EQUITABLE

Dental

Benefit Summary

San Jose State University Research Foundation **Effective Date:** January 01, 2019

Policy Number: 004201

Class Definition: Class 1: All Active Full Time Employees working at least 20 hours per week

Easily access the care you need with our comprehensive dental coverage

Regular dental care is one of the best ways to maintain a winning smile. It's also an important way to protect your overall health, though the cost of care can add up with preventive cleanings, exams, and more serious procedures. Dental insurance can help. We partnered with Dental Choice 360, a leading national PPO network, to provide flexible, comprehensive dental coverage and access to an extensive network of 300,000 dental access points and over 105,000 unique dental providers.

Dental ID cards are not needed in order to receive treatment from a dentist, but can help to simplify our members' office experience so we encourage that they are printed. ID cards can be printed from www.equitable.com/employeebenefits.

What your benefits cover:

Plan Benefits and Features	In-Network	Out-of-Network
Reimbursement	Contracted Allowances	90th percentile R&C
Coinsurance	100/90/60	100/90/60
Annual Individual Deductible (Waived for Preventive Services)	$50	$50
Annual Family Deductible (Waived for Preventive Services)	$150	$150
Annual Individual Maximum Benefit	$2,500	$2,500
Orthodontia		
Child Orthodontia Individual Deductible	$0	$0
Child Orthodontia Lifetime Maximum Benefit	$1,500	$1,500

Preventive Services	In-Network	Out-of-Network	Limitations
Evaluations			
• Periodic Oral Evaluation	100%	100%	2 times per 12 months combined with Limited and Comprehensive Oral Examination limitations
• Limited Oral Evaluation - Problem Focused	100%	100%	2 times per 12 months combined with Periodic and Comprehensive Oral Examination limitations
• Comprehensive Oral Evaluation	100%	100%	2 times per 12 months combined with Periodic and Limited Oral Examination limitations
Treatments			
• Routine Dental Prophylaxis	100%	100%	2 times per 12 months including periodontal cleanings and full mouth debridement
• Fluoride Treatment	100%	100%	2 times per 12 months
• Sealants - child	100%	100%	Covered for a child up to age 13 Limited to one per tooth per 36 months for non-restored first and second permanent molars.
X-Rays			
• Complete Series of X-Rays	100%	100%	Once every 36 consecutive months against panoramic x-rays
• Periapical X-Rays	100%	100%	Allowed on an emergency or episodic basis
• Bitewing X-Rays	100%	100%	2 sets every 12 months
• Panoramic X-Ray	100%	100%	Once every 36 consecutive months against complete series of x-rays
Lab and Tests			
• **Tests** - Adjunctive Pre-Diagnostic, HBA1c and Pulp Vitality	100%	100%	N/A
• **Labs** - Accession of Tissue and Laboratory Accession of Sample	100%	100%	N/A

Basic Services	In-Network	Out-of-Network	Limitations
• Emergency Palliative Treatment	90%	90%	N/A
• Basic Restorative Services (amalgam fillings on all teeth, resin based composite fillings on anterior teeth)	90%	90%	1 per tooth surface per 12 consecutive months
• Simple Extractions	90%	90%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services
• Surgical Extractions and Removal of Impacted Teeth	90%	90%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services

Basic Services	In-Network	Out-of-Network	Limitations
• Endodontics	90%	90%	Root Canal - 1 per tooth per lifetime
• Non-Surgical Periodontal (scaling and root planing)	90%	90%	1 per quadrant per 24 consecutive months
• Non-Surgical Periodontal (full mouth debridement)	90%	90%	When dentally necessary to enable comprehensive evaluation and diagnosis. Counted towards periodontal maintenance and teeth cleanings.
• Non-Surgical Periodontal (administration of antibiotic to clear infectious bacteria from areas below the gumline).	90%	90%	1 per quadrant per 24 consecutive months
• Periodontal Surgery	90%	90%	1 per quadrant per 24 consecutive months
• Oral Surgery	90%	90%	Limited to 1 unique site per 36 months
• Periodontal Maintenance	90%	90%	Only where periodontal treatment has been performed, limited to 4 times in every 12 months less the number of teeth cleanings and debridements received during such benefit period
• Space Maintainers and Recementation of Space Maintainers	90%	90%	Once per every 60 consecutive months for Children under age 18. Benefit includes all adjustments within 6 months of installation
• Anesthesia	90%	90%	General Anesthesia covered when medically or dentally necessary in conjunction with covered dental services. Local anesthesia is included in the fee for procedure being performed.

