ONEOK, INC.

Welfare Benefits Wraparound Plan Document

and

Summary Plan Description

Effective January 1, 2024

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SECTION I: INTRODUCTION

This Welfare Benefits Wraparound Plan Document and Summary Plan Description (the “Plan”) is intended to provide you with an overview of the underlying benefits (the “Component Benefits”) that are available under the terms of this Plan established by ONEOK, Inc. (the “Company”). This Plan replaces a number of separate welfare benefit plans that previously governed the Component Benefits.

Additional terms and conditions of the Plan’s Component Benefits are contained in the various insurance policies, booklets, and summaries (the "Benefit Documents") and are incorporated into this Plan by reference. You do not have a complete copy of this plan unless you have each of the Benefit Documents referenced in this plan. These Benefit Documents can be requested from HR Solutions (contact information listed below).

This Plan is also intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 (“ERISA”) as well as other important information. This Plan and the Benefit Documents, certificates and other descriptive material provided to you by the Company and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed provisions. You may obtain copies of this Plan and its related documents or examine these documents by contacting HR Solutions at the address below. Every effort has been made to ensure that all these materials contain a consistent description of the Plan’s benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator (consisting of the ONEOK, Inc. Benefit Plan Administration Committee (the “BPAC”) or its designee)’s responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. No one speaking on behalf of the Plan or the Company can alter the terms of the Plan.

In the event of any conflict between the information contained in this Plan and any Benefit Document, the terms of the Benefit Document will control with respect to all fully insured benefits and the terms of this Plan will control with respect to self-insured benefits and determinations as to eligibility, participant contributions and the rights, duties, and responsibilities reserved to the Benefit Plan Sponsor Committee (“BPSC”) or the BPAC. This Plan is not to be construed as a contract of or for employment and does not give you any right to be retained in the Company’s employment.

If you have any questions that are not answered by this Plan or would like to request copies of the Benefit Documents, please contact:

ONEOK, Inc.
Attn: HR Solutions
100 W. 5th St.
Tulsa, OK 74103
Phone: (855) 663-6547

SECTION 2: ELIGIBILITY AND PARTICIPATION

An Eligible Employee with respect to the Plan is any Employee who is eligible to participate in and receive benefits under one or more of the Component Benefit programs in accordance with the terms and conditions of the Plan (including the terms of the applicable Benefit Documents).

Eligible Employees

Any special eligibility requirements for any Component Benefit can be found in the applicable Benefit Documents. Generally speaking, “Eligible Employees” include all active, Full-time, salaried and hourly employees of the Company. “Full-time” means regularly scheduled to work forty (40) hours or more per week. Employees who work less than full-time may be eligible to participate in and receive benefits under one or more of the Component Benefit programs in accordance with the terms and conditions of the applicable Component Benefit program and will be considered an Eligible Employee solely for the purpose of such Component Benefit. To the extent eligibility is provided to a non-full-time employee (a “part-time employee”), such employee shall be considered an Eligible Employee for purposes of the applicable Component Benefit program under this Plan. Please refer to Section 4 for a description of the classes of individuals eligible to participate in, and be considered Eligible Employees, for each Component Benefit program. Employees who are part of a collective bargaining unit or employees who are nonresident aliens who do not receive U.S. source income are not Eligible Employees. Individuals who are classified by the Company as leased employees or independent contractors are not eligible to participate in the Plan, even if they are determined to be common law employees of the Company. Unless notified otherwise, employees will remain eligible for the Plan while on an authorized leave of absence.

The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Plan, and the Plan Administrator has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Plan.

Eligible Family Members

Any special family member eligibility restrictions or requirements for any Component Benefit can be found in the applicable Benefit Documents. For example, participation in the Chemical Dependency Treatment, Travel Accident and Long Term Disability Component Benefits is strictly limited to Eligible Employees, as defined above. Generally speaking, family members who are eligible to participate in Component Benefits under this Plan (“Eligible Family Members”) and the documents that the Plan Administrator may require in order to verify their eligibility consist of the following:

Spouse/Domestic Partner or Dependent Family Member	Verification Document Requirements
Your *Spouse*, meaning a person who is recognized as your legal spouse for purposes of federal income tax laws. Neither of you is married to anyone else under either statutory or common law.	State-issued marriage certificate. For common law marriages: Proof of joint ownership (or Certificate of Informal Marriage).
Your *Domestic Partner,* meaning a person with whom you have had a committed relationship for at least 12 months, who you live with, but who is not considered your legal spouse for purposes of federal income tax laws. Neither of you is married to or legally separated from anyone else under either statutory or common law.	Jointly signed Declaration for Domestic Partnership (must be submitted with initial enrollment) **and** Affidavit of Dependent Status for Domestic Partnership (must be submitted with initial enrollment) **and** two items showing proof of financial interdependence. Proof of financial interdependency includes: joint ownership of an automobile or home; a joint checking, bank or investment account; a joint credit account, mortgage or a lease for a residence identifying both partners as tenants; a will and/or life insurance policies signed and completed to the effect that one domestic partner is the primary beneficiary of the other; a beneficiary designation form for a retirement plan signed and completed to the effect that one domestic partner is the primary beneficiary of the other. Registration of domestic partners if the domestic partners reside in a state that provides for registration. Official recognition of civil union for persons who reside in states that recognize civil unions. If you do not provide a completed Affidavit of Dependent Status at time of enrollment, the Plan Administrator will assume that neither your domestic partner nor your domestic partner's child(ren) qualify as your tax dependent(s) and will impute income to you for the value of coverage provided to your domestic partner and your domestic partner's child(ren).
Your *natural child(ren)* until they reach age 26	State-issued birth certificate (or foreign equivalent) listing employee as a parent.[1]
Your *stepchild(ren)*, meaning your Spouse or Domestic Partner's children until they reach age 26 or earlier if your marriage or domestic partnership with their natural parent ends.	State-issued birth certificate (or foreign equivalent) listing employee's Spouse or Domestic Partner as a parent, **and** state-issued marriage certificate proving employee and Spouse are married and recorded in legal records **or** domestic partnership registration or Declaration for Domestic Partnership, as applicable, documenting the relationship.[1]

Spouse/Domestic Partner or Dependent Family Member	Verification Document Requirements
Adopted child(ren), meaning child(ren) you (or your Spouse or Domestic Partner) have adopted or who have been placed for adoption with you until the child(ren) turns age 26. You or your Spouse or Domestic Partner must be one of the adopting parents; the child must have been placed in your (or your Spouse or Domestic Partner's) custody; and the adoption proceeding must have assigned the responsibility for benefits coverage to you (or your Spouse or Domestic Partner).	Adoption or placement for adoption documents and court granted custody documents, as applicable; state-issued birth certificate (or foreign equivalent) or similar information obtained in connection with adoption proceeding.[1]
Your *foster child(ren),* meaning child(ren) who are placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction until the child(ren) turn age 26.	Foster placement judgment, decree or order.
Your *child covered by QMCSO*, meaning Your child(ren) on whose behalf a Qualified Medical Child Support Order (QMCSO) has been entered or issued, indicating that coverage must be provided by you until the child covered or turns 26 years of age, the QMCSO expires or the Plan receives notice from the issuing party that the QMCSO is no longer valid, whichever occurs first in time.	QMCSO
Other *Eligible* Dependent, meaning person who is not your child (or the child of your Spouse or your Domestic Partner) but to whom you are related; for whom you have been appointed legal guardian and is your dependent for federal income tax purposes; and is (i) under age 19, or (ii) under age 24 and a full-time student.	State-issued birth certificate (or foreign equivalent) **and** court legal guardianship documents (if applicable) **and** copy of the first page (income amounts blacked out) of your federal tax return filed within the last tax year, **and** and proof of full-time education Student, if applicable.[1] If a new legal guardian is appointed in the current calendar year, no tax return is required.
Incapacitated person. Continued coverage is provided for your child(ren) or Other Eligible Dependent(s), who is physically or mentally incapable of self-support while remaining incapacitated, as long as (i) you remain an Eligible Employee, (ii) the Dependent meets the requirements as set out in the section entitled "Coverage of an Incapacitated Person" below, and (iii) the Dependent satisfies the criteria for eligibility under one of the categories described above but for his or her age.	To continue coverage for a Dependent under this provision, proof of disability or incapacity (obtained at your own expense) must be received by HR Solutions within 31 days after coverage would otherwise terminate (or within 30 days of employee's employment start date for employees who become Eligible Employees after June 1, 2020). The Plan requires annual re-certification of the Dependent's eligibility.

