The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-996-0271.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$100** Individual / **$300** Family Out-of-Network: **$100** Individual / **$300** Family Deductibles cross apply. Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$2,500** Individual / **$7,500** Family Out-of-Network: **$2,500** Individual / **$7,500** Family Out-of-pocket limits cross apply. Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-800-996-0271** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance, deductible does not apply.	30% coinsurance	Virtual visits - 10% coinsurance by a Designated Virtual Network Provider, *Cost share applies to any other Telehealth service based on provider type. deductible does not apply.
	Specialist visit	10% coinsurance, deductible does not apply.	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	*30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance, deductible does not apply.	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Imaging (CT/PET scans, MRIs)	10% coinsurance, deductible does not apply.	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $30 copay, deductible does not apply.	Retail: $10 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 -day supply. Mail-Order: Up to a 90- day supply or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: $30 copay, deductible does not apply. Mail-Order: $90 copay, deductible does not apply.	Retail: $30 copay, deductible does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: $50 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply.	Retail: $50 copay, deductible does not apply.	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, deductible does not apply.	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Physician/surgeon fees	10% coinsurance, deductible does not apply.	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance, deductible does not apply.	10% coinsurance, deductible does not apply.	None
	Emergency medical transportation	10% coinsurance	*10% coinsurance	*Network deductible applies
	Urgent care	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, deductible does not apply.	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Physician/surgeon fees	10% coinsurance, deductible does not apply.	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance, deductible does not apply.	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance, deductible does not apply. Preauthorization is required out-of-network for certain services or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	10% coinsurance, deductible does not apply.	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance, deductible does not apply.	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance, deductible does not apply.	30% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Limited to 150 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	10% coinsurance, deductible does not apply.	30% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 60 visits each; Cardiac: 36 visits; Pulmonary: 20 visits. Preauthorization is required out-of-network for certain services or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Habilitative services	10% coinsurance, deductible does not apply.	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services. Preauthorization is required out-of-network for certain services or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Skilled nursing care	10% coinsurance, deductible does not apply.	30% coinsurance	Limited to 120 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
	Hospice services	No Charge	30% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 30% of allowed amount not to exceed $400 per service and $1,000 per year.
If your child needs dental or eye care	Children's eye exam	10% coinsurance	30% coinsurance	Limited to 1 exam every 12 months.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care • Glasses	• Long-term care • Non-emergency care when travelling outside - the U.S.	• Private duty nursing • Routine foot care – Except as covered for Diabetes • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic (Manipulative care) – 24 visits per calendar year	• Hearing aids • Infertility treatment - 1 In Vitro procedure per lifetime	• Routine eye care (adult) - 1 exam per 12 months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Hawaii Department of Commerce & Consumer Affairs at 1-808-586-2804 or hawaii.gov/dcca/ins.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-996-0271.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-996-0271.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-996-0271.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-996-0271 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-996-0271.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-996-0271.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-996-0271.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-996-0271.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$30
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,290**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$90
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$100
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare 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 number listed within this Summary of Benefits and Coverage (SBC), 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 other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

st:e_l-0-f(Korean) A!-§"B.A.le 9- '2:!O-f;q.A.il::l(.A. ¥li£ OI§ "? :::L(c. e 5'lls!J !i!.RQJ'.A.i(Summary of Benefits and Coverage, SBC)  (7IAIJ  ¥li  *'c!:1.£.£  *"5  .A.1.2..

PAUNA\VA: Kungnagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

BHHMAHHE:6ecnnaTHl>Ie ycnyrn nepeBo,ila.ilOcryDHl>I,!IJIII mo,!1eliq eli po,!1Holi .im,rx .imID1erc.ii pyccKoM**(Russian).** Ilo3BOHHTe no 6ecnnaTHoMy HOMepy Teneq>oHa, YI<alaHHOMYв ,ilaHHOM«Ofoope m.roT H DOI<pl>ITH.ll» (Summary of Benefits and Coverage, SBC).

<;W)l_, ylj..11   l.>ic_;.wl ..,.iWIL1J1..,]I?'-.*J!* Jl,...:i':11,s>-,), ..ill  ti.o<.;.i4-,.ll  I$.,,,,t.....)\ct..,;, J,,,;(Arabic) ¼.Juluw:i u;5 b) :"-,l!ii _\:,.,,(Summary of Benefits and Coverage, SBC)

ATANSYON:Si wpale **Kreyol ayisyen (Haitian Creole),** ou kapab benefisye sevis ki gratis pou ede w nan lang paw. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez **franc;ais (French),** des services d'aidelinguistique vous soot proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

U\VAGA: Jezeli m6,visz po **polsku (Polish),** udostpnilismy darmoweuslugi tlumacza. Prosimy zadzwonicpod bezplatny numer podanyw niniejszym Zesta,vieniu s,viadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;AO:Se voce fala **portugues (Portuguese),** contate o servic;o de assistencia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia **l'italiano (Italian),** sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'intemo di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen lhnenkostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubemahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

7.±  t  : **B●  ** **(Japanese)**  ii!i  h<Q  g., AA1*  0)i!3'lfi-i1-l::'.A  :::·11Jffiv't::t:::  tT.
::$: r{*  lt:s'J:V:iit{tO)ffilJ (Summary ofBenefits and Coverage, SBC)  .:ic!l½  h "rv'<Q7*1]*-
 -..;"I"*JJ.,.*  -=*"[t:s'  ii!i\ t:::l,'.

,ywJ! _,ylj.o "--◆ 0JI _;>,.,..:;fa J$-JI_;.:,.il:i,_;W \.iUW.,.:;4 <s"W _;1◆1_;>J$-JI_; _;.,lo'4 ◆\.ij ab.Id...,;.,u..1**(Farsi) crvU**W J;j p1 :.._..;i .:>J,.>.N<Y'W (Summary of Benefits and Coverage, SBC)

t-<!Tof t:◆ .3fJq ◆ **(Hindi)** ◆ t,◆ IITT'!l1 {1j;il<lc'11◆ f.=r:◆R><I>3q<'i""-' ◆I °<'1rn Jth. clid◆.j (Summary of Benefits and Coverage, SBC) ct ◆ ◆Tct ◆c'H {1"-i◆isl<&GIB ◆ .=i.R tl< ◆ <!>ti

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong),** muaj kev pab txhais !us pub dawbrau koj. Thov hu rau tus xov tooj hu dawb teevmuaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

CH1..mUH'l!◆M: IU/\JS\il'lSUJ1WmfiJ1i◆1(Khmer) 1n.1na◆wmfiJ1lthWl'll'1◆l'li◆rl1:flSM1UlJl'l'1 t\Jl:!ltinJ◆ls11CU8i'll'ilti[!)i◆iclCU1:flSl'lrilITTQll lfl.l06n.11vUH◆ll.JlUflclS Sllmfnu611:l(Summary of Benefits and Coverage, SBC)12:'1

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawatnga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagupdagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dff BAA'A.KONINIZIN **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. T'aa shqqdi Naaltsoos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii bee hodiilnih.

OGO\.V: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).