Major Services	In-Network	Out-of-Network	Limitations
• Inlays/Onlays/Crowns	60%	60%	1 replacement per tooth per 60 consecutive months. Covered when medically or dentally necessary.
• Dentures - Complete, partial, overdenture, (upper and lower)	60%	60%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Implants	60%	60%	1 per tooth per lifetime. Covered when medically or dentally necessary.
• Bridges	60%	60%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Other Dental Prosthetics	60%	60%	N/A
• Adjustments, Repairs, Reline and Rebase of Dentures	60%	60%	Adjustments limited to after 6 months of installation if performed by the same dentist

Orthodontic Services	In-Network	Out-of-Network	Limitations
Child Orthodontic Services	50%	50%	Covered for dependent children only

Whitening Services	In-Network	Out-of-Network	Limitations
Teeth Whitening by Dentist	50%	50%	Not to exceed $400 every 2 years

Manage Your Benefits

Go to www.equitable.com/employeebenefits and log on to **EB360®** to view your account details.

Find A Dentist

Visit www.equitable.com/finddentist

Choose from 300,000 dental access points and over 105,000 unique dental providers.

If you have any questions, please don't hesitate to contact us at 1-866-274-9887.

We look forward to helping you manage your benefits with confidence and ease.

More about your Dental coverage

If you are working for your employer on the effective date - the waiting period is the first of the month following 3 continuous days.
If you start working for your employer after the effective date - the waiting period is the first of the month following 0 continuous days.

An Employee who is employed on the effective date of the policy will receive credit towards satisfying the waiting period for time employed with the employer provided he or she was employed on the day prior to the effective date of the policy.

What is not covered?

Limitations: In addition to the limitations listed in the schedule of benefits, payment of benefits is limited under this certificate as follows:

1. Orthodontic services must begin while this insurance is in force. If the insurance ends during the course of the treatment plan, the monthly benefits will end. Services are considered to have begun when the initial banding or appliance is inserted. For takeover groups with Orthodontic coverage under the prior carrier, we will pay for work in progress up to our lifetime maximum benefit considering any amounts already paid under the prior carrier. For takeover groups without Orthodontic coverage under the prior carrier, we will not pay for work in progress.
2. Services must begin after the end of any applicable waiting period. Waiting periods for each category of service show on the schedule of benefits.
3. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.
4. Alternate Benefit: If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:
    - would produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the individual's dental condition; and
    - would qualify as a Covered Service. For example, if an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our determination on the less costly amalgam filling.

    If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Any procedures not specifically listed as a covered service in the schedule of benefits.
2. Services which are not dentally necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
3. Services for which the insured person would not be required to pay in the absence of dental insurance.
4. Services or supplies received by an insured person before the dental insurance starts for that person.
5. Treatment or services received outside of the United States.
6. Services which are primarily cosmetic, except for services covered under the Teeth Whitening Benefit.

7. Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments.
8. Services or appliances which restore or alter occlusion or vertical dimension.
9. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
10. Restorations or appliances used for the purpose of periodontal splinting.
11. The prophylactic removal of third molars is not a covered service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.
12. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
13. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
14. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
15. Charges for missed appointments.
16. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by your employer, labor union, mutual benefit association, or VA hospital.
17. Services covered under other coverage provided by your employer.
18. Temporary or provisional restorations.
19. Temporary or provisional appliances.
20. Prescription drugs.
21. Services for which the submitted documentation indicates a poor prognosis.
22. Fixed and removable appliances for correction of harmful habits.
23. Application of desensitizing agents.
24. Repair or replacement of an orthodontic device.
25. The following, when charged by the dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
26. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
27. Caries susceptibility tests.

28. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
29. Precision attachments associated with fixed and removable prostheses.
30. Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
31. Duplicate prosthetic devices or appliances.
32. Replacement of a lost or stolen appliance, cast restoration or denture.
33. Intra and extra-oral photographic images.
34. Cone beam imaging.
35. Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders.
36. Diagnostic casts, unless part of overall treatment plan for medically necessary orthodontia .
37. Labial veneers.
38. Modification of removable prosthodontic and other removable prosthetic services.
39. Occlusal adjustments
40. The following services are not Covered Services:
    - a connector bar,
    - a stress breaker,
    - coping,
    - pediatric partial dentures
41. Basic restorative services are limited as follows:
    a. Amalgam or resin based restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a covered service.
    b. Micro filled resin restorations which are non-cosmetic.
    c. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Equitable is not affiliated with Careington Benefit Solutions, NovaNet Inc, Maximum Care PPO Network or Maximum Care Plus Connection.