Other forms of dependent verification documentation may be accepted, at the Plan Administrator's sole discretion, on a case-by-case basis.

[1] If the eligible family member's name is different than the name on the state-issued (or foreign equivalent) birth certificate, a state-issued marriage certificate or Social Security Card may be required.

Coverage of an Incapacitated Person

Coverage under a Plan may be provided for a Dependent with a mental or physical disability who reaches an age when coverage would otherwise end, as long as the Dependent meets the following requirements:

1. The Dependent was enrolled in the Plan prior to his or her turning 26 years of age (for natural, adopted, foster and stepchildren), or attaining age 24 (for other eligible dependents), as the case may be, and remained covered through such age;
2. The Dependent is unable to be self-supporting due to a severe mental or physical handicap or disability, depends mainly on an Eligible Employee for support and is considered a Dependent under the terms of this Plan;
3. The Dependent is unmarried; and
4. Proof of the Dependent's incapacity and status as a Dependent is provided to HR Solutions within thirty-one (31) days after coverage would have otherwise terminated and at any time upon the Plan's request.

The proof might include medical examinations at your expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within thirty-one (31) days, the Plan may decline to enroll your Dependent or may prospectively terminate his or her coverage.

In the case of a newly Eligible Employee following June 1, 2020, the requirements in (1) and (4) above are modified to require enrollment in the applicable component plan of the Eligible Employee's former employer immediately prior to date of hire with the Company and proof of coverage and the child's incapacity and dependency must be provided within 30 days from your date of hire and before coverage can commence. These requirements are subject to the Plan Administrator's discretion.

Coverage will continue, as long as the enrolled Dependent meets the foregoing requirements and you remain an Eligible Employee, or, unless coverage is otherwise terminated in accordance with the terms of the Plan.

If You Fail to Provide Dependent Verification Documents

In all cases, we require proof of dependency (where applicable) and Spouse/Domestic Partner and Dependent Social Security Number as conditions to enrolling an Eligible Family Member or retaining an enrolled Eligible Family Member on the Plan. In the course of enrolling an Eligible Family Member, or retaining enrollment of one, you will be required to affirm that any information you provide about an individual's status as your Eligible Family Member is true and correct, and that you understand that the Plan relies on your representations. The Plan Administrator may request you verify eligibility in order to re-enroll or maintain enrollment of an Eligible Family Member at any time. If documentation is requested to prove the eligibility status of one or more persons you have enrolled or are seeking to enroll under the Plan, and you fail to supply the requested documentation within ninety (90) days of enrollment (or such other date as indicated in the Plan Administrator's request), the Plan may decline to enroll your Spouse/Domestic Partner or Dependent or may prospectively terminate his or her coverage. By contrast, if in the course of enrolling an individual or retaining his or her enrollment, you instead make a misrepresentation of a material fact or do something, or fail to do something, that constitutes fraud (both as determined by the Plan Administrator or its designee in its sole discretion), then your Eligible Family Member will have a Rescission of Coverage retroactive to the date of

that fraud or misrepresentation. No COBRA continuation coverage will be available in either type of case. If the Plan Administrator believes a retroactive termination is appropriate you will receive a Notice of Rescission of Coverage at least 30 days before coverage is terminated and be afforded the opportunity to treat any such adverse action as an Adverse Benefit Determination with respect to a claim, and appeal the Plan's action under the Plan's claims and appeals provisions. *See Section 5: Claims and Appeal Procedures.*

For the 2024 Annual Open Enrollment Period, Legacy Magellan Employees have until April 1, 2024, to provide documentation for family member(s) eligible to be Covered Person(s) under the Plan. If documentation is not received by this date, your spouse, domestic partner and/or dependents will be removed from the Plan prospectively and you will not be able to enroll your family members until the following Annual Open Enrollment Period (or until you experience a Change in Status Event) and until you provide the necessary proof of dependency.

Employment Eligibility Waiting Period

A newly-eligible Employee (*i.e*., a new hire or someone who transitions to an eligible employment status) shall become eligible for participation in the Plan, effective their employment start date (or date of transition).

Eligibility for Rehired Employees

When you are rehired by the Company, you are treated the same as a new hire for purposes of the Plan. That means you would be considered an Eligible Employee as of your date of rehire in order to be eligible. In order to re-enroll your family members you must also provide Dependent Verification Documents and Social Security Numbers.

SECTION 3: ENROLLMENT

Certain benefit programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends can be found in the applicable Benefit Documents to the extent not separately provided in a new hire or Open Enrollment packet.

When and How You May Enroll

For Component Benefits that require enrollment, you must complete your elections in Workday, within two weeks (14 days) of your employment start date, If you do not elect to participate in the Plan, you must wait until the next Annual Open Enrollment Period to elect to participate, unless you have experienced a qualified change in status event. A comprehensive list of permitted election changes due to a change in status event can be found in the Change in Status Events section of the ONEOK, Inc. Cafeteria Plan Document and Summary Plan Description (the "Cafeteria Plan").

Duration of Participation

Except to the extent provided in *Section 7: Continuation Coverage Rights or in the applicable Benefit Documents,* you will cease to participate in the Plan or any applicable Component Benefit as of the earlier of:

- The date on which the Plan or Component Benefit terminates;
- The date you cease to be an Eligible Employee, except that your eligibility for certain Component Benefits* may continue if you are in a Short Term Disability status as defined in ONEOK Policies and Procedures (including an approved FMLA Leave) or on an approved Military Leave of Absence to the extent provided under ONEOK Policies and Procedures or required by applicable law;
- For your Eligible Family Members, the date they cease to be an Eligible Family Member or the date you fail to provide the required verification documents in accordance with the terms of the Plan, whichever occurs first; or
- The date you fail to make a required contribution under the terms of the Plan or Component Benefit.

* Dental, Vision, Employee Assistance, Chemical Dependency Treatment Component Benefits, Life Insurance and Accidental Death & Dismemberment Insurance continue while you are in Short Term Disability status or on an approved Military Leave of Absence, with the Company paying its normal share (if any) of the cost of coverage for the first 30 days and in accordance with established Company policies thereafter. The Company will pay the cost of continuing Long Term Disability coverage while you are in Short Term Disability Status, but not during an approved Military Leave of Absence. The Travel Accident Insurance Component Benefits are not eligible for continuation of coverage while in a Short Term Disability status or on an approved Military Leave of Absence.

Upon loss of group insurance coverage, individual conversion policies may be available for Life Insurance and Accidental Death & Dismemberment Insurance, along with any other fully insured Component Benefits that may be offered under the Plan from time to time, as described in the applicable Benefit Documents.

