U.S. Retirees
2018 Health Care Brochure for Annual Enrollment:
What You Need to Know

2018 Annual Enrollment is Oct. 10 through Oct. 27, 2017

Note that information contained 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 Jan. 1, 1992, or Wyeth retirees covered by the Change in Control (CIC) arrangement.
TIPS FOR USING THIS BROCHURE

As you’re learning about your Pfizer benefits, keep an eye out for the following icons:

**Things To Remember...**  Additional considerations as you use certain benefits.

**Tips on how to get the most from your benefits.**

**Tools to help you understand your benefits and how they can help you and your family.**
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Welcome to Annual Enrollment for 2018 Pfizer Benefits

Welcome to Annual Enrollment for your 2018 health care coverage. This is your opportunity to evaluate your current coverage and determine whether you need to make changes—particularly if your health or circumstances have changed over the last year.

Review the information in this brochure to become familiar with the 2018 medical and prescription drug plan options, the plan changes that are being made for 2018 (except where otherwise noted) and how to make a coverage change for Jan. 1, 2018.

The information in this brochure is based on your specific situation and/or that of your dependents.

<table>
<thead>
<tr>
<th>If...</th>
<th>See...</th>
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<tbody>
<tr>
<td>You and your dependent(s) are not eligible for Medicare</td>
<td>Page 3</td>
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<td>You and your dependent(s) are eligible for Medicare</td>
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<tr>
<td>You have split family coverage (one of you is eligible for Medicare and the other isn’t)</td>
<td>Page 18</td>
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<td>You or your dependent(s) are turning 65 after Oct. 1, 2017, or in early 2018</td>
<td>Page 19</td>
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NOTE TO CAREGIVERS

If you are a caregiver to a Pfizer retiree or dependent, please see page 24 of this brochure for information on accessing health care information and helping with enrollment elections.

VALIDATE ELIGIBILITY AND COVERAGE FOR YOUR DEPENDENTS

You are required to validate that your dependents covered under Pfizer’s Retiree Medical Plan meet the Pfizer dependent eligibility requirements during Annual Enrollment. During first quarter 2018, Pfizer will be conducting a random audit of covered dependents to ensure they meet Pfizer’s eligibility requirements. During the audit, proof of eligibility will be required for continued coverage. If you do not provide proof of eligibility, your dependent will lose coverage and retirees found to be covering ineligible dependents may be subject to loss of retiree medical coverage. Refer to the Pfizer Retiree Medical Summary Plan Description (SPD) for more details about dependent coverage and eligibility. The SPD can be found in the Reference Library on Fidelity NetBenefits® at netbenefits.com. Click the Health & Insurance section on the home page, and then click Quick Links and Reference Library.
Non-Medicare-Eligible (Under Age 65) Retiree Coverage Options

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). Note: If some family members are eligible for Medicare and some aren’t, you are considered to have “split family” coverage. Please go to page 18 for more information on how split family coverage works.

What’s Changing for 2018

Effective 2018 there will be a few changes to medical and prescription drug coverage that you should be aware of.

<table>
<thead>
<tr>
<th>Program/Feature</th>
<th>What’s Changing Jan. 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Coverage</td>
<td>Annual deductibles will increase under both Plan options.</td>
</tr>
<tr>
<td></td>
<td><strong>Retiree PPO Plan</strong></td>
</tr>
<tr>
<td></td>
<td>• In-network deductible is increasing from $700 individual / $1,750 family to $800 individual / $2,000 family; and</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network deductible is increasing from $1,400 individual / $3,500 family to $1,600 individual / $4,000 family.</td>
</tr>
<tr>
<td></td>
<td><strong>High-Deductible PPO Plan</strong></td>
</tr>
<tr>
<td></td>
<td>• In-network deductible is increasing from $3,000 individual / $7,500 family to $3,300 individual / $8,250 family; and</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network deductible is increasing from $6,000 individual / $15,000 family to $6,600 individual / $16,500 family.</td>
</tr>
<tr>
<td>Contributions</td>
<td>Contributions are increasing for the Retiree PPO Plan and High-Deductible PPO Plan. Your 2018 contribution amounts will be shown on your Personal Fact Sheet (PFS), which is being mailed to you separately at the same time as this mailing.</td>
</tr>
<tr>
<td>Behavioral Health and</td>
<td>United Behavioral Health (UBH), the claims administrator for behavioral health and substance use claims under both Pfizer Retiree Medical Plan options, is changing its name to Optum.</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Telemental Health, offered through Optum, provides convenient access to behavioral health care services when and where you want it. You’ll get to speak with a behavioral health professional through video conferencing technology. The visit will be covered as any other in-network behavioral health office visit based on the Plan option in which you are enrolled. To learn more or schedule a Telemental Health visit, go to liveandworkwell.com and use code 61550.</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>In order to comply with Affordable Care Act (ACA) provisions, aspirin will no longer be available at no cost, unless you are under age 60 and eligible for Medicare due to disability.</td>
</tr>
<tr>
<td>Coverage</td>
<td></td>
</tr>
</tbody>
</table>
Choose Your Claims Administrator: UnitedHealthcare or Horizon Blue Cross Blue Shield

The claims administrator you choose for your medical plan determines your network of providers. Pfizer offers two claims administrators for you to choose from—UnitedHealthcare (UHC) or Horizon Blue Cross Blue Shield (Horizon). It’s a good idea to review your current providers to determine if they are in-network with either UHC or Horizon.

Both claims administrators regularly review the quality of their in-network providers and can direct you to experienced providers with successful track records in treating specific illnesses and conditions. Go to the UHC and Horizon websites to find out if your providers are in-network or to search for providers who have designations indicating high quality and efficiency ratings as UHC Premium and Horizon Blue Distinction providers. Using in-network providers can greatly reduce your out-of-pocket health care costs and eliminate the need to file claims. (See Your Resources on page 23 for details on how to contact UHC and Horizon and refer to the In-Network vs. Out-of-Network section below.)

The claims administrators typically differ in two ways: they each use a different network of providers and their contracted rates with providers may vary (which affects how much you pay for services if you pay a coinsurance). Keep in mind, however, you’ll receive coverage for the same services and pay the same contributions regardless of which medical claims administrator you choose.

In addition, behavioral health coverage is administered by Optum, regardless of which claims administrator you choose. You can contact Optum directly for more information and to find a provider. See Your Resources on page 23 for contact information.

In-Network vs. Out-of-Network

No matter which option you choose, you will receive a greater benefit when you use in-network providers. By using in-network providers, you have a lower annual deductible and are reimbursed at a higher rate. Additionally, you save money because your provider has agreed to charge a contracted rate, which is generally lower than the rate charged for out-of-network care. To locate an in-network provider, please refer to Your Resources on page 23 for your claims administrator’s website, network name and telephone contact information.

Choose a Medical Plan Option: Retiree PPO or High-Deductible PPO

Pfizer continues to offer two medical plan options to retirees who are not yet eligible for Medicare—the Retiree PPO option and the High-Deductible PPO option. Both options provide in-network and out-of-network coverage, preventive care and prescription drug coverage (with most Pfizer medications dispensed through a pharmacy, including Greenstone generics, covered at no cost to you). As mentioned earlier, whichever option you choose, you must also choose a medical claims administrator: UHC or Horizon.

Choosing the Right Coverage

Selecting the right medical plan option should be based on several factors, including the amount of coverage you need and how you prefer to pay for your medical costs:

- Lower monthly contributions with the potential for higher out-of-pocket costs when you receive services; or
- More predictable costs through higher monthly contributions with lower out-of-pocket costs when you receive services.

