2027 Plan Guide

The Episcopal Church Medical Trust

PDP Comprehensive

Group Number: 25853, 25854

Effective: January 1, 2027 through December 31, 2027

United Healthcare®

EPISCOPAL CHURCH MEDICAL TRUST

UnitedHealthcare MedicareRx for Groups (PDP) plan

The Episcopal Church Medical Trust (ECMT) has selected UnitedHealthcare® to offer medical and prescription drug coverage to you and your Medicare-eligible spouse and/or dependents. For prescription drug coverage, you'll be enrolled in either the Premium or Comprehensive prescription drug plan that corresponds to your medical selection.

Read this Plan Guide to get to know your prescription drug plan

The guide includes:

- A description of the options and how they work
- Information about covered drugs and how much they cost
- What you can expect after your enrollment

To learn about other benefits, (including dental) available to you as a retiree of the Medical Trust, visit **cpg.org/otherbenefits**.

Please keep this Plan Guide. It has information that will be helpful once you become a member.

Visit **retiree.uhc.com/ECMT** to access information about your prescription drug plan and all the benefits it includes. Select the **Chat now** button to connect with one of our Customer Service Advocates. Or, use the Group Number on the front cover of this book to access plan materials online.

You'll be automatically enrolled in new plans

Your current plan will end on December 31, 2026.

- If you currently have the **GMA Premium PPO** plan, you'll be automatically enrolled in the **MA Premium** plan and the corresponding **PDP Premium**.
- If you currently have the **GMA Comprehensive PPO** plan, you'll be automatically enrolled in the **MA Comprehensive** plan and the corresponding **PDP Comprehensive**.

Your new plans will replace your current coverage, starting on January 1, 2027.

If you want different coverage, you'll need to select a new medical plan during Annual Enrollment, which ends on **November 20, 2026**. To choose a medical plan and its corresponding prescription drug plan or to select a dental plan:

- Sign in to MyCPG Accounts

OR

- Complete the enrollment form at **cpg.org/MAenrollmentform**

Need help enrolling?

Please contact ECMT Client Services at **1-800-480-9967**, 8:30 a.m.–8 p.m. ET, Monday–Friday.

Understanding your Medicare Part D

What is Medicare Part D?

Original Medicare Part A (hospital coverage) and Part B (doctor and outpatient care) help pay for some of your health care costs, but they don't cover many prescription drugs. Medicare Part D plans help with prescription drug costs. You can get Part D coverage through a private insurance company, like UnitedHealthcare.

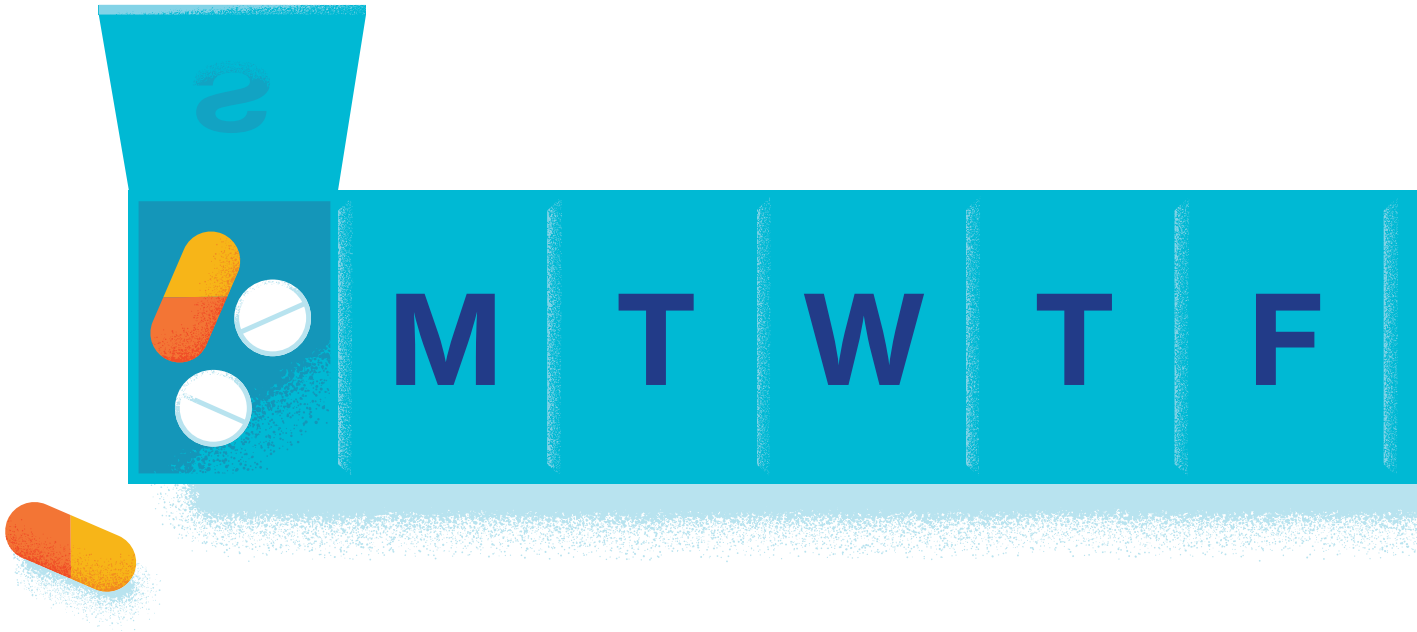
Do I have to enroll in a Medicare Part D plan?