SECTION 4: PLAN AND COMPONENT BENEFIT INFORMATION

Summary of Welfare Benefits Wraparound Plan

Below is a summary of Plan Information for the ONEOK, Inc. Welfare Benefits Wraparound Plan:

PLAN NAME	**ONEOK, Inc. Welfare Benefits Wraparound Plan**
PLAN NUMBER	531
EMPLOYER IDENTIFICATION NUMBER (EIN)	73-1520922
TYPE OF PLAN	ERISA welfare benefit plan
PLAN YEAR	January 1 – December 31
SOURCE OF CONTRIBUTIONS	Company and Employees (varies by Component Benefit)
SOURCE OF BENEFITS	Self-Insured Benefits: General Assets of the Company Fully Insured Benefits: Group Insurance Policies
PLAN SPONSOR	ONEOK, Inc. Benefit Plan Sponsor Committee 100 W. 5th St. Tulsa, OK 74103 (918)588-7000
PLAN ADMINISTRATOR AND NAMED FIDUCIARY	ONEOK, Inc. Benefit Plan Administration Committee ONEOK, Inc. 100 West Fifth Street Tulsa, OK 74103 (918) 588-7000
AUTHORIZED REPRESENTATIVE OF PLAN ADMINISTRATOR	Vice President, Total Rewards ONEOK, Inc. 100 West Fifth Street Tulsa, OK 74103 (918) 588-7000
AGENT FOR SERVICE OF LEGAL PROCESS	National Registered Agents, Inc. of OK 1833 South Morgan Road Oklahoma City, OK 73128

Summary of Component Benefits

The Component Benefits in the Plan include Dental, Vision Insurance, Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance, Travel Accident Insurance, Long Term Disability (LTD) Insurance, Employee Assistance Program (EAP), and Chemical Dependency Treatment Program (CDTP). A summary of each of these Component Benefits is listed below. For details regarding specific benefits plan provisions, restrictions, exclusions and procedures for obtaining necessary authorizations and approvals please see individual Benefit Documents.

Dental Benefits	
FORMER PLAN NAME	ONEOK, Inc. Dental Plan
TYPE OF ADMINISTRATION	Self-insured
SOURCE OF CONTRIBUTIONS	The cost of dental premiums for Employees is dependent upon the coverage level elected and is deducted from Employee paychecks on a pre-tax basis through the Cafeteria Plan.
CLAIMS ADMINISTRATOR (FOR BENEFIT CLAIMS AND MANDATORY LEVELS OF APPEAL)	Delta Dental of Oklahoma Attn: Claims Administration P.O. Box 548809 Oklahoma City, OK 73154-8809
APPLICABLE BENEFITS DOCUMENT	ONEOK, Inc. Group Dental Plan Summary Plan Description
Eligible Employees	Full-time employees; part-time employees regularly scheduled to work between 20-39 hours per week.

Vision Benefits	
FORMER PLAN NAME	ONEOK, Inc. Vision Plan
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	Eligible Employees who become participants pay 100% of the premium for vision insurance. Active Employee premiums are generally paid through employee pre-tax payroll deductions through the Cafeteria Plan.
INSURANCE COMPANY AND NAMED FIDUCIARY (FOR BENEFIT CLAIMS AND APPEALS)	MetLife Vision Claim Service 200 Park Avenue New York, NY 10166 Telephone: 855-638-3931
APPLICABLE BENEFITS DOCUMENT	Certificate of Insurance Group Policy Policy Amendment January 1, 2019 Certificate Rider January 1, 2022
Eligible Employees	Full-time employees; part-time employees regularly scheduled to work between 20-39 hours per week.

Life Insurance Benefits	
FORMER PLAN NAME	ONEOK, Inc. Life Insurance Plan
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	Basic term life insurance is paid for by ONEOK. The Employee may elect additional coverage for themselves or their spouse, domestic partner, or dependents. (Certain Former Employees and Former Employee LTD Participants may have basic term life insurance paid for by ONEOK). The additional coverage is paid for by the Employee or Former Employee as applicable on an after-tax basis.

INSURANCE COMPANY AND NAMED FIDUCIARY (FOR BENEFIT CLAIMS AND APPEALS)	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 Telephone: 877-282-1752
APPLICABLE BENEFITS DOCUMENT	Group Life Insurance Certificate Group Life Insurance Policy
Eligible Employees	Full-time employees; part-time employees regularly scheduled to work between 20-39 hours per week. Former Employees and Former Employee LTD Participants are eligible for certain group retiree life insurance as more fully detailed in the applicable Certificate and Policy.

Accidental Death & Dismemberment	
FORMER PLAN NAME	ONEOK, Inc. Accidental Death & Dismemberment Plan
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	Basic coverage is paid for by ONEOK at no cost to the employee or Former Employee LTD Participant as applicable. The employee may elect additional coverage for themselves or their spouse, domestic partner, or dependents. The additional coverage is set by the insurance company and paid for by the employee on an after-tax basis.
INSURANCE COMPANY AND NAMED FIDUCIARY (FOR BENEFIT CLAIMS AND APPEALS)	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 Telephone: 877-282-1752
APPLICABLE BENEFITS DOCUMENT	Group Accident Insurance Certificate Group Accident Insurance Policy
Eligible Employees	Full-time employees; part-time employees regularly scheduled to work between 20-39 hours per week. Former Employee LTD Participants are eligible for certain group retiree life insurance as more fully detailed in the applicable Certificate and Policy

Travel Accident Benefits	
FORMER PLAN NAME	ONEOK, Inc. Travel Accident Plan
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	The Company pays 100% of the premium for travel accident coverage out of its general assets.
INSURANCE COMPANY AND NAMED FIDUCIARY (FOR BENEFIT CLAIMS AND APPEALS)	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 Telephone: 877-282-1752
APPLICABLE BENEFITS DOCUMENT	Blanket Accident Policy
Eligible Employees	Full-time employees; part-time employees regularly scheduled to work between 20-39 hours per week.

Long Term Disability (LTD) Benefits	
FORMER PLAN NAME	ONEOK, Inc. Long-Term Disability Plan
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	All premiums for this coverage are set by MetLife and are paid 100% by employees on an after-tax basis.
INSURANCE COMPANY AND NAMED FIDUCIARY (FOR BENEFIT CLAIMS AND APPEALS)	Unum 1 Fountain Square Chattanooga, TN 37402 Telephone: 866-868-6736
APPLICABLE BENEFITS DOCUMENT	Certificate of Insurance Group Policy Certificate Rider January 1, 2022
Eligible Employees	Full-time employees

Employee Assistance Program (EAP) Benefits	
FORMER PLAN NAME	ONEOK, Inc. Employee Assistance Program
TYPE OF PLAN ADMINISTRATION	Fully Insured
SOURCE OF CONTRIBUTIONS	The costs of the EAP are paid directly from the general assets of the Company. Contributions by employees or their dependents are not required.
THIRD PARTY ADMINISTRATOR	Lyra Health 287 Lorton Ave. Burlingame, CA 74010 877-849-1348
APPLICABLE BENEFITS DOCUMENT	Summary of Employee Assistance Program Applicable Company Policies and Forms
Eligible Employees	Full-time and part-time employees without restriction.

Chemical Dependency Treatment Program (CDTP) Benefits	
FORMER PLAN NAME	ONEOK, Inc. Chemical Dependency Treatment Program
TYPE OF PLAN ADMINISTRATION	Self-Insured
SOURCE OF CONTRIBUTIONS	Financial assistance is paid for 100% by the Company up to a maximum of $3,000 per admission for inpatient or outpatient alcohol and/or drug abuse treatment and aftercare provided at an Approved Treatment Provider.
DRUG PROGRAM ADMINISTRATOR	Drug Program Administrator c/o HR Solutions 100 West 5th St. Tulsa, OK 74103-4298
APPLICABLE BENEFITS DOCUMENT	Summary of Chemical Dependency Treatment Program Applicable Company Policies and Forms
Eligible Employees	Full-time employees

SECTION 5: CLAIMS AND APPEAL PROCEDURES

Fully Insured Benefit Claims and Appeals

For our fully insured Component Benefits (Vision, Life Insurance, Accidental Death & Dismemberment Insurance, Travel Accident Insurance, Long Term Disability Insurance, EAP), the insurance company will decide a Covered Person's claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA if applicable.

