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

A guide to the claims process

Long-Term Care Services℠ Rider with my indexed universal life insurance policy

EQUITABLE

Cat. #154636

For use in Non-ICC states only

Table of contents

1 Introduction to the Long-Term Care Services℠ Rider

2 Claims process step 1: Initiate claim

4 Claims process step 2: Submit required documentation

7 Claims process step 3: Receive decision

7 Distribution of the benefit payment

9 Calculation of the benefit payment

11 Taxes

12 What happens while on claim

13 How to recertify benefit eligibility

14 Termination of coverage period

15 Frequently asked questions – rider benefit payments

Cat. #154636

The Long-Term Care Services℠ Rider

Long-Term Care Services℠ Rider (the rider) provides an acceleration of a portion of the life insurance policy's death benefit if the insured is receiving qualified long-term care services as defined in the rider.

The rider is available at an additional cost with indexed universal life insurance policies. The rider may only be elected at the time of application for the life insurance policy and requires an approval by us beyond that for the underlying life policy.

To learn more about the rider, ask your financial professional or refer to your rider.

Purpose of this guide

The purpose of this guide is to provide information about the Long-Term Care Services℠ Rider claims process, which may not be initiated for many years from the time the rider is elected. Keep this guide with the life insurance policy and other important documents.

It is recommended that family and friends be informed that this rider is active on the policy in the event that the insured becomes incapacitated or otherwise requires assistance in filing a claim.

This claims guide is written from the perspective that the optional nonforfeiture benefit is not elected at issue with the rider for an additional cost or the nonforfeiture benefit is not exercised. The only discussion of the nonforfeiture benefit is on pages 14 and 16. For more details on the nonforfeiture benefit, please refer to the client brochure and ask your financial professional for a policy illustration with the rider nonforfeiture benefit.

In this claims guide, "we," "our" and "us" mean Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America. Life insurance products are issued by Equitable Financial Life Insurance Company (NY, NY) or affiliate Equitable Financial Life Insurance Company of America, an Arizona stock company with an administrative office located in Charlotte, NC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their own claims-paying abilities. "You" and "your" mean the policyowner.

Cat. #154636

Step 1: Inititate claim | Step 2: Submit required documentation | Step 3: Receive decision

Claims process

Step 1: Initiate claim

Contact our special claims department

As soon as long-term care services are required for or are being received by the insured, contact our special claims department and give notice of claim.

Our claims specialist will provide guidance on all necessary steps for submitting a claim, and will send the claims kit to you (the policyowner) or any other authorized individual via email or mail within 15 days after we receive notice of claim. People who may request this claims kit include you (the policyowner), the insured, your financial professional or legal third-party representative. Benefits are paid to the policyowner unless we receive a written request to make benefits payable to a nursing home, an assisted living center or a long-term care facility on the claimant's statement.

If the policyowner is unable to complete or sign these forms due to an incapacitated state, the forms can be signed by the holder of a Power of Attorney or a legal representative, in which case, a copy of the Power of Attorney or court document must accompany the forms when the claim is submitted.

Before a claim is submitted, please check to see that eligibility criteria for benefits under the rider are met. In the next section, we detail the forms that need to be submitted for claims evaluation.

Eligibility

To be eligible for benefits under the rider, a U.S.-licensed healthcare practitioner must evaluate the insured's health. This U.S.-licensed healthcare practitioner can be a physician, registered nurse (R.N.), licensed social worker, or any other individual who meets the requirements as prescribed by the U.S. Secretary of the Treasury. It cannot be you (the policyowner), the insured person or a member of the insured person's immediate family (as defined in the rider).

Special claims department contact information

Phone:
(800) 777-6510

Mail:
Equitable Life Operations
8501 IBM Drive, Suite 150
Charlotte, NC 28262

Remember, three things need to happen for the insured to qualify for benefits under the rider:

1. A U.S.-licensed healthcare practitioner (the practitioner) must certify in writing that the insured is chronically ill and is receiving qualified long-term care services in accordance with a plan of care. An individual who is chronically ill is someone who either (a) is unable to independently perform at least **two activities of daily living (ADLs)** or (b) requires substantial supervision to protect themselves from threats to health and safety due to **cognitive impairment**, defined as "severe deficiency in the insured person's short- or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness."

The following preview from the claims kit shows the ADLs considered.