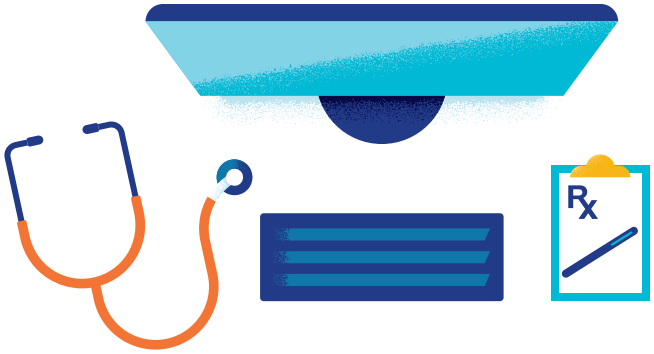
Enrolling in a Part D plan is your choice, but delaying your enrollment could cost you more money in the long run. If you do not enroll in a Part D plan when you first become eligible, you may incur a Late Enrollment Penalty (LEP), which is a late fee Medicare charges if you had 63 days or more without creditable prescription drug coverage. This can happen if:

- You didn't enroll in a Medicare prescription drug plan when you were first eligible
- You didn't have a plan that met Medicare's minimum standards

The LEP is added to your monthly premium every month and billed to the ECMT separately by UnitedHealthcare.

When you become a plan member, your former employer or plan sponsor will be asked to confirm that you have had continuous Medicare Part D coverage. **If your former employer or plan sponsor asks for information about your prescription drug coverage history, please respond as quickly as possible to avoid an unnecessary LEP.**





Your prescription drug coverage

This plan has a comprehensive drug list and a broad pharmacy network to support your health.

Here's how this Medicare Part D plan works:

Covered drugs are grouped into tiers
Generally, the lower the tier, the less you'll pay. All drugs in the Drug List are assigned to one of these tiers.
Tier 1: Preferred Generic
Tier 2: Preferred Brand
Tier 3: Non-Preferred Drug
Tier 4: Specialty Tier

Your plan's drug coverage stages and costs
Annual deductible –You pay the total cost of your drugs until you reach your plan's deductible.
Initial coverage – You pay a copay or coinsurance (percentage of a drug's total cost) for covered drugs.
Catastrophic coverage – After you and others on your behalf have paid a combined total of $2,400 for your prescription drugs, you won't pay anything for your Medicare-covered Part D drugs for the rest of the calendar year.

Always use network pharmacies
There are thousands of network pharmacies you can go to — including local and national options. Be sure to use a network pharmacy, or the plan may not pay for your prescriptions, except in an emergency. To search for a network pharmacy, visit **retiree.uhc.com/ECMT**.

Enjoy the convenience of prescriptions delivered right to your door
Optum® Home Delivery Pharmacy is part of our network.* Optum Home Delivery Pharmacy will send the medications you take regularly right to your door with no cost for standard shipping.