Self-Insured Benefit Claims and Appeals (Other than Dental)

For CDTP Benefits, an employee or eligible dependent may submit a claim for benefits by contacting the Human Resources Department, ONEOK, Inc., 100 West Fifth Street, Tulsa, Oklahoma 74103, telephone (918) 588-7000.

If a claim is denied, in whole or in part, the Claims Administrator, as CDTP applicable, shall send the claimant a Notice of Denial, which shall include:

- The specific reason(s) that the claim was denied;
- A reference to the specific Plan provision(s) on which the denial was based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why this material or information is necessary;
- A description of the appeal procedures and the time limits that apply to such procedures, including a statement of the right to bring a civil action under ERISA § 502(a) if the claim is denied on appeal;
- Any materials required under 29 C.F.R. § 2560.503-1(g)(1)(v) (relating to claims that are denied on the basis of an internal guideline, medical necessity limitation, or experimental treatment limitation); and
- In the case of an urgent care claim, a description of the expedited appeal procedures for such claims.

A claimant whose claim has been denied, or his authorized representative, may request a review of the denial, but such a request must be in writing and must be submitted to the Plan Administrator within 180 days after the claimant’s receipt of the Notice of Denial. If the claimant fails to appeal a denied claim in writing within the prescribed period of time, the claimant will have failed to exhaust the administrative review process and the denial will be deemed final, binding and conclusive.

A review of the claim and its denial shall be under procedures established by the Plan Administrator, which shall include, but not be limited to, a claimant or higher authorized representative being permitted to review pertinent documents and submit issues and comments in writing to the Plan Administrator in connection with the appeal. In deciding the appeal:

- No deference will be given to the decision denying the initial claim;
- The appeal will be decided by an individual who did not decide the initial claim, and who is not

a subordinate of anyone that decided the initial claim;

- If the appeal is based in whole or in part on a medical judgment, the individual deciding the appeal shall consult with a health care professional who has appropriate training and experience in the relevant field. The health care professional must not be an individual who participated in the denial of the initial claim and must not be the subordinate of any such individual; and
- If the Plan Administrator obtained advice from any medical or vocational experts in conjunction with the initial claim, then such experts must be identified to the claimant. This identification must occur even if the Plan Administrator did not rely on the advice obtained.
- A review of a claim which has been denied, and a decision on it, shall be made by the Plan Administrator within 30 days of the receipt of the request for review, unless the Plan Administrator determines that special circumstances require additional time, in which case a decision shall be rendered not later than 45 days after receipt of the initial request for review. The decision on the review shall be furnished to claimant or his/her authorized representative in writing and shall include the following:
- The specific reason(s) for the decision;
- References to the pertinent provisions on which the decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of any voluntary appeal procedures and the claimant's right to obtain the information about such procedures;
- A statement of the claimant's right to bring an action under § 502(a) of ERISA;
- Any materials required under 29 C.F.R. § 2560.503-1(j)(5)(i) or (ii) (relating to claims that are denied on the basis of an internal guideline, medical necessity limitation, or experimental treatment limitation); and
- If applicable, a statement about mediation and any available consumer assistance resource programs.

Dental Benefit Claims

This Plan does not require any preauthorization for receipt of dental services, but dental services are subject to specific limitations, exclusions, deductibles and co-payments, as well as any charges over your annual or lifetime maximum. Your dentist can submit a treatment plan to DDPOK for predetermination of benefits. This enables you and your dentist to know in advance what services are covered, how much of the cost will be paid by the Plan, and how much of the cost you will be responsible for paying.

For network providers, you simply present your identification card to the dentist at the time of treatment and he or she will file your claim for you. DDPOK will pay the participating dentist direct for any covered services. Benefit claims are reimbursed based on the lesser of the dentist’s submitted fee for his or her service or the maximum allowable amount he or she has agreed to accept as payment for covered services. Participating dentists accept the maximum allowable amount as payment in full. However, you are responsible for paying for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

For out-of-network providers, any benefit payment will be paid directly to you, or to other participant or beneficiary if required by law, and will be based on either the dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental Premier Participating Dentists. You are responsible for paying the dentist and filing your own claim. You may obtain claim forms from ONEOK HR Solutions, the Claims Administrator or the ONEOK Online HR portal.

Anytime you or a dentist file a claim, you will receive a form called an Explanation of Benefits (EOB) from DDPOK within a reasonable time, but no later than 30 days after receipt of a claim. DDPOK may extend this time period one time up to 15 days, prior to the expiration of the 30-day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be given 45 days from receipt of the notice within which to provide the necessary information. The EOB indicates what services were covered and what services, if any, were not. You are responsible to pay only the amount designated as "Patient Payment"; if you are billed for amounts over those identified, please contact DDPOK's Customer Service Department. An explanation of how to appeal a claim is included on the EOB.

Any Adverse Benefit Determination will be provided, in writing, or by electronic notification, and will state the specific reason for the determination, refer to the specific Plan provisions on which the determination is based, describe any additional material or information necessary for a claim to be approved and an explanation of why such material or information is necessary, a description of the Plan's appeal and review procedures, and contain a statement of your right to bring legal action following any Adverse Benefit Determination on appeal and review under the Plan. If an Adverse Benefit Determination is based upon any internal rule, guideline, protocol or similar criterion that was relied upon in making that determination, you will be provided a copy of such rule, guideline, protocol or similar criterion, or a statement that it was relied upon in making the determination and that a copy of it will be provided free of charge to you upon request. If an Adverse Benefit Determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the Plan has approved any ongoing course of treatment over a specified time or for a specified number of treatments, any reduction or termination of the Plan or course of treatment before the end of such period of time or number of treatments will constitute an Adverse Dental Benefit Determination. The Claims Administrator will notify you of such an Adverse Benefit Determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the Adverse Benefit Determination before the Dental Benefits or Covered Services involved are reduced or terminated.

Dental Benefit Appeals

If you receive an Adverse Benefit Determination that denies or terminates any Dental Benefit, or otherwise adversely affects you or your eligible family members who are Covered Persons under the Dental Plan, you have a right to appeal that determination. The Plan has established the following process to review Adverse Benefit Determinations. If you have designated an Authorized Representative, that person may act on your behalf during the appeal process. If you have any questions or complaints, an initial attempt should be made to resolve the problem by directly communicating with a Customer Service Representative at Delta Dental of Oklahoma toll-free at 800-522-0188. In most cases, a Customer Service Representative should be able to provide you with a satisfactory solution to your problem. However, if a

resolution cannot be reached in an informal exchange, you must follow the mandatory appeal procedure described below.

The Claims Administrator will make a full and fair review of each appeal and may require additional documents, as it deems necessary or desirable. The Claims Administrator's staff will review your appeal unless it involves dental judgment. Appeals that require dental judgment are reviewed by a dental consultant retained by the Claims Administrator. In carrying out its respective responsibilities under the Plan, including without limitation, the determination of claims and determinations in review of appeals under the Plan, the Plan Administrator (or such other designated Plan fiduciaries, including the Claims Administrator) shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Dental Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and binding on all parties and entities, and given full force and effect.