Please indicate the level of assistance required (if any) by the insured with regard to the following activities. (Check all that apply) **Review the rider for the specific activities of daily living that affect benefit eligibility**.

Bathing
- ○ independent
- ○ needs assistance within arm's reach
- ○ needs hands-on assistance
- ○ is bathed

Continence
- ○ continent
- ○ needs assistance performing personal hygiene
- ○ incontinent

Transferring (moving in or out of bed, chair or wheelchair)
- ○ independent
- ○ needs assistance within arm's reach
- ○ needs hands-on assistance
- ○ needs total help

Eating (does not include preparing meals)
- ○ independent
- ○ needs assistance getting food to mouth
- ○ is spoon-fed
- ○ aspirates (choking danger when fed)

Dressing
- ○ independent
- ○ needs assistance
- ○ has to be dressed

Toileting
- ○ independent
- ○ needs assistance getting to/from toilet
- ○ needs assistance getting on/off toilet
- ○ needs assistance performing personal hygiene
- ○ needs total help

2. Written notice of claim and proof of claim must be provided.

3. Proof that the elimination period has been satisfied must be provided. Proof that the insured must have received qualified long-term care services for 90 days within a consecutive period of 24 months will be required to satisfy the elimination period for benefits under the rider to be payable. The 90-day elimination period does not need to be 90 consecutive days. To enhance customer service, the 90-day elimination period may be deemed satisfied by Equitable if the insured provides proof of care (care logs) from a licensed provider for at least 60 service days (approximately 5 days per week) within 90 calendar days. Otherwise, the insured must provide proof of 90 days of within 24 months. A service day is any day that service is provided by a licensed professional for a type of required care outlined in the plan of care. The 90-day clock begins with the first service day from a licensed professional. The elimination period needs to be satisfied only once while the rider is in effect.

Note: A preexisting condition may limit our ability to pay long-term care benefits. No benefits will be paid under the rider during the first 6 months from the later of (i) the register date of the policy and (ii) the effective date of the restored policy, for qualified long-term care services received by the insured due to a preexisting condition. Therefore, a preexisting condition is defined as a condition for which medical advice or treatment was received by (or recommended to) the insured from a provider of healthcare services within 6 months from the later of (i) the register date of the policy and (ii) the effective date of the restored policy. Days of service received by or recommended to the insured person for a preexisting condition during the first 6 months that the rider is inforce will not count toward satisfying the elimination period. If the policy was restored, this limitation does not apply if the preexisting condition is cognitive impairment or loss of functional capacity.

Cat. #154636

Step 1: Inititate Claim | **Step 2: Submit required documentation** | Step 3: Receive decision

Claims process
Step 2: Submit required documentation

The claims kit includes the following forms listed below. Previews of each form have been provided.

Claims kit checklist

- Claimant's statement
- Practitioner statement
- Plan of care
- Care provider assessment
- Proof that the elimination period has been satisfied

Where to submit claims kit

This claims kit is to be completed and returned to Equitable's Life Operations Center by mail or fax.

Claims kit return:

Regular mail:	Equitable Life Operations Special Claims Division P.O. Box 1047 Charlotte, NC 28201-1047
Express mail:	Equitable Life Operations 8501 IBM Drive, Suite 150 Charlotte, NC 28262
Email:	life-service@equitable.com
Fax:	**(855) 268-6373**

Previews of forms required

Claimant's statement — The policyowner or his/her legal representative needs to fully complete the claimant's statement. If forms are completed by someone other than the owner, such as a legal representative, a copy of the document establishing legal representation is necessary.

1 I have received, read and understand the information provided by Equitable Financial Life Insurance Company or its affiliates explaining the benefits available under the rider:

2 I understand and agree that if my request to use the available proceeds of the above numbered policy(ies) is approved a lien will be placed against the policy(ies) for all benefits paid. This lien will be deducted from any death benefit paid under the policy. While receiving benefits under the rider the Cash Surrender Value (CSV) is determined by reducing the base policy face amount and unloaned policy account value by a percentage. If there is an outstanding policy loan and accrued loan interest at the time we pay benefits under the rider, an amount equal to a percentage of the loan and accrued loan interest will be deducted from the Monthly Benefit Payment and used as a loan repayment and will reduce the amount otherwise payable to you. This percentage will equal the Monthly Benefit Payment divided by the portion of the Maximum Total Benefit for rider form R12-LTCSR and state variations that we have not accelerated prior to this date.