The chart below compares certain key elements of the Retiree PPO and High-Deductible PPO options:

<table>
<thead>
<tr>
<th></th>
<th>Retiree PPO</th>
<th>High-Deductible PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Contributions</td>
<td>Higher</td>
<td>Lower</td>
</tr>
<tr>
<td>Deductible and</td>
<td>Lower</td>
<td>Higher</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td>In-Network Coverage</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Plan pays 60%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Coverage*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* When medical services are received by an out-of-network provider, Reasonable and Customary (R&C) amounts are generally based on 250 percent of the Maximum Non-Network Reimbursement Plan (MNRP), or as determined by the claims administrator. You are responsible for paying the difference between what the provider charges and the R&C amount, and these amounts do not apply to your annual deductible or out-of-pocket maximum.

Review the coverage chart on page 7 for more details and to determine which option best meets your needs.
Non-Medicare-Eligible (Under 65) Retiree Coverage Options

EXPERT MEDICAL OPINION SERVICE THROUGH PINNACLECARE

You and your covered dependents have access to an Expert Medical Opinion Service, offered through PinnacleCare. This concierge service is available at no cost and is designed to help you and your covered dependents navigate a serious or complex health issue, such as cancer or a major surgery. PinnacleCare provides objective guidance that will help you confirm your diagnosis, evaluate available treatment options, identify the most qualified provider or Center of Excellence, schedule appointments and get answers to your health questions. A PinnacleCare Health Advisor will support and guide you through your health care challenge and connect you with other Pfizer-sponsored resources available to you and your covered dependents, such as the Cancer Support Program.

For more details about this service go to pinnaclecare.com/support or call 1-877-280-7466. Representatives are available Monday through Friday from 8 a.m. to 6 p.m., Eastern time.

TELEMENTAL HEALTH

Telemental Health provides convenient access to behavioral health care services when and where you want it. You’ll get to speak with a behavioral health professional through video conferencing technology.

Telemental Health is offered through Optum, with access to a network of over 3,000 Telemental Health providers across the country. The visit will be covered as any other in-network behavioral health office visit based on the Plan option in which you are enrolled.

To learn more or schedule a Telemental Health visit, go to liveandworkwell.com and use code 61550.

Things To Remember...

If you or a non-Medicare-eligible covered dependent have a non-emergency health condition, with a $15 copay, the Teladoc service may be a convenient and less costly alternative. Registration is required before you can access services. Go to evisit.pfizer.com or call 1-800-TELADOC (1-800-835-2362) to learn more.

Look for in-network providers whenever possible so you can get the benefit of your claims administrator’s contracted rate for medical services.

Remember, some medical services require pre-authorization and medical necessity verification in order to be covered under the Retiree PPO or High-Deductible PPO option. Refer to the SPDs for additional information, available at netbenefits.com in the Reference Library.

If you have a planned hospital stay coming up, make sure your claims administrator is notified in advance if you are using an out-of-network provider.
Prescription Drug Coverage

Prescription drug coverage, administered through CVS Caremark®, is automatically included with your retiree medical coverage and covers medications dispensed through a pharmacy. Coverage varies based on your medical plan option. For details, see the chart on page 7.

Specialty Medications

Specialty medications are injectable, infused, oral, topical or inhaled medications that often require specialized delivery, handling, monitoring or administration and are generally high cost. When you are prescribed a specialty medication, that medication must be ordered through CVS Specialty and can be delivered to the location of your choice—or you can choose to pick it up at a CVS Pharmacy. For more information, including a list of specialty medications, please call CVS Specialty at 1-800-237-2767 or go to cvsspecialty.com.

Note: Medications that are infused or otherwise 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 Medical Plan. Please contact your medical claims administrator for coverage details, including preauthorization requirements.

IMPORTANT INFORMATION ABOUT PFIZER AND GREENSTONE ZERO COST MEDICATIONS

When filling a prescription for a non-Pfizer brand or a generic medication, ask your pharmacist if a Greenstone generic is available. Most Pfizer medications, including Greenstone generics, dispensed through a pharmacy are available at no cost to you.

The Pfizer Zero Cost Prescription Drug List (including Greenstone generics) may change from year to year as new medications are added and some are removed. Because the list includes medications co-branded or co-marketed with other companies, medications may be removed from the list as these agreements expire.

The Pfizer Zero Cost Prescription Drug List (including Greenstone generics) is included in this package for your reference. The Pfizer Zero Cost Prescription Drug List will be updated for 2018. It can also be found at netbenefits.com in the Reference Library. Click the Health & Insurance section on the home page, and then click Quick Links and Reference Library.

HOW TO MAXIMIZE YOUR PRESCRIPTION DRUG BENEFITS

• Use Pfizer medications: Most Pfizer medications, including Greenstone generics, dispensed at a pharmacy are covered at 100 percent. Make sure your doctor writes “dispense as written” on your Pfizer brand drug prescriptions to avoid substitution with a generic medication and a potential charge.

• Fill a 90-day supply for all non-specialty maintenance medications through the Maintenance Choice Program: 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 have your prescription delivered to the location of your choice). Both options provide a 90-day supply of your medication at mail-order pricing, and your cost will not exceed the 60-day supply coinsurance maximum. Keep in mind, mail-order pricing is generally lower than retail (whether you use a CVS Pharmacy or the CVS Caremark Mail Service Pharmacy). Remember, non-specialty maintenance medications are medications that are typically prescribed and taken on a regular or daily basis to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. For a full list, go to caremark.com.

• Use a participating pharmacy: To receive the maximum Plan benefit, fill your prescriptions at a CVS Caremark participating pharmacy. Note: the CVS Caremark network includes CVS and Target pharmacies along with many local pharmacies, other large pharmacy chains (including Walgreens) and other retail store pharmacies (such as Walmart). Go to caremark.com to find a participating pharmacy near you. If you use a non-participating pharmacy, you will be required to pay the full cost of the prescription (even for an eligible Pfizer and Greenstone generic medication) at the time of purchase and then submit a claim to CVS Caremark for reimbursement. The out-of-network reimbursement you receive, including for Pfizer medications, may be less than the full cost of the prescription if the cost is over the CVS Caremark contracted rate.

For more information, contact the pharmacist at a CVS Pharmacy, call CVS Caremark at 1-866-804-5881 or go to caremark.com.
### How the Plan Options Compare

See the chart below for a high-level comparison of the key provisions of the Retiree PPO option and the High-Deductible PPO option for non-Medicare-eligible participants.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Retiree PPO</th>
<th>High-Deductible PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Deductible</strong> (Individual/Family)</td>
<td>$800/$2,000</td>
<td>$1,600/$4,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong> (Individual/Family)</td>
<td>$4,500/$7,250</td>
<td>$7,500/$14,500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% of contracted rate; You pay 20%</td>
<td>Plan pays 60% up to R&amp;C amount; You pay 40%²</td>
</tr>
<tr>
<td><strong>Preventive Care</strong>³</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong> (Annual allowance maximum is combined for in-network and out-of-network expenses)</td>
<td>Plan pays 80%; You pay 20% up to your annual allowance maximum of $1,500 per ear per year</td>
<td>Plan pays 60%; you pay 40% up to your annual allowance maximum of $1,500 per ear per year</td>
</tr>
</tbody>
</table>