Level I Mandatory Appeals

If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of an Adverse Benefit Determination, including a Predetermination decision, you may file an appeal within one hundred eighty (180) days from the date you received notice of the Adverse Benefit Determination**.** ***If you do not request and complete a Level I Mandatory Appeal, you will lose your right to file suit in a federal or state court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court).*** You must submit your Level I Mandatory Appeal, in writing, to the following address for your elected coverage:

Delta Dental of Oklahoma
P.O. Box 54709
Oklahoma City, OK 73154-1709 (written appeal only)

The written appeal should include the name of the Employee, Employee number, Covered Person, the Covered Person's identification number, the nature of the complaint, the facts upon which the complaint is based, and the resolution or relief you are seeking**.** You should include any additional documentation, including Dental records that you want to become a part of the review file. The Claims Administrator may request further information if necessary. Necessary facts are:

- Dates and places of services;
- Name of the Provider of services; and
- Types of services or procedures received (if applicable).

All Level I requests for review of an Adverse Benefit Determination will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review of an Adverse Benefit Determination will be conducted by a person other than the individual who made the Adverse Benefit Determination and who is not subordinate to that individual. No deference will be given to the Adverse Benefit Determination.

In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a dental judgment, the Claims Administrator conducting the review shall consult with a dental care professional that has appropriate training and experience in the field of dentistry. The dental experts whose advice is obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination will be

identified upon request, without regard to whether the advice was relied upon in making the determination. This dental care professional will not be an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of any suchindividual.

The Claims Administrator will provide you (or your Authorized Representative) with written or electronic notification of the Plan's Benefit determination made in the review of your appeal within 30 days of receipt. In the case of an Adverse Benefit Determination, the notification will state the specific reason or reasons for the determination, refer to the specific Plan provisions on which the determination is based, contain a statement that you are entitled to receive on request, and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim, a statement involving additional appeal procedures through the Plan, and a statement of the rights to bring legal action under Section 502(a) of ERISA following a Level II Adverse Benefit Determination or an Appeal.

If an Adverse Benefit Determination on review of your appeal is based upon any internal rule, guideline, protocol or similar criterion that was relied upon in making that determination, you will be provided a copy of such rule, guideline, protocol or similar criterion, or a statement that it was relied upon in making the determination and that a copy of it will be provided free of charge to you upon request.

If an Adverse Benefit Determination on review of your appeal is based on Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided an explanation of the scientific or clinical judgment for the determination, applying the terms of the Dental Plan to your dental circumstances, or a statement that such explanation will be provided free of charge upon request.

Level II Mandatory Appeals

If you are not satisfied with the outcome of a Level I Mandatory Appeal, you may file an appeal within sixty (60) days of the date you received notice of the Level I Mandatory Appeal determination. ***If you do not request and complete a Level II Mandatory Appeal, you will lose your right to file suit in a federal or state court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court).*** You must submit your Level II Mandatory Appeal, in writing, to the following address for your elected coverage:

Delta Dental of Oklahoma
P.O. Box 54709
Oklahoma City, OK 73154-1709 (written appeal only)

The Level II Mandatory Appeal Reconsideration review of an Adverse Benefit Determination will be conducted by a person other than the individual who made the Adverse Benefit Determination in the Level I Mandatory Appeal process and who is not subordinate to that individual. No deference will be given to the Level I Mandatory Appeal determination.

In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a dental judgment, the Claims Administrator conducting the review shall consult with a dental care professional that has appropriate training and experience in the field of dentistry. The dental experts whose advice is obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination will be identified upon request, without regard to whether the advice was relied upon in making the determination. This dental care professional will not be an individual who was consulted in connection with the Adverse Benefit Determination in the Level I Mandatory Appeal process, nor the subordinate of any such individual.

The Claims Administrator will provide you (or your Authorized Representative) with written or electronic notification of the Plan's Benefit determination made in the review of your appeal within 30 days of receipt. In the case of an Adverse Benefit Determination, the notification will state the specific reason or reasons for the determination, refer to the specific Plan provisions on which the determination is based, contain a statement that you are entitled to receive on request, and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim, a statement involving additional appeal procedures through the Plan, and a statement of your right to bring legal action under Section 502(a) of ERISA following a Level II or Voluntary Appeal Adverse Benefit Determination.

If an Adverse Benefit Determination on review of your appeal is based upon any internal rule, guideline, protocol or similar criterion that was relied upon in making that determination, you will be provided a copy of such rule, guideline, protocol or similar criterion, or a statement that it was relied upon in making the determination and that a copy of it will be provided free of charge to you upon request.

If an Adverse Benefit Determination on review of your appeal is based on Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your dental circumstances, or a statement that such explanation will be provided free of charge upon request.

Level III Voluntary Appeals

After exhausting Level I and Level II Mandatory Appeals listed above, you may, but are not required to, submit a Level III Voluntary Appeal to the Plan Administrator. The written request should include the name of the Employee, Employee number, Covered Person, the Covered Person identification number, the nature of the complaint, the facts upon which the complaint is based, and the resolution or relief you are seeking. Necessary facts are: dates and places of services, the name of the Provider of services and types of services or procedures received (if applicable). You should include any documentation, including medical records that you want to become a part of the review file. The Claims Administrator may request further information if necessary. To request a Level III Voluntary Appeal of your Dental Benefits Determination, you should submit your request in writing to the following address:

Vice President, Total Rewards
ONEOK, Inc.
100 West Fifth Street
Tulsa, Oklahoma 74103-4298

The Plan will not charge you any fees or costs as a part of the voluntary review process. If you elect to pursue your voluntary review rights, any statute of limitations or other defense based on timeliness will be tolled during the time that any voluntary review is pending. The Plan cannot claim that you failed to exhaust the administrative remedies available to you for failing to submit the Dental Benefit dispute to the Plan's voluntary review process. Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your right to any other benefits under the Plan.

The Plan Administrator will provide you (or your Authorized Representative) with written or electronic notification of the Plan's Benefit determination made in the review of your appeal within 30 days of receipt. In the case of an Adverse Benefit Determination, the notification will state the specific reason or reasons for the determination, refer to the specific Plan provisions on which the determination is based,

contain a statement that you are entitled to receive on request, and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim, a statement involving

any additional appeal procedures offered by the Plan, and a statement of your right to bring legal action following the Adverse Benefit Determination.

If an Adverse Benefit Determination on review of your appeal is based upon any internal rule, guideline, protocol or similar criterion that was relied upon in making that determination, you will be provided a copy of such rule, guideline, protocol or similar criterion, or a statement that it was relied upon in making the determination and that a copy of it will be provided free of charge to you upon request.

If an Adverse Benefit Determination on review of your appeal is based on Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your dental circumstances, or a statement that such explanation will be provided free of charge upon request.

Eligibility and Cost of Coverage Claims and Appeals

Either you or your authorized representative may file a claim regarding eligibility for coverage for any Component Benefit with HR Solutions. If the claim is denied, you will receive a written notice from HR Solutions within 90 days after the claim was received, as long as all needed information was provided with the claim. If a time extension is necessary to process your claim, written notice of the extension will be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination.

If a claim regarding eligibility for coverage under the Plan or the cost of coverage under the Plan is denied, the claimant has the right to appeal this denial to the BPAC. There is only one level of appeal for denied eligibility and cost of coverage claims.

A claimant has 180 days from receipt of the notice of denial to file an appeal. All appeals must be in writing. Claimants may submit, within two weeks of the date the appeal is filed, written comments, documents, records, and any other information that supports the position(s) taken in the appeal.

The Benefit Plan Administration Committee will provide a full and fair review of a claim and any supporting documentation submitted, including all comments, documents, records, and other information either not previously submitted or not considered in the initial decision. Upon request and free of charge, a claimant will also be provided reasonable access to and copies of all documents, records, and information relevant to the claim.

