will be eligible to enroll in COBRA and pay the full COBRA cost to continue your active dental coverage, in most cases for 18 additional months following your active coverage end date. If you choose to continue COBRA dental, you will then have the opportunity to enroll in the retiree dental options listed above after your COBRA dental coverage ends.

Covering Both Non-Medicare Eligible and Medicare Eligible Family Members

Split Family Coverage

If you and your dependents differ in Medicare eligibility (e.g., one or more of you are non-Medicare eligible, and the rest are Medicare eligible), you will need to enroll yourself and your eligible dependent(s) separately in the Retiree Medical Plan based on each individual's Medicare eligibility; this is referred to as **"Split Family"** coverage.

Pfizer Colleague/Retiree Couples — Spouse/Domestic Partner Under the Retiree Benefits Program

If you and your spouse/domestic partner are Pfizer retirees, you can do one of the following:

- Each of you enrolls in your own coverage — only one of you covers your dependent children (if applicable);
- Enroll to cover your spouse or domestic partner under your retiree coverage; or
- Receive coverage under your spouse/domestic partner coverage (either as a non-Medicare eligible or Medicare eligible dependent along with eligible dependent children).

Deductibles and Out-of-Pocket Maximums

When you and your spouse/domestic partner or dependent are enrolled in different retiree medical plan options (e.g., one of you is enrolled in the Pfizer Medicare Advantage Plan with Rx Plus and the other is enrolled in the Retiree PPO option), each will need to satisfy the deductible and reach the out-of-pocket maximum for that plan. Those amounts are not combined or transferable to another plan.



Additional Things to Consider (for Non-Medicare Eligible and Medicare Eligible Retirees)

Hardship Provisions

If you meet certain criteria, you may qualify for reduced contributions. Action may be required each year.

Note: The hardship provision is not available to retirees with Access-Only coverage:

- **Non-Medicare Eligible:** If you are single and your income in 2024 was less than \$23,475, or if you are married and your combined income in 2024 was less than \$31,725, you may qualify for a hardship provision and reduced Pfizer retiree medical plan contributions. You may only apply for assistance once a year during Annual Enrollment if your gross income for 2023 was lower than the thresholds outlined above.

To obtain an application, call Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950** to speak with a representative. You will be required to submit a copy of your 2024 income tax return as part of the application process. If approved, your reduced contribution rate will take effect as of January 1, 2026, and will remain in effect through December 31, 2026. Should you qualify, you will be notified of your contribution rate in writing.

Note: The income thresholds above are updated every few years and are similar to the criteria used to determine eligibility for Extra Help under Medicare Part D.

Action May Be Required Each Year for Non-Medicare Eligible Retirees

To confirm your eligibility for a hardship provision, contact Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950**. You must re-apply each year during the Annual Enrollment period. If you apply and do not qualify, you have the opportunity to re-apply the following year.

- **Medicare Eligible:** Retirees who have been approved for the Medicare Part D low-income subsidy (called “Extra Help”) will automatically be eligible for Pfizer’s contribution hardship provision. Medicare eligible retirees should receive information from the Social Security Administration. For more information, you can contact them:
 - Online at [socialsecurity.gov/extrahelp](https://www.socialsecurity.gov/extrahelp);
 - By calling the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778); or
 - In person at your local Social Security office.

Once you have completed your application process, Social Security will send you a letter to advise you of your acceptance or denial.

If CMS approves your eligibility for Extra Help, CMS will notify Fidelity at the **Pfizer Benefits Center**, and your monthly contribution will automatically be adjusted when you are invoiced or when the deduction is taken via automatic bank withdrawal. This reduction will include any amount from Extra Help.

Important: The process of applying for the Pfizer hardship provision will be based on the Pfizer retiree’s age, not the dependent’s age.

Hardship Provision: Action May Be Required Each Year for Medicare Eligible Retirees

At the end of September, Social Security sends a letter to certain Extra Help recipients with a form outlining the financial and personal information they have on file. If you receive this letter, you will be required to confirm within 30 days whether the information has changed. If you do not respond to this request, Medicare will end your enrollment in Extra Help, and your eligibility for the Pfizer hardship provision will also end.

