Equitable's Employee Benefits Group
8501 IBM Dr., Ste. 150-B
Charlotte, NC 28262

J M SMITH CORPORATION
101 W Saint John St, Ste 305
Spartanburg, SC 29306

WELCOME PACKET

important information about your benefits

EQUITABLE

POLICYHOLDER	J M SMITH CORPORATION
POLICY NUMBER	017995
STATE OF ISSUE	South Carolina
EFFECTIVE DATE	January 01, 2024

GROUP VISION INSURANCE POLICY

Equitable Financial Life Insurance Company of America
2999 North 44th Street, Suite 250, Phoenix, Arizona 85018
(866) 274-9887

We issue this Policy and the certificates based on the Policyholder's and Insured Persons' applications and payment of premium when due. We agree to pay the benefits of this Policy subject to all terms, conditions and limitations outlined in this Policy and the certificate. READ THESE PAGES WITH CARE.

This Policy is governed by the laws of the state of issue. Any Insured Person's rights and benefits under the Policy shall not be less than those stated in the certificate.

Read This Policy Carefully. It is a legal contract between the Policyholder and Equitable Financial Life Insurance Company of America.

Mark Pearson, Chairman of the Board and Chief Executive Officer

Jose Ramon Gonzalez,
Senior Executive Vice President, Secretary and General Counsel

A note on capitalization in this Policy:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase is a defined term in the Policy or certificate or refers to a specific provision in such forms.

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Administrative Office:
The address of Our Administrative Office is shown below. Correspondence should be sent to that office. Premium payments should be sent to the address listed on the Policyholder's billing notice, unless premiums are made by a direct payment method.

ADMINISTRATIVE OFFICE:

FOR INFORMATION OR TO MAKE A COMPLAINT REGARDING THIS GROUP POLICY, PLEASE CALL OR WRITE:

Equitable Financial Life Insurance Company of America
8501 IBM Drive, Suite 150-B
Charlotte, NC 28262
EBCustomerService@equitable.com
(866) 274-9887

FOR CERTIFICATEHOLDER CLAIMS OR COMPLAINTS, PLEASE CONTACT US AT:
(866) 274-9887

WE WILL NOTIFY THE POLICYHOLDER OF ANY CHANGE IN OUR ADDRESS.

POLICY INFORMATION – POLICY NUMBER 017995

ELIGIBLE CLASS(ES): Class 1: All Active Full Time Employees working at least 30 hours per week.

We may periodically add eligible new employees or their dependents to the group originally insured.

PREMIUM DUE DATE: The first day of every month

MINIMUM PARTICIPATION REQUIREMENTS: 25% of all eligible employees

Employees and their enrolled Spouse and Dependent Children are entitled to coverage for vision services subject to the terms, conditions, limitations and exclusions set forth in the certificates, incorporated in this Policy. The certificate(s) describe the vision services covered, including any optional riders and amendments, and the terms, conditions, limitations and exclusions related to coverage.

Definitions

Certificateholder means the person designated as the certificateholder on a certificate, who is eligible for benefits provided by this Policy and who has received a certificate of insurance.

Effective Date means the date that this Policy begins. This date is shown on the cover page.

Insured Person means the person(s) insured for the benefits of the certificate or any attached rider.

Policy means this document that is issued to the Policyholder and all forms incorporated pursuant to the Incorporation Provision below.

Policy Renewal Date means the date on which this Policy may be renewed at the Policyholder's election and Our agreement.

Policyholder means the owner of this group Policy, as shown on the cover page.

Policy Year means the 12 month period beginning on the Effective Date.

Premium Due Date means the date on which a premium is due to Us. The Premium Due Date is shown on the Policy Information page.

We, **Our** and **Us** means Equitable Financial Life Insurance Company of America.

Incorporation Provision

The forms listed below are incorporated in and made part of the Policy:

(1) the group application;
(2) all employee enrollment forms, including any evidence of coverage forms;
(3) the certificate(s) of coverage; and
(4) any other amendments, riders or endorsements to the Policy or certificates.

If there is any conflict between the terms and conditions of this Policy and any incorporated form, this Policy shall be controlling. However, in no case will any Insured Person's rights and benefits under the Policy be less than those stated in the certificate.

Premiums, Grace Period and Reinstatement

Premium Payments: The Policyholder must pay premiums to Us on or before the Premium Due Date, subject to the Grace Period provision.

The premium due will be the sum of the premiums applicable for all Insured Persons. The premium for additional, increased, reduced or terminated insurance will cause a pro-rata adjustment on the next Premium Due Date.

We may use any reasonable method to compute premiums due under the Policy.

If the Certificateholder is not responsible for the cost of premiums, the Policyholder may not require the Certificateholder to contribute to the cost of insurance, except where necessary for the Policyholder to comply with applicable tax law. If the Certificateholder is responsible for some or all of the cost of premiums, the maximum amount that a Certificateholder shall be required to contribute to the cost of such insurance shall not exceed the premium charged for the amounts of such insurance.

Premium Change: The initial premium rate is guaranteed for 36 month(s). After this initial period, We may change the premium rates. We will send the Policyholder written notice of any such change at least 45 days before the change becomes effective, though a change may take effect on an earlier date when both We and the Policyholder agree in writing. Rates will not change more than once in any 12 month period.

Notwithstanding the above, We may change premium rates at any time for reasons which affect the risk assumed, including those reasons shown below:

(1) the terms of this Policy change;
(2) a division, subsidiary, or affiliated company is added to or deleted from the Policy;
(3) the number of insured Certificateholders changes by 10% or more in a 12 month period; or
(4) there is a change in classes covered by this Policy.

Grace Period: This Policy has a 31 day grace period for all premiums except the first premium. This means that after the payment of the first premium, any overdue premium may be paid within 31 days after the Premium Due Date. Coverage under this Policy will continue in force during the grace period.

If the Policyholder has given Us advance notice of an earlier cancellation date, the Policy will terminate on the earlier date. No such termination will take effect during any period for which the required premium has been paid to Us. If the Policyholder replaces the Policy with another group policy but does not give Us written notice of intent to end the Policy, the grace period provisions of the Policy and certificate will apply.

If the premium is not paid on the Premium Due Date, We will give written notification to the Policyholder explaining that if the premium is not paid by the end of the grace period, the Policy will end on the last day of the grace period. If We fail to give such written notice, the insurance provided under the Policy will continue in effect until the date such notice is given.

We may extend the grace period by giving written notice of such intent to the Policyholder. Such notice shall specify the date the Policy will end if the premium remains unpaid. Premiums shall be paid for any grace period, any extension of such period, and any period for which insurance under this Policy was in effect and premium was not paid.

PREMIUMS, GRACE PERIOD, AND REINSTATEMENT CONTINUED

Reinstatement: If We terminate coverage for non-payment of premium, the Policyholder may reinstate coverage within 60 days following the date of termination, subject to Our underwriting requirements in effect at that time. The Policy will be reinstated upon Our approval of the application. If We do not notify the Policyholder of Our disapproval in writing within 45 days of the date that the application is received by Us, the Policy will be deemed reinstated. The reinstated policy will cover loss resulting from treatment or services received on or after the date of reinstatement. In all other respects, the parties under this Policy will have the same rights as provided immediately before the date of termination, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with the reinstatement will be applied to the period for which premiums have not been previously paid.

Termination

Termination by the Policyholder: After this Policy has been in force for 12 months, the Policyholder may terminate the Policy for any reason upon 31 days advance written notice. The Policy will terminate on the date such notice is received or, if later, on the date named in the notice. The Policyholder will be responsible for any premium due up to the date of termination.

Termination by Us: We may terminate this Policy at any time if We do not receive premiums due by the end of the grace period.