**Prescription Drug Coverage**

- **Coverage for most Pfizer Medications including Greenstone Generics**: Plan pays 100%

**Coverage for Non-Pfizer Medications**

- **Coverage for Blood Glucose Testing Meters**: 100% coverage for OneTouch⁶ blood glucose testing meters⁵

| Retail (30-day supply)                      | You pay 20% with a $10 minimum/$125 maximum coinsurance per prescription⁵ | You pay 30% with a $15 minimum/$150 maximum coinsurance per prescription⁵ |
| Retail (90-day supply)                      | You pay 20% with a $30 minimum/$375 maximum coinsurance per prescription⁵ | You pay 30% with a $45 minimum/$450 maximum coinsurance per prescription⁵ |

- **Maintenance Choice Program (Non-specialty maintenance medications up to a 90-day supply)**
  - Only when filled at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy
  - You pay 20% with a $20 minimum/$250 maximum coinsurance per prescription⁵
  - You pay 30% with a $30 minimum/$300 maximum coinsurance per prescription⁵

- **Specialty Medications**
  - You pay 20% with a $10 minimum/$125 maximum coinsurance for each 30-day supply of your prescription⁵
  - You pay 30% with a $15 minimum/$150 maximum coinsurance for each 30-day supply of your prescription⁵

- **Prescription Drug Out-of-Pocket Maximum (Individual/Family)**
  - $3,500/$5,500
  - $3,500/$5,500

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¹ Eligible expenses in a given calendar year for covered services such as deductibles and coinsurance amounts are applied toward the out-of-pocket maximum, if applicable.

² When medical services are received by an out-of-network provider, Reasonable and Customary (R&C) amounts are generally based on 250 percent of the Maximum Non-Network Reimbursement Plan (MNRP), or as determined by the claims administrator. You are responsible for paying the difference between what the provider charges and the R&C amount, and these amounts do not apply to your annual deductible or out-of-pocket maximum. This is in addition to your coinsurance.

³ Includes annual physical and related preventive tests, such as mammography or a colonoscopy. Contact your claims administrator for details. Preventive care must be coded as such to be covered at 100 percent (out-of-network services subject to R&C amounts).

⁴ Blood glucose testing meters are provided by LifeScan Inc. (OneTouch) and must be purchased through the Diabetic Meter Program. Contact 1-800-588-4456 for program information. Choice of meter is subject to change.

⁵ If the cost of the medication is less than the minimum coinsurance, you will pay the lower cost.
Vision Plan

Vision benefits are included as part of your Pfizer retiree medical coverage and are administered by EyeMed Vision Care (EyeMed). EyeMed provides coverage for routine eye care expenses, including eye examinations and eyewear, with a large network of independent and national retail providers such as LensCrafters, Pearl Vision, Sears Optical, Target Optical and JCPenney Optical.

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses – Single Vision</td>
<td>$20 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses – Bifocal</td>
<td>$20 copay</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Lenses – Trifocal</td>
<td>$20 copay</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Frames2 (Any available frame at provider location)</td>
<td>$0 copay, $130 allowance; you receive a discount of 20% over the $130 allowance</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Contact Lenses3 (Disposable)</td>
<td>$0 copay, $150 allowance</td>
<td>Up to $150</td>
</tr>
<tr>
<td>Contact Lenses3 (Medically necessary)</td>
<td>$0 copay, paid in full</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>

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 Frames are covered once every other calendar year.
3 Contact lens allowance includes materials only.

To find a network vision provider, go to eyemedvisioncare.com/pfizer and choose the Insight network, or 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.
Important Things to Consider:  
Non-Medicare-Eligible Coverage

The Cost of Coverage
Your personal fact sheet (PFS) includes your cost of coverage and will be mailed to you separately at the same time as this brochure. If you haven’t received it yet, please call the Pfizer Benefits Center at 1-877-208-0950.

Paying for Coverage:  
The Retiree Medical Subsidy
If you are eligible for Pfizer’s Retiree Medical Subsidy (RMS), an RMS is established at the time of your retirement to help pay the cost of your retiree medical coverage.* The RMS defines the total dollar amount that Pfizer will contribute toward the cost of your Company-sponsored 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.

To see your current RMS balance, refer to your PFS or go online to netbenefits.com and click on the Health & Insurance section. You can see your balance in the window that pops up. For more information, call the Pfizer Benefits Center at 1-877-208-0950.

Hardship Provision
The expense of making regular medical and prescription drug contributions can be difficult for retirees living within a limited income. If this is the case, you may qualify for reduced contributions if you meet certain criteria.

If you are single and your income in 2016 was less than $18,090 or if you are married and your combined income in 2016 was less than $24,030, you may qualify for a hardship provision and reduced medical plan contributions. These income thresholds, updated each calendar year, are similar to the criteria used to determine eligibility for Extra Help under Medicare Part D. You may apply for assistance during the upcoming Annual Enrollment period if your gross income for 2016 was lower than the thresholds outlined above.

To obtain an application, call the Pfizer Benefits Center at 1-877-208-0950 to speak with a representative. You will be required to submit a copy of your 2016 income tax return as part of the application process. If you don’t apply by the deadline, you will have to wait until next year’s Annual Enrollment to apply again. If approved, your reduced contribution rate will take effect as of Jan. 1, 2018, and will remain in effect through Dec. 31, 2018. The reduced contribution will equal 10 percent of the full plan cost for retirees under age 65. Should you qualify, you will be notified of your contribution rate in writing.

CONFIRM HARDSHIP ELIGIBILITY
To confirm your eligibility for a hardship provision, contact the Pfizer Benefits Center at 1-877-208-0950. Remember, 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.

Note that the hardship provision is not available to retirees with Access-Only coverage.

* The RMS is provided to legacy Pfizer retirees who retired after Jan. 1, 2010, and legacy Wyeth retirees who retired after Jan. 1, 2012. For non-Medicare-eligible retirees, a chart reflecting the 2018 RMS monthly withdrawal can be found at netbenefits.com by clicking on the Reference Library link in the Health & Insurance section or by contacting the Pfizer Benefits Center directly at 1-877-208-0950.
Medicare-Eligible (Over Age 65 or Medicare-Disabled) Retiree Coverage Options

Pfizer offers medical, prescription drug and vision coverage for retirees and/or dependents who are eligible for Medicare (i.e., have reached age 65 or are disabled and eligible for Medicare). **Note:** If some family members are eligible for Medicare and some aren’t, you are considered to have “split family” coverage. Please go to page 18 for more information on how split family coverage works. We encourage you to read this brochure and carefully consider your choices for the upcoming year.

You will also receive information directly from UnitedHealthcare (UHC) regarding the Medicare Advantage Plan options and from SilverScript® Insurance Company regarding prescription drug coverage.

**What’s Changing for 2018**

For retirees and covered dependents who are eligible for Medicare, the choice of plan options and claims administrator remains the same, however, there are some changes and enhancements you should be aware of.

