UnitedHealthcare®

GROUP SHORT TERM DISABILITY CERTIFICATE OF COVERAGE

FOR BA HOLDINGS, INC.

POLICY NUMBER: 371448

EFFECTIVE DATE: January 1, 2024

CA – UHIC

(9-24)

STATE MANDATED DISABILITY REQUIREMENTS

The following states legislatively mandate that certain employers provide state disability benefits for employees working in the state:

California
Hawaii
New Jersey
New York
Rhode Island
Puerto Rico

The disability coverage available under this plan is not intended to replace any state mandated disability coverage. The disability benefits provided in this Certificate of Coverage will be reduced by any benefits received under a state mandated disability plan.

UnitedHealthcare Insurance Company

(Hereinafter referred to as We, Us or Our)

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: BA Holdings, Inc.

Effective Date: January 1, 2024

Policy Number: 371448

Beneficiary: As on file with the Administrator

We, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person. This Certificate becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at Our Home Office of as of the Effective Date shown above.

Tracy A. Arney, Secretary

Jessica Paik, President

Group Short Term Disability Insurance
Policy Non-Participating

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

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SCHEDULE OF BENEFITS

Class of Employees

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All active full-time Employees working in non-SDI states, excluding temporary and seasonal employees

Description of Class:

Employees are considered full-time if they customarily work: 30 hours per week

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date, January 1, 2024.
2. The first day of the month on or next following the date he begins continuous employment with the Policyholder.

If the Covered Person's employment ends and the same employer rehires him within 30 days, We will apply his previous employment in an eligible class toward completing the Waiting Period.

Cost of Insurance: The Covered Person is not required to contribute to the cost of his Core Short Term Disability insurance. He is required to contribute to the entire cost of his Buy-up Short Term Disability insurance.

Covered Person Insurance:

Short Term Disability Benefit:

- **Core Benefit Percent:** 60% of the Covered Person's Pre-Disability Weekly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings.
- **Buy-up Benefit Percent:** 66.67% of the Covered Person's Pre-Disability Weekly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings.

Pre-Disability Weekly Earnings means the average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings do not include commissions, bonuses, overtime pay, and other extra compensation.

Disability Earnings means the earnings which the Covered Person receives while Partially Disabled.

Fluctuation of Disability Earnings: If the Covered Person's Disability Earnings fluctuate, We may average his Disability Earnings over the most recent 3 months to determine if his claim should continue subject to all other terms and conditions in the Policy.

If We average his Disability Earnings, We will not terminate his claim unless the average of his Disability Earnings from the last 3 months exceeds 80% of his Indexed Pre-Disability Monthly Earnings.

We will not pay the Covered Person for any month during which Disability Earnings exceed the amount allowable under the Policy.

STDBARIDER-CA

SCHEDULE OF BENEFITS (continued)

Other Income Benefits – please see page 11 of this certificate.

Core Maximum Weekly Benefit: $400

Core Maximum Weekly Benefit: $1,500

Minimum Weekly Benefit: $50

Elimination Period:	For Disability due to Injury:	14 days
	For Disability due to any other cause:	14 days

Elimination Period means the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability.

Maximum Benefit Period:	For Disability due to Injury:	24 Weeks of benefits
	For Disability due to any other cause:	24 Weeks of benefits

Premium contributions must continue while the Covered Person is receiving Short Term Disability payments.

Injury means physical harm or damage to the Covered Person.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period shown in the Schedule of Benefits, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
    a. the date the Employee is eligible for insurance, regardless of when he applies; or
    b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his Employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his Employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his Employer just prior to the date his Leave of Absence started to determine Our payments to him.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance or a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard Time on the earliest of the following dates:

1. the date for which a premium payment is made, if the next payment is not made;
2. the date he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date he ceases to be Actively at Work. The Policyholder may deem the Covered Person's employment continued during a temporary layoff or approved leave of absence. In such cases, insurance will not continue more than 3 months from the date the temporary layoff or approved leave begin.
5. the date he is no longer Actively at Work due to a labor dispute, including but not limited to a strike, work slow-down or lock out.

SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

Disability Provision:
We will pay a weekly benefit for each week that the Covered Person is continuously Disabled provided the period of Disability begins while covered under the Policy and continues beyond the Elimination Period.

Receipt of Disability Payments: The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each week for any period for which We are liable. If he is Partially Disabled, proof of Disability Earnings will be required before benefits are paid.

The Covered Person must notify Us immediately when he returns to work in any capacity.

Disabled or Disability means Total Disability or Partial Disability as those terms are defined herein.

Partially Disabled or Partial Disability means the Covered Person is able to:

1. perform with reasonable continuity one or more of the substantial and material acts necessary to pursue his usual occupation in the usual and customary way, but he is unable to perform all of the substantial and material acts or he is unable to perform them for as long as normally required.
2. perform with reasonable continuity one or more of the substantial and material acts necessary to engage in another occupation which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity, but he is unable to perform all of the substantial and material acts or he is unable to perform them for as long as normally required.

If the Covered Person is working during the Elimination Period, the days that he is working will count towards satisfying his Elimination Period, provided he meets the Definition of Partially Disabled.

Totally Disabled or Total Disability means the Covered Person has a disability that renders him unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Elimination Period means the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability.

The Benefit Percent, Elimination Period, Maximum Payment Period and Maximum Weekly Benefit are shown in the Schedule of Benefits.**Pre-Disability Weekly Earnings** means the average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings includes commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.

Calculating the Weekly Payment – Total Disability:

The Covered Person's weekly payment will be determined as follows:

1. Multiply his Pre-Disability Weekly Earnings by the Benefit Percent shown in the Schedule.

   Pre-Disability Weekly Earnings means the average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings does not include commissions, bonuses, overtime pay, and other extra compensation.

2. Compare the result in Step 1 with the Maximum Weekly Benefit shown in the Schedule.
3. The lesser of these two amounts is the Covered Person's weekly Gross Disability Payment.

   Gross Disability Payment means the payment amount before We subtract Other Income Benefits and Disability Earnings.

4. Subtract from his weekly Gross Disability Payment any Other Income Benefit amounts. The result is the Covered Person's Weekly Payment.

Other Income Benefits: Please see definition on page 11.

Effect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Weekly Benefit shown in the Schedule of Benefits. The Minimum Weekly Benefit, however, may be applied toward an outstanding overpayment.

After the Elimination Period, if the Covered Person is Disabled for only part of a week, We will send him 1/7th of his Weekly Payment for each day of Disability.

Calculating the Weekly Payment – Partial Disability:

Calculation:

The Benefit Percent and Maximum Weekly Benefit are shown in the Schedule of Benefits.

The Covered Person's weekly payment will be determined as follows:

1. Multiply his Pre-Disability Weekly Earnings by the Benefit Percentage shown in the Schedule.

   Pre-Disability Weekly Earnings means the average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings does not include commissions, bonuses, overtime pay, and other extra compensation.

2. From 100% of his Pre-Disability Weekly Earnings subtract any Other Income Benefits, and any income he earns or receives from any form of employment.

   Other Income Benefits: Please see definition on pages 11.

3. Compare the results from Steps 1 and 2 with the Maximum Weekly Benefit shown in the Schedule.

The lesser of the amounts from Step 3 is the amount We will pay the Covered Person each week.

Effect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Weekly Benefit shown in the Schedule of Benefits. The Minimum Weekly Benefit, however, may be applied toward an outstanding overpayment.

SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

Work Incentive Benefit Calculation:

The Covered Person's weekly payment will be determined as follows:

1. Add the Covered Person's weekly Disability Earnings to his weekly Gross Disability Payment, as calculated on the prior page.

   Disability Earnings means the earnings which the Covered Person receives while Partially Disabled.

   Fluctuation of Disability Earnings: If the Covered Person's Disability Earnings fluctuate, We may average his Disability Earnings over the most recent 3 months to determine if his claim should continue subject to all other terms and conditions in the Policy.