We may terminate this Policy on any Premium Due Date by providing 31 days written notice to the Policyholder:

(1) if the Policyholder fails to maintain minimum participation requirements; or
(2) if the Policyholder fails to provide requested information on a timely basis or to perform any obligations required under this Policy and/or applicable law.

Minimum participation requirements are shown on the Policy Information page.

On any Policy Renewal Date, We may terminate this Policy for any reason by giving at least 31 days prior written notice to the Policyholder.

If the Policy ends, written notice shall be given to all Certificateholders as soon as reasonably possible. The Policyholder shall be responsible for giving such notice.

If this Policy ends, all premiums due must be paid. Our acceptance of premium after the Policy ends shall not act to reinstate the Policy. We will refund any unearned premium.

Termination Due to Inability to Perform Obligations: This Policy may be immediately suspended or terminated if We or the Policyholder are unable to perform obligations of this Policy for reasons beyond Our or the Policyholder's control, including:

(1) complete or partial destruction of facilities or equipment; or
(2) lockout, strike, riot, war, act of God, or any law, order or decree of a governmental authority.

If this Policy is suspended or terminated pursuant to this provision, neither We nor the Policyholder will be liable for damages arising from the suspension or termination.

General Provisions

Agency: For all purposes of this Policy, the Policyholder or its third party administrator acts on its own behalf or as an agent of the Certificateholder. The Policyholder or its third party administrator shall not be deemed an agent of Ours.

Clerical Error: Clerical error or delays in making entries on the records by Us or Our designees will not void this Policy or any Insured Person's insurance if it would otherwise have been in effect. Such clerical error will not cause any person to become insured if such person was not otherwise eligible. Such clerical error will also not extend any Insured Person's coverage if such coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

Conformity with State and Federal Statutes: Any provision of this Policy that is in conflict with the statutes of the state in which it was issued or with any federal statute is amended to conform to the minimum requirements of such statutes.

Continuation of Coverage: We agree to provide coverage under the Policy for those Insured Persons who are eligible to continue coverage under federal or state law, as described in the certificate.

We will not provide any administrative duties with respect to the Policyholder's compliance with federal or state law. All duties of the plan sponsor or plan administrator, including but not limited to notification of federal and/or state law continuation rights, and billing and collection of premium, remain the sole responsibility of the Policyholder.

Contract Changes: The terms and provisions of the Policy and certificates may be changed, at any time, without the consent of Insured Persons or anyone else with a beneficial interest in it. We may issue riders, endorsements or amendments to effect changes and these forms are subject to approval by the state in which the Policy is delivered. Any changes will be consistent with state law. No change to this Policy will be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent/producer or other representative has authority to change this Policy or waive any of its provisions. No rider, endorsement or amendment will affect the insurance provided under certificates until the effective date of change, unless retroactivity is required by state law. Any rider, endorsement or amendment affecting Insured Persons will be provided to the Certificateholder for attachment to the certificate.

Discretionary Authority: If the certificate provides coverage under an employee welfare benefit plan governed by ERISA, 29 U.S.C. 1001 et seq., We have the discretion and authority to construe the provisions of the certificate and to make all decisions regarding eligibility or entitlement to coverage or benefits. Whenever We make determinations which are not arbitrary or capricious in the administration of the certificate, such determinations shall be final and conclusive.

Entire Contract: This Policy, the Policyholder's application, the certificates, enrollment forms and any riders or endorsements to the Policy or certificates make up the entire contract. Only Our Chairman of the Board, Our President or a person authorized by Our Board of Directors can modify this contract or waive any of Our rights or requirements under it. The person making these changes must put them in writing and sign them.

GENERAL PROVISIONS CONTINUED

ERISA: When this Policy is purchased by the Policyholder to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act, 29 U.S.C., 1001 et seq. (ERISA), We will not be named as and will not be the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

Incontestability: Any statement made by the Policyholder will be deemed a representation and not a warranty. No statements will be used to avoid insurance, reduce benefits or defend a claim unless they are included in a written application or enrollment form that has been made a part of the Policy and given to You, the Insured Person, or the Insured Person's beneficiary or personal representative. No such statement will be used to contest this coverage after it has been in force for two years during the Insured Person's lifetime, except in the case of fraud where allowed by the state where the certificate is delivered or issued for delivery. Any statement used to contest coverage must be material to the risk accepted or the hazard assumed by Us.

Individual Certificates: We will issue to the Policyholder an individual certificate to be given to each Certificateholder. Such certificate will describe the features of the insurance to which Insured Persons are entitled and to whom benefits are payable.

No Replacement for Workers' Compensation: The Policy does not replace workers' compensation or affect any requirement for workers' compensation coverage.

Records: The Policyholder will provide Us any information We need to administer this Policy. At any time while the Policy is in force and for one year after that, We may inspect any of the Policyholder's documents, books or records which may affect the insurance or premiums of this Policy. Information shall be provided within 30 days after Our request.

Failure to provide information within the time required may be grounds for terminating this Policy. However, no person will be deprived of coverage to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the Policyholder or Insured Person. Any required adjustment may be made in coverage, premiums or benefits. Payment of premium by or on behalf of an ineligible person will not entitle that person to coverage.

Right to Audit: We reserve the right to audit, once every 2 years, the Policyholder's billing records and premium accounting practices. If We discover:

(1) an underpayment of premium by the Policyholder, the Policyholder will be obligated to pay Us the underpayment amount, in a timely manner; or
(2) an overpayment of premium, We will return any overpayment amount in a timely manner.

Time Periods: All time periods start and end at 12:01 a.m. standard time at the Policyholder's place of business.

GROUP VISION INSURANCE

Equitable Financial Life Insurance Company of America
2999 North 44th Street, Suite 250, Phoenix, Arizona 85018

Attached are the certificates for the policies in the state of South Carolina

Equitable Financial Life Insurance Company of America
2999 North 44th Street, Suite 250, Phoenix, Arizona 85018
(866) 274-9887

This certificate is a part of the Policy, which is a legal contract between the Policyholder and Us. We issue this certificate based on the Insured Persons' applications and payment of premium when due. We agree to pay the benefits of this certificate subject to all terms, conditions and limitations outlined in the Policy and this certificate. The Policy provides vision insurance to eligible certificateholders and Dependents. You may review the Policy by notifying Us in writing that You wish to do so. READ THESE PAGES WITH CARE.

Any conflict between the provisions of the Policy and of this certificate will be settled according to the provisions of the Policy. However, any Insured Person's rights and benefits under the Policy shall not be less than those stated in this certificate.

Read Your Certificate Carefully. Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions.

The Policy under which this certificate is issued may be amended, changed, canceled or discontinued by Us or the Policyholder, pursuant to the terms of the Policy. Premiums are subject to change.

Mark Pearson, Chairman of the Board and Chief Executive Officer

Jose Ramon Gonzalez,
Senior Executive Vice President, Secretary and General Counsel

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase is a defined term in the certificate or refers to a specific provision herein.

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FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

CERTIFICATE INFORMATION PAGE

ELIGIBLE CLASS(ES):	Class 1: All Active Full Time Employees working at least 30 hours per week.		
POLICYHOLDER:	J M SMITH CORPORATION	POLICY NUMBER:	017995
POLICYHOLDER'S ADDRESS:	101 W Saint John St Ste 305 Spartanburg, SC 29306		
STATE OF POLICY ISSUE:	South Carolina		
NETWORK:	VSP		
CERTIFICATE DATE:	As Reported to Us by the Policyholder		

FOR INFORMATION, CLAIMS OR TO MAKE A COMPLAINT, PLEASE CONTACT US AT:

(866) 274-9887

WE WILL NOTIFY YOU OF ANY CHANGE IN OUR CONTACT INFORMATION.

ELIGIBILITY PERIOD: If You are working for the Policyholder on the effective date - the waiting period is the first of the month coinciding with or next following 1 continuous day(s).
If You are working for the Policyholder after the effective date - the waiting period is the first of the month coinciding with or next following 1 continuous day(s).