<table>
<thead>
<tr>
<th>Program/Feature</th>
<th>What’s Changing Jan. 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Coverage</strong></td>
<td>Diabetic supplies (e.g., test strips and glucose meters) that are covered under Medicare Part B, are currently being covered under both the UnitedHealthcare (UHC) Medicare Advantage Plans and SilverScript prescription drug coverage. <strong>Effective Jan. 1, 2018,</strong> diabetic supplies will only be covered under the UHC Medicare Advantage Plan and will no longer be covered under your SilverScript prescription drug coverage. If you are currently enrolled in the Prescription Drug-Only option, you will no longer have coverage for Medicare Part B diabetic supplies through your Pfizer prescription drug coverage. Instead, diabetic supplies will only be covered under your Medicare Part B coverage. <strong>Note:</strong> Diabetic medications, such as insulin, will continue to be covered under your Pfizer prescription drug coverage.</td>
</tr>
<tr>
<td></td>
<td>As previously communicated in June 2017, Pfizer made temporary coverage enhancements to the Medicare Advantage Plans that will reduce costs and expand coverage for you and any Medicare-eligible dependents covered by these plans. These changes took effect on Jul. 1, 2017, and will continue through Dec. 31, 2018. Effective Jan. 1, 2018 there will be one additional temporary coverage enhancement. The copay for Medicare Part B medications is being reduced from $35 to $25 under both Medicare Advantage options. This reduction will be in effect through Dec. 31, 2018. See page 12 for details.</td>
</tr>
<tr>
<td>Contributions</td>
<td>There will be contribution increases to all plan options for 2018. Your 2018 contribution amounts will be shown on your Personal Fact Sheet (PFS), which is being mailed to you separately at the same time as this mailing.</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>In order to comply with Affordable Care Act (ACA) provisions, aspirin will no longer be available at no cost, unless you are under age 60 and eligible for Medicare due to disability.</td>
</tr>
</tbody>
</table>
Medical Plan Options
If you and/or your eligible dependent(s) are eligible for Medicare, you can choose from among three coverage options:

- Pfizer Medicare Advantage Base Plan;
- Pfizer Medicare Advantage Buy-Up Plan; and
- Prescription Drug-Only Plan.

Note that under the Pfizer Medicare Advantage Base Plan, you will each be required to satisfy an individual annual deductible. This, however, will be your only annual deductible—you do not need to satisfy separate Medicare Part A and B deductibles. Under the Pfizer Medicare Advantage Buy-Up Plan, you do not need to satisfy any deductible including the separate Medicare Part A and B deductibles. Under both the Pfizer Medicare Advantage Base Plan and the Medicare Advantage Buy-Up Plan, you will also each be required to satisfy separate out-of-pocket maximums. The Centers for Medicare and Medicaid Services (CMS) do not allow deductibles and out-of-pocket maximums to coordinate for a family covered under a Medicare Advantage plan.

Pfizer-Sponsored Medicare Advantage Plans
You may only enroll in the Pfizer Medicare Advantage Base Plan or the Pfizer Medicare Advantage Buy-Up Plan if you meet the eligibility requirements established by the CMS, namely that you:

- Are enrolled (and remain enrolled) in Medicare Parts A and B;
- Provide the Pfizer Benefits Center with your Health Insurance Claim Number (HICN);
- Have a permanent U.S. street address (no P.O. Box)* on file; and
- 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.

These plans are administered through UHC, and replace Medicare Part A and Part B coverage. Please note, however, that you must continue to pay your Part A (if applicable) and Part B monthly contributions to Medicare. Failure to enroll in both Medicare Parts A and B will affect your eligibility to elect coverage under the Pfizer Retiree Medical Plan.
How the Medicare Advantage Plan Options Compare

See the chart below for a comparison of the key provisions of the 2018 Medicare-eligible coverage options.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Pfizer Medicare Advantage Base Plan</th>
<th>Pfizer Medicare Advantage Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Plan Features</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible1</td>
<td>$100 per individual</td>
<td>$0</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Includes deductible)</td>
<td>$3,400 per individual</td>
<td>$2,400 per individual</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$25 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Lab/X-ray</td>
<td>$20 per procedure/test</td>
<td>$10 per procedure/test</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>$50 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>PT/OT/Speech Therapy Visit</td>
<td>$25 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Inpatient Hospital Stay</td>
<td>$250 per admission</td>
<td>$175 per admission</td>
</tr>
<tr>
<td>Outpatient Hospital Stay (Facility/Urgent Care)</td>
<td>$175 per admission</td>
<td>$125 per admission</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>$25 copay; maximum of 20 visits per year</td>
<td>$15 copay; maximum of 20 visits per year</td>
</tr>
<tr>
<td>Routine Chiropractic Services</td>
<td>$20 copay; maximum of 20 visits per year</td>
<td>$15 copay; maximum of 20 visits per year</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$65 copay</td>
<td>$65 copay</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$35 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Plan pays 80%; you pay 20%2</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies (only covered under the UHC Medicare Advantage plans)</td>
<td></td>
<td>100% coverage for OneTouch® and Accu-Chek blood glucose testing strips and meters3</td>
</tr>
<tr>
<td>Hearing Aid (UHC’s hiHealth Innovations Program offers discounts on hearing aids)</td>
<td>$500 allowance every 36 months</td>
<td>$500 allowance every 36 months</td>
</tr>
<tr>
<td>Medicare Part B Prescription Drugs (covered under medical)</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
</tbody>
</table>

1 Deductible only applies to inpatient and outpatient services, the purchase or rental of durable medical equipment and Medicare Part B medications.
2 Medicare participating providers must be used. Providers who participate in the UHC network will be reimbursed at the contracted rate. Providers who participate with Medicare but do not participate with UHC will be reimbursed based on the Medicare fee schedule.
3 Blood glucose testing meters are provided by LifeScan Inc. (OneTouch) and Roche (Accu-Chek) and require a prescription from your doctor. To learn more about this benefit, call UHC at 1-866-868-0329.

**Note:** The Prescription Drug-Only option does not include coverage for any medical services. Refer to page 14 for more information on your coverage if you are enrolled in this option.

Additional Premium for Higher-Income Retirees

You may be required to pay an “Income-Related Monthly Adjustment Amount” to Medicare because of your annual income. This Medicare Part D Income-Related Monthly Adjustment Amount is also referred to as “D-IRMAA.”

If your 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 D-IRMAA based on your income. For 2018, the 2016 income thresholds are $85,000 for an individual and $170,000 for a married couple filing jointly. There is no D-IRMAA if your income is below these amounts. Each family member determined to be high income and enrolled in a Medicare Part D plan will pay the applicable D-IRMAA. For example, if both you and your spouse are enrolled in a Medicare Part D plan and determined to be high income, you both will pay the D-IRMAA.

Neither Pfizer nor SilverScript are notified if you are required to pay the D-IRMAA, unless you are disenrolled by Medicare for non-payment.
If You are Enrolled in a Non-Pfizer Medicare Plan

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

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 the Prescription Drug-Only option if you would like to keep your Pfizer prescription drug coverage.