Waiving Coverage

Pfizer recognizes that you may find other insurance that is less costly than Pfizer's coverage or better meets your health care needs. If you choose to drop your Pfizer coverage, you may re-enroll within 31 days of a qualified life event, including the loss of other medical coverage. You must certify that you have maintained continuous creditable coverage while not enrolled in the Pfizer Retiree Medical Plan, in accordance with the Plan's rules. Refer to the **Pfizer Retiree Medical Plan Summary Plan Description (SPD)** for details.

Important: If you are Medicare eligible, supplemental Medicare plans (including Medigap plans and local Medicare Advantage plans) may ask you to provide evidence of health if you enroll in their plan after you become Medicare eligible; these enrollment rules vary by state. Some states may view the loss

of employer-provided coverage (including Pfizer's Medicare Advantage Plan, which is an employer group-sponsored plan) as a qualified life event and allow you to enroll in their plan without providing evidence of health.

It is your responsibility to understand the rules for any non-Pfizer Medicare plans you are considering. **To help you understand the general rules for other Humana Medicare plans you are considering, you can contact a Humana Customer Service advocate at 1-800-654-1092**, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.

If you are considering a non-Pfizer plan, contact that plan's administrator to discuss the specific rules for the plan, including the effect of waiving coverage and the requirements to re-enroll at a future date.

If You Are Enrolled in a Non-Pfizer Medicare Plan — Action May Be Required

CMS does not allow enrollment in more than one Medicare Advantage plan or more than one Medicare Part D prescription drug plan, so if you are already enrolled in one of those plans, you will need to choose between that plan and Pfizer retiree medical coverage.

If you are enrolled in a Medigap or Medicare Supplemental plan, these types of plans are intended to supplement Medicare. Since the Pfizer Medicare Advantage Plan replaces Medicare, you would not receive any additional benefits from your Medigap or Medicare Supplemental Plan. In this case, you may want to consider enrolling in one of the Prescription Drug-Only options if you would like to keep your Pfizer prescription drug coverage.

Your Contributions

Your cost of coverage varies based on your retiree group/legacy company and your retirement date, whether you (and your covered family members) are non-Medicare eligible or Medicare eligible. Additional details about how contributions are determined are included in the Plan's **Summary Plan Description** located in the *Reference Library* on netbenefits.com.

For questions about your contributions, refer to your **Personal Fact Sheet**, log in to netbenefits.com, or call Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950**. Representatives will be available Monday through Friday from 8:30 a.m. to midnight, Eastern Time.

Paying for Coverage

You will receive a monthly invoice from Fidelity for your required contribution. Failure to submit your required contribution by the due date may result in a loss of your Pfizer coverage. Consider enrolling in Automatic Bank Withdrawal (ABW) so your contributions are paid automatically, helping you avoid additional costs or loss of your Pfizer coverage.

Call Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950** to enroll by phone or to request that an ABW enrollment form be mailed to you. You can enroll in ABW at any time.

Additional Premium for Higher-Income Retirees

Medicare may require you to pay an "Income-Related Monthly Adjustment Amount" (IRMAA) based on your annual income. Income thresholds are reviewed and set each year by the Centers for Medicare and Medicaid Services (CMS). If the modified adjusted gross income, as reported on your IRS tax return from two years ago, is more than a certain income level, Medicare will require you to pay the Part B IRMAA and Part D IRMAA based on your income. Each family member determined to be high income and enrolled in Medicare Part B and Medicare Part D will pay the applicable Part B IRMAA and Part D IRMAA.

The Part B IRMAA will automatically be added to your premium bill from Medicare. The Part D IRMAA will be reflected as a surcharge on your premium bill from Medicare.

Neither Pfizer, UHC, Humana, nor SilverScript are notified if you are required to pay the Part B IRMAA and Part D IRMAA, unless you are disenrolled by Medicare for non-payment.

Retiree Medical Subsidy (RMS)

If you are eligible for Pfizer's Retiree Medical Subsidy (RMS), which is an unfunded, notional account, it will be established at the time of your retirement*. The RMS defines the total dollar amount that Pfizer will contribute toward the cost of your Company-sponsored retiree medical coverage and is used to pay Pfizer's share of your retiree medical coverage costs. Your RMS balance will decrease over time based on the cost of the coverage you choose while you are enrolled in the Pfizer Retiree Medical Plan. You will pay the difference, in the form of monthly contributions, between the total cost of coverage and the amount Pfizer pays through the RMS. You may also refer to the **Summary Plan Description** located in the *Reference Library* on netbenefits.com to understand how your RMS was originally determined.