Covered Services with an In-Network Provider

Covered Service	Description	In-Network Benefit	In-Network Copay	Frequency
Eye Examination	Comprehensive examination of visual functions and prescription of corrective eyewear.	Covered in Full	$10	Every 12 months
Prescription Eyeglasses	The In-Network provider will prescribe and order the Insured Person's lenses, verify accuracy of finished lenses and assist the covered person with frame selection and adjustment.		$25	
• Frames		$200	Included in prescription glasses	Every 12 months
• Lenses	(1) Spectacle lenses (single, lined bifocal, lined trifocal lenses or lenticular) (2) Polycarbonate lenses for Dependent Children	Covered in Full	Included in prescription glasses	Every 12 months
Contact Lenses	Contact lenses are available in place of spectacle lens and frame benefits.			
• Elective	The elective contact allowance applies to the doctor's fitting, evaluation fees and to materials.	$200	$0	Every 12 months
• Necessary	Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by the Insured Person's In-Network Provider.	Covered in Full	$25	Every 12 months
Low Vision	Professional services for severe visual problems not correctable with regular lenses. Low Vision services are a plan benefit when specific benefit criteria are satisfied and when prescribed by the Insured Person's In-Network Provider.	Maximum benefit for all Low Vision services and materials is $1000.00		Every 2 years
• Supplemental Testing	Includes evaluation, diagnosis and prescription of vision aids where indicated.	Covered in Full, subject to Low Vision maximum	$0	No more than 2 supplemental tests every 2 years
• Supplemental Aids		75% of In-Network Provider fee, subject to Low Vision maximum	$0	

Covered Services with an Out-of-Network Provider

Covered Service	Description	Out-of-Network Benefit	Frequency
Eye Examination	Comprehensive examination of visual functions and prescription of corrective eyewear.	up to $45	Every 12 months
Prescription Eyeglasses			
• Frames		up to $70	Every 12 months
• Lenses	Single vision lenses Lined bifocal lenses Lined trifocal lenses Lenticular	up to $30 up to $50 up to $65 up to $100	Every 12 months
Contact Lenses	Contact lenses are available in place of spectacle lens and frame benefits.		
• Elective	The elective contact allowance applies to the doctor's fitting, evaluation fees and to materials.	up to $105	Every 12 months
• Necessary	Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by the Insured Person's Provider.	up to $210	Every 12 months
Low Vision	Professional services for severe visual problems not correctable with regular lenses. Low Vision services are a plan benefit when specific benefit criteria are satisfied and when prescribed by the Insured Person's In-Network Provider.	Maximum benefit for all Low Vision services and materials is $1,000.00	Every 2 years
• Supplemental Testing	Includes evaluation, diagnosis and prescription of vision aids where indicated.	up to $125, subject to Low Vision maximum	No more than 2 supplemental tests every 2 years
• Supplemental Aids		75% of In-Network Provider fee, subject to Low Vision maximum	

Coverage with a participating retail chain may be different. Once Your benefit is effective, visit www.vsp.com for details. Based on applicable laws, benefits may vary by location.

DEFINITIONS

Actively at Work or Active Work means that the certificateholder is performing all of the usual and customary duties of his or her job on a full-time basis. This may be done at the Policyholder's place of business, an alternate place approved by the Policyholder, or a place to which the Policyholder's business requires the certificateholder to travel. A certificateholder will be deemed to be Actively at Work on weekends or Policyholder approved vacations, holidays or business closures if the certificateholder was Actively at Work on the last scheduled work day preceding such time off.

Benefit Authorization means the process used to confirm eligibility of an individual named as an Insured Person eligible for Network benefits, and identifying those Covered Services to which Covered Person is entitled.

Change in Family Status means the occurrence of any of the following:

(1) You acquire or lose a Spouse;
(2) You acquire a Dependent Child; or
(3) Your Spouse is no longer employed, resulting in a loss of group insurance.

Civil Union means a state sanctioned and/or recognized union of two eligible individuals of the same sex. Parties to a Civil Union will receive the same benefits and protections under this certificate and be subject to the same responsibilities as spouses in a marriage, except where prohibited by law.

Copayment means a fixed amount payable directly to a Provider for a Covered Service when service is received by the Insured Person.

Covered Service means a service used to treat an Insured Person's eye condition and which is:

(1) performed by a Provider while the vision insurance provided by this certificate is in effect;
(2) Visually Necessary to treat the condition; and
(3) included in the Schedule of Benefits.

Dependent means Your Spouse and Dependent Children covered under the Policy.

Dependent Child or Children means an individual who is under age 26 and is:

(1) Your biological child;
(2) Your legally adopted child;
(3) Your foster child from the time he or she is placed in the home;
(4) Your stepchild;
(5) the child of Your Civil Union partner;
(6) the child of Your Domestic Partner; or
(7) a child under a court appointed guardianship.

In addition to the Dependent Children described above, any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship may be covered to the same extent as a Dependent Child under this certificate, provided the child depends on You for most of his or her support and maintenance and resides in Your household. A Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and became so incapacitated prior to age 26. We reserve the right to require that You provide proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship.

Any person insured as a certificateholder under the group Policy may not also be insured as a Dependent Child.

Domestic Partner means an individual who is age 18 or older, who is the same sex as You, and who has established a domestic partnership with You by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from his or her local registrar.

Effective Date means the date that coverage begins under this certificate as described in the Effective Date provision.

Eligible Employee means an employee who has worked for the Eligible Employer:

(1) for at least 12 months; and
(2) for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
(3) at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Immediate Family means Your Spouse; brothers or sisters (including stepbrothers and stepsisters); children; parents (including stepparents); grandchildren (including step-grandchildren); grandparents (including step-grandparents); father-or mother-in-law; brothers-or sisters-in-law; and their Spouses.

In-Network Benefit means the amount that is payable for a Covered Service that is performed by an In-Network Provider.

In-Network Provider means:

(1) a Provider or retail chain who is contracted with the Network specified on the Certificate Information page,
(2) a Provider who is properly licensed or certified to provide eye care, such as an ophthalmologist or optometrist, under the laws of the state where he or she practices and is performing services within the scope of such license; and
(3) a Provider who is not either You or a member of Your Immediate Family.

You may obtain further information about the participating status of providers and out-of pocket expenses by calling the toll-free number on the Certificate Information page.

Insured Person means the person(s) covered under the type of coverage. See Type of Coverage definition.

Network means the entity that has contracted with providers to offer Covered Services at a discounted rate. The Network is shown on the Certificate Information page.

Out-of-Network Benefit means the amount that is payable for a Covered Service that is performed by an Out-of-Network Provider.

Out-of-Network Provider means a provider who does not participate in the Network specified on the Certificate Information page.

Policy means the document that is issued to the Policyholder and all forms incorporated in the Policy, including the master application, all certificates of coverage and enrollment forms.

Policy Year means the 12 month period beginning on the Effective Date.

Policyholder means the group entity named on the Certificate Information page.

Provider means an In-Network Provider or Out-of-Network Provider.

Spouse means the person to whom You are legally married**,** Your Domestic Partner, or Your Civil Union partner.

Type of Coverage means one of the following types of coverage:

(1) **Individual (AKA "Employee Only")** means coverage for You only.
(2) **Individual/Spouse Only (AKA "Employee + Spouse")** means coverage for You, *plus* Your Spouse (who is named in the application for this certificate).
(3) **One-Parent Family (AKA "Employee + Child(ren)")** means coverage for You, *plus* all Your Dependent Children (who are named in the application for this certificate or any application amendment).
(4) **Two-Parent Family (AKA "Employee + Family")** means coverage for You, *plus* Your Spouse and all Your Dependent Children or the Dependent Children of Your Spouse (who are named in the application for this certificate or any application amendment).