Medicare Advantage Plan Features and Programs

UHC offers a variety of additional programs as part of your Medicare Advantage enrollment to help support you and your loved ones. For more detailed information about the Pfizer-sponsored Medicare Advantage options, go to the UHC website at uhcretiree.com/pfizer, or call UHC’s Pfizer-dedicated toll-free number at 1-866-868-0329, TTY 711, from 8 a.m. to 8 p.m. in your local U.S. time zone, seven days a week. Following is a summary of the current additional programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| Virtual Doctor Visits | • Free eVisits—no copay and plan deductibles, if applicable, do not apply.  
  – See and speak to specific doctors any time, anywhere, using your computer or mobile device (including tablets and smartphones).  
  You have the option of two service providers for this benefit. If you wish to schedule a visit, please contact Doctors on Demand at 1-800-997-6196 or Amwell at 1-844-733-3627.  
  You can find a list of virtual medical doctors at uhcretiree.com/pfizer.* |
| HouseCalls            | • Free (no copay) annual visit to your home by a health care practitioner to:  
  – Review your health history and medications;  
  – Perform a physical evaluation;  
  – Identify health risks; and  
  – Provide education information.  
  Results of the HouseCalls visit are sent to your doctor. |
| SilverSneakers®       | • Free basic fitness membership and access to more than 13,000 participating locations.  
  • The SilverSneakers Steps Program is available to participants who live 15 miles or more from a SilverSneakers fitness center.  
  – Choose one of four kits based on your lifestyle and fitness level.  
  – Utilize the Steps wellness tools available for general fitness, strength training, walking or yoga to help you get fit at home or on the go. |
| hiHealth Innovations  | • You are able to purchase custom programmed digital hearing aids at a discount. Additionally, both Pfizer Medicare Advantage Plan options include a $500 annual hearing aid allowance. |
| Solutions for Caregivers | • Free information, education, resources and care planning, including:  
  – On-site evaluation by a Registered Nurse; and  
  – Personal plan of care developed by a Geriatric Case Manager. |

* Virtual Doctor Visits are not available in the state of Arkansas.
Prescription Drug Coverage

Prescription drug coverage, administered through SilverScript® Insurance Company (which is affiliated with CVS Caremark®), for Medicare-eligible participants is a Pfizer-sponsored Medicare Part D prescription drug plan, and covers medications dispensed through a pharmacy.

The plan, called SilverScript Employer PDP sponsored by Pfizer ("SilverScript"), combines a standard Medicare Part D plan with additional prescription drug coverage provided by Pfizer. It covers most Pfizer medications, including Greenstone generics, dispensed through a pharmacy at no cost to you.

Prescription drug coverage for the Medicare Advantage Plan options and the Prescription Drug-Only option is shown in the chart below.

<table>
<thead>
<tr>
<th>Prescription Drug Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage for Most Pfizer Medications</strong></td>
</tr>
<tr>
<td>including Greenstone Generics</td>
</tr>
<tr>
<td>Plan pays 100 %</td>
</tr>
<tr>
<td><strong>Coverage for Non-Pfizer Prescription Medications</strong></td>
</tr>
<tr>
<td>Retail (30-day supply)</td>
</tr>
<tr>
<td>You pay 20% with a $10 minimum/$125 maximum per prescription¹</td>
</tr>
<tr>
<td>Retail (90-day supply)</td>
</tr>
<tr>
<td>You pay 20% with a $30 minimum/$375 maximum per prescription¹</td>
</tr>
<tr>
<td>Maintenance Choice Program²</td>
</tr>
<tr>
<td>(Non-specialty maintenance medications up to a 90-day supply)</td>
</tr>
<tr>
<td>Only when filled at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy</td>
</tr>
<tr>
<td>You pay 20% with a $20 minimum/$250 maximum coinsurance per prescription¹</td>
</tr>
<tr>
<td>Specialty Medications</td>
</tr>
<tr>
<td>You pay 20% with a $10 minimum/$125 maximum coinsurance for each 30-day supply of your prescription¹</td>
</tr>
<tr>
<td>Prescription Drug Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>$3,400 per individual</td>
</tr>
</tbody>
</table>

¹ If the cost of the medication is less than the minimum coinsurance, you will pay the lower cost.
² Referred to in SilverScript materials as Preferred Network Pharmacy.

The Pfizer Zero Cost Prescription Drug List (including Greenstone generics) is included in this package for your reference. The Pfizer Zero Cost Prescription Drug List will be updated for 2018. It can also be found at netbenefits.com in the Reference Library. Click the Health & Insurance section on the home page, and then click Quick Links and Reference Library.

Effective Jan. 1, 2018, diabetic supplies will only be covered under the UHC Medicare Advantage Plan and will no longer be covered under your SilverScript prescription drug coverage.

If you enroll in the Prescription Drug-Only option, you will no longer have coverage for Medicare Part B diabetic supplies through your Pfizer prescription drug coverage. Instead, diabetic supplies will only be covered under your Medicare Part B coverage.

Note: Diabetic medications, such as insulin, will continue to be covered under your Pfizer prescription drug coverage.
Prescription Drug-Only Option

If you have medical coverage available elsewhere (e.g., you are enrolled in a Medigap plan or a Medicare Supplemental plan), or don’t wish to enroll in the Pfizer Medicare Advantage Base Plan or Pfizer Medicare Advantage Buy-Up Plan, you can still take advantage of valuable Pfizer prescription drug benefits by enrolling in the Prescription Drug-Only option, which provides Medicare Part D prescription drug coverage through SilverScript Insurance Company (which is affiliated with CVS Caremark) along with additional benefits provided by Pfizer.

You may only enroll in the Pfizer Prescription Drug-Only option if, in addition to meeting Pfizer’s eligibility requirements, you meet the eligibility requirements established by the CMS, namely that you:

- Are enrolled (and remain enrolled) in Medicare Parts A and B;¹
- Provide the Pfizer Benefits Center with your Health Insurance Claim Number (HICN); and
- Have a permanent U.S. street address (no P.O. Box) on file.²

Medicare does not allow you to be enrolled in more than one Medicare prescription drug plan at the same time, which means if you enroll in Pfizer’s Prescription Drug-Only option, your enrollment in any other Medicare Part D plan, as well as any individual Medicare Advantage plan or other (non-Pfizer) employer-sponsored Medicare Advantage plan, will be automatically canceled, as will the enrollment for your covered Medicare-eligible dependents. If you enroll in a non-Pfizer Medicare prescription drug plan or Medicare Advantage plan any time after Annual Enrollment ends on Oct. 27, 2017, you and any enrolled dependents will lose your Pfizer-sponsored retiree medical and prescription drug coverage.

HOW TO MAXIMIZE YOUR PRESCRIPTION DRUG BENEFITS

- **Use Pfizer medications**: Most Pfizer medications, including Greenstone generics, dispensed at a pharmacy are covered at 100 percent. Make sure your doctor writes “dispense as written” on your Pfizer brand drug prescriptions to avoid substitution with a non-Greenstone generic medication and a potential charge.

- **Use a network pharmacy**: Fill your prescriptions at a network pharmacy in order to receive the maximum Plan benefit. If you use an out-of-network pharmacy, you may be required to pay the full cost of the prescription (even for an eligible Pfizer and Greenstone generic medication) and send your request for reimbursement to SilverScript, along with your receipt showing the payment you made. Reimbursement will be provided up to the SilverScript contracted rate, which may be lower than the amount you have paid out of pocket. Keep in mind that you must use a network pharmacy to have your medication costs count toward your Medicare total medication costs and Medicare out-of-pocket costs, except in an emergency or non-routine circumstance. You can find participating pharmacies near you on the SilverScript website. See Your Resources on page 23 for details and contact information.

- **Fill a 90-day supply for all non-specialty maintenance medications through the Maintenance Choice Program³**: 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 have your prescription delivered to the location of your choice). Both options provide a 90-day supply of your medication at mail-order pricing, and your cost will not exceed the 60-day supply coinsurance maximum. Keep in mind, mail-order pricing is generally lower than retail (whether you use a CVS Pharmacy or the CVS Caremark Mail Service Pharmacy). For more information, call SilverScript at 1-844-774-2273 or go to pfizer.silverscript.com. Remember, non-specialty maintenance medications are medications that are typically prescribed and taken on a regular or daily basis to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. For a full list, go to caremark.com.