3 I (We) have read and understand the applicable Fraud Warning Statement shown on Pages 4 and 5.

Policyowner Signature(s) X_____

OR

Legal Representative Signature(s) X_____

Practitioner statement — The licensed healthcare practitioner who is primarily responsible for the insured's care must complete this form.

I certify that the above named patient:

○ A. The insured is a chronically ill individual requiring lifetime confinement and is receiving qualified long-term care services in accordance with a plan of care and the insured will require continuous care for the remainder of his or her life.

○ B. Requires **substantial supervision** to protect herself/himself or others from threats to health or safety. Condition is due to a cognitive impairment.

○ C. Requires **substantial assistance** from another individual to perform at least _____**of the activities of daily living** named on the previous page. Condition is due to loss of functional capacity and this condition is expected to last at least 90 days.

○ D. None of the above apply.

Plan of care — This must accompany the completed practitioner statement. The U.S.-licensed healthcare practitioner who is primarily responsible for the insured's care must complete this form. It is a written plan for qualified long-term care services designed especially for the insured. It must specify the type, frequency and providers of all qualified long-term care services the insured requires.

Plan of care

Name of patient (insured)				Policy number	
Type of care recommended	**Purpose**	**Provider name**	**Phone number**	**Frequency per week**	**Duration**
A.					
B.					
C.					
Certification dates of the plan of care: From_____To_____					

Care provider assessment — This form is to be completed by the qualified long-term care facility or licensed home healthcare provider providing qualified long-term care services to the insured based on the plan of care provided by the U.S.-licensed healthcare **practitioner.**

PROVIDER INFORMATION

Facility/Agency Name_____

Caregiver Name_____

Address:_____Phone Number_____

City_____State_____Zip Code_____

Do you have a nurse on-call 24 hours per day? ○ Yes ○ No

Are you a licensed provider? **(If yes, please provide copy of license.)** ○ Yes ○ No

Type of care for which you're licensed?_____

If yes, by whom?_____Type of License_____Date of License_____

Are you related to the insured in any way? ○ Yes ○ No

If yes, what is your relationship to the insured?_____

Date care began_____

Date discharged/care ended (if applicable)_____

Proof that the elimination period has been satisfied.
To enhance customer service, the elimination period may be deemed satisfied by Equitable if the insured provides proof of care (care logs) from a licensed provider for at least 60 service days (approximately 5 days per week) within 90 calendar days. Otherwise, the insured must provide proof of 90 days of service within 24 months as discussed earlier in this guide.

Optional retroactive payment for expenses incurred during the elimination period.
Once the elimination period has been satisfied, Equitable will provide an additional optional "retroactive payment" which may help cover expenses incurred during the elimination period, if the U.S. licensed healthcare practitioner provides written certification that the insured meets the definition of chronically ill, and is expected to need long-term care services for the rest of the insured's life.

Claims process

Step 3: Receive decision

Once the claim is received, it is assigned to a claims analyst. If any additional information or requirements are needed, the claims analyst will correspond with you by phone or by mail within 5–7 business days.

Once all needed information is obtained and reviewed, the claims decision is delivered in writing.

If we do not approve your claim for benefits, you have the right to appeal our claims decision by submitting a written request. You may also request all information directly related to our denial. We will provide you with the information within 60 days after our receipt of your written request.

Distribution of the benefit payment

If your claim is approved, benefits will be paid monthly to the policyowner from the policy on an "indemnity-style" basis. This means benefit payments are made directly to the policyowner without the need for the policyowner to submit bills and keep track of monthly receipts, as would be the case for benefits paid on a "reimbursement-style" basis.

A policyowner may choose to take the full amount of the monthly benefit available under the rider subject to the maximum monthly benefit even if the insured's expenses for qualified long-term care services are less than the full benefit amount. This provides the policyowner with convenience and flexibility when it comes to managing benefits. However, taking the full benefit amount may mean fewer benefits available in the future even if insured's expenses increase. Benefits exceeding the excludable amount will generally be taxable. You may need to keep track of expenses with receipts if your expenses exceed HIPAA. Please refer to the Taxes section for more details.

Benefit payments are paid monthly by check and mailed to the policyowner on the policy's **"monthly processing day"** of the following month after the insured qualifies for benefits under the rider. Benefits are paid to the policyowner unless we receive a written request to make benefits payable to a nursing home, an assisted living center or a long-term care facility on the claimant's statement. See the next page for more details.