Scan this code to view the Drug List

*Optum® Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

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Get to know your plan

It's important that you understand your plan and what benefits are covered. You can find the Drug List, Pharmacy Directory and more at **retiree.uhc.com/ECMT**.

Review the online Drug List (Formulary) to see what prescription drugs are covered
And what drug tier they are in. Generally, the lower the drug tier, the less you'll pay.

Review the online Pharmacy Directory to see what pharmacies are in our network
If your pharmacy is not in the network, you will need to select a new network pharmacy to pay your plan's lowest cost for prescription drugs.

Review the Summary of Benefits in this guide to see how much you'll pay for prescription drugs
You can also review the Summary of Benefits online.

If you're not sure if you are enrolled in Medicare Part B, check with Social Security at ssa.gov/locator or call 1-800-772-1213, TTY 1-800-325-0778, 8 a.m.–7 p.m., Monday–Friday, or call your local office.

You may be disenrolled from this plan if you stop paying your Medicare Part B premium.

You're eligible to enroll in this plan if you:

Are entitled to Medicare Part A and/or enrolled in Medicare Part B.

Continue to pay your Part B premium (unless it's paid for you).

Remember: If you drop or are disenrolled from your group-sponsored retiree coverage, you may not be able to re-enroll. Limitations and restrictions vary by former employer or plan sponsor.

Summary of Benefits 2027

PDP Comprehensive

Group Name (Plan Sponsor): The Episcopal Church Medical Trust
Group Number: 25853
S5820-814-000

Look inside to learn more about the plan and the drug services it covers. Contact us for more information about the plan.

Download the **UnitedHealthcare app**

Visit **retiree.uhc.com/ECMT**

Call toll-free **1-866-519-5401**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

United Healthcare

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Summary of Benefits

January 1, 2027 - December 31, 2027

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

PDP Comprehensive

Premium, deductible and limits	
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Annual prescription drug deductible	$300 per year for Part D prescription drugs

Prescription drugs		
Deductible	$300 You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.	
Initial coverage	In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.	
Tier drug coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing** **31-day supply**	**Mail Order Cost-Sharing** **90-day supply**
Tier 1: Preferred Generic	$10 copay	$25 copay
Tier 2: Preferred Brand ˜	$30 copay	$70 copay
Tier 3: Non-Preferred Drug ˜	$50 copay	$120 copay
Tier 4: Specialty Tier ˜	$50 copay	$120 copay
Catastrophic coverage	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.	

Prescription drugs	
	If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.

~ You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at retiree.uhc.com/ECMT or call Customer Service to have a hard copy sent to you.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 31-day supply at a retail pharmacy.

You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. There's no penalty for applying, and you can re-apply every year. To see if you qualify for Extra Help, call:

- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office

The UnitedHealthcare Savings Promise

UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

About this plan

PDP Comprehensive is a Medicare Prescription Drug Plan with a Medicare contract.

To join PDP Comprehensive, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all U.S. territories.

Use network pharmacies

PDP Comprehensive has a network of pharmacies. If you use out-of-network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.

You can go to retiree.uhc.com/ECMT to search for a network pharmacy using the online directory. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

Required Information

PDP Comprehensive is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Benefits and features vary by plan. Limitations and exclusions may apply.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. There may be other pharmacies in our network. Optum Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

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Summary of Benefits 2027

PDP Premium

Group Name (Plan Sponsor): The Episcopal Church Medical Trust
Group Number: 25854
S5820-814-000

Look inside to learn more about the plan and the drug services it covers. Contact us for more information about the plan.

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PDP Premium

Premium, deductible and limits	
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Annual prescription drug deductible	$150 per year for Part D prescription drugs

Prescription drugs		
Deductible	$150 You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.	
Initial coverage	In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.	
Tier drug coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing** **31-day supply**	**Mail Order Cost-Sharing** **90-day supply**
Tier 1: Preferred Generic	$5 copay	$12 copay
Tier 2: Preferred Brand ˜	$25 copay	$60 copay
Tier 3: Non-Preferred Drug ˜	$40 copay	$100 copay
Tier 4: Specialty Tier ˜	$40 copay	$100 copay
Catastrophic coverage	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.	