Usual, Customary and Reasonable Fees mean fees calculated by Us based on available data resources of competitive fees in that geographic area.

Usual fees are the lowest fee regularly charged, offered or received by an individual Provider for a Covered Service. Customary fees are fees within the accepted range of usual fees charged by Providers of similar training in a specific and limited geographic area. Reasonable Fees are both usual and customary or are otherwise justifiable considering special circumstances.

Visually Necessary means treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of eye disease based upon generally accepted vision practice.

We, **Our** and **Us** means Equitable Financial Life Insurance Company of America.

You and **Your** means the certificateholder.

BENEFITS WE PAY

We will pay the vision benefits shown in the Schedule of Benefits.

Payment of benefits is subject to:

(1) payment of the required Copayment;
(2) frequency limits and benefit amounts shown in the Schedule of Benefits; and
(3) this certificate's Exclusions and Limitations provisions.

In-Network: If a Covered Service is performed by an In-Network Provider and the Insured Person received the necessary Benefit Authorization, We will pay the In-Network Benefit of each Covered Service listed in the Schedule of Benefits. In-Network Providers have agreed to accept discounted payments for services with no additional billing to the Insured Person other than Copayment amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on the Certificate Information page.

Out-of-Network: If a Covered Service is performed by an Out-of-Network Provider, You may submit a claim for reimbursement. The maximum Out-of-Network Benefit We will reimburse for each Covered Service is listed in the Schedule of Benefits. If You elect to utilize the services of an Out-of-Network Provider for a Covered Service, Your benefit payments may be less than the amount billed. You will be responsible for payment of any excess due. In order to be a Covered Service, services provided by an Out-of-Network Provider must be in lieu of the receipt of services from an In-Network Provider.

If You live in a Large metro designation (such as Fairfield County) and cannot locate a Vision Provider within 20 minutes and 10 miles of your location, or a metro designation (all other counties) and cannot locate a Vision Provider within 30 minutes and 20 miles of your location, You are entitled to a benefit payment based on the Covered Percentage of each Covered Service as listed in the Schedule of Benefits for in-network level of cost share for an out-of-network Provider.

Choice of Provider and Treatment: The Insured Person may receive services from any vision Provider.

The Insured Person and the vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, the extent to which benefits, if any, are payable will be determined according to the conditions set forth in this certificate.

Benefit Authorization: The Insured Person must obtain a Benefit Authorization before obtaining Covered Services from an In-Network Provider. When the Insured Person seeks Covered Services from an In-Network Provider, the Insured Person must schedule an appointment and identify himself/herself as an Insured Person under a VSP plan so the In-Network Provider can obtain a Benefit Authorization from the Network. Each Benefit Authorization will contain an expiration date and must be used by the Insured Person to obtain benefits prior to the date the Benefit Authorization expires.

ELIGIBILITY AND EFFECTIVE DATE

Certificateholder Eligibility: You must be in the class or classes shown in the Certificate Information page to be eligible for coverage. You become eligible for coverage on the latest of the following:

(1) the Policy Effective Date; or
(2) the date You become a member of an eligible class; or
(3) the date You complete the eligibility period shown in the Certificate Information page.

Dependent Eligibility: Your Dependents become eligible for Dependent coverage on the latest of the following:

(1) the date You become insured under the Policy; or
(2) the date You acquire Your first Dependent.

No Individual may be covered as both an Employee and Spouse.
No Dependent Child may be covered by more than one Certificateholder.

Enrollment: You must complete and sign an enrollment form which is satisfactory to Us, for Your and Your Dependents' insurance. The Policyholder will provide instructions.

If You do not enroll for Your coverage or Your Dependents' coverage within 30 days after becoming eligible or if You were eligible to enroll under a prior policy and did not do so, You may enroll only:

(1) during an enrollment period designated by the Policyholder; or
(2) within 30 days of the date on which You have a Change in Family Status.

Effective Date: Your insurance becomes effective on the first of the month following the date You meet all of the following:

(1) the required premium is paid or, if You are responsible for premiums, You have authorized premium payment; and
(2) You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will be effective on the day You resume Active Work. The Actively at Work requirement is waived for all enrollees who were covered under a prior group vision policy being replaced by this group Policy.

A Dependent's insurance becomes effective on the first of the month following the date all of the following occur:

(1) You are covered under this Policy;
(2) the applicable premium is paid; and
(3) the individual meets the definition of an eligible Dependent.

Credit for Prior Coverage: If You and Your Dependents become covered under this Policy due to a mid-year plan change, You will need to submit evidence of coverage under Your prior carrier's plan in order to receive credit under this Policy.

You will also need to submit evidence of total benefits paid under Your prior policy and We will apply these benefits to this Policy's applicable Maximum Benefits.

PREMIUM PAYMENTS

Payment of Premiums: Premium payments will be made to Us by the Policyholder. Premiums shall be paid before their due date, subject to the Grace Period provision.

If the certificateholder is not responsible for the cost of premiums, the Policyholder may not require the certificateholder to contribute to the cost of insurance, except where necessary for the Policyholder to comply with applicable tax law. If the certificateholder is responsible for some or all of the cost of premiums, the maximum amount that a certificateholder shall be required to contribute to the cost of such insurance shall not exceed the premium charged for the amounts of such insurance.

Premium Change: The initial premium rate is guaranteed for 36 month(s). After this initial period, We may change the premium rates. We will send the Policyholder written notice of any such change at least 45 days before the change becomes effective, though a change may take effect on an earlier date when both We and the Policyholder agree in writing. Rates will not change more than once in any 12 month period.

Grace Period: The Policy and this certificate have a 31 day grace period for all premiums except the first premium. This means that any overdue premium except the first premium may be paid within 31 days after the due date. Coverage will continue in force during the grace period.

If You or the Policyholder give Us advance notice of an earlier cancellation date, coverage will terminate on the earlier date. No such termination will take effect during any period for which the required premium has been paid to Us. If the Policyholder replaces the Policy with another group policy but does not give Us written notice of intent to end the Policy, the grace period provisions of the Policy and certificate will apply.

If the premium (other than the first premium) is not paid on the due date, We will give written notification to the Policyholder explaining that if the premium is not paid by the end of the grace period, the Policy will end on the last day of the grace period. If We fail to give such written notice, the insurance provided under the Policy will continue in effect until the date such notice is given.

TERMINATION

Termination of Certificateholder's Coverage: Your insurance will terminate upon the earliest of the following:

(1) Your written request to terminate;
(2) the date the certificate lapses due to nonpayment of premium;
(3) the date You are no longer a member of an eligible class;
(4) the date the Policy terminates; or
(5) Your death.

Termination of Your insurance will be without prejudice to any claim originating before the date of termination.

Termination of Dependents' Coverage: Your Dependents' coverage will terminate upon the earliest of the following:

(1) the date Your coverage terminates;
(2) the date the Dependent no longer meets the definition of Spouse or Dependent Child, as applicable;
(3) the date the Policy is modified to remove Spouse or Dependent Child coverage; or
(4) upon the Dependent's death.

Termination of a Dependent's insurance will be without prejudice to any claim originating before the date of termination.

Extension of Benefits: In the event that any Insured Person(s) is/are in a course of receiving a Covered Service on the date that the certificate is terminated, We will continue coverage under the Policy as to such Insured Person(s) if:

(1) the Covered Service was recommended in writing by the Insured Person's Provider while the Insured Person(s) was/were covered under the Policy and this certificate;
(2) termination is not due to Your nonpayment of premium or voluntary termination.

Extended benefits under this provision terminate upon the earliest of the following:

(1) the end of the 90-day period after the date coverage would otherwise terminate; or
(2) the date the Insured Person becomes covered by another vision insurance plan that provides coverage for similar vision services and the Insured Person(s) has/have satisfied any eligibility requirements for such plan.