Policy Form MOEBP18IDEN, MOEBP15DEN; AXEBP15DEN and State Variations.

1290 Avenue of the Americas, New York, NY 10104. (212) 554-1234.

GE-2839211 (6/20) (Exp. 6/22)

EQUITABLE

Dental

Benefit Summary

San Jose State University Research Foundation **Effective Date:** January 01, 2019

Policy Number: 004201

Class Definition: Class 2: All Active Retirees working at least 0 hours per week

Easily access the care you need with our comprehensive dental coverage

Regular dental care is one of the best ways to maintain a winning smile. It's also an important way to protect your overall health, though the cost of care can add up with preventive cleanings, exams, and more serious procedures. Dental insurance can help. We partnered with Dental Choice 360, a leading national PPO network, to provide flexible, comprehensive dental coverage and access to an extensive network of 300,000 dental access points and over 105,000 unique dental providers.

Dental ID cards are not needed in order to receive treatment from a dentist, but can help to simplify our members' office experience so we encourage that they are printed. ID cards can be printed from www.equitable.com/employeebenefits.

What your benefits cover:

Plan Benefits and Features	In-Network	Out-of-Network
Reimbursement	Contracted Allowances	90th percentile R&C
Coinsurance	100/90/60	100/90/60
Annual Individual Deductible (Waived for Preventive Services)	$50	$50
Annual Family Deductible (Waived for Preventive Services)	$150	$150
Annual Individual Maximum Benefit	$2,500	$2,500
Orthodontia		
Child Orthodontia Individual Deductible	$0	$0
Child Orthodontia Lifetime Maximum Benefit	$1,500	$1,500

Preventive Services	In-Network	Out-of-Network	Limitations
Evaluations			
• Periodic Oral Evaluation	100%	100%	2 times per 12 months combined with Limited and Comprehensive Oral Examination limitations
• Limited Oral Evaluation - Problem Focused	100%	100%	2 times per 12 months combined with Periodic and Comprehensive Oral Examination limitations
• Comprehensive Oral Evaluation	100%	100%	2 times per 12 months combined with Periodic and Limited Oral Examination limitations
Treatments			
• Routine Dental Prophylaxis	100%	100%	2 times per 12 months including periodontal cleanings and full mouth debridement
• Fluoride Treatment	100%	100%	2 times per 12 months
• Sealants - child	100%	100%	Covered for a child up to age 13 Limited to one per tooth per 36 months for non-restored first and second permanent molars.
X-Rays			
• Complete Series of X-Rays	100%	100%	Once every 36 consecutive months against panoramic x-rays
• Periapical X-Rays	100%	100%	Allowed on an emergency or episodic basis
• Bitewing X-Rays	100%	100%	2 sets every 12 months
• Panoramic X-Ray	100%	100%	Once every 36 consecutive months against complete series of x-rays
Lab and Tests			
• **Tests** - Adjunctive Pre-Diagnostic, HBA1c and Pulp Vitality	100%	100%	N/A
• **Labs** - Accession of Tissue and Laboratory Accession of Sample	100%	100%	N/A

Basic Services	In-Network	Out-of-Network	Limitations
• Emergency Palliative Treatment	90%	90%	N/A
• Basic Restorative Services (amalgam fillings on all teeth, resin based composite fillings on anterior teeth)	90%	90%	1 per tooth surface per 12 consecutive months
• Simple Extractions	90%	90%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services
• Surgical Extractions and Removal of Impacted Teeth	90%	90%	Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services

Basic Services	In-Network	Out-of-Network	Limitations
• Endodontics	90%	90%	Root Canal - 1 per tooth per lifetime
• Non-Surgical Periodontal (scaling and root planing)	90%	90%	1 per quadrant per 24 consecutive months
• Non-Surgical Periodontal (full mouth debridement)	90%	90%	When dentally necessary to enable comprehensive evaluation and diagnosis. Counted towards periodontal maintenance and teeth cleanings.
• Non-Surgical Periodontal (administration of antibiotic to clear infectious bacteria from areas below the gumline).	90%	90%	1 per quadrant per 24 consecutive months
• Periodontal Surgery	90%	90%	1 per quadrant per 24 consecutive months
• Oral Surgery	90%	90%	Limited to 1 unique site per 36 months
• Periodontal Maintenance	90%	90%	Only where periodontal treatment has been performed, limited to 4 times in every 12 months less the number of teeth cleanings and debridements received during such benefit period
• Space Maintainers and Recementation of Space Maintainers	90%	90%	Once per every 60 consecutive months for Children under age 18. Benefit includes all adjustments within 6 months of installation
• Anesthesia	90%	90%	General Anesthesia covered when medically or dentally necessary in conjunction with covered dental services. Local anesthesia is included in the fee for procedure being performed.