Prescription drugs	
	If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.

~ You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

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Our service area includes the 50 United States, the District of Columbia and all U.S. territories.

Use network pharmacies

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You must continue to pay your Medicare Part B premium.

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Additional Drug Coverage

The Episcopal Church Medical Trust provides prescription drug coverage beyond what is listed in the plan's Drug List (Formulary).

Your plan includes extra coverage for drugs not included on your plan's Drug List.

The cost of these drugs is based on the tier each drug is placed in. You can find tier descriptions and costs in the Summary of Benefits.

Drug name	Drug tier	Coverage rules or limits on use
Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions		
Inflammation		
Salsalate	1	
Urinary Tract Pain		
Phenazopyridine	1	
Anorexiants - drugs to promote weight loss		
Liraglutide	1	QL (maximum of 5 pens per 30 days)
Phentermine	1	QL (maximum of 1 capsule/tablet per day)
Saxenda	3	QL (maximum of 5 pens per 30 days)
Anticoagulants - drugs to prevent clotting		
Heparin Lock Flush	1	
Dermatological agents - drugs to treat skin conditions		
Dry, Itchy Skin		
Sulfacetamide Sodium (Liquid Wash 10%)	1	
Sulfacetamide Sodium w/Sulfur (Cream 10-5%)	1	
Itching Or Pain		
Pramoxine/Hydrocortisone (Cream 1-2.5%)	1	
Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions		
Hemorrhoids		
Hydrocortisone Acetate (Suppository 25 mg)	1	
Lidocaine/Hydrocortisone (Perianal Cream 3%-0.5%)	1	

Bold type = Brand name drug Plain type = Generic drug

Drug name	Drug tier	Coverage rules or limits on use
Irritable Bowel Or Ulcers		
Hyoscyamine Sulfate	1	
Levbid	3	
Genitourinary agents - drugs to treat bladder, genital and kidney conditions		
Erectile Dysfunction		
Avanafil	1	QL (maximum of 6 tablets per month)
Edex	3	QL (maximum of 6 cartridges per month)
Sildenafil (25 mg, 50 mg, 100 mg)	1	QL (maximum of 6 tablets per month)
Tadalafil	1	QL (maximum of 6 tablets per month)
Vardenafil	1	QL (maximum of 6 tablets per month)
Sexual Desire Disorder		
Addyi	3	QL (maximum of 1 tablet per day)
Vyleesi	3	QL (maximum of 8 injections per 30 days)
Urinary Tract Infection		
Uro-MP (118 mg)	3	
Urinary Tract Spasm And Pain		
Belladonna Alkaloids & Opium (Suppositories)	1	MME, 7D, DL
Hormonal agents - hormone replacement/modifying drugs		
Thyroid Supplement		
Armour Thyroid	3	
NP Thyroid	1	
Nutritional supplements - drugs to treat vitamin and mineral deficiencies		
Potassium Supplement		
Effer-K (Effervescent Tab 25 mEq)	3	
K-Phos (Tab)	3	
Vitamins And Minerals		
Cyanocobalamin (Injection) (Vitamin B12) (1000 mcg)	1	

Bold type = Brand name drug Plain type = Generic drug

Drug name	Drug tier	Coverage rules or limits on use
Folic Acid (1 mg) (Rx only)	1	
Folic Acid-Vitamin B6-Vitamin B12 (Tablet 2.5-25-1 mg)	1	
Phytonadione (Tab)	1	
Reno (Cap)	1	
Vitamin D (50,000 unit) (Rx only)	1	
Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions		
Cough And Cold		
Benzonatate (100 mg, 200 mg)	1	
Brompheniramine/Pseudoephedrine/ Dextromethorphan (Syrup)	1	
Guaifenesin/Codeine (Syrup)	1	DL
Hydrocodone Polst/Chlorpheniramine (ER Susp) (generic for Tussionex)	1	DL
Hydrocodone/Homatropine	1	DL
Promethazine/Codeine (Syrup)	1	DL
Promethazine/Dextromethorphan (Syrup)	1	

Bold type = Brand name drug Plain type = Generic drug

Payments for these bonus drugs don't count towards your Medicare Part D out-of-pocket maximum.