Along with the benefit payment, we will send a monthly statement that specifies the accelerated death benefit payment paid to date and the balance of the long-term care benefit amount available to the policyowner.

The **monthly statement** contains the following information:

- **Monthly accelerated death benefit paid**
  - Including disclosure that this monthly benefit was added to your Accumulated Benefit Lien
- **Remaining maximum total benefit**
- **Policy values after benefit payment**
  - The actual policy values will be adjusted at the end of your period of coverage to reflect the Accumulated Benefit Lien
  - Formula for calculating policy values

While you are receiving monthly benefits under the rider, any policy values available for loan or surrender will be reduced to reflect the Accumulated Benefit Lien as described further in the rider.

Monthly processing day

The monthly processing day is defined as the same day of the month as that of the register date of the policy, and is when most activities become effective. Benefit payments are paid from the monthly processing day to the next month's processing day. If the insured qualifies for benefits under the rider before or after the monthly processing day, a partial payment will be included in the payment sent. The payment is generally sent one business day after the monthly processing day.

Example: If the insured qualified for benefits under the rider on April 7 and monthly processing day is April 16, the payment will include a partial benefit payment from April 7 through April 16 plus, the monthly benefit payment from April 17 through May 16. The payment is sent on May 17.)

April

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Satisfied eligibility period Monthly processing day Payment sent Partial payment Monthly payment

For details on when benefits may cease, refer to section Termination of Coverage Period.

Calculation of the benefit payment

For [2023], the daily HIPAA limit is [$420] (www.irs.gov), and is subject to an annual cost-of-living adjustment (COLA) thereafter.

The Health Insurance Portability and Accountability Act (HIPAA) determines the daily limit, which represents a national average adjusted by a defined cost-of-living formula. HIPAA provides for a monthly equivalent of 100% of the daily limit as determined by the IRS. We permit up to a 30-day monthly equivalent of 200% of the daily HIPAA limit because various factors concerning the long-term care, the facility and the geographic locale of where the services are provided could cause actual expenses to significantly exceed the HIPAA limit. This provides policyowners with greater flexibility to tailor their requested long-term care benefit payment amounts to their particular circumstances. For more information on how benefits under the rider are taxed, ask your financial professional for a copy of the Long-Term Care Services℠ Rider Planning Perspective.

When on claim, the policyowner can request any monthly benefit payment amount between: **$500** and the lesser of the Maximum Monthly Benefit Amount and the 30-Day Monthly Equivalent **of 200%** of the daily HIPAA limit then in effect.

Maximum Monthly Benefit Calculation Example A

Policy with Death Benefit Option A (DBO A) — Level death benefit and assuming no policy changes after issue.

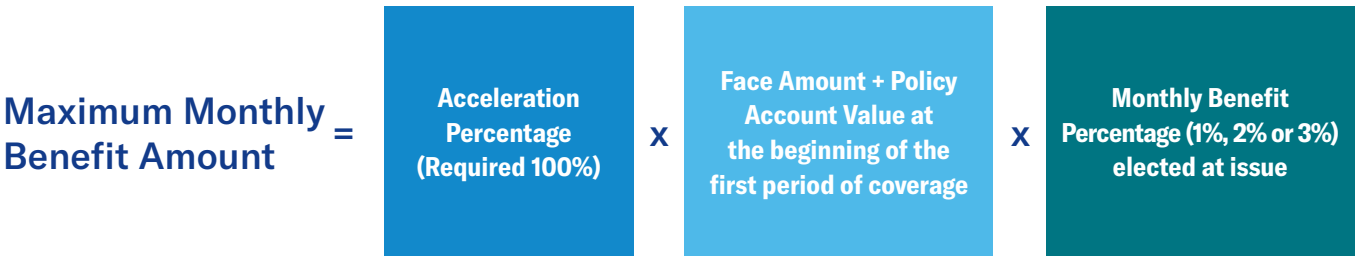
Maximum Monthly Benefit Amount = **Acceleration Percentage (20%–100%)** x **Face Amount (which could be less than the death benefit)** x **Monthly Benefit Percentage (1%, 2% or 3%) elected at issue**

DBO A Example: Jennifer owns a $2,000,000 [indexed universal] life insurance policy with the Long-Term Care Services℠ Rider. Assuming Jennifer chooses a 1% monthly benefit percentage at policy issue with a 50% acceleration percentage, her $2,000,000 policy will generally allow her to receive $10,000/month (50% x $2,000,000 x 1%= $10,000) for 100 months (subject to 200% of HIPAA limits).