After your RMS is depleted, you pay the full cost of coverage. To see your current RMS balance, refer to your **Personal Fact Sheet** or go online to netbenefits.com and navigate to the *Health & Insurance* section and scroll down to see Your Current Benefits. For more information, call Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950**.

* The RMS is provided to legacy Pfizer retirees who initially retired after January 1, 2010, and legacy Wyeth retirees who initially retired after January 1, 2012. For information on your RMS balance, contact Fidelity at the **Pfizer Benefits Center** directly at **1-877-208-0950**. If you are not eligible for the RMS and have questions about your cost of coverage including your contributions, contact Fidelity at the **Pfizer Benefits Center**.

Support for Caregivers Assisting with Enrollment

If you are a caregiver assisting a Pfizer retiree or eligible dependent with enrollment elections or navigating health care, you may need to provide certain permissions, and in some cases a power of attorney may be required in order to speak with the **Pfizer Benefits Center** on behalf of the retiree or dependent. For your security, the **Pfizer Benefits Center** requires their own documentation, even if you have a power of attorney on file with the medical plan administrator (Horizon or UHC). If these permissions or a power of attorney is on file with the **Pfizer Benefits Center**, we can help.

Call Fidelity at the **Pfizer Benefits Center** to speak with a representative at: **1-877-208-0950**, Monday through Friday from 8:30 a.m. to midnight, Eastern Time.

If you are enrolled in the Pfizer Medicare Advantage Plan, you can also take advantage of the Caregiver Support program offered by Humana as described on page 15. Humana also provides resources for caregivers; visit Humana.com/caregiver.

Resources

Topic	Contact
Non-Medicare Eligible Coverage	
Medical Coverage Through Horizon (For medical and mental health/substance use) <i>Blue Card Network</i>	Horizon (for medical and mental health/substance use coverage) • Horizonblue.com/pfizer — Select <i>Tools & Services</i>, then <i>Find a Doctor</i> to search for providers. Scroll to the bottom of the selected <i>Find a Provider</i> option and click on the applicable sample ID Card; or • Call Horizon at 1-888-340-5001, Monday through Friday from 8 a.m. to 11 p.m., Eastern Time. • Telehealth Services: To access care, you can use the member online services under horizonblue.com/pfizer or download the Horizon Blue mobile app.
Medical Coverage Through UHC including the Holding Plan (For medical and mental health/substance use) <i>Choice Plus Network*</i>	UnitedHealthcare (for medical coverage) • Myuhc.com • Log in to the UnitedHealthcare Health4Me mobile app, which can be downloaded from the Apple App Store or Google Play; • Call UHC at 1-800-638-8010, Monday through Friday from 8 a.m. to 8 p.m., Eastern Time; or • Telehealth Services: myuhc.com/virtualvisits or download the UnitedHealthcare app. Optum (for mental health/substance use coverage) • Liveandworkwell.com; log in or use access code 61550 to enter the site anonymously; • Call Optum at 1-866-834-7603, Monday through Friday from 8 a.m. to 8 p.m., Eastern Time; or • Telemental Health Visits: liveandworkwell.com; log in or use access code 61550 to enter the site anonymously. Go to the <i>Find Care</i> tab and select <i>Virtual Visits</i>.
Prescription Drug Coverage Through Caremark	CVS Caremark • Caremark.com; or • Call Caremark at 1-866-804-5881, 24 hours a day, seven days a week. • CVS Specialty: visit cvsspecialty.com or call 1-800-237-2767
TrestleTree (health coaching programs)	Free Diabetic Supply and Healthy Weight Programs Call TrestleTree at 1-866-237-0967 , Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m., Eastern Time.
Vision Coverage Through EyeMed <i>Insight Network</i>	EyeMed Vision Care • Eyemedvisioncare.com/pfizer; or • Log in to the EyeMed Members mobile app, which can be downloaded from the Apple App Store or Google Play. • Call EyeMed at 1-855-629-5015, Monday through Saturday from 7:30 a.m. to 11 p.m. and Sunday from 11 a.m. to 8 p.m., Eastern Time.
Expert Medical Opinion Service	Health Navigator (powered by PinnacleCare) • Sunlife.com/pfizer • Call Sunlife at 1-877-280-7466, Monday through Friday from 8 a.m. to 6 p.m., Eastern Time.