You cannot file a Medicare appeal or grievance for these drugs and Extra Help from Medicare does not apply to these drugs.

Drugs with coverage rules or limits are noted in the chart and described below.

QL - Quantity limits
The plan only covers a certain amount of this drug for one copay or over a certain number of days. These limits can help ensure safe and effective use of the drug.

MME - Morphine Milligram Equivalent
Additional quantity limits may apply to all opioid drugs used to treat pain. This additional limit is called a cumulative Morphine Milligram Equivalent (MME). It is designed to monitor safe dosing levels of opioids for people who may be taking more than one opioid drug for pain management. If your doctor or prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.

7D - 7-day limit
An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate. Drugs with coverage rules or limits are noted in the chart and described below.

DL - Dispensing limit
Dispensing limits apply to this drug. This drug is limited to a one-month supply per prescription.

BDL: U

This information is not a complete description of benefits. Contact the plan for more information.
Limitations, copay, and restrictions may apply.
Benefits and/or copay/coinsurance may change each plan/benefit year.
The Drug List may change at any time. You will receive notice when necessary.
This information is available for free in other languages. Please call our Customer Service number on the cover.

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Here's what you can expect next

You'll receive 2 separate member ID cards in the mail – one for your health plan and one for your prescription drug plan. When your coverage begins, be sure to show your health plan ID card to your providers and your prescription drug ID card to the pharmacy. This will help make sure your benefits work the right way.

You are here
UnitedHealthcare will process your enrollment

Create your account to review your plans online

Receive your member ID cards

Coverage begins! Start using your plans

Manage your plans online

If you haven't already, use your Medicare number or member ID number and email address to create an account at **retiree.uhc.com/ECMT**. Online you can:

- Find network pharmacies
- View plan documents, like your plan's covered Drug List (Formulary)

Once your coverage begins

- Review your prescriptions with your provider and ask about lower-cost options that may be available
- Fill your prescriptions through the UnitedHealthcare pharmacy network for your plan's lowest prices
- Get your medications with free delivery through Optum® Home Delivery Pharmacy*

Benefits and costs may change at the end of your plan year

Before your plan year ends, we'll send you an Annual Notice of Changes that explains what's changing for next year.

Thank you for trusting UnitedHealthcare with your prescription drug coverage

If you have any questions, please call the toll-free number on the back of this Plan Guide. This number will also be on your member ID card when you get it.

Scan this code to access the member site

*Optum® Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

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Statements of understanding

By enrolling in this plan, I agree to the following:

- **UnitedHealthcare® MedicareRx for Groups (PDP) is a Medicare Prescription Drug Plan and has a contract with the federal government.**

  This prescription drug coverage is in addition to my coverage under Medicare. I need to keep my Medicare Part A and/or Part B, and I must continue to pay my Medicare Part B premium if I have one, and if not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.

- **UnitedHealthcare MedicareRx for Groups (PDP) is available in all U.S. states, the District of Columbia and all U.S. territories.**

  I understand that I must use network pharmacies except in an emergency when I cannot use the plan's network pharmacies.

- **I can only be in one Medicare Part D Prescription Drug Plan at a time.**
  - By enrolling in this plan, I will automatically be disenrolled from any other Medicare Part D Prescription Drug Plan.
  - Enrollment in this plan is generally for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

- **My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**

  Medicare may also release my information for research and other purposes that follow all applicable federal statutes and regulations.

- **For members of the Group Medicare Part D Prescription Drug Plan.**

  I understand that when my coverage begins, I must get all of my prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

Notice of availability
of language assistance services and alternate formats

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ማሳሰቢያ፡- አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظه: إذا كنت تتحدث **اللغه العربيه (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

請注意： 如果您說**中文 (Chinese)**, 您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。 請致電您的會員身份卡上的免付費電話號碼。

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION : Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

注意事項: **日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

알림 사항: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

אויפמערק: אויב איר רעדט **אידיש (Yiddish)**, קענט איר באקומען אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אויף אנדערע פארמאטן, אזוי ווי גרויסע אותיות. רופט דעם אומזיסטן נומער אויף אייער מעמבער אידענטיפיקאציע קארטל.

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