

**Connecticut General Life Insurance Company (“CIGNA”)**

**Individual Services - California  
P. O. Box 30365  
Tampa, FL 33630  
1-877-484-5967**

**Individual CIGNA Dental Preferred Provider Insurance**

**POLICY FORM NUMBER: DENINDCA082010**

**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 Connecticut General Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**A. Coverage is provided by Connecticut General 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, FL 33630  
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 Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

## D. Covered Services and Benefits

Some of the benefits covered by your Dental Plan include Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan may also include Basic Restorative Care such as fillings and anesthetics. Major Restorative Care covered under your plan would include 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, below lists some of the limitations under your plan, refer to your Policy for any specific limitations on frequency under your plan.

### Benefit Limitations

Clinical Oral Evaluation	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	Only 1 prophylaxis per consecutive 6-month period.
Fluoride Treatments	Limited to persons less than 14 years old. Only 1 per person per consecutive 12-month period.
X-rays (routine)	Bitewings: Only 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Complete Mouth Survey or Panoramic x-rays: Only 1 in any consecutive 60-month period.
Periapical x-rays	A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.
Intraoral occlusal x-rays	Limited to 2 films in any consecutive 12-month period.
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No white/tooth colored fillings on bicuspid or molar teeth.
Sealants	Per tooth, on an unrestored permanent bicuspid or molar tooth for a person less than 14 years old - Only 1 treatment per tooth per lifetime.

Minor Periodontics (non-surgical)	Root planing-1 per quadrant per 36 consecutive months.
Periodontic Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits limited to resin or stainless steel.
Stainless Steel & Resin Crowns	1 per 36 consecutive months for participants younger than age 16.
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Dentures and Partial	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.
Alternate Benefit	When more than one Covered Dental Service could provide suitable treatment based on common dental standards, CIGNA will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expense.

## Deductibles

- **Annual Calendar Year In-Network Deductible** is the amount of Covered Expenses incurred from Participating Providers, for dental services, that You or a Family Member must pay each Year before any benefits are available, unless expressly stated otherwise in the Benefit Schedule. The amount of the Annual Calendar Year In-Network Deductible is described in the Benefits Schedule section of this Policy. There are no other Annual Calendar Year In-Network Deductibles except as specifically stated otherwise in the Benefits Schedule.
- **Annual Calendar Year Out-of-Network Deductible** is the amount of Covered Expenses incurred from Non-Participating Providers, for dental services, that You or a Family Member must pay each Year before any benefits are available, unless expressly stated otherwise in the Benefit Schedule. The amount of the Annual Calendar Year Out-of-Network Deductible is described in the Benefit Schedule section of this Policy. There are no other Annual Calendar Year Out-of-Network Deductibles except as specifically stated otherwise in the Benefit Schedule.

## Calendar Year Maximums

- **Calendar Year Maximum Benefits:** The combined total of all benefits paid to You is limited to a maximum during each calendar year as long as You remain insured under this Policy.

## 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.

	<b>CIGNA Dental PPO</b>	
<b>Benefits</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Calendar Year Maximum - Class I, II and III expenses</b>	\$1,000	\$1,000
<b>Annual Calendar Year Deductible</b>	\$50 Per Person \$150 Per Family	\$50 Per Person \$150 Per Family
	<b>Plan Pays</b>	<b>Plan Pays</b>
<b>Class I – Preventive/diagnostic services</b> Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% No Deductible	80% No Deductible
<b>Class II – Basic restorative services</b> Fillings Non-Routine X-rays Emergency Services to Relieve Pain Oral Surgery, Simple Extractions	80% After Deductible	60% After Deductible
<b>Class III – Major restorative services</b> 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	50% After Deductible	40% After Deductible

	<b>CIGNA Dental PPO</b>	
<b>Benefits</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
Repairs - Dentures Anesthetics Dentures Bridges		
<b>Class IV – Orthodontia</b>	Class Not Covered	Class Not Covered
<b>Class V – TMJ (Non-surgical)</b>	Class Not Covered	Class Not Covered
<b>Class IX – Surgical Implants</b>	Class Not Covered	Class Not Covered

**Note:** All plan deductibles and maximums (dollar and occurrence) **cross-accumulate** between In-Network and Out-of-Network unless otherwise noted.

### **Maximum Reimbursable Charge**

The Maximum Reimbursable Charge for covered services is the lesser of: (1) the provider's normal charge for a similar service or supply; or (2) calculated at the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received. To determine if a charge exceeds the Maximum reimbursable Charge, the nature and severity of the injury or sickness may be considered. CIGNA uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

### **E. Dental Emergency Services**

**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.

### **F. 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, Copayment, Additional Deductibles, Penalties and any amounts charged by Non-Participating Providers in excess of the Maximum Reimbursable Charges. In addition, any charges for Dentally Necessary items that are excluded under this Policy are the responsibility of the Insured.