CONTINUATION OF COVERAGE

Coverage that would otherwise terminate may also be continued as described in this section. Vision coverage that may continue will be the same as coverage in effect on the day before coverage would otherwise terminate, unless otherwise noted below. Continued coverage is subject to any reductions in the Policy and will terminate if the Policy terminates. Any premium due must be paid for coverage to continue. The Policyholder will advise You of Your rights to continuation coverage and the cost. You must pay any required premium for continuation coverage directly to Your employer. We are not responsible for determining who is eligible for continuation coverage. If You and Your Dependents are eligible to continue vision insurance under this provision and any other provision of the certificate, all such continuation periods will be deemed to run concurrently with each other.

Continuation under the Consolidated Omnibus Budget Reconciliation Act (COBRA): Under the federal Consolidated Omnibus Budget Reconciliation Act. (COBRA), if Your or Your Dependents' coverage ends under the Policy due to a qualifying event, You and Your Dependents may be entitled to elect to continue coverage. You and Your Dependents may elect to continue coverage for the following reasons:

(1) You and Your Dependents may elect to continue coverage in the event of Your voluntary or involuntary termination of employment or reduction in Your work hours for any reason other than gross misconduct.
(2) Your Spouse may elect to continue coverage in the event of Your divorce or legal separation.
(3) Your Dependent Child may elect to continue coverage upon attainment of age 26.
(4) Your Dependents may elect to continue coverage if You become entitled to Medicare.
(5) Your Dependents may elect to continue coverage upon Your death.

You and Your Dependents must elect to continue coverage within 60 days from a qualifying event or notification of rights by Your employer, whichever is later.

Continuation under the Federal Family and Medical Leave Act (FMLA): Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA). This is a general summary of the FMLA and how it affects the Policy. Contact the Policyholder for details regarding continuation of coverage during a leave pursuant to the FMLA.

If the Policyholder is an Eligible Employer and if the FMLA applies to continue Your coverage, any FMLA continuation provisions applicable to Your coverage:
(1) are in addition to any other continuation provisions of the Policy and this certificate, if any; and
(2) will run concurrently with any other continuation provisions of the Policy and this certificate for sickness, injury, layoff, or approved leave of absence, if any.

If Your coverage qualifies for continuation under both the FMLA and any similar state law, the continuation period under the Policy or this certificate will be counted concurrently toward satisfaction of the continuation period under both the applicable state and FMLA continuation periods.

Under the FMLA, Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:
(1) the birth of a child of an Eligible Employee and in order to care for the child;
(2) the placement of a child with the Eligible Employee for adoption or foster care;
(3) to care (physical or psychological care) for the Spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
(4) a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
(5) because of a "qualifying exigency" arising out of a Spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed force

members, reserve members, National Guard members, and members in contingency operations, as defined under federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a “covered service member” with a “serious injury or illness”.

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements under this certificate.

Continuation under the Uniformed Services Employment and Reemployment Rights Act of 1994: If You are a member of the Armed Forces, Reserves or the National Guard, You may elect to continue Your coverage for up to 24 months if You are called to active duty. You may reinstate Your coverage as of the date You return to Active Work. You may also continue coverage for Your Dependents under this provision.

LIMITATIONS AND EXCLUSIONS

Additional Limitations: Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Insured Persons may obtain details regarding frame brand availability by calling the information number shown in the Certificate Information page.

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

(1) Services provided without a Benefit Authorization or after expiration of a Benefit Authorization;

(2) Services and/or materials not specifically included in the Schedule of Benefits;

(3) Orthoptics or vision training and any associated supplemental testing;

(4) Plano lenses (less than a ±.50 diopter power), except as specifically allowed in the frames benefit shown in the Certificate Information page;

(5) Two pair of glasses in lieu of bifocals;

(6) Medical or surgical treatment of the eyes;

(7) Replacement of eyeglass lenses, frames or contact lenses furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available;

(8) Plano contact lenses to change eye color cosmetically;

(9) Artistically-painted contact lenses;

(10) Contact lens insurance policies or service contracts;

(11) Additional office visits associated with contact lens pathology;

(12) Contact lens modification, polishing or cleaning;

(13) Costs for Covered Services and/or materials above In-Network or Out-of-Network benefit allowance;

(14) Services or materials of a cosmetic nature;

(15) Services and/or materials not indicated in this Certificate as Covered Services;

(16) Pathological treatment;

(17) Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology;

(18) Laser or any other form of refractive surgery;

(19) Pre- and post-operative services;

(20) Local, state and/or federal taxes, except where We are required by law to pay; or

(21) Corrective vision treatment of an Experimental Nature.

CHANGES IN COVERAGE

After the Effective Date, You may add an eligible Dependent Child or Spouse to this certificate, or request other changes in coverage as specified in the following provisions. You must add anyone who becomes eligible for coverage after the Effective Date either by an application amendment or notifying Us in writing, as specified below.

Newborn and Adopted or Foster Children Added to this Certificate: Generally, newborn children are automatically covered under the terms of this certificate from the moment of birth. Adopted or foster children are covered from the date of petition or date of placement in foster care, respectively. However, coverage will begin from the moment of birth if the petition for adoption is filed, or placement in foster care occurs, within 60 days after the birth of the minor. This coverage shall terminate upon the dismissal or denial of a petition for adoption or the dismissal of placement in foster care. Coverage for newborn, adopted or foster children will be in effect through the 90th day following the date of such event or before the next premium due date, whichever is later.

Children born to Your Dependent Children or children born to the Dependent Children of Your Spouse are not covered under this certificate.

If the Type of Coverage elected is either Employee Only or Employee + Spouse coverage and You want uninterrupted coverage for a newborn, adopted, or foster child, You must notify Us in writing within 90 days of the child's birth or the date the petition is filed for adoption of a child or the date of placement of foster care of a child or before the next premium due date, whichever is later. Upon notification, We will change the Type of Coverage for this certificate to Family, Employee + Child(ren) or Employee + Family coverage, as applicable, and advise You of the additional premium due.

However, if the Type of Coverage elected is either Employee + Child(ren) or Employee + Family coverage, You must notify Us in writing within 90 days of the birth of Your child or the date the petition is filed for adoption of a child or the date of placement of foster care of a child. We will not require an additional premium payment.

Other Persons Added to this Certificate: If the Type of Coverage elected is either Employee Only or Employee/Spouse coverage and You want a Dependent Child (other than a newborn, newly adopted, or newly placed foster child) to be added to this certificate after the Effective Date, You must apply for such coverage by completing an application amendment, and that person will be subject to Our underwriting requirements in effect at that time. Otherwise, You must notify Us in writing if You want to add any such child to this certificate after the Effective Date.

If the Type of Coverage elected is Employee Only coverage and You want a new Spouse to be covered under this certificate after the Effective Date, that person may be added to this certificate without an application amendment, provided that You notify Us in writing within the first 31 days of Your marriage, Civil Union, or domestic partnership. Otherwise, You must apply for a Spouse to be covered under this certificate after the Effective Date by completing an application amendment, and that person will be subject to Our underwriting requirements in effect at that time.

If any of these changes in coverage occur, We will advise You of the additional premium due, if any. If We change the Type of Coverage under Your certificate, We will also send You written notice, as appropriate. Coverage for Insured Person(s) added to this certificate by written notification to Us will become effective as of the date of the request.

Persons Excluded from this Certificate: You may request to exclude any persons from coverage by notifying Us in writing. We will determine the appropriate premium payment due, including returning any unearned premium. If We change the Type of Coverage under this certificate due to this request, We will send You written notice, as appropriate.

