

Dental Insurance

Cigna Health and Life Insurance Company (“Cigna”)

Individual Services
P. O. Box 30365
Tampa, FL33630
1-877-484-5967

Cigna Dental 1000

POLICY FORM NUMBER: INDDENTPOLCA0713

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

A. Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as “Cigna”), an insurance company that provides participating provider benefits.

B. To obtain additional information, including Provider information write to the following address or call the toll-free number:

Cigna
Individual Services – California
P. O. Box 30365
Tampa, FL33630
1-877-484-5967

C. A Participating Provider Plan enables the Insured to incur lower dental costs by using providers in the Cigna network.

A Participating Provider - Cigna Dental Preferred Provider is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at predetermined fees with regard to a particular Policy under which an Insured Person is covered. The providers qualifying as Participating Providers may change from time to time.

A Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Contracted Fee which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

Cigna Dental contracts with healthcare professionals to provide dental services at a contracted rate, This plan design includes a combination of insurance coverage and services offered at Cigna Dental contracted rates. The insurance coverage shall be only for the classes of service referred to in The Schedule. The covered person will also be eligible to pay Cigna Dental contracted rates for other selected services in Class IV when these services are provided by a Cigna contracted health care professional who has entered into a contract with Cigna agreeing

to render such services at a contracted rate. Note: A covered person will not be eligible to receive contracted rates if he/she receives services from a health care professional that has not entered into a contract with Cigna.

D. Covered Services and Benefits

Benefits covered by your Dental Plan include Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under your plan and includes Crowns, Dentures and Bridges. For a complete listing of covered services, please read your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under your plan.
 HC-NOT30.OOC

BENEFIT SCHEDULE

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.
 HC-SOC188.OOC

CIGNA DENTAL PREFERRED PROVIDER INSURANCE <i>The Schedule</i>
For You and Your Dependents
The Schedule
If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.
<p>Emergency Services The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.</p>
<p>Deductibles Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.</p>
<p>Participating Provider Payment Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CHLIC.</p>
<p>Non-Participating Provider Payment Non-Participating Provider services are paid based on the Contracted Fee.</p>
<p>Simultaneous Accumulation of Amounts Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.</p> <p>Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.</p>

BENEFIT HIGHLIGHTS	Cigna DPPO Advantage Participating Providers	Cigna DPPO Participating Providers** and Non-Participating Providers
Classes I, II, III Calendar Year Maximum	\$1,000 per person	
Calendar Year Deductible	\$50 per person	
Individual	Not Applicable to Class I	
Family Maximum	\$150 per family	
	Not Applicable to Class I	
Class I	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays
Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100%*	100%*
Class II	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays
Basic Restorative Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after plan deductible*	80% after plan deductible*
Class III	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays
Major Restorative Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after plan deductible*	50% after plan deductible*

HC-SOC184.OOC

*For explanation of any additional payment responsibility to the covered person, see section entitled **Dental PPO – Participating and Non-Participating Providers.**

**If you choose to visit a Cigna DPPO provider, you will receive a discounted rate. For the greatest potential savings, please see a Cigna DPPO Advantage provider.

Waiting Periods

An Insured Person may access their dental benefit insurance once he or she has satisfied the following waiting periods.

- there is no waiting period for Class I services;
- after 6 consecutive months of coverage dental benefits will increase to include the list of Class II procedures;
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class III procedures;

HC-DBW6.OOC

E. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, and any amounts charged by Non-Participating Providers in excess of the Contracted Fee. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.

HC-POB50.OOC

F. Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not Medically Necessary and/or Dentally Necessary.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit under this provision).
- the initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was

insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.

- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to tooth decay or fracture.
- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
 - (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
 - (b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to an extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
 - (c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by tooth decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (lamine).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment, except for the treatment of cleft lip and cleft palate.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.

- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, crowns, temporary fixed bridges and temporary partial or complete dentures, that are considered transitional or interim dental services.
- any temporary, transitional or interim dental service; diagnostic cast, diagnostic model, or study model procedure not expected to successfully correct the covered person's dentally necessary condition for a period of at least three years;
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of \$100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that would be covered under medical plan;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- For services not specifically listed as Covered Services in this Policy.
- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
 - Yourself or Your employer;
 - a person who lives in the Insured Person's home, or that person's employer;
 - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures. Experimental procedure(s) means services(s) in which current research has not yet established its effectiveness to diagnose and treat the presenting condition;
- Procedures that are a covered expense under any other dental plan which provides dental benefits;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.

Cigna will take into account any adjustment option chosen under such part by you or any one of your Dependents.

HC-DEX25.OOC

G. Predetermination of Benefits Program

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed \$500.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

HC-DEN82.OOC

H. General Provisions

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our complaint and adverse determination appeal procedures. Complaints and adverse determination appeals may be reported by telephone or in writing. All complaints and adverse determination appeals received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

CIGNA uses binding arbitration to settle disputes, including claims of dental malpractice and disputes relating to the delivery of services under the Policy. It is understood that any dispute as to dental malpractice, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as provided in California Code of Civil Procedure sections 1281 and 1294 for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute or dental malpractice, relating to the delivery of service under the Policy, and to any claims in tort, contract or otherwise, between individual(s) seeking service under the Policy, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and CIGNA (including any of their agents, successors –or predecessors-in-interest, employees or providers.) The parties will mutually select a single neutral arbitrator to settle any disputes under the policy. If the parties are unable to agree on the selection of a single neutral arbitrator, the method provided in Section 1281.6 of the California Code of Civil Procedure shall be utilized. **Each party will assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs will be borne equally by the parties.** Arbitration will take place at a mutually agreed time and place. The arbitrator shall have no jurisdiction to award more than fifty thousand dollars (\$50,000). If You are dissatisfied with the arbitrator's decision or find the remedy inadequate, You may appeal the arbitrator's decision using the judicial system.

HC-APL160.OOC

The Following Will Apply To Residents of California When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you", "your" or "Yourself" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on mycigna.com,
explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by Cigna.

Appeal to the State of California

You have the right to contact the California Department of Insurance for assistance at any time. The Commissioner may be contacted at the following address and fax number:

California Department of Insurance
Claims Service Bureau, Attn: IMR
300 South Spring Street
Los Angeles, CA 90013
Or fax to 213-897-5891

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific Policy provisions on which the decision is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrate compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

HC-APL159.OOC

I. Participating Providers

Cigna will provide a current list of dentists currently participating with Cigna and their locations to each Insured upon request.

To verify if a dentist is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should visit our website at mycigna.com.

HC-IMP102.OOC

J. Renewability, Eligibility, and Continuation

1. The Policy will renew subject to the timely payment of premium. Cigna may change the premiums of the Policy with 60 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan is designed for residents of California who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.

3. You or Your Insured Family Member(s) will become ineligible for coverage:
 - When premiums are not paid according to the due dates and grace periods described in the premium section.
 - With respect to Your spouse or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
 - With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
 - The date the Policy terminates.
 - When the Insured no longer lives in the Service Area.
4. If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

HC-ELG74.OOC

K. Premium

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals who pay monthly. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional \$45 charge for any check or electronic funds transfer that is returned to Us unpaid.

There is a grace period of 31 days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

Your premium may change from time to time due to (but not limited to):

- a. Deletion or addition of a new eligible Insured Person(s)
- b. A change in age of any member which results in a higher premium
- c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 31 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

HP-POL190.OOC

This document may include the following filed and approved form numbers

HC-NOT30.OOC
HC-SOC188.OOC
HC-SOC184.OOC
HC-DBW6.OOC
HC-DFS539.OOC
HC-POB50.OOC
HC-DEX25.OOC
HC-DEN82.OOC
HC-APL160.OOC
HC-APL159.OOC
HC-IMP102.OOC
HC-ELG74.OOC
HP-POL190.OOC