The Claimant will be notified of any decision on appeal within 60 days after the Benefit Plan Administration Committee receives the appeal request and all other supporting documentation.

Limitation of Action

You cannot bring any legal action against the Company, the Plan Administrator, or the Claims Administrator to recover reimbursement until ninety (90) days after you have exhausted the administrative procedures described in this section. If you want to bring a legal action against the Company, the Plan Administrator or the Claims Administrator, you must do so within one (1) year after an adverse determination (or deemed adverse determination) on appeal.

Jurisdiction and Venue

Any legal proceeding in connection with the Plan can only be filed in the United States District Court for the Northern District of Oklahoma, located in Tulsa, Oklahoma.

No Assignment of Benefits

Benefits provided to Covered Persons are for the personal benefit of such Covered Persons and cannot be transferred or assigned. Any attempt to do so shall automatically terminate all rights of the Covered Person, except to the extent otherwise required by law.

Limitation of Liability

The Choice of a provider is solely yours. The Plan itself does not furnish services, but merely pays for services you receive from providers. Neither the Company, the Claims Administrator, nor the Plan makes any warranty of the abilities or professional competency of any provider. Neither the Company, the Claims Administrator, nor the Plan is liable for any act or omission of any provider and shall have no responsibility for a provider's failure, refusal or negligence in providing services to you.

SECTION 6: GENERAL INFORMATION

Amendment or Termination of Plan

The Company, as the Plan Sponsor, has and retains the right to amend, change, cancel, discontinue, or terminate the Plan at any time without the consent of employees, or participants in the Plan, or any other person covered by the Plan except for those authorities and responsibilities which are expressly reserved to the Board of Directors herein, the BPSC shall possess and exercise all non-fiduciary "settlor" authority to act on behalf of the Company with respect to the Plan.

The BPSC shall consist of the officers designated as members of the BPSC pursuant to the management committees list maintained by the Company's Corporate Secretary and their respective successors in title or duties, authority and function.

The procedure for amending the Plan and for identifying the persons who have authority to amend the Plan shall be for the BPSC to adopt, authorize, approve, and/or ratify amendment of the Plan by action duly approved by the BPSC. The BPSC may amend the Plan at a meeting of the BPSC or without a meeting in a written memorandum of action signed by all the members of the BPSC, or by electronic transmission. The minutes or record of the meeting, or writing or writings or electronic transmission or transmissions, shall be filed and maintained in the records of the Company by the BPSC. An amendment of the Plan pursuant to this procedure shall be stated and incorporated in the governing written documents of the Plan in such form and manner as authorized and approved by the BPSC, which may, without limitation, be a duly adopted resolution of the BPSC approving such Plan amendment or restatement, a written amended and restated plan document containing the amendment signed by an officer of the Company or an authorized representative of the BPSC designated by it, or a written instrument signed by an officer of the Company or an authorized representative of the BPSC designated by it with the form of an amended and restated plan document containing the amendment that is not signed attached as an exhibit thereto. Such an amendment may be made a part of or referred to in a summary plan description or other documents related to the Plan from time to time in the form and manner determined by the BPSC or its designated authorized representatives. Amendment of the Plan pursuant to such procedure shall not require approval or action of the Board of Directors of the Company; provided, the Board of Directors is also authorized to, at any time, amend, modify, or change the Plan by resolution approved by it. The Company may cancel, discontinue, or terminate the Plan by either (i) a written instrument signed by the Chief Executive Officer of the Company, or (ii) a resolution approved by the Board of Directors of the Company.

Plan Administration

The Plan shall be administered by the Plan Administrator, which is the BPAC.

The BPAC shall serve as the "plan administrator" within the meaning of Section 3(16)(A) of ERISA and as the Plan's "named fiduciary" within the meaning of Section 402 of ERISA.

The Plan Administrator may delegate authority and responsibility for administration of the Plan to other persons, including but not limited to the Company and its Employees, pursuant to a duly adopted resolution or memorandum of consent, and all discretionary actions taken pursuant to any such delegation shall be entitled to the same deference as if taken by the Plan Administrator. The discretionary authority and duties of the Plan Administrator include interpreting the Plan; prescribing forms; establishing claims and other administrative procedures and rules; determining rights to and the amount of Benefits; reviewing determinations on claims for Benefits and other determinations and actions; authorizing other Benefit payments; obtaining and transmitting information necessary for the administration of the Plan; employing agents, counsel, accountants, actuaries, consultants, record keepers and other service providers, including the appointment of investment managers under Section 402(c)(3) of ERISA to manage any assets of the Plan; opening, closing and managing accounts at

one or more commercial banks, investment banks, trust companies, insurance companies, broker-dealers, investment advisers, investment managers, registered investment companies, investment funds and other financial institutions; depositing and withdrawing money, securities or other property in and from such accounts and providing written or oral instructions with respect to the administration and management of such accounts; making, signing, furnishing, delivering or filing reports, returns, forms or other instruments with respect to, on behalf of or for the Plan or any trustee; and otherwise having authority to control and manage the operation and administration of the Plan.

In carrying out its responsibilities under the Plan, the Plan Administrator (or such other designated Plan fiduciaries or persons to whom it has delegated authority) has discretionary authority to interpret the terms of this Plan and to determine eligibility for and entitlement to Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and conclusive, binding on all persons and entities and be given full force and effect. To the extent permitted by law, the Plan Administrator and other designated or functional Plan fiduciaries who are employees of the Company shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of the Plan.

The Plan Administrator has delegated fiduciary responsibility for deciding benefit claims and appeals to the insurance companies identified in “Summary of Component Benefits” below, and as more specifically described in the Benefit Documents.

Role of Insurance Company

The Component Benefits in this Plan are both fully insured and self-insured and in some instances, provided by contract with an insurance carrier. For the Plan’s fully insured Component Benefits, the insurance companies are responsible for prescribing claims procedures to be followed and the claims forms to be used by Covered Persons pursuant to their respective Component Benefit policies. The insurance companies are responsible for paying claims with respect to these Component Benefit programs. The Company shares responsibility with the insurance companies for administering these benefits.

Insurance premiums for Covered Persons may be paid in part by the Company out of its general assets and in part by Employees (generally through payroll deductions) and, if applicable, pursuant to the terms of the Cafeteria Plan.

Plan Costs and Contributions

The cost of the benefits provided through the Component Benefit programs will be funded in part by the Company and in part by employee contributions (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable Component Benefit program). The Company will determine and periodically communicate the Eligible Employee's share of the cost of the benefits provided through each Component Benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the Component Benefits that are not otherwise funded by employee contributions. The Company will pay its contribution and employee contributions to an insurer or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of Covered Persons from the Company's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

For a complete list of pre-tax contribution options please refer to Section 2: Pre-tax Contributions in the Cafeteria Plan.

Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations under ERISA. For avoidance of doubt, with respect to any insurance company rebate received by the Company that is subject to the Medical Loss Ratio ("MLR") provisions of the PPACA, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of Participants; which Participants need not be the same Participants who made contributions under the policy that issued the rebate.

Payment of Plan Administration Expenses

All reasonable expenses of administering the Plan shall be paid by the Company (to the extent not paid out of a trust) at the direction of the Plan Administrator or its duly authorized representatives. To the extent that a trust serves as a funding vehicle for more than one plan, expenses paid by such trust may be fairly allocated among such plans at the reasonable discretion of the Plan Administrator or its duly authorized representatives.

Right to Recover Benefit Overpayments

If, for any reason, any Component Benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or designee), or the applicable insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's, or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to Component Benefit programs provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured Component Benefit programs, subrogation or reimbursement rights may be set forth in the Benefit Document.