Changes in Coverage Under this Certificate Due to Termination of Insurance of Dependent Children: Coverage under this certificate for any Dependent Child will terminate on the Dependent Child's 26th birthday. Such termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining Insured Person(s) under this certificate. When coverage on all Dependent Children has terminated, You may notify Us in writing within 31 days from the date of such termination, and elect whether to continue this certificate on an Employee Only or Employee + Spouse basis. We will determine the appropriate premium payment due, including returning any unearned premium. If We do not receive Your written notice, We will change Your coverage from Employee + Child(ren) or Employee + Family Type to Employee Only or Employee + Spouse, as appropriate.

However, existing coverage provided under any Employee + Child(ren) or Employee + Family Type certificate will continue to include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under this certificate. You must furnish proof of continued incapacity and dependency at Our request, but not more often than annually after the two-year period following the Dependent Child's 26th birthday.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has vision coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

Coordination of Benefit Definitions

The following definitions are applicable to this Coordination of Benefits provision.

Allowable Expense means a vision care expense, including copayments and coinsurance, that is covered at least in part by any Plan covering the Insured Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Insured Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If an Insured Person is covered by two or more Plans that compute their benefit payments on the basis of Usual, Customary and Reasonable Fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If an Insured Person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the applicable negotiated fees is not an Allowable Expense.

(3) If an Insured Person is covered by one Plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable Fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan means a Plan that provides vision care benefits to insured persons primarily in the form of services through a panel of providers that have contracted with or who are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Plan means any of the following that provides benefits or services for vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup vision insurance contracts, health maintenance organization (HMO) vision contracts, medical benefits under group or individual automobile contracts, and any other federal vision governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Order of Benefit Determination Rules

When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(1) The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(2) A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary.

There is one exception to this rule: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and which provides that such supplemental coverage shall be excess to any other parts of the Plan provided by the policyholder. Examples include major medical coverages that are supplemental to base coverage Plan hospital and surgical benefits, and insurance coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

(3) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(4) Each Plan determines its order of benefits using the first of the following rules that apply:

- **Non-Dependent or Dependent:** The Plan that covers the Insured Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary Plan and the Plan that covers the Insured Person as a dependent is the secondary Plan.

- **Dependent Child Covered Under More Than One Plan:** Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

    (1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
        - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or
        - If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- If a court decree states that one of the parents is responsible for the Dependent Child's vision care expenses or vision care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the Dependent Child's vision care expenses, the provisions of (1) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the vision care expenses or vision care coverage of the Dependent Child, the provisions of (1) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the Dependent Child's vision care expenses or vision care coverage, the order of benefits for the child are as follows:
    a. The Plan covering the Custodial Parent;
    b. The Plan covering the spouse of the Custodial Parent;
    c. The Plan covering the non-Custodial Parent; and
    d. The Plan covering the spouse of the non-Custodial Parent.

- **Active Employee or Retired or Laid-off Employee.** The Plan that covers an Insured Person as an active employee, that is, an employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same Insured Person as a retired or laid-off employee is the secondary Plan. The same would hold true if an Insured Person is a dependent of an active employee and that same Insured Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent or Dependent" rule can determine the order of benefits.

- **Continuation of Coverage.** If an Insured Person whose coverage is provided pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Insured Person as an employee, member, subscriber or retiree or covering the Insured Person as a dependent of an employee, member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent or Dependent" rule can determine the order of benefits.

- **Longer or Shorter Length of Coverage.** The Plan that covered the Insured Person as an employee, member, policyholder, subscriber or retiree longer is the primary Plan and the Plan that covered the Insured Person as such for the shorter period of time is the secondary Plan.

- If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between each of the Plans meeting the definition of a Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Effect on the Benefits of This Plan

When this Plan is the secondary Plan, it may reduce its payment by the amount so that, when combined with the amount paid by the primary Plan and any other Plans, the total benefits paid or provided by all Plans for the claim do not exceed the lesser of the total Allowable Expense or amount billed for that claim.

Right to Receive and Release Needed Information

Certain facts about vision care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the Insured Person claiming benefits. We need not tell, or get the consent of, any Insured Person to do this. Each Insured Person claiming benefits under this Plan must provide Us with any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, We may recover the excess from one or more of the Insured Persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS

For questions regarding claims, please call (866) 274-9887.

In-Network Claims: Claims for Covered Services provided by an In-Network Provider will be submitted to Us directly by the In-Network Provider.

Out-of-Network Claims: Claims for Covered Services provided by an Out-of-Network Provider may be submitted by You for reimbursement following the procedure below.

Written notice of claim must be submitted to Us within 30 days after a covered loss starts; if You are unable to provide such notice within this time, it must be submitted to Us as soon as reasonably possible. The notice should include the name of the Insured Person and the certificate number.

We will furnish You with forms for submitting proof of loss within 15 days after We receive notice of claim. Written proof of loss must be given to Us within 90 days after the date of such loss. Failure to provide such proof within the time required will not invalidate or reduce a claim if it was not reasonably possible to give proof within such time. However, such proof must be given to Us as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year after the date of such loss.

Notice, claim forms and proof of loss may be provided by mail, telephone or electronically at address, phone number or website shown on the Certificate Information page.

Initial Determination: After We receive a claim for vision benefits, We will review Your claim and notify You of Our decision to approve or deny Your claim. We will send this notification within 30 days from the date You submitted the claim, unless We require an extension due to matters beyond Our control. Any extension will not be more than 15 days.

If We need an extension, We will notify You in writing before the end of the initial 30 day period. The notice of extension will explain the reasons for the extension and will state when We will make Our determination. If an extension is needed because We need additional information from You or because You filed an incomplete claim, the time from the date of Our notice requesting further information and the time We receive the necessary information does not count toward the time period We are allowed to notify You of our claim decision. You will have 45 days from the date You receive Our request for additional information to provide the requested information.

Claim Denial: If We deny Your claim in whole or in part, You or Your authorized representative may submit a request for a full review of the denial. You may designate any person, including Your Provider as Your authorized representative. We will provide You written notification of the claim decision stating the reason why the claim was denied. If the claim is denied because We need more information, the claims decision will describe the additional information We need and why We need the information.

Appeal Rights: If We deny Your claim, You have the right to appeal the initial determination within 180 days following the denial of Your claim. Upon Your written request, We will provide You copies of documents, records and other information relevant to Your claim and reference the specific Policy provisions upon which the denial is based. This information is provided at no charge to You. Additionally, You may review, during normal business hours, any documents relevant to Your claim that are held by Us. Appeals must be in writing and must include at least the following information:

(1) name of employee;
(2) name of claimant;
(3) group policy number; and
(4) an explanation why You are appealing the initial determination.

As part of the appeal, You may submit any written comments, documents, records, or other information relating to Your claim. After We receive Your written request appealing the initial determination, We will review Your claim. Our review will look at the claim anew.

We will notify You in writing of Our decision within 30 days after Our receipt of Your written request for review, or as required by any state or federal laws or regulations.

If We deny the claim on appeal, We will send You a written decision that states the reason(s) why the claim You appealed is being denied.

If You disagree with Our initial appeal determination, You may request a second level appeal. A request for a second level appeal must be submitted to Us within 60 days after receipt of Our response to the initial appeal. We will notify You in writing of Our final decision within 30 days after Our receipt of Your written request for review, or as required by any state or federal laws or regulations. Our final written decision will state the reason(s) why the second level appeal is being denied.

After You have completed Our appeals process, You may have additional voluntary alternative dispute resolution options, including mediation and arbitration.

Time of Payment of Claims: We will pay benefits under this certificate promptly upon Our receipt of due written proof of loss.

Payment of Claims: Out-of-Network benefits will be payable to You unless You assign payment of benefits to the Provider. If You assign benefits to the Provider, We will pay the Provider directly.

COMPLAINTS AND GRIEVANCES

The complaint and grievance procedure applies to any disagreements regarding services You receive under this certificate.

