UnitedHealthcare of Illinois, Inc.
200 E. Randolph Street / Suite 5300 / Chicago, IL 60601

UnitedHealthcare®

Benefit Summary

Navigate Platinum 0
Illinois - Navigate
Navigate - Plan BHPD

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the UnitedHealthcare Navigate® Plan?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time.

> **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.

> **You need to get online referrals from your PCP to see a network specialist.**

> **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/navigate** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	**(Your cost before the plan starts to pay)**	**(Your cost share after the deductible)**
$20	You have no individual deductible.	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Annual Deductible

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

Medical Deductible - Individual	You do not have to pay a medical deductible.
Medical Deductible - Family	You do not have to pay a medical deductible.
Dental - Pediatric Services Deductible - Individual	You do not have to pay a dental deductible.
Dental - Pediatric Services Deductible - Family	You do not have to pay a dental deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays and co-insurance (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$2,000 per year
Out-of-Pocket Limit - Family	$6,000 per year

Your Costs

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount or percentage (for example, $50 or 20%). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits
Ambulance Services	
Emergency Ambulance:	You pay nothing. A deductible does not apply.
Non-Emergency Ambulance:	You pay nothing. A deductible does not apply. Prior Authorization is required for Non-Emergency Ambulance.
Amino Acid-Based Elemental Formulas	
	You pay nothing. A deductible does not apply or as stated under the Outpatient Prescription Drug Schedule of Benefits.
Cellular and Gene Therapy	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Clinical Trials	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
	Benefits will be the same as stated under Hospital - Inpatient Stay.
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing. A deductible does not apply.
Fluoride Treatments Limited to two times every 12 months.	You pay nothing. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing. A deductible does not apply.
Space Maintainers (Spacers)	You pay nothing. A deductible does not apply.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Diagnostic Services	
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing. A deductible does not apply.
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	20% co-insurance. A deductible does not apply.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance. A deductible does not apply.
Oral Surgery	20% co-insurance. A deductible does not apply.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance. A deductible does not apply.
Minor Restorative Services (Amalgam or Anterior Composite)	20% co-insurance. A deductible does not apply.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance. A deductible does not apply.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance. A deductible does not apply.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.
Implant Procedures Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.
Dental - Pediatric Medically Necessary Orthodontics	
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance. A deductible does not apply. Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only	
	You pay nothing. A deductible does not apply.
Dental Services - Anesthesia and Facility	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for certain services.
Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Schedule of Benefits.
Durable Medical Equipment (DME), Orthotics and Supplies	
	You pay nothing. A deductible does not apply.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Emergency Health Care Services - Outpatient	
	$300 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Examination and Treatment for Sexual Assault	
	You pay nothing. A deductible does not apply.
Gender Dysphoria	
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Schedule of Benefits. Prior Authorization is required for certain services.
Habilitative Services	
Inpatient:	The amount you pay is based on where the covered health care service is provided.
Outpatient:	$40 co-pay per visit for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply. $20 co-pay per visit for all other habilitative services. A deductible does not apply.
Hearing Aids	
Limited to two hearing aids every 36 months. Replacement of a hearing aid would apply to this limit in the same manner as a purchase.	You pay nothing. A deductible does not apply.
Home Health Care	
For the administration of intravenous infusion, you must receive services from a provider we identify.	You pay nothing. A deductible does not apply.
Hospice Care	
	You pay nothing. A deductible does not apply.
Hospital - Inpatient Stay	
	You pay nothing for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits
Infertility Services	
Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.	You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician or when services are provided by an obstetrician or gynecologist. A deductible does not apply. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient	
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	$40 co-pay per service. A deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient:	$40 co-pay per service. A deductible does not apply.
Major Diagnostic and Imaging - Outpatient	
	$400 co-pay per service. A deductible does not apply.
Mental Health Care and Substance Use Disorders Services	
Inpatient:	You pay nothing. A deductible does not apply.
Outpatient:	$20 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing. A deductible does not apply.
Naprapathic Services	
Limited to 15 visits per year.	$40 co-pay per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.
Obesity - Weight Loss Surgery	
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	30% co-insurance. A deductible does not apply. Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits
Oral Surgery	
	The amount you pay is based on where the covered health care service is provided.
Ostomy Supplies	
Limited to $2,500 per year.	You pay nothing. A deductible does not apply.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing. A deductible does not apply.
Physician Fees for Surgical and Medical Services	
	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.
Physician's Office Services - Sickness and Injury	
	Covered persons less than age 19: You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. All other Covered Persons: $20 co-pay per visit for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. $40 co-pay per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.

Additional co-pays or deductible may apply when you receive other services at your physician's office. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
Note: We will waive the Annual Deductible or Co-payment on the newborn's fees during the time the mother and baby are in the Hospital together. This waiver applies to the baby's eligible inpatient claims including, but not limited to, Physician fees and facility fees. However, if baby stays longer than the mother, the baby's Annual Deductible will apply upon mother's discharge from the Hospital. If the baby's birth mother is not covered under the policy, the baby's Annual Deductible is not waived.	The amount you pay is based on where the covered health care service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay or deductible.	
Private Duty Nursing	
	You pay nothing. A deductible does not apply.
Prosthetic Devices	
	You pay nothing. A deductible does not apply.
Reconstructive Procedures	
	The amount you pay is based on where the covered health care service is provided.

Covered Health Care Services	Your cost if you use Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
	$40 co-pay per visit for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply. $20 co-pay per visit for all other rehabilitation services. A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. You pay nothing for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
	You pay nothing. A deductible does not apply.
Surgery - Outpatient	
	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. You pay nothing for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply.
Telehealth Services	
	The amount you pay is based on where the covered health care service is provided.
Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services	
	The amount you pay is based on where the covered health care service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing. A deductible does not apply.
Transplantation Services	
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits
Urgent Care Center Services	
	$50 co-pay per visit. A deductible does not apply.
Additional co-pays or deductible may apply when you receive other services at the urgent care facility. For example, surgery and lab work.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Exam Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost between $130 - 160.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost between $160 - 200.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost between $200 - 250.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost greater than $250.	You pay nothing. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing. A deductible does not apply.
Low Vision Care Services Limited to once every 24 months.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

UnitedHealthcare of Illinois, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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