Subrogation And Reimbursement

Upon payment of any Benefit by the Plan, the Plan shall be subrogated to all claims, demands, actions, and right of recovery from and against any third party who may have contributed to the injury, illness or condition for which the Benefit is paid. By accepting Plan Benefits, you agree that (1) the Plan shall have an equitable first lien on any amount you recover or become entitled to recover from any such third party or insurer via claim, lawsuit, arbitration, mediation, settlement, judgment or otherwise; and (2) you will reimburse the Plan, up to the amount paid by the Plan, from any amounts recovered from

any such third party or insurer. You are required to hold any such recovery in trust for the Plan. You are required to reimburse the Plan, on a first-priority basis, regardless of whether a lawsuit is actually filed, how any settlement is structured, which items of damages are included, and whether you are fully compensated for your injury, illness, or condition. Such reimbursement shall not be reduced by the common fund, make-whole or any other legal or equitable doctrine or defense. In other words, if the reimbursement obligation exceeds the amount recovered by the Covered Person, (including legal costs and attorney's fees Incurred by the Covered Person in obtaining such recovery), the Covered Person shall reimburse the Plan the entire amount of such recovery. You may be required to confirm your written agreement to this reimbursement in a form provided by the Plan. The Company and Plan shall not be liable or responsible for any expenses in connection with any such recovery from a third party, unless, the Company or Plan shall have agreed, in writing, to bear a proportion of all such expenses. The Plan will be entitled to attorneys' fees incurred in enforcing its subrogation and reimbursement rights. You are required to cooperate and furnish information and assistance which the Plan may require to obtain this reimbursement, including signing legal documents. Your failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

Coordination of Benefits (COB)

The Coordination of Benefits rules of this Plan are designed to provide maximum coverage if a Covered Person is eligible for benefits under two or more dental plans and more than one of those plans provides coverage for a particular service. In no event will either dental plan pay a greater amount than it would have paid had dual coverage not existed, and the dental programs together will not pay more than 100% of covered expenses. The coordination of benefits provision is intended to avoid duplication of benefits. Under these circumstances, it is not intended that a dental plan provide duplicate benefits. The amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans."

Compliance with State and Federal Mandates

The Plan, including the Component Benefit plans, will comply to the extent applicable with the requirements of all applicable state and federal laws, including but not limited to USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

No Guarantee of Employment

The Plan shall not be construed to give any Employee the right to be retained in employment by the Company, nor any right to claim a Component Benefit, payment or compensation unless the right to such a Component Benefit is in accordance with the terms of the Plan.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Oklahoma, to the extent not superseded by the Code, ERISA, or any other federal law.

Headings

The headings of the various Parts of this Plan are stated for convenience of reference and are not to be regarded as indicating or controlling the meaning or construction of any provisions.

Severability

Should any part of the Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any QMCSO under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. Covered Persons and beneficiaries can obtain, without charge, a copy of such procedures from ONEOK, Inc.'s Human Resource Department.

Covered Persons Responsibilities And Rights to Information

Each Eligible Employee shall be responsible for providing the Plan Administrator and the Company and, if required by an insurance company with respect to a fully insured benefit, the insurance company with his or her current address and, if required, with the address of any individual covered through the Eligible Employee. Any notices required or permitted to be given to a Covered Person hereunder shall be deemed given if directed to the address most recently provided by the Eligible Employee and mailed by first-class United States mail. The insurance companies, the Plan Administrator, and the Company shall have no obligation or duty to locate a Covered Person.

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Covered Person examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Covered Person related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Reliance on Participant Information

The Plan Administrator may rely upon the information submitted by an Employee and Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited to the Plan following 1 year after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the benefits to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include directing the Company with respect to the withholding of any amounts due to the Plan or the Company from compensation paid to the Participant by the Company.

Waiver

Failure by the Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances will not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan will be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

No Assignment of Benefits

Participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any Benefit payable under the Plan or the right to assert legal or equitable rights, including an administrative claim, action under state law or lawsuit against any of the following: the Plan, the Plan Administrator, the Claims Administrator, or any Plan fiduciary, or the Company, or their officers, shareholders, or employees. For example, Participants may not assign their right to receive Benefits and legal rights relating to the Plan to any other party, including any care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction) or to bring any administrative claim, action under state law or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

SECTION 7: CONTINUATION COVERAGE RIGHTS

COBRA Continuation Coverage

You are receiving this notice because you are an Employee covered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end under any Component Benefit considered a "group health plan" benefit, which currently consists of the Dental, Vision, EAP and CDTP Component Benefits.

This notice generally explains COBRA coverage, when it may become available to you, and what you need to do to protect the right to receive it.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan.

This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You could become a qualified beneficiary and be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

When the qualifying event is the end of employment or reduction of hours of employment, the Plan will offer COBRA coverage to you automatically. You need not notify the Plan Administrator of these qualifying events.

For other qualifying events, a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the Plan's prescribed form and you must follow the Plan's notice procedures. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED TO THE PLAN ADMINISTRATOR DURING THE 60-DAY NOTICE PERIOD, THEN YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. ANY QUALIFIED BENEFICIARY FOR WHOM COBRA IS NOT ELECTED WITHIN THE 60-DAY ELECTION PERIOD SPECIFIED IN THE PLAN'S COBRA ELECTION NOTICE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

• the date of the Social Security Administration's disability determination;
• the date of the covered employee's termination of employment or reduction of hours; and
• the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's prescribed form, and you must follow the procedures specified in the box at the end of this notice. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED TO THE PLAN ADMINISTRATOR DURING THE 60-DAY NOTICE PERIOD AND WITHIN 18 MONTHS AFTER THE COVERED EMPLOYEE'S TERMINATION OF EMPLOYMENT OR REDUCTION OF HOURS, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second Qualifying Event Extension of COBRA Coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse, domestic partner and dependent children receiving COBRA or COBRA-equivalent coverage can get up to 18 additional months of additional coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse, domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally

separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse, domestic partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must use the Plan's prescribed form, and you must follow the procedures specified at the end of this notice. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED TO THE PLAN ADMINISTRATOR DURING THE 60-DAY NOTICE PERIOD, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Continuation Coverage under the Uniformed Services Employment and Reemployment Rights Act

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services you may elect to continue coverage under certain Component Benefits (Dental, Vision, Employee Assistance, Chemical Dependency Treatment) for yourself and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution. If your Military Service is for a period of time less than 31 days, you may not be required to pay more than the regular contribution amount for continuation of the Plan or Component Benefit coverage.

You may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of your absence from work; or
- the day after the date on which you fail to apply for, or return to, a position ofemployment.

Regardless of whether an Employee continues coverage in the Plan, if the Employee returns to a position of employment, the Employee and the Employee's Eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's Eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue Plan coverage under USERRA.

SECTION 8: HIPAA NOTICE OF PRIVACY PRACTICES

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

Background:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") require group health plans to notify plan participants and beneficiaries about their policies and practices to safeguard the privacy and security of their protected health information. This notice ("Notice") is intended to satisfy HIPAA's notice requirement with respect to all protected health information created, received, transmitted or maintained by any Component Benefit considered a "group health plan" benefit, which currently consists of the Dental, Vision, EAP and CDTP Component Benefits.

The Plan needs to create, receive and maintain records that contain protected health information about you to administer the Plan and provide you with health care Benefits. This Notice describes the Plan's health information privacy policy and practices with respect to your Component Benefits. The Notice tells you the ways the Plan may use and disclose protected health information about you, describes your rights and the obligations the Plan has regarding the use and disclosure of your protected health information. However, this Notice does not state the policies or practices of your health care Providers (such as doctors, Hospitals or laboratories) with respect to privacy of health information.

