**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Service

**Coverage Period:** 01/01/2020-12/31/2020

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**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
What is the overall deductible? | Network: $2,850 Individual / $5,700 Individual +1 / $7,125 Family  
Non-Network: $5,700 Individual / $11,400 Individual +1 / $14,250 Family per calendar year.  
Does not apply to services listed below as “No Charge”. | 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 policy, the overall family deductible must be met before the plan begins to pay.

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 annual 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 services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/)

Are there other deductibles for specific services? | No, there are no other deductibles. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

What is the out-of-pocket limit for this plan? | Medical- Network: $5,000 Individual / $10,000 Individual +1 / $12,500 Family ($7,900 embedded per individual in Individual + 1 or Family plan)  
Non-Network: $10,000 Individual / $20,000 Individual +1 / $25,000 Family per calendar year ($25,000 embedded per individual in Individual + 1 or Family plan) | 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, the overall family out-of-pocket limits must be met.

What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services. | Even though you pay these expenses, they don’t count toward the out-of-pocket.
### Important Questions | Answers | Why This Matters:

**Will you pay less if you use a network provider?**

Yes. See [www.myuhc.com](http://www.myuhc.com) or call 1-800-996-2057 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.

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Virtual Visit- In network 30% coinsurance after plan deductible by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply.</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No Charge</td>
<td>60% Coinsurance deductible does not apply</td>
<td>Includes preventive health services specified in the health care reform law. 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. Non-Network Prior Authorization required for Genetic Testing for BRCA or $250 penalty</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
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<td>------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Non-Network Prior Authorization required for Sleep Studies or $250 penalty</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic Drugs (Tier 1)</td>
<td>Retail: 10% Coinsurance &amp; Mail Order: 10% Coinsurance</td>
<td>Retail: 10% Coinsurance</td>
<td>Retail Coverage up to 30-day supply $7 min/$50 max after Deductible. Mail Coverage up to 90-day supply $17.50 min/$125 max after Deductible</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at hrdirect.jll.com</td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: 25% Coinsurance &amp; Mail Order: 25% Coinsurance</td>
<td>Retail: 25% Coinsurance</td>
<td>Retail Coverage up to 30-day supply $30 min/$85 max after Deductible. Mail Coverage up to 90-day supply $75 min/$200 max after Deductible</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: 50% Coinsurance &amp; Mail Order: 50% Coinsurance</td>
<td>Retail: 50% Coinsurance</td>
<td>Retail Coverage up to 30-day supply $75 min/$125 max after Deductible. Mail Coverage up to 90-day supply $150 min/$300 max after Deductible</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A &amp; Mail Order: N/A</td>
<td>Retail: N/A &amp; Mail Order: N/A</td>
<td>$15000 Lifetime Maximum for Infertility Drugs</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>30% Coinsurance</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% Coinsurance</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Non-Network Prior Authorization required or $250 penalty</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Network Provider (You will pay the least) 30% Coinsurance 60% Coinsurance</td>
<td>EAP allows six face-to-face sessions per issue per calendar year. Non-Network Prior Authorization required or $250 penalty. Neurobiological Disorders - Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td>Non-Network Prior Authorization required or $250 penalty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td>$250 penalty may apply for out of network Inpatient facility services w/o Prior Auth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td>75 continuous visits per calendar year In/Out Network combined. Non-Network Prior Authorization required or $250 penalty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td>25 visits per year. In/Out Network combined. Physical Therapy for children birth to age 18 are allowed 60 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% Coinsurance 60% Coinsurance</td>
<td>60 days per calendar year In/Out Network combined. Non-Network Prior Authorization required or $250 penalty</td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>30% Coinsurance</td>
<td>60% Coinsurance</td>
</tr>
</tbody>
</table>

#### 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.)**

- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Travel Immunizations
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment ($25,000 medical lifetime maximum; $15,000 drug lifetime maximum)
- Private-duty nursing
- Routine foot care
**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: 1-800-996-2057 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.


**Does this plan provide Minimum Essential Coverage?** Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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:**
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 1-866-580-7421.

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*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: $2,850
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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

| Total Example Cost | $12,800 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,410</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,590</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $60

The total Peg would pay is $5,060

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

- The plan’s overall deductible: $2,850
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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 | $7,400 |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,850</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $60

The total Joe would pay is $4,410

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

- The plan’s overall deductible: $2,850
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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 | $1,900 |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,140</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$580</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

The total Mia would pay is $1,720

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  
**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.

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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 đại thơ bảo hiểm (Summary of Benefits and Coverage, SBC) này.
알림: 한국어 (Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita 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 Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of Benefits and Coverage (SBC)

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 nan Rezime avantaj ak pwoteksyn sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios 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 il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsmittel zum Gebrauch zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निष्पादन उपलब्ध हैं। नाम और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टॉल फ्री 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 dawb tec muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

互々語取扱い: ប្រការិយាចៃន្តខ្មែរ (Khmer) ការដកើណឈការជួយគ្នារៀនមក វីបសានិភ័យ។ ការដកើណឈការជួយគ្នារៀនមក វីបសានិភ័យ៖ ផ្នែកជាតិឆ្លងកាយ បញ្ហាលើកសម្រាប់ប្រការិយាចៃន្តខ្មែរ (Summary of Benefits and Coverage, SBC)។

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

DÍÍ BAA'ÁKÓNÍNÍZIN: Diné (Navajo) bizaad bee yánili'go, saad bee áka'anida'awo'ígíí, t'áá jiik'eh, bee ná'ahóó'tí'. T'áá shqoñdi Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'è'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jiik'ehgo béésh bee hane'i biká'ígíí bee hodíilnih.

OGOW: 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 Caymska (Summary of Benefits and Coverage, SBC).