¹ Failure to enroll in both Medicare Parts A and B will affect your eligibility to elect coverage under Pfizer’s retiree medical program.
² 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.
³ Referred to in SilverScript materials as Preferred Network Pharmacy.
Vision Plan

Vision benefits are included as part of Pfizer retiree medical coverage. **Note:** Vision coverage does not apply to the Prescription Drug-Only option.

Vision benefits are administered by EyeMed Vision Care (EyeMed). EyeMed provides coverage for routine eye care expenses, including eye examinations and eyewear, with a large network of independent and national retail providers such as LensCrafters, Pearl Vision, Sears Optical, Target Optical and JCPenney Optical.

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

<table>
<thead>
<tr>
<th>2018 Vision Plan</th>
<th></th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit</strong></td>
<td>In-Network</td>
<td></td>
</tr>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses – Single Vision</td>
<td>$20 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses – Bifocal</td>
<td>$20 copay</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Lenses – Trifocal</td>
<td>$20 copay</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Frames²</td>
<td>$0 copay, $130 allowance; you receive a discount of 20% over the $130 allowance</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Contact Lenses³</td>
<td>$0 copay, $150 allowance</td>
<td>Up to $150</td>
</tr>
<tr>
<td>(Disposable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses³</td>
<td>$0 copay, paid in full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>(Medically necessary)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Frames are covered once every other calendar year.

³ 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 Saturday from 7:30 a.m. to 11 p.m. and Sunday from 11 a.m. to 8 p.m., Eastern time.

Note that if you or an eligible dependent is enrolled in the Pfizer Medicare Advantage Base Plan or the Pfizer Medicare Advantage Buy-Up Plan, you can choose whether to receive the annual vision exam through UHC or through EyeMed. All other vision benefits are provided through EyeMed.
Important Things to Consider: Medicare-Eligible Coverage

The Cost of Coverage

Your personal fact sheet (PFS) includes your cost of coverage and will be mailed to you separately at the same time as this brochure. If you haven’t yet received it, please call 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.

Paying for Coverage: The Retiree Medical Subsidy

If you are eligible for Pfizer’s Retiree Medical Subsidy (RMS), an RMS is established at the time of your retirement to help pay the cost of your retiree medical coverage. The RMS defines the total dollar amount that Pfizer will contribute toward the cost of your Company-sponsored 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. 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.

To see your current RMS balance, refer to your PFS or go online to netbenefits.com and click on the Health & Insurance section. You can see your balance in the window that pops up. For more information, call the Pfizer Benefits Center at 1-877-208-0950.

HARDSHIP PROVISION

The process of applying for the Pfizer Hardship provision will be based on the Pfizer retiree’s age, not the dependent’s. If the Pfizer retiree is not yet Medicare eligible, please refer to page 9. If the Pfizer retiree is Medicare-eligible, please refer to the information on this page.

Hardship Provision

Pfizer is sensitive to the fact that the expense of making regular medical and prescription drug contributions can be difficult for retirees living within a limited income. As a result, you may qualify for reduced contributions if you meet certain criteria.

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 must apply for Extra Help through Medicare. If approved, Medicare will notify SilverScript, who will in turn notify the Pfizer Benefits Center.

You can apply for Extra Help:

- By calling Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 available 24 hours a day, 7 days a week. Or, go online to medicare.gov;
- Online at socialsecurity.gov/extrahelp;
- By calling the Social Security Administration at 1-800-772-1213 to either apply by phone or request an application by mail; 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 the Pfizer Benefits Center, and your monthly Pfizer contribution (the amount you are invoiced, or the deduction taken from your pension check or automatic bank withdrawal) will be automatically adjusted. This reduction will include any amount from Extra Help.

Action May Be Required Each Year:

Each year, by 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, subsequently, your eligibility for the Pfizer hardship provision will also end.

* The RMS is provided to legacy Pfizer retirees who retired after Jan. 1, 2010, and legacy Wyeth retirees who retired after Jan. 1, 2012. For Medicare-eligible retirees, a chart reflecting the 2018 RMS monthly withdrawal can be found at netbenefits.com by clicking on the Reference Library link in the Health & Insurance section or by contacting the Pfizer Benefits Center directly at 1-877-208-0950.
If Medicare Eligibility Differs Among Family Members (Split Family Coverage)

Please refer to the plan options and provisions as described beginning on page 3 for non-Medicare-eligible participants and beginning on page 10 for Medicare-eligible participants.

**Enrolling in Coverage**

All eligible dependents are required to elect a Pfizer Retiree Medical Plan option based on whether or not each individual is eligible for Medicare. For example, if you are Medicare-eligible and your spouse is not:

- You will elect from the Medicare-eligible options—the Pfizer Medicare Advantage Base Plan, the Pfizer Medicare Advantage Buy-Up Plan or the Prescription Drug-Only Plan (as outlined on pages 11 – 15)—for “Yourself Only.”

- You will elect from the non-Medicare-eligible options—the Retiree PPO or the High-Deductible PPO (as outlined on pages 4 – 7)—for your spouse as “Your Spouse.”

Similarly, if your spouse is Medicare-eligible and you are not, you will elect from the non-Medicare-eligible options for “Yourself Only,” and elect from the Medicare-eligible options for your spouse as “Your Spouse.”

If you are married to another Pfizer colleague or retiree, you may enroll together as a family or separately each in your own coverage. Keep in mind that you may not enroll in more than one plan at a time; each person can only be covered once.

For those family members who are not Medicare-eligible, they may elect either UHC or Horizon as their medical claims administrator. For those who are Medicare-eligible, UHC is the only medical claims administrator.

**Understanding How Deductibles and Out-of-Pocket Maximums Work for Split Family Coverage**

If you or your spouse/eligible dependent is enrolled in one of the Medicare Advantage plan options and the other is enrolled in the Retiree PPO or the Retiree High-Deductible PPO option, you and your spouse/eligible dependent will be required to satisfy separate deductibles and out-of-pocket maximums. This means amounts that count toward the deductible and out-of-pocket maximum in the Medicare Advantage plan will not cross-apply with the deductible and out-of-pocket maximum in the Retiree PPO or High-Deductible PPO.

**Things To Remember…**

To enroll or remain enrolled in medical coverage, you must provide a valid Social Security number to the Pfizer Benefits Center for yourself as well as your covered dependents.
Turning Age 65

There are several things you will need to keep in mind if you are approaching your 65th birthday. If you are turning 65 after Feb. 1, 2018, the information below will be helpful to you.

You will generally 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. In order to be eligible for one of the Pfizer-sponsored Medicare Advantage plan options, including SilverScript prescription drug coverage, there are a few steps you will need to complete first.

**STEP 1.** Enroll in Medicare Parts A and B. You should receive information regarding the enrollment process directly from Medicare at least six months before your 65th birthday. If you do not, contact your local Social Security office. Your enrollment period begins three months before your Medicare eligibility date.

**STEP 2.** Enroll in a Pfizer-sponsored Medicare Advantage Plan option or the Prescription Drug-Only option (see pages 11 – 15 for details). If you’re planning to enroll in one of the Pfizer sponsored Medicare Advantage plans, there’s certain information that you will need to provide to the Pfizer Benefits Center:

- **a.** Health Insurance Claim Number (HICN) from your Medicare ID card;
- **b.** Street address (if P.O. Box on file); and
- **c.** Your current contact information, including best telephone number.