Policy loans and withdrawals are two ways to access life insurance account values. Each reduces the amount that may be available for claims under the rider for a policy with Death Benefit Option A. If there is an outstanding policy loan (and accrued loan interest) at the time we pay benefits under the rider, an amount equal to a percentage of the loan and accrued loan interest will be deducted from the Monthly Benefit Payment and used as a loan repayment, and will reduce the benefit amount otherwise payable to you. This percentage will equal the Monthly Benefit Payment divided by the portion of the Maximum Total Benefit that we have not accelerated prior to this date. If there are policy withdrawals prior to a period of coverage, the Maximum Monthly Benefit Amount will be reduced.

Maximum Monthly Benefit Calculation Example B

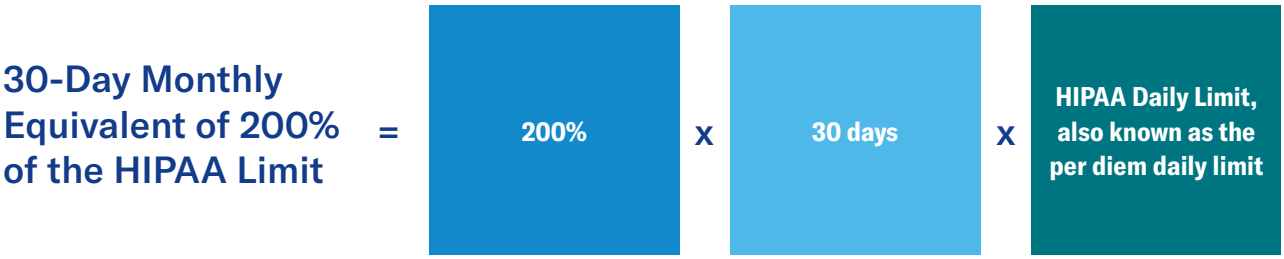
Policy with Death Benefit Option B (DBO B) —
Increasing death benefit and assuming no policy changes after issue.



DBO B: Matthew owns a $2,000,000 indexed universal life insurance policy with the Long-Term Care Services℠ rider and has $500,000 in policy account value as of the beginning of the first period of coverage. Assuming Matthew chooses a 1% monthly benefit percentage at policy issue with a 100% acceleration percentage, his $2,000,000 policy will generally allow him to receive $25,000/month (100% x ($2,000,000 + $500,000) x 1%) = $25,000) for 100 months (subject to 200% of HIPAA limits).

Policy loans reduce the amount that may be available for claims under the rider for a policy with Death Benefit Option B. If there is an outstanding policy loan (and accrued loan interest) at the time we pay benefits under the rider, an amount equal to a percentage of the loan and accrued loan interest will be deducted from the Monthly Benefit Payment and used as a loan repayment, and will reduce the benefit amount otherwise payable to you. This percentage will equal the Monthly Benefit Payment divided by the portion of the Maximum Total Benefit that we have not accelerated prior to this date.

30-Day Monthly Equivalent of 200% of the Daily HIPAA Limit



Actual claim payments are limited to 200% of the 30-day monthly equivalent of the HIPAA daily limit for the applicable calendar year.

For [2023], the HIPAA daily limit of [$420] translates into an actual monthly limit of [$25,200] for the calendar year [2023], since 200% x 30 days x [$420] = [$25,200].

The client can request an amount less than the monthly limit so the rider benefit may last longer, subject to a $500 monthly benefit minimum.

Taxes

Can any portion of the benefits be subject to income taxation?

Benefit payments made from policies that provide qualified long-term care benefits[1] will generally be excluded from income if payments are not more than published IRS maximum amounts or actual expenses, whichever is greater.

Generally, the income exclusion for all benefit payments from all sources with respect to an insured person will be limited to the higher of:

- The HIPAA per diem limit or per month (30-day monthly equivalent of 100% of the HIPAA daily limit); or
- Actual costs incurred for qualified long-term care services by the policyowner on behalf of the insured person (receipts of actual costs could be helpful in determining the amount of benefit payments to exclude).

Note: The policyowner can elect to take a benefit amount under the rider as low as $500 per month. The monthly amount we will pay is equal to the lesser of: (1) the maximum monthly benefit (or lesser amount requested by the policyowner); and (2) the 30-day monthly equivalent of 200% of the daily HIPAA limit.