### **G. Exclusions, Limitations, and Reductions**

**The Participating Provider Plan does not provide benefits for:**

- Cosmetic dentistry or cosmetic dental surgery (dental services or dental surgery performed solely with the intention to change the appearance of otherwise normal functioning teeth), or when any dental service is performed solely for reasons of beautification, or to improve or alter aesthetic appearance.) except as described in the Dental Benefits: What This Policy Pays For section;
- Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;

- Core buildup, labial veneers; 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;
- Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type;
- Instruction for plaque control, oral hygiene and diet;
- Prosthesis Over Implant — A prosthetic device, supported by an implant or implant abutment
- Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers' compensation or similar law;
- Charges in excess of the reasonable and customary allowances; Amounts in excess of Maximum Reimbursable Charges;
- IV sedation or general anesthesia, except when dentally or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless CIGNA agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- 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 major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Professional services received or supplies purchased from Yourself, a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption, or the Insured Employee's employer;
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CIGNA; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;



- Any charge for any treatment performed outside of the United States other than for Dental Emergency Services (any benefits for Dental Emergency Services which are performed outside of the United States will be limited to a maximum of \$100.00 per 12 consecutive month period);
- Procedures that are a covered expense under any other dental plan which provides dental benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- 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;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

### **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.

### **H. 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. 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.

### **I. Complaint Resolution Procedures**

#### ***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 "Member" 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 your Benefit Identification card, 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 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post-service 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.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist would cause you severe pain which cannot be managed without the requested services. CIGNA's Dental reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

## **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 Dental reviewer in the same or similar specialty as the care under consideration, as determined by CIGNA's Physician reviewer. 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 required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service 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 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist would cause you severe pain which cannot be managed without the requested services. CIGNA's Dental reviewer, in consultation with the treating Dentist will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing

## **External 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 HealthCare 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 external 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. The amount payable for the denied service or treatment must be at least \$500. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. Post-service issues are not eligible for external review unless you may be held financially responsible for the denied service or treatment. You must first complete CIGNA's level-one and level-two appeal processes before you request an external review unless:

- Your treating Dentist certifies in writing that you have a serious medical condition or the coverage denial is based on a determination that the recommended or requested health care service or treatment is experimental or investigational. If the requested health care service or treatment is experimental or investigational, your treating Dentist must include information that:

(1) you have a life-threatening or seriously disabling condition;

(2) at least one of the following applies:

- (a) standard dental care services or treatments have not been effective in improving your condition;
- (b) standard dental care services or treatment are not medically appropriate for you; or
- (c) the recommended or requested service or treatment is more beneficial than the standard dental care service or treatment covered by CIGNA; and

(3) medical and scientific evidence using accepted protocols demonstrate that the dental care service or treatment requested by you that is the subject of the appeal is more beneficial to you than standard dental care services or treatments and the adverse risks of the recommended or requested dental care service or treatment would not be substantially increased over those of the standard services or treatments.

- You filed an appeal pursuant to CIGNA's level-one or level-two processes and CIGNA has not issued a written decision within the time frames for making a decision if CIGNA has received all the information needed to complete the appeal review and you have not agreed to a delay.
- CIGNA has agreed to waive the completion of the level-one or level-two appeal processes.

To request a review, you must notify the Appeals Coordinator within 60 days of your receipt of CIGNA's level-two appeal denial. To request an expedited external review, you must notify the Appeals Coordinator within 15 days of your receipt of CIGNA's level-two appeal review denial. CIGNA will then forward the file to the Independent Review Organization. CG will review all newly submitted information to determine if the appeal can be approved before being sent to the Independent Review Organization.

The Independent Review Organization will render an opinion on standard external review within 45 days. An expedited external review shall be completed as expeditiously as possible, but no later than 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 for either a complaint or an Adverse Determination appeal. The California Department of Insurance may be contacted at the following address and telephone 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) demonstrates 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 Policy 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.

### ***Dispute Resolution***

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances 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

### **J. 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](http://mycigna.com).

### **K. Renewability, Eligibility, and Continuation**

1. The Policy will renew except for the specific events stated in the Policy. 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: when the spouse is no longer married to the Insured.
  - 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.

## **L. 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. Please see "General Provisions," for further information regarding cancellation and reinstatement.

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 60 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.