**STEP 3:** Your information will be submitted to Centers for Medicare and Medicaid Services (CMS). Note that CMS must approve your enrollment in a Medicare Advantage and/or SilverScript Prescription Drug Plan, and that coverage can only become effective on the first of the month (beginning with the first of the month you turn age 65). Therefore it’s recommended that you plan ahead.

**TURNING 65 MID-YEAR**

Note that if you become Medicare-eligible mid-year, any amounts you have paid through that date toward your annual medical deductible and out-of-pocket maximum will not carry over; however, your prescription drug amounts will carry over.

**TURNING 65 BY FEB. 1, 2018**

Note that if you are turning age 65 between Oct. 1, 2017, and Feb. 1, 2018, you will receive a separate package with instructions on what you need to do to enroll in coverage. You must enroll by phone.

**Initial Enrollment Period for Medicare Parts A and B**

As mentioned earlier, you must first enroll in Medicare Parts A and B to be eligible to enroll in either one of the Pfizer-sponsored Medicare Advantage plan options or the Prescription Drug-Only option. Your initial enrollment period for Medicare is a seven-month period that begins three months before the month you turn age 65, includes the month you turn age 65, and ends three months after the month you turn age 65. You should enroll in Medicare Parts A and B as soon as you are able and before your 65th birthday to avoid any delays in coverage. To maintain Pfizer coverage, you are required by Medicare to pay the Medicare Part B premium.

**General Enrollment Period**

If you didn’t sign up for Medicare Part A and/or Part B when you were first eligible, you can sign up between Jan. 1 and Mar. 31 each year. Your coverage will begin the following Jul. 1. In general, Medicare assesses you with 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. **Contact the Pfizer Benefits Center for information about how your coverage will be affected prior to being enrolled in Medicare Parts A and B.**

**Health Insurance Claim Number (HICN)**

Once you enroll in Medicare, the Social Security Administration assigns you a health insurance claim number. This number appears on your Medicare ID card as well as your health insurance claims and other Medicare-related paperwork. **CMS requires that you provide Pfizer with your HICN, as well as a valid street address (no P.O. boxes) in order for you to enroll in one of the Pfizer-sponsored Medicare Advantage plan options.** It may also be a good idea to make sure the Pfizer Benefits Center has your contact phone number(s) on file in case any questions or issues arise during the enrollment process.
Enrollment Checklist

This year’s Annual Enrollment period will run from Oct. 10 through Oct. 27, 2017. Although plan changes may not affect your coverage, thoughtful and informed decision-making about your health and well-being is important at Annual Enrollment—and during the year. You can call the Pfizer Benefits Center to get answers to questions regarding the Pfizer retiree plan options, the differences in coverage for Medicare-eligible and non-Medicare-eligible retirees and/or dependents and more.

If you and/or your covered dependents are Medicare-eligible, please note that both your Medicare Advantage and SilverScript enrollments must be approved by Medicare. While this process is administered by UHC and SilverScript, it is important that you know Medicare does not allow enrollment in more than one Medicare plan at a time. Therefore, if you are enrolled in another (non-Pfizer) Medicare Part D prescription drug plan and/or another Medicare Supplement plan, your enrollment into the Pfizer-sponsored Medicare Advantage and/or SilverScript prescription drug plans will automatically terminate your other enrollments. Likewise, if you first enroll in your Pfizer Medicare Advantage and/or SilverScript plans and later enroll in another Medicare Part D or Medicare Supplement plan, your Pfizer Retiree Medical coverage will automatically terminate. Medicare considers eligibility into the latest enrolled plan as the only plan in effect.

To Prepare for Enrollment

- **Review the Pfizer retiree health care options** based on your Medicare status. If you are not Medicare-eligible, see pages 3 – 9; if you are Medicare-eligible see pages 10 – 17.

- **Ask yourself the following questions** to help assess your personal situation and what health care choices may best meet your needs:
  - Am I eligible for Medicare? If yes, have I enrolled in Medicare Parts A and B?
  - Does Pfizer have my HICN and street address on file?
  - When do I expect to be eligible for Medicare?
  - Do I need to add or drop dependents?
  - Has my or my dependent(s)’ health status changed?
  - Am I currently undergoing regular medical treatment? Are my dependent(s)? Can I expect this in the near future?
  - Am I currently taking any regular maintenance medications?

- **Make sure you have the information you need to enroll:**
  - **Your Fidelity customer username.** If you have been using a Social Security number as your username, you may be required to change this when you log in.
  - **Your Fidelity password.** You can create or change your Fidelity password by calling the Pfizer Benefits Center at 1-877-208-0950 or online at netbenefits.com by clicking Having trouble with your Username and Password?
  - **Date of birth and Social Security number for covered dependents.** This information is required for Medicare purposes. You should also review the eligibility rules for your covered dependents to confirm they still meet the requirements.

- **Validate your dependents during Annual Enrollment.**
  - During first quarter 2018, Pfizer will be conducting a random audit of covered dependents to ensure they meet Pfizer’s eligibility requirements. During the audit, proof of eligibility will be required for continued coverage. If you do not provide proof of eligibility, your dependent will lose coverage and retirees found to be covering ineligible dependents may be subject to loss of retiree medical coverage.

- **Enroll, make a change, or add or remove a dependent(s) during the Annual Enrollment period from Oct. 10 – Oct. 27.** You can make your elections online or by phone:
  - Go to netbenefits.com; click Compare Benefits on the banner at the top of the home page. Then, click the option(s) you wish to choose for 2018. When you’re done, click Save & Submit on the Benefits Election page. (Note: If you and/or your dependent(s) are Medicare-eligible, refer to the enrollment instructions included with your personal fact sheet (PFS) that will be mailed to you.)
  - Call the Pfizer Benefits Center at 1-877-208-0950 Monday through Friday from 8:30 a.m. to Midnight, Eastern time, to speak with a representative who will take your elections.

- If you enroll online, make sure to print your confirmation statement when your enrollment is complete. If you enroll by phone, your confirmation statement will be mailed to you.
ID Cards

If you are not Medicare-eligible, you will only receive a new medical and/or prescription ID card if you enroll in or change your coverage. Note that you should continue to use your current EyeMed ID card for vision benefits.

If you are Medicare-eligible, every family member who is enrolled in a Pfizer-sponsored Medicare Advantage plan option will receive his/her own Medicare Advantage ID card—unique ID numbers—from UHC in December. When receiving medical services under the plan, you will need to present your Medicare Advantage ID card. You will not need to show your original Medicare ID card, although you should keep it in a safe place for your records. If you are currently enrolled in prescription drug coverage through SilverScript, you will not receive a 2018 SilverScript ID card. Note that you should continue to use your current EyeMed ID card for vision benefits.

ELECTION CORRECTIONS AND CHANGES

As a reminder, you can make corrections or changes to your 2018 elections through Dec. 29, 2017. Note, however, if you make changes after Dec. 1, 2017, you may not receive your new ID card by Jan. 1, 2018. As of Jan. 1, 2018, you must have a qualified event in order to change your coverage.

Things To Remember...

Keep in mind that the Patient Protection and Affordable Care Act (also known as Health Care Reform) requires individuals to have medical coverage or pay a penalty.

To enroll or remain enrolled in retiree medical coverage, you must provide a valid Social Security number to the Pfizer Benefits Center for yourself as well as your covered non-Medicare-eligible dependents. This information is used to satisfy the required tax reporting to the Internal Revenue Service (IRS) on Form 1095C. If you do not have a Social Security number or other tax identifying number for your covered dependent(s), please contact the Pfizer Benefits Center to provide the date of birth for each covered individual.