When on claim, the policyowner can request any monthly benefit payment amount between: **$500** and the lesser of the Maximum Monthly Benefit Amount and the 30-Day Monthly Equivalent **of 200%** of the daily HIPAA limit then in effect.

For more information on how benefits under the rider are taxed, please read your copy of the Long-Term Care Services℠ Rider Planning Perspective. If you need a copy, ask your financial professional.

1 The benefits paid under the rider are intended to be treated for federal income tax purposes as accelerated death benefits under the Internal Revenue Code (the Code) on the life of a chronically ill individual receiving qualified long-term care services within the meaning of section 7702B of the Code.

Cat. #154636

What happens while on Long-Term Care Services℠ Rider claim?

Physical examination

- We, at our own expense, may generally have the insured examined as often as we may reasonably require during a period of coverage.

Premiums/charges

- Premium payments are not accepted. Charges for the Long-Term Care Services℠ Rider will be waived.
- Base policy charges will continue to be deducted from the policy (Cost of Insurance Charges (COIs), per $1,000 charge, policy fee, etc.) unless the policy includes Disability Waiver of Monthly Deductions/Disability Premium Waiver (DDW/DPW) and policy charges are being waived under the DDW/DPW riders.
- The rider provides lapse protection while on Long-Term Care Services℠ Rider claim. If the net policy value is not sufficient to cover policy monthly deductions while benefits under the rider are being paid, the policy will not lapse.

Policy transactions

- If there is a loan on the policy, a portion of each benefit payment is applied toward any outstanding loan and accrued loan interest.
- If there is a policy surrender before the end of a period of coverage under the rider, the unloaned policy value and surrender charge, if any, are reduced. See the rider for details.
- While on claim, certain transactions and changes to the life insurance policy are not permitted, including partial withdrawals and face amount decreases.

Liens

- Life insurance death benefits accelerated under the rider result in a lien (Accumulated Benefit Lien Amount) being set up against policy values unless benefits are being paid under the nonforfeiture benefit. The lien increases with each benefit payment. The Accumulated Benefit Lien Amount will not accrue interest.

Death claims

- If there is a death claim before the end of a period of coverage under the rider, the Accumulated Benefit Lien Amount and any outstanding policy loan and accrued loan interest are subtracted from the base policy death benefit.

Note: The following policy changes aren't permitted if Long-Term Care Services℠ Rider is in effect, whether or not the policy is on claim:

- **Face amount increases**
- **Death Benefit Option change from Option A to B**
- **Long-Term Care Monthly Benefit Percentage cannot be changed after policy issue**
- **Long-Term Care Acceleration Percentage cannot be changed after policy issue.**

How to recertify benefit eligibility

For monthly benefit payments to continue under the rider, a U.S.-licensed healthcare practitioner must recertify, every 12 months from the date of the initial or subsequent certification, that the insured person is still a chronically ill individual receiving qualified long-term care services in accordance with a plan of care. Otherwise, benefit payments will terminate at the end of the 12-month period or, if earlier, as specified in the "period of coverage" provision of the rider.

We will send a recertification package annually after the initial claim start date to remind the policyowner.

The following three forms must be sent to our administrative office:

Practitioner Recertification Form (included in the recertification package as shown beloiw)

An updated plan of care

We will also require an updated HIPAA Statement in order to access medical records for review

PRACTITIONER RECERTIFICATION: The U.S.-licensed healthcare practitioner is to certify that:

_____

First name Middle initial Last name

_____

Last four digits of insured's Social Security number

_____is confined to a licensed long-term care facility, which provides skilled nursing care, intermediate care or custodial care; or

_____is currently receiving care at home by a licensed home healthcare provider on a continuous basis; or

_____requires substantial supervision to protect himself or herself from threats to health and safety due to the presence of a cognitive impairment, and such care has been continuously administered on a continuous basis.