Topic	Contact
Medicare Eligible Coverage	
Medical Coverage Through Humana Medicare Advantage (medical and mental health/substance use)	Humana Medicare Advantage • Humana; or • Call Humana at 1-800-654-1092, TTY 711, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time. Telehealth Services: • For a non-emergency health condition, you can schedule a visit with MDLive at 1-888-673-1992 or at https://members.mdlive.com/humanamedicare/landing_home. • Find a list of virtual medical and mental health providers at https://findcare.humana.com.
Vision Coverage Administered Through Humana via EyeMed Insight Network	Humana via EyeMed Vision Care • To locate a provider, through the Humana Medicare Insight Network for routine vision, use the provider locator at https://findcare.humana.com. • Call Humana at 1-800-654-1092, Monday through Friday from 8 a.m. to 9 p.m., Eastern Time.
Medicare Enrollment Assistance	Allsup • Call Allsup at 1-888-271-1173.
Prescription Drug Coverage Through SilverScript	SilverScript • Pfizer.silverscript.com; or • Call SilverScript at 1-844-774-2273, 24 hours a day, seven days a week.
Non-Medicare Eligible and Medicare Eligible Coverage	
Eligibility, Enrollment, and Contributions	Pfizer Benefits Center • Netbenefits.com; or • Call Fidelity at the Pfizer Benefits Center at 1-877-208-0950; representatives will be available to assist you Monday through Friday from 8:30 a.m. to midnight, Eastern Time.

Important Documents

Summary Plan Description (SPD)

Refer to the **Summary Plan Description** (SPD) for the Pfizer Retiree Medical Plan for more detailed information on plan eligibility and what services are and are not covered. This SPD is available at netbenefits.com in the *Reference Library*. Find the *Health & Insurance* section on the home page, and then click *Quick Links* and *Reference Library*.

Legal Notices Booklet

Review the legal notices booklet, which provides details on many of your rights under your health care plans. The booklet is available at netbenefits.com in the *Reference Library*. Find the *Health & Insurance* section on the home page, and then click *Quick Links* and *Reference Library*.

HSA Preventive Drug List (if Non-Medicare Eligible)

If you're enrolled in the HSA-Eligible PPO option and you are taking a medication on the **HSA Preventive Drug List** (e.g., for diabetes or hypertension), the deductible won't apply; you will pay your cost share. View the **HSA Preventive Drug List** available at netbenefits.com in the *Reference Library* or call CVS Caremark for more information.

Pfizer Zero Cost Prescription Drug List*

Review the **Pfizer Zero Cost Prescription Drug List** located on netbenefits.com in the *Reference Library*. Find the *Health & Insurance* section on the home page, then click *Quick Links* and *Reference Library*. As a reminder, if you are enrolled in the Rx Base option, covered Pfizer medications are covered at the same cost-sharing level as non-Pfizer medications.

* **Note:** This list is subject to change during the year as Pfizer may add or remove products from this list at any time, for any reason.



This brochure contains information about Pfizer retiree health care benefits and the Pfizer Retiree Medical Plan, but it is not intended to provide every detail. Complete details can be found in the **Pfizer Retiree Medical Plan Document** or its accompanying **Summary Plan Description**. Both are available upon request to the Company, or can be accessed at netbenefits.com or by calling Fidelity at the **Pfizer Benefits Center** at **1-877-208-0950**.

While Pfizer expects to continue the benefits described in this brochure, it reserves the right to amend, suspend, or terminate the Pfizer Retiree Medical Plan and any retiree health care benefits offered by the Company at any time, with or without notice, and for any reason, including, without limitation, the right to increase costs and/or reduce or eliminate any Pfizer contribution. Pfizer may also need to adjust the Pfizer Retiree Medical Plan or this program, or any/all of the benefit plans it offers, to comply with applicable laws or regulations.