If you have an address change or want to update your personal information, you must call 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.
What to Expect in the Coming Months

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<th>When…</th>
<th>What…</th>
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<tr>
<td>Early Oct. 2017</td>
<td>A personal fact sheet (PFS) with your 2018 options and costs will be mailed to you.</td>
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<tr>
<td>Oct. 10 – 27, 2017</td>
<td>During the 2018 Annual Enrollment period, you can make your 2018 elections by going to netbenefits.com or by calling 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.</td>
</tr>
<tr>
<td>Dec. 2017</td>
<td>If you enroll in any type of retiree coverage, an invoice for your January retiree contributions will be mailed to you (if your contributions are not automatically deducted from your pension). Avoid Having Your Coverage Terminate If your contributions are deducted from your monthly pension or if you’re enrolled in Automatic Bank Withdrawal, please be sure your pension or bank account will cover your 2018 deduction. If your contributions are not deducted from your Pfizer pension, consider enrolling in Automatic Bank Withdrawal (ABW) so your contributions are paid automatically, helping you avoid additional costs or a loss of your Pfizer coverage. Call the Pfizer Benefits Center at 1-877-208-0950 to enroll by phone or to request that an enrollment form be mailed to you. You can enroll in ABW starting now, to be sure deductions begin for Jan. 1, 2018. If You Are Non-Medicare-Eligible: • You will receive a new ID card only if you made a change to your coverage. If You Are Medicare-Eligible: • You will receive a new Medicare Advantage ID card for 2018 from UHC. Under Medicare Advantage, you receive a new ID card every year, whether or not you change your plan option. • As a reminder, if you or your covered dependent(s) are eligible for Medicare you will also receive information from UHC and SilverScript directly, concerning your Medicare Advantage and SilverScript coverage.</td>
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STAY CONNECTED WITH PFIZER PLUS!

We want to make sure you stay informed about what’s happening at Pfizer. If you aren’t already, we encourage you to consider becoming a member of Pfizer PLUS online. By joining, you will be able to keep up with the latest important retiree information through the PLUS e-newsletter. PLUS also keeps a database of local events, photos and an In Memoriam section. Think of PLUS as your online community.

Join the Pfizer PLUS Community Corner on PLUS online at pfizerplus.com today. And don’t forget to indicate that you would like to receive the monthly e-newsletter.
## Your Resources

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| **Enrolling in 2018 Benefits or Updating Your Covered Dependents** | Pfizer Benefits Center  
- [netbenefits.com](http://netbenefits.com)  
- Call the Pfizer Benefits Center at **1-877-208-0950** and follow the prompts to Retiree Medical; Representatives will be available to assist you Monday through Friday from 8:30 a.m. to Midnight, Eastern time |
| **Medical Coverage through UHC (Non-Medicare-Eligible Coverage)**  
Choice Plus Network* | UnitedHealthcare  
- [myuhc.com](http://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  
- [uhcretiree.com/pfizer](http://uhcretiree.com/pfizer)  
- Call UHC at **1-866-868-0329**, TTY 711, from 8 a.m. to 8 p.m. local time, 7 days a week |
| Medicare Advantage |  
*If you reside in Massachusetts, Maine or New Hampshire, select Passport Connect Choice Plus as the provider network to begin your search.|
| **Medical Coverage through Horizon (Non-Medicare-Eligible Coverage)**  
Blue Card Network | Horizon  
- [horizonblue.com/pfizer](http://horizonblue.com/pfizer)  
- Call Horizon at **1-888-340-5001**, Monday through Wednesday and Friday, from 8 a.m. to 8 p.m.; and Thursday, from 9 a.m. to 8 p.m., Eastern time |
| **Behavioral Health and Substance Use Services (Non-Medicare-Eligible Coverage)** | Optum  
- [liveandworkwell.com](http://liveandworkwell.com) and use code 61550  
- Call your medical claims administrator and select the option for behavioral health or substance use  
Telemental Health  
- [liveandworkwell.com](http://liveandworkwell.com) and use code 61550. Then, click Telemental Health to schedule a visit  
- Call **1-800-638-8010** |
| **Prescription Drug Coverage (Non-Medicare-Eligible Coverage)**  
(Medicare-Eligible Coverage) | CVS Caremark  
- [caremark.com](http://caremark.com)  
- Call Caremark at **1-866-804-5881**, 24 hours a day, 7 days a week  
SilverScript  
- [pfizer.silverscript.com](http://pfizer.silverscript.com)  
- Call SilverScript at **1-844-774-2273**, 24 hours a day, 7 days a week |
| **Vision Plan Insight Network** | EyeMed Vision Care  
- [eyemedvisioncare.com/pfizer](http://eyemedvisioncare.com/pfizer)  
- Log in to the EyeMed Member 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 |
| **Discount Programs (Non-Medicare-Eligible Coverage)** | UnitedHealthcare  
- [unitedhealthallies.com](http://unitedhealthallies.com)  
- Call **1-800-860-8773**  
Horizon  
- [horizonblue.com/blue365](http://horizonblue.com/blue365)  
- Call **1-888-340-5001** |
| **Expert Medical Opinion Service** | PinnacleCare  
- [pinnaclecare.com/support](http://pinnaclecare.com/support)  
- Call **1-877-280-7466**, Monday through Friday from 8 a.m. to 6 p.m., Eastern time |
Important Documents

Summary Plan Descriptions (SPDs)
As always, refer to the summary plan description (SPD) for each plan for more detailed information. An SPD is a legally required document that gives plan participants the most important facts about a benefit plan. For example, an SPD provides details on plan eligibility and what services are and are not covered. SPDs for the Pfizer retiree health plans are available at netbenefits.com in the Reference Library. Click the Health & Insurance section on the home page, and then click Quick Links and Reference Library.

Legal Notices Booklet
Please review the enclosed legal notices booklet. It provides details on many of your rights under your health care plans.

Pfizer Zero Cost Prescription Drug List
Please review the Pfizer Zero Cost Prescription Drug List (including Greenstone generics) and perhaps share it with your physician. Because these medications dispensed at a pharmacy are provided at no cost to you, your doctor may choose to prescribe Pfizer-branded medications, rather than one that will result in a cost to you. Please remind your doctor to indicate “dispense as written” or “no generic substitution” when a Pfizer medication is being prescribed to ensure you do not incur a cost.

CAREGIVER ASSISTANCE
If you are a caregiver assisting a Pfizer retiree or eligible dependent with enrollment elections or navigating health care, you may require 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 claims administrator (UHC or Horizon). If these permissions or power of attorney are on file with the Pfizer Benefits Center, we can help.

Just call 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. If you are enrolled in either of the Pfizer-sponsored Medicare Advantage options, you can also take advantage of the Solutions for Caregivers program offered by UHC as described on page 13.
This document serves as the Summary of Material Modifications (SMM) for the Pfizer Retiree Medical Plan. The IRS has assigned Pfizer Inc. the Employer Identification Number 13-5315170, and the Plan Number is 559. This SMM is not a substitute for the official plan document(s). It supplements or modifies the most recent Summary Plan Description (SPD) for each benefit plan. Please keep this document with the SPDs for future reference.

This brochure contains information about Pfizer retiree health care benefits and the Pfizer Retiree Medical Plan; however, 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 by going to netbenefits.com or calling 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 or all of the benefit plans it offers, to comply with applicable laws or regulations.