Termination of coverage period

A period of coverage is the period of time during which the insured receives services that are covered under this rider and for which benefits are payable. This starts on the first day covered services are received after the end of the elimination period. A period of coverage will end on the earliest of the following dates:

- The date we receive the Notice of Release that must be sent to us when the insured is no longer receiving qualified long-term care services;
- The date we discover the insured is no longer receiving qualified long-term care services in accordance with the plan of care written for that period of coverage;
- The date you request that we terminate benefit payments under the rider;
- The date the Accumulated Benefit Lien Amount equals the maximum total benefit (or, if your coverage is continued as a nonforfeiture benefit, the date the maximum total nonforfeiture benefit has been paid out);
- The date you surrender the policy (except to the extent of any nonforfeiture benefit you may have);
- The date we make a payment under the Accelerated Death Benefit Rider for terminal illness (if it occurs before coverage is continued as a nonforfeiture benefit); and
- The date of death of the insured.

After the period of coverage has ended (if you come off claim), we will adjust your policy values to reflect the Accumulated Benefit Lien Amount and provide you with notice of the adjusted values.

If the reduction in the policy account value would exceed the unloaned portion of the policy account, this policy will terminate subject to the "Grace Period" provision of the policy.

For policyowners who elected the Long-Term Care Services℠ Rider with the nonforfeiture benefit at time of issue with an additional charge:

- If the rider ends, for example, because the policy lapses, was surrendered or there was a request to terminate the rider, and the rider has been inforce for 3 or more years, your long-term care coverage may be continued as a nonforfeiture benefit in a reduced benefit amount. No additional charges are due or payable thereafter subject to the provisions in the rider.
- If coverage is being continued under the nonforfeiture benefit, you will receive additional information regarding this benefit, including the available maximum total nonforfeiture benefit.

Frequently asked questions — rider benefit payments

Are benefits under the rider payable if the insured goes overseas?

If the insured is overseas, he or she may be paid benefits under the rider if the initial plan of care and any recertification is performed by a U.S.-licensed healthcare practitioner. In addition, the provider of the care must be appropriately licensed in the jurisdiction where the care is received as applicable to the insured's prescribed plan of care.

Can the insured's family members participate in caring for the insured?

Yes. During the elimination period, services identified in the plan of care must be provided by a licensed professional who is qualified to provide such services but is not a member of the insured person's family. Potential licensed providers include, but are not limited to, adult day care center, residential care facility, home healthcare, hospice services facility and skilled nursing facility. A licensed provider identified in the "plan of care" also includes an employee of a licensed facility who renders services and who is qualified to provide such services. The elimination period needs to be satisfied only once while the rider is in effect. Once the elimination period has been satisfied, we will look to ensure an ongoing LTC need as part of the annual recertification. While we will review medical records as part of this process, we will not request information regarding providers.

When on claim, the policyowner can request any monthly benefit payment amount between: $500 and the lesser of the Maximum Monthly Benefit Amount and the 30-Day Monthly Equivalent of 200% of the daily HIPAA limit then in effect.

How is the benefit payment distributed?

If your claim is approved, benefits will be paid monthly to the policyowner from the policy on an "indemnity-style" basis. This means benefit payments are made directly to the policyowner without the need for the policyowner to submit bills and keep track of monthly receipts, as would be the case for benefits paid on a "reimbursement-style" basis. Benefits are paid to the policyowner unless we receive a written request to make benefits payable to a nursing home, assisted living center or long-term care facility on the claimant's statement.

The rider does not reimburse for expenses incurred; it provides a monthly benefit determined by the policyowner, subject to the maximum monthly benefit, if the conditions are met and a "provider" delivers any qualified long-term care services pursuant to a plan of care.

A policyowner may choose to take the full amount of the monthly benefit available under the rider, subject to the maximum monthly benefit, even if the insured's expenses for qualified long-term care services are less than the full benefit amount. This provides the policyowner with convenience and flexibility when it comes to managing benefits. However, taking the full benefit amount may mean fewer benefits available in the future, even if the insured's expenses increase. Benefits exceeding the excludable amount will generally be taxable. You may need to keep track of expenses with receipts if your expenses exceed the amount allowed under HIPAA. Please refer to the Taxes section for more details.

Frequently asked questions — rider benefit payments (cont.)

Can I change the monthly benefit payment?

You may change the monthly benefit payment as long as it is between $500 and the lesser of the maximum monthly benefit amount and the monthly equivalent of 200% of the daily HIPAA limit then in effect. Note that you will not be able to change the acceleration percentage or monthly benefit percentage, as these are elected at issue and cannot be changed thereafter.

What would my long-term care benefits be if I become chronically ill while the long-term care nonforfeiture benefit is in effect?