Major Services	In-Network	Out-of-Network	Limitations
• Inlays/Onlays/Crowns	60%	60%	1 replacement per tooth per 60 consecutive months. Covered when medically or dentally necessary.
• Dentures - Complete, partial, overdenture, (upper and lower)	60%	60%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Implants	60%	60%	1 per tooth per lifetime. Covered when medically or dentally necessary.
• Bridges	60%	60%	1 replacement per 60 consecutive months. Covered when medically or dentally necessary.
• Other Dental Prosthetics	60%	60%	N/A
• Adjustments, Repairs, Reline and Rebase of Dentures	60%	60%	Adjustments limited to after 6 months of installation if performed by the same dentist

	In-	Out-of-	

Orthodontic Services	Network	Network	Limitations
Child Orthodontic Services	50%	50%	Covered for dependent children only

Whitening Services	In-Network	Out-of-Network	Limitations
Teeth Whitening by Dentist	50%	50%	Not to exceed $400 every 2 years

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If you have any questions, please don't hesitate to contact us at 1-866-274-9887.

We look forward to helping you manage your benefits with confidence and ease.

More about your Dental coverage

If you are working for your employer on the effective date - the waiting period is 0 continuous days.
If you start working for your employer after the effective date - the waiting period is 0 continuous days.

An Employee who is employed on the effective date of the policy will receive credit towards satisfying the waiting period for time employed with the employer provided he or she was employed on the day prior to the effective date of the policy.

What is not covered?

Limitations: In addition to the limitations listed in the schedule of benefits, payment of benefits is limited under this certificate as follows:

1. Orthodontic services must begin while this insurance is in force. If the insurance ends during the course of the treatment plan, the monthly benefits will end. Services are considered to have begun when the initial banding or appliance is inserted. For takeover groups with Orthodontic coverage under the prior carrier, we will pay for work in progress up to our lifetime maximum benefit considering any amounts already paid under the prior carrier. For takeover groups without Orthodontic coverage under the prior carrier, we will not pay for work in progress.
2. Services must begin after the end of any applicable waiting period. Waiting periods for each category of service show on the schedule of benefits.

3. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.
4. Alternate Benefit: If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:
    - would produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the individual's dental condition; and
    - would qualify as a Covered Service. For example, if an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our determination on the less costly amalgam filling.

    If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Any procedures not specifically listed as a covered service in the schedule of benefits.
2. Services which are not dentally necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
3. Services for which the insured person would not be required to pay in the absence of dental insurance.
4. Services or supplies received by an insured person before the dental insurance starts for that person.
5. Treatment or services received outside of the United States.
6. Services which are primarily cosmetic, except for services covered under the Teeth Whitening Benefit.
7. Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments.
8. Services or appliances which restore or alter occlusion or vertical dimension.
9. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
10. Restorations or appliances used for the purpose of periodontal splinting.
11. The prophylactic removal of third molars is not a covered service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.
12. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.

13. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
14. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
15. Charges for missed appointments.
16. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by your employer, labor union, mutual benefit association, or VA hospital.
17. Services covered under other coverage provided by your employer.
18. Temporary or provisional restorations.
19. Temporary or provisional appliances.
20. Prescription drugs.
21. Services for which the submitted documentation indicates a poor prognosis.
22. Fixed and removable appliances for correction of harmful habits.
23. Application of desensitizing agents.
24. Repair or replacement of an orthodontic device.
25. The following, when charged by the dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
26. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
27. Caries susceptibility tests.
28. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
29. Precision attachments associated with fixed and removable prostheses.
30. Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
31. Duplicate prosthetic devices or appliances.
32. Replacement of a lost or stolen appliance, cast restoration or denture.
33. Intra and extra-oral photographic images.
34. Cone beam imaging.
35. Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders.
36. Diagnostic casts, unless part of overall treatment plan for medically necessary orthodontia .

37. Labial veneers.
38. Modification of removable prosthodontic and other removable prosthetic services.
39. Occlusal adjustments
40. The following services are not Covered Services:
    - a connector bar,
    - a stress breaker,
    - coping,
    - pediatric partial dentures
41. Basic restorative services are limited as follows:
    a. Amalgam or resin based restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a covered service.
    b. Micro filled resin restorations which are non-cosmetic.
    c. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

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Policy Form MOEBP18IDEN, MOEBP15DEN; AXEBP15DEN and State Variations.

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GE-2839211 (6/20) (Exp. 6/22)