Complaints and grievances may be submitted by mail, telephone or online at the address, phone number or website shown on the Certificate Information page, or through Your In-Network Provider. We will resolve all complaints and grievances within 30 days following receipt of such complaint or grievance unless We require an extension of time. If We require an extension, We will resolve all complaints and grievances as soon as possible, but not later than 120 days from receipt of the complaint or grievance. If a complaint or grievance cannot be resolved within 30 days, We will notify You of the expected resolution date. We will notify You in writing of Our resolution of such complaint or grievance.

If You are not satisfied with the resolution of any complaint or grievance, You may file an appeal by contacting Us at the mailing address, phone number or online, as shown in the Certificate Information page. You have up to 60 business days from receipt of the claim or grievance to file an appeal. We will make a determination of an appeal within 30 business days of receipt of all necessary information. We will notify You in writing of Our final resolution of all complaints and grievances.

All complaints and grievances shall be resolved within time periods established by state or federal law. If You remain dissatisfied with Our appeal determination, You may call or write to Your state department of insurance.

GENERAL PROVISIONS

Agreements between Us and In-Network Providers: Any agreement between Us and In-Network Providers may only be terminated by Us or the Providers. This certificate does not require any Provider to accept an Insured Person as a patient. We do not guarantee an Insured Person's admission to any In-Network Provider or any vision benefits program.

Conformity with State and Federal Statutes: Any provision of this certificate that is in conflict with the applicable statutes of the state whose law governs this certificate or with any applicable federal statute is amended to conform to the minimum requirements of such statutes.

Entire Contract: This certificate, the Policy, any riders or endorsements, any attached applications and all subsequent application amendments to change this certificate, and all additional Certificate Information sections added to this certificate, make up the entire contract. Only Our Chairman of the Board, Our President or a person authorized by Our Board of Directors can modify this contract or waive any of Our rights or requirements under it. The person making these changes must put them in writing and sign them.

Legal Action: Unless otherwise specified by the laws of the state in which this certificate was issued:

(1) no legal action shall be brought to recover under this certificate within 60 days after written proof of loss has been given in accordance with the requirements of this certificate; and

(2) no legal action may be brought aftersix years from the time when written proof of loss is required to be given.

Misstatement of Age: If the age of an Insured Person has been misstated in the application or any application amendment, premiums will be changed to the appropriate rate.

Physical Examination: At Our expense, We reserve the right to have the Insured Person examined while a claim is pending unless it is forbidden by applicable law.

Time Limit on Certain Defenses: After two years from the Effective Date, no misstatements, except fraudulent misstatements, made by You in the application or any application amendment will be used to void this certificate or to deny a claim for loss incurred after the expiration of such two-year period. No claim for loss commencing after 12 months from the Effective Date will be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Your Vision Records: In order to provide benefits under this certificate, process claims, make payments or review appeals and/or grievances, We may need to obtain information and records from Providers who provided Your services or treatment. Your acceptance of coverage under this certificate gives Us permission to obtain, copy and use Your vision records and information for such purposes and authorizes Your Provider to disclose information that pertains to Your physical condition or the services or treatment Your receive. We agree to maintain Your vision records and information in accordance with state and federal confidentiality requirements.

GROUP VISION INSURANCE	**Equitable Financial Life Insurance Company of America** **2999 North 44th Street, Suite 250, Phoenix, Arizona 85018** **This is a group vision insurance certificate, subject to the Exclusions and Limitations provisions.**

EQUITABLE

Notice of Privacy Practices

Ralph Browning, HIPAA Privacy Official
877-806-4573

Equitable Holdings, Inc.
8501 IBM Drive Ste 150, ME-15
Charlotte, NC 28262
Attention: HIPAA Privacy Officer
Email: CustomerPrivacy@equitable.com

Effective Date: August 11, 2023

Revised:
August 11, 2023

THE FOLLOWING IS NOT APPLICABLE TO SHORT-TERM DISABILITY INSURANCE, LONG-TERM DISABILITY INSURANCE, AND/OR GROUP LIFE INSURANCE.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical and health information. We maintain records of your health services we cover (claims), and we also maintain information about your health status that we have used for enrollment processing and may receive such records from others. We use these records to administer your health plan benefits and coverage; we may also use these records to coordinate benefits with other health plans, ensure appropriate quality of services provided to you and to enhance the overall quality of our services, and to meet our obligations as a health plan. We consider this health information, and the records we maintain, to be protected health information. We are required by law to maintain the privacy of protected health information and to provide individuals such as health plan participants with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information. If you have any questions about this Notice, please contact our Privacy Official listed above.

A. How We May Use or Disclose Your Health Information

We collect health information about you and store it in paper or electronic records formats. This is your health plan record. The health plan record is the property of Equitable Holdings, but the information in the health plan record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. As a health plan, we may provide information to a health provider who is directly involved in your health care. While this plan does not engage in health care treatment, we may disclose or use your health information to assist in coordinating your care among different providers. Or we may use this information to manage referrals and authorizations for your care with providers, diagnostic facilities, pharmacies, and other providers involved in your care.

2. Payment. We use and disclose protected health information about you to adjudicate and pay claims for services rendered to you that are covered by this plan. We may use and disclose information about you to other health plans or third parties to obtain payment when they are also responsible (known as coordination of benefits). We may use and disclose information about you for the purpose of billing and receiving premium payment by your employer, or for the purpose of obtaining reimbursement from a re-insurer of your health plan. We may use and disclose protected health information to work with organizations providing certain specialized benefits. We always take care to ensure that we use or disclose only the minimally necessary protected health information to accomplish these purposes.

3. Health Care Operations. We may use and disclose protected health information about you to operate our health plan. For example, we may use and disclose this information to review and improve the quality of care that is rendered by the health care professionals and providers who treat you. We may use and disclose this information for the purpose of determining your coverage and benefits (commonly known as underwriting and enrollment) and for renewal or changes in your benefits and coverage. We may use or disclose your information for the purpose of improving our benefits and coverage, or to provide disease management services. We may use or disclose information for the purpose of authorizing referrals and services. We may also use and disclose this information as

necessary for medical, dental or vision claim reviews, legal services and audits, including fraud and abuse detection, compliance programs and business planning and management. We may also share your protected health information with our "business associates", such as our third-party administrator, enrollment processor, reinsurance carrier, and other firms that perform administrative or other services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your protected health information.

4. Communication. We may communicate with you by mail or by telephone regarding health plan coverage, eligibility questions and coordination of benefits. We will contact you at the home address we have on file for the plan member or the home telephone number on file.

5. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Disclosures to your employer. We may disclose protected health information about you to the plan sponsor, which is usually your employer, with certain restrictions. We will only disclose whether or not you are enrolled in the health plan and summary health information (which summarizes claims paid and related information but does not identify you or your services). The plan sponsor may use this information to evaluate its sponsorship of the health plan, such as obtaining quotes from other health plans or working with its broker or benefits consultant to modify plan coverage and design. If the plan sponsor requires more than summary or enrollment information, we will only provide that information if the plan documents (your summary plan description or enrollment package) allow this, or are modified to give you notice of this. In any case, the plan sponsor is not allowed to use any such information for employment related decisions about you. Plan sponsors must make certifications to us regarding their uses and disclosures of this information or protected health information and must assure that their agents and subcontractors do the same.

8. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with a list of providers and services covered by the plan. We may also communicate to you about services and products that add value to you but are not necessarily covered benefits. We may also communicate to you about alternative treatment options, alternative settings of care or providers or for case management or improved care such as with disease management. We may communicate with you about a drug or biologic that is currently being prescribed. Our representatives may communicate to you face to face or even provide you a promotional gift of nominal value, for example during a health

fair. These activities described above do not require your authorization. For any other marketing activities, including those for which we may receive remuneration, we will not otherwise use or disclose your protected health information without your written authorization. You may also ask to opt out of any marketing communications by notifying the Privacy Official listed above.

9. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public health. We may, and are sometimes required by law to, disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health oversight activities. We may, and are sometimes required by law to, disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by applicable law.

12. Judicial and administrative proceedings. We may, and are sometimes required by law to, disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law enforcement. We may, and are sometimes required by law to, disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order, warrant, or grand jury subpoena; and for other law enforcement purposes.

14. Coroners. We may, and are often required by law to, disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public safety. We may, and are sometimes required by law to, disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, when a worker's compensation carrier requests information to coordinate benefits or to determine benefits based on claims we have paid or information we possess.

19. Underwriting Purposes. We may use protected health information to conduct underwriting and underwriting analyses, and for premium rate setting purposes. However, federal law prohibits the use or disclosure of genetic information about an individual for such purposes.

B. When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose health information which identifies you without your written authorization. If you do authorize, us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request to the Privacy Official specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing to the Privacy Official, which specify how or where you wish to receive these communications; however, you may be required to pay for special communications methods. We may require a statement that all or part of the information we disclose could endanger you.

3. Right to Inspect and Copy. You have the right to inspect and/or copy your health information, with limited exceptions. To access your protected health information, you must submit a written request to the Privacy Official detailing what information you want access to and whether you want to inspect it or get a paper or electronic copy. We will charge a reasonable fee, as allowed by applicable law. We may deny your request under limited circumstances; if we do so, in certain circumstances you have the right to request a review of our denial.

4. Right to Amend or Supplement. You have a right to request that we amend your health information in our possession that you believe is incorrect or incomplete. You must make a request to amend in writing to the Privacy Official and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about our denial of such a request and how you can disagree with the denial. We may deny your request for reasons which include the following: we do not have the information, we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by Equitable Holdings, except that we do not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 17 (specialized government functions) of Section A of this Notice of Privacy Practices, or for disclosures for purposes of research or public health which exclude direct plan participant/member identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent that we have received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously consented to its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Official listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will provide you with a revised Notice upon a material change to the Notice within 60 days of the material change and revision. We will provide the Notice to you via mail, or via email if you have consented to receive information by email. A copy of the revised Notice is available upon request. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how we handle your health information should be directed to our Privacy Official listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which Equitable Holdings handles a complaint, you may submit a formal complaint to the:

U.S. Department of Health and Human Services

Office for Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Bldg.

Washington, D.C. 20201

You can determine the best method for filing a complaint by visiting www.hhs.gov/ocr including whether to send your complaint to the address above or to your regional Office for Civil Rights.

You will not be penalized or retaliated against in any way by Equitable Holdings, its employees or business associates if you file a complaint. If you believe you are being retaliated against, please immediately contact the Privacy Official listed at the top of this Notice of Privacy Practices.

EQUITABLE

EQUITABLE

Privacy notice

What does Equitable do with your personal information?

Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some, but not all, sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. **Please read this notice carefully to understand what we do.**

What?

The types of personal information we collect and share depend on the product or service you have with us. When you open an account, we will use this information to verify your identity to comply with laws. This information can include:

- Social Security number and date of birth
- Financial information
- Medical information
- Demographic information
- Contact information (e.g., residential address, phone number)
- Other information specific to you (e.g., driver's license number, passport number, employment status)

When you are no longer our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information, the reasons Equitable chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Equitable share?	Can you limit this sharing?
For our everyday business purposes, and those of your financial professional — such as processing your transactions, maintaining your account(s), responding to court orders and legal investigations, or reporting to credit bureaus	Yes	No
For our marketing purposes — to offer you our products and services	Yes	Yes
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliated companies to market to you	No[1]	We don't share

1 For clients of Equitable Advisors: If your financial professional (FP) moves to another brokerage or investment advisory firm, your FP is permitted to take certain basic contact information about you to the new firm so your FP may inform you of the move; you always have the option of keeping your investments at Equitable Advisors or moving them to another firm.

Who we are...

Who is providing this notice?	Equitable, on behalf of itself, and those of its affiliates listed in the **Other important information** section.

What we do...

How does Equitable protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law, including computer safeguards, and secured files and buildings. We also comply with applicable state laws and regulations regarding protection of personal information.
How does Equitable collect my personal information?	We collect your personal information, for example, when you: • Open an account • Purchase products • Request information about a product or marketing materials • Make a financial transaction • Make a claim Your personal information may be collected from persons other than you (e.g., credit bureaus, Medical Information Bureau, payment processors), and may be disclosed in certain circumstances to third parties without your authorization; however, you do have the right to access and correct any and all personal information we have collected about you.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes — information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliated companies to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies (e.g., distribution entities, investment managers, reinsurers).
Nonaffiliated companies	Companies not related by common ownership or control. They can be financial and nonfinancial companies (e.g., print vendors, payment processors, third-party administrators).
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Questions?

Call (877) 806-4573 or visit equitable.com/about-us/privacy-security-and-fraud.

Other important information:

This privacy notice applies to Equitable Holdings, Inc. and its following affiliates: Equitable Financial Life Insurance Company; Equitable Financial Life and Annuity Company (Equitable Financial Life Insurance and Annuity Company in CA); Equitable Financial Life Insurance Company of America; Equitable Advisors, LLC; Equitable Distributors, LLC; and Equitable Network, LLC (Equitable Network Insurance Agency of Utah, LLC in UT; Equitable Network Insurance Agency of California, LLC in CA; Equitable Network of Puerto Rico, Inc. in PR).

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company; and Equitable Distributors, LLC. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN).

 | G2290558 | Cat. #134310 (Revised 8/23)

EQUITABLE

Group Employee Benefits
Producer Compensation Notice

Regular Mail:
Equitable
Employee Benefits Group
P.O. Box 4728
Syracuse, NY 13202

Express Mail:
Equitable
Employee Benefits Group
(34-1)
100 Madison Street
Syracuse, NY 13202

EQUITABLE

Equitable Financial Life Insurance Company*
Equitable Financial Life Insurance Company of America*

For Assistance Call (866) 274-9887

PRODUCER COMPENSATION NOTICE

Equitable[1] utilizes the services of brokers, advisors, and consultants (collectively, "Producers") in connection with the sale of our Employee Benefits products. We believe that the expertise of these Producers is valuable to our customers, and so Equitable provides compensation to these Producers for their services. A Producer may receive one or more of the compensationtypes listed below in connection with the sale of Equitable Employee Benefits products to you and/or your employees.[2]

Base Compensation – this compensation, which varies by product, is payable as a percentage of annual premium on a pre-defined flat commission scale or on a graded schedule under which the commission percentage decreases as the annual premium increases.

Supplemental Compensation – this compensation, which is payable only in connection with sales of certain Equitable Employee Benefits products, is payable to all Producers other than advisors who meet certain pre-defined annual sales thresholds. This compensation is also payable as a percentage of annual premium on a pre-defined flat commission scale or on a graded schedule; however, unlike base compensation, under the supplemental compensation graded schedule, the commission percentage increases as the annual premium increases. Persistency Bonus – Producers may also qualify for an additional bonus payment based on the persistency of their in-force block. Persistency is the percentage of in-force business that is retained year over year.

The payment of supplemental compensation as to any particular sale does not affect the cost of the product purchased because the cost of supplemental compensation is considered part of the overhead expenses for all of Equitable's Employee Benefits products.

For more information about Equitable's Producer Compensation Program for its Employee Benefits products, please email ebappointments@equitable.com.

1 Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY) and Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company. Equitable's Employee Benefits products are issued by either Equitable Financial or Equitable America. Equitable Financial or Equitable America are each responsible for their respective obligations, which are backed solely by each company's respective claims-paying abilities.

2 Note that Producers or their affiliates may have other relationships with Equitable unrelated to the sale of Equitable Employee Benefits products as to which those Producers may receive separate compensation from Equitable.

3 Advisors may be eligible to receive supplemental compensation on a case-by-case basis.