If the rider would otherwise terminate, and the Long-Term Care Services℠ Rider with the nonforfeiture benefit option was elected at the time of issue for an additional charge, and the benefit is in effect, coverage may be continued under the following circumstances. Coverage will continue in a reduced benefit amount without additional charges for the rider after the policy has been inforce for three (3) or more policy years unless the benefits already paid out to the policyowner exceed the total charges deducted for the rider. Refer to the rider for additional information regarding the nonforfeiture benefit.

The nonforfeiture benefit becomes effective if, after the third policy year, one of the following occurs:

- The rider is terminated on request.
- The policy is surrendered.
- The policy terminated without value at the end of a grace period.

Limitations and exclusions:

(a) Preexisting conditions. This rider does not cover conditions for which the insured person received medical advice or treatment from a provider of healthcare services (or a condition for which treatment was recommended to the insured person by a healthcare provider) within 6 months preceding the effective date of this rider. No benefits will be provided under the rider during the first 6 months for long-term care services received by the insured due to a preexisting condition. Days of service of the insured person for a preexisting condition during the first 6 months that the rider is inforce will not be counted toward the satisfaction of the elimination period.

(b) Exclusions, exceptions and limitations. This rider does not cover services provided by a facility or an agency that does not meet the rider definition of such facility or agency. The rider does not cover care or treatment:

- From a facility that primarily treats drug addicts or alcoholics;
- From a facility that primarily provides domiciliary, residency or retirement care;
- From a facility owned or operated by a member of the policyowner's or insured's immediate family;
- From anyone who is under suspension from Medicare or Medicaid;
- If benefits are sought only because a third party requires that this rider be exercised (as, for example, to obtain or maintain a government assistance benefit);
- For an attempted suicide or intentionally self-inflicted injuries;
- As a result of alcoholism or drug abuse (unless drug abuse was a result of the administration of drugs as part of treatment by a physician);
- Due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units;
- Due to committing or attempting to commit or participating in a felony, riot or insurrection;
- Received outside the United States unless the initial and any annual renewal certifications are completed by a U.S.-licensed healthcare physician. For purposes of this exclusion, United States shall mean the 50 states, District of Columbia, Puerto Rico and the U.S. Virgin Islands.

This rider may not cover all the expenses associated with the insured's long-term care needs. If your policy is subject to a loan, a portion of the monthly benefit payment will be applied to repay a portion of the outstanding policy loan.

The purpose of this method of marketing is solicitation of insurance, and contact may be made by an insurance agent, producer, insurance company or insurance agency.

Actual terms and conditions of the Long-Term Care Services℠ Rider are contained in rider form R12-10 and state variations. This rider has exclusions and limitations under which the rider may be continued in force or discontinued. It may not be available in all jurisdictions. For more information, costs and complete details of coverage, contact your life and health insurance licensed financial professional or the company. For an additional charge, the rider may be available with a nonforfeiture benefit.

Life insurance products are issued by Equitable Financial Life Insurance Company (NY, NY) or Equitable Financial Life Insurance Company of America and co-distributed by affiliates Equitable Network, LLC (Equitable Network Insurance Agency of California in CA; Equitable Network Insurance Agency of Utah in UT; Equitable Network of Puerto Rico, Inc. in PR) and Equitable Distributors, LLC. When sold by New York state-based (i.e., domiciled) financial professionals, life insurance products are issued by Equitable Financial Life Insurance Company (NY, NY). All companies are affiliated and directly or indirectly owned by Equitable Holdings, Inc., and do not provide tax or legal advice. You should consult with your tax and legal advisors regarding your particular circumstances.

For complete details regarding rider costs of coverage, call your financial professional. The issuing life insurance company has sole financial responsibility for its own obligations.

The rider is intended to be federally tax-qualified.

In Connecticut, the rider is referred to as the Long-Term Care Benefits Rider.

Long-Term Care Services℠ is a service mark of Equitable Financial Life Insurance Company.

Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company with an administrative office located in Charlotte, NC; Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN); and Equitable Distributors, LLC. The obligations of Equitable Financial and Equitable America are backed solely by their claims-paying abilities.

Life Insurance: • Is Not a Deposit of Any Bank • Is Not FDIC Insured • Is Not Insured by Any Federal Government Agency • Is Not Guaranteed by Any Bank or Savings Association • May Go Down in Value

Cat. #154636 (5/24)

EQUITABLE

GE-5884997 (5/24) (Exp. 5/26)