   If We average his Disability Earnings, We will not terminate his claim unless the average of his Disability Earnings from the last 3 months exceeds 80% of his Indexed Pre-Disability Monthly Earnings.

   We will not pay the Covered Person for any month during which Disability Earnings exceed the amount allowable under the Policy.

   Gross Disability Payment means the payment amount before We subtract Other Income Benefits and Disability Earnings.

2. Compare the result in Step 1 to his Pre-Disability Weekly Earnings.

If the result from Step 2 is less than or equal to 100% of the Covered Person's Pre-Disability Weekly Earnings, We will not further reduce his weekly payment, as calculated above.

If the result in Step 2 is greater than 100% of the Covered Person's Pre-Disability Weekly Earnings, We will subtract the amount over 100% from his weekly payment, as calculated above. This is the amount We will pay the Covered Person each week.

Other Income Benefits:

1. any temporary disability benefits he receives under Workers' Compensation Law;
2. any benefits and awards he receives under:
   a. occupational disease Law; or
   b. any other similar Act or Law.
3. any Disability income benefits he receives under:
   a. any compulsory benefit act or Law;
   b. any other group insurance policy with the Employer or with an association;
   c. any other group insurance policy with another employer under which he becomes covered while he is Disabled under the Policy; or
   d. any governmental retirement system as the result of his job with his Employer.

4. any Disability benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, the Jones Act and any other similar plan or Act. Benefits include:
   a. Disability benefits he receives and any Disability benefits his Spouse or his children receive as a result of his Disability.
   b. retirement benefits he receives and any retirement benefits his Spouse or his children receive as a result of his receipt of retirement benefits.

   If the Covered Person's Disability begins after his 70th birthday, and he was receiving Social Security retirement benefits before his Disability began, then We will not reduce Our payments to him by these retirement benefits.

   Pension Plan means a plan that provides retirement benefits and which is not wholly funded by Employee contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.
5. any benefits he receives from his Employer's sick leave or salary continuation plan.
6. any benefits from the Employer's Retirement Plan he:
   a. receives as disability benefits;
   b. voluntarily chooses to receive as retirement benefits; or
   c. receives as retirement benefits once he reaches the greater of age 62 or normal retirement age, as defined in his Employer's Retirement Plan.

   Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to the Covered Person, We consider Employee and Employer contributions to be distributed at the same time throughout the Covered Person's lifetime.

   We will not reduce payments the Covered Person receives from Us for his contributions to the Employer's Retirement Plan, or for amounts he rolls over or transfer to an eligible Retirement Plan.

   Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

   Retirement benefits under a retirement plan are benefits that are paid based on the Covered Person's Employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

   Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition.
7. any benefits for loss of time or lost wages he receives from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.
8. any amount he receives under any unemployment compensation Law.
9. any amounts he receives from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise that are awarded as a result of lost earnings.

   If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension Plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a Retirement plan from another employer
12. Individual Retirement Accounts (IRA)
13. benefits from individual disability plans

Disability During a Temporary Layoff or Approved Leave of Absence: If the Covered Person becomes Disabled while he is on a temporary layoff or approved leave of absence, We will calculate his benefit using his Pre-Disability Weekly Earnings from his Employer in effect just prior to the date his absence begins.

Continuity Of Insurance Upon Transfer Of Insurance Carriers: In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Employees as follows:

Employees who are not Actively at Work due to Disability:

We will insure the Employee under the Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Employee will be limited to the lesser of the weekly payment under this Policy or the weekly payment the prior group insurance policy would have paid him, had that policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

General Limitations:

Recurrent Disability: If the Covered Person's current Disability is due to the same or related medical causes as a prior Disability for which We made a payment, We will treat the current Disability as part of his prior claim if less than 14 consecutive days have passed since the prior Disability. The current Disability will be subject to the same terms of the Policy as the prior claim and will be treated as a continuation of that Disability ,except the Covered Person will not be required to satisfy another Elimination Period.

Any Disability which occurs after 14 consecutive days from the date his prior claim ended will be treated as a new claim. The new claim will be subject to all of the provisions of the Policy , including the Elimination Period.

SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

Multiple Causes: If a period of Disability is extended by a new, unrelated cause while benefits are payable, benefits will continue while the Covered Person remains Disabled, subject to the following:

1. benefits will not continue beyond the end of the original Maximum Benefit Period; and
2. any Exclusions will apply to the new cause of Disability.

Concurrent Disabilities: Benefits for a Disability that is caused by more than one condition will be paid as if the Disability were caused by one condition. In no event will You be considered to have more than one Disability at the same time.

Termination of Benefits: We will stop sending the Covered Person payments and his claim will end on the earliest of:

1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period as stated in the Schedule of Benefits;
3. the date he dies;.

General Exclusions:

We will not cover a Disability under the Policy if it is due to:

1. an act of war, declared or undeclared, whether civil or international;
2. intentionally self-inflicted injuries;
3. active participation in a riot;
4. committing or attempting to commit a felony;
5. cosmetic or elective surgery.

If a Covered Person becomes entitled to benefits under any other Group Short Term Disability policy, he will not be eligible for payments under the Policy.

LUMP SUM SURVIVOR INCOME BENEFIT UNDER THE SHORT TERM DISBILITY

When We receive proof that the Covered Person died, We will pay his spouse, if living, otherwise, his children under age 26 a lump sum benefit equal to 3 weeks of the Covered Person's weekly Gross Disability Payment but not to exceed $3,000.

Gross Disability Payment means: the payment amount before We subtract Other Income Benefits and Disability Earnings.

Disability Earnings mean: the earnings which the Covered Person receives while Partially Disabled.

Fluctuation of Disability Earnings: If the Covered Person's Disability Earnings fluctuate, We may average his Disability Earnings over the most recent 3 months to determine if his claim should continue subject to all other terms and conditions in the Policy.

If We average his Disability Earnings, We will not terminate his claim unless the average of his Disability Earnings from the last 3 months exceeds 80% of his Indexed Pre-Disability Monthly Earnings.

We will not pay the Covered Person for any month during which Disability Earnings exceed the amount allowable under the Policy.

Other Income Benefits: Please see definition on page 11.

The Lump Sum Survivor Benefit will be paid if, on the date of the Covered Person's death:

1. his Disability had continued for at least 15 consecutive days; and
2. he was receiving or was entitled to receive a weekly payment under the Policy.

If the Covered Person has no living spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on his claim.

CERTIFICATE GENERAL PROVISIONS

Entire Group Contract; Changes: This Policy, the application of the Policyholder, if any, and the individual applications, if any, of the employees, constitute(s) the entire contract between the parties, and any statement made by the Policyholder, or by any employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void the Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or Disability commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in the Policy shall be valid unless approved by an executive officer of Ours and unless such approval be endorsed thereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses: No claim for loss incurred or Disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period: A grace period of 60 days from the Premium Due Date will be granted for the payment of premiums accruing after the first premium, during which grace period, the Policy will continue in force, but he Policyholder shall be liable for the payment of the premium accruing for the period the Policy continues in force.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at the administrative address shown on the face page of this Certificate, or to any authorized agent of Ours, with information sufficient to identify the insured employee (i.e. Name, the Policyholder's name and the Policy number) shall be deemed notice to Us.

Claim Forms: We, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the clamant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the date the Elimination Period ends, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under the Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this Policy provides periodic payment will be paid to the insured employee monthly/weekly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

CERTIFICATE GENERAL PROVISIONS (continued)

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to Your estate. Any other accrued indemnities unpaid at Your death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to You.

If any indemnity of this Policy shall be payable to the estate of the insured employee, or to an insured employee or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose condition is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Misstatement of Age: If the age of any individual covered under this Policy has been misstated, the amount payable shall be such as the premium paid for would have purchased at the correct age.

Cancellation: After the Policy has been in force for 12 months, We may cancel this Policy at any time by written notice delivered to the Policyholder, or mailed to its last address as shown on Our records, stating when, not less than 31 days thereafter, such cancellation shall be effective; and the Policyholder may cancel this Policy at any time by written notice delivered or mailed to Us, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on a prorate basis the earned premium which has not been paid. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

We may also cancel a portion of the risk insured under the Policy on a class basis, such as termination of all persons within the same Enrolling Group, or same geographic, occupational, or eligibility class. In addition, We may cancel or modify the Policy, or an insurance option offered under the Policy if: a) the number of persons covered under the Policy falls below 75% or; b) the number of persons covered in an option falls below the lesser of 10 eligible persons or 25% of all persons eligible for the coverage . Such cancellation shall be in accordance with the preceding paragraph.

Conformity with State Statutes: Any provision of the Policy which, on it effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

Right to Audit: While We are paying benefits, We have the right to audit Your earnings at reasonable intervals if You are Disabled and working.

Overpayment of Claim: We have the right to recover any overpayments due to:

1. any error We make in processing a claim; and
2. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's Spouse if living, otherwise child under the age 26 or estate.

GLOSSARY OF TERMS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person is working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave.

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee/Member insured under the Policy. References to "Covered Person", "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Disabled or Disability: Total Disability or Partial Disability as those terms are defined in the Disability Benefit Provisions.

Employee/Member: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Policyholder will be considered an Employee unless he meets the above conditions.

Employer: The Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Physician: A practitioner of the healing arts who is:

1. duly licensed and practicing in the United States and in the state in which the treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company
A Stock Company
Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343
1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP
(1-800-927-4357)
http://www.insurance.ca.gov/01-consumers/

CERTIFICATE MODIFICATIONS RIDER

Certificate Modification(s) to the Certificate

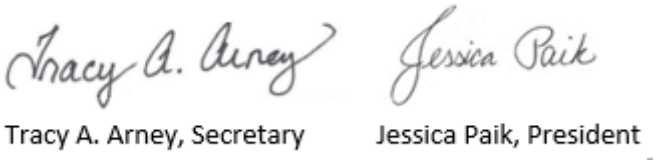
Policyholder: BA, Holdings, Inc.

Policy Number: 371448

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate:

Signed for the Company by:



Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

STATUTORY PROVISIONS

ALASKA

Residents of the state of Alaska, the following provisions are included to bring your Certificate into conformity with Alaska state law:

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section, it is hereby deleted in its entirety.

Overpayment of Claim

The Overpayment of Claim section as contained in the Certificate is hereby changed to read as follows:

Overpayment of Claim: Within 180 days of payment of a benefit, We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's Spouse if living, otherwise child under the age 26 or estate.

ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to:
UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota situsedEmployers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits
Contract Services
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343

MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

Conformity with Montana Statutes: For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

Disability Pre-Existing Exclusion

Any applicable Pre-Existing exclusion will not be applied to any disability that begins more than 12 months after the Covered Person's Effective Date of insurance.

NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

Discretionary Authority

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Occupational Injury or Sickness Exclusion

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following:

An Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

NORTH DAKOTA

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

20 Day Right to Examine Certificate: There is a 20 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 20 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 20 day period will be deducted from the refund.

OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

Certificates delivered to residents of state of Oklahoma are subject to Oklahoma laws.

Incontestability

The Incontestability provision shown in the Certificate GENERAL PROVISIONS section is replaced by the following:

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

Incontestability

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000
- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS DENIAL FOR DISABILITY INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial which must contain a complete discussion of why the claim was denied, including the basis for disagreeing with the views of medical or vocational experts whose advice was obtained either by the claimant or by the plan in connection with the denial; 2) the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied on in denying a claim or a statement that none exists; 3) a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; 4) reference to the provision(s) of the Plan on which the denial is based; 5) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; 6) an explanation of the claim review procedure. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR DISABILITY INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision must give specific reason(s) for the decision and include the above-referenced information set out above in the Claim Denial For Disability Insurance Section, items 1-4. A description of any applicable contractual limitations period and its expiration date must also be included. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations.
4. Prior to the decision on appeal, the Plan must also provide any new or additional evidence or rationale that were not included at the denial stage and give the claimant notice and a fair opportunity to respond.