Plan Policy on Privacy of Your Health

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Generally speaking, PHI includes information provided by you or created, received or maintained by a health care Provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan. Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal and state health information privacy laws.

HIPAA Plan Privacy Requirements

The Plan is required by law to:

- Maintain the privacy of PHI about you;
- Provide you with certain rights with respect to your PHI;
- Provide you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and,
- Follow the terms of this Notice that are currently in effect, as amended from time to time.

How the Plan may Use and Disclose Health Information about You

Although HIPAA generally requires that the Plan protect the confidentiality of your PHI, there are certain uses and disclosures by the Plan allowed under HIPAA and applicable regulations. Those uses and disclosures are allowed in order to properly operate and administer the Plan for your Benefit according to its terms.

The following are the most common ways the Plan may use and disclose your PHI:

- **For treatment.** The Plan may disclose your PHI to a health care Provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room Physician about the types of Prescription Drugs you currently take.
- **For payment.** The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care Providers may be paid for your Benefit according to the Plan's terms. For example, the Plan may receive and maintain information about Surgery you received to enable the Plan to process a Hospital's claim for reimbursement of surgical expenses Incurred on your behalf.
- **For health care operations.** The Plan may use and disclose your PHI to enable the Plan to operate or operate more efficiently, or to make certain that all of the Plan's Participants receive their Benefits. For example, the Plan may use your PHI for Case Management or to perform population-based studies designed to reduce health care costs.
- In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan Participants and disclose it to the Company in summary fashion so the Company can decide what coverages the Plan should provide. The Plan will remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning who the specific Participants are. The amount of PHI used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Plan is prohibited from using or disclosing PHI that contains genetic information about an individual for underwriting purposes.
- **To the Company.** The Plan may disclose your PHI to designated Company personnel so they can carry out their Plan related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the Plan Administrator, the Company's Vice President, Total Rewards (the "Privacy Officer"), personnel of the Company's Human Resources Department, and personnel in the Company's Legal, Audit and Information Technology Departments who support the Company's Human Resources Department These individuals will protect the privacy of your health information and ensure it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Company Employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other Employee Benefit Plan Sponsored by the Company.
- **To a business associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Claims Administrator of the Plan so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require all its business associates, through contract, to appropriately safeguard your health information.

- **Treatment alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-related Benefits and services.** The Plan may use and disclose your PHI to tell you about health-related Benefits or services that may be of interest to you. However, your PHI will not be used or disclosed for marketing, sales or fundraising purposes without your authorization.
- **Authorizations.** The Plan may disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide a written authorization and any supporting documents (e.g., power of attorney). A separate authorization is required from you in order to use or disclose psychotherapy notes. To designate an authorized representative, complete and return the Individual Authorization form is available to you at www.oneokonline.com . If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not withdraw or change any uses or disclosures already made by the Plan in reliance on your prior authorization. The Plan does not have to disclose information to a personal representative if it has a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- Any other uses and disclosures of health information that are not described above in this Notice, or allowed by the laws that apply to the Plan, will be made only with your prior written authorization.
- **Spouses and Other Family Members.** With only limited exceptions, the Plan will send all mailto the employee. This includes mail relating to a Spouse/Domestic Partner and other Dependents who are covered under the Plan, and includes mail with information on the use of Benefits by the Spouse/Domestic Partner and other Dependents and information on the denial of any Benefits to the Spouse/Domestic Partner and other Dependents. However, if a person covered under the Plan has requested restrictions or confidential communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for restrictions or Confidential communications.
- **Individual involved in your care or payment of your care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example,that you are in the Hospital), or death.
- **As required by law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.
- **Special Use and Disclosure Situations**
- The Plan may also use or disclose your PHI under the following circumstances:
- **Lawsuits and disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process that requires such use or disclosure.
- **Law enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.
- **To avert serious threat to health or safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public health risks.** The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, Injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Health oversight activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes if (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.
- **National security, intelligence activities, and protective services.** The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and tissue donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plan may disclose your PHI to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Coroners, medical examiners, and funeral directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.
- **Government Audits.** The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA privacy rule.

Your Rights Regarding Health Information About You

Your rights regarding the protected health information the Plan maintains about you are as follows:

- **Right to inspect and copy.** You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.
- To inspect and copy your PHI maintained by the Plan, submit your request in writing to the Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing your PHI that you request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review

of the denial.

- **Right to amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an Amendment for as long as the information is kept by or for the Plan.
- To request an Amendment, send a detailed request, in writing, to the Privacy Officer. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that either: (1) is accurate and complete, (2) was not created by the Plan; (3) is not part of the health information kept by or for the Plan; or (4) is not information that you would be permitted to inspect and copy.
- **Right to an accounting of disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.
- To request an accounting of disclosures that have occurred since the Effective Date of this Notice, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested.
- **Right to request restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a Surgery you had.
- To request restrictions, make your request in writing to the Privacy Officer. You must advise the Privacy Officer: (1) what health information you want to restrict or limit; (2) whether you want to restrict or limit the Plan's use, disclosure, or both; and (3) to whom you want the restriction(s) and limit(s) to apply.
- **Note:** *A Plan may refuse to agree to a requested restriction on uses and disclosures necessary to properly administer the Plan. The Plan will advise you if it does not agree to follow a restriction you request, or if it terminates a restriction it has previously agreed to follow.*
- **Right to request confidential communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you Explanation of Benefits (EOB) forms about your Benefit claims to a specified address.
- To request confidential communications, make your request in writing to the Privacy Officer. The Plan will take action needed to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to be notified of a breach.** You have the right to be notified in the event that the Plan or a business associate discovers a breach of your unsecured PHI.
- **Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice. You may access this Notice at www.oneokonline.com or write to the Privacy Officer to request a written copy of this Notice at any time.

CHANGES TO THIS NOTICE

The Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current Notice on ONEOK online (www.oneokonline.com) at all times.

COMPLAINTS

If you believe your HIPAA privacy rights described in this Notice have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may make a complaint to the Secretary of the U.S. Department of Health and Human Services, generally within one-hundred eighty (180) days of when the act or omission complained of occurred.

Note: **You will not be penalized or retaliated against for filing a complaint**.

CONTACT INFORMATION

If you have any questions or want further information about this Notice, please contact:

Privacy Officer
Vice President, Total Rewards
ONEOK, Inc.
P.O. Box 871
Tulsa, Oklahoma 74102-0871
Telephone Number: (918) 588-7000

SECTION 9: STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 the materials and pay you up to $110 a day until you receive the 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 suit in a state or Federal court upon exhaustion of your administrative remedies within the permitted time frame. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. 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 court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 10: GLOSSARY

AD&D - Accidental death and dismemberment insurance

Adverse Benefit Determination - A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for any Benefit, including, but not limited to, any such action based on a determination of a person's eligibility to participate in the Plan, resulting from application, any utilization review, or failure to cover an item or service because it is determined to be Experimental or Investigational or not customary, necessary or appropriate.

Affidavit of Common Law Marriage – A legal document showing a relationship between you and your Spouse.

Annual Open Enrollment Period – The annual period of time during which current Eligible Employees may Enroll in the Plan(s) will begin paying Benefits in that calendar year.

Appeal (or Internal Review Appeal) - An appeal or internal appeal means review by the Plan of an Adverse Benefit Determination, as required by the Plan and applicable Department of Labor Regulations.

Benefit(s) – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan.

Benefit Determination - A determination made by the Claims Administrator as to providing or making payment of Benefits under the provisions of the Plan.

Benefit Documents - The actual terms and conditions of the Plan's component benefits as contained in the various insurance policies, booklets, and plan documents etc.

BPAC – The ONEOK, Inc. Benefit Plan Administration Committee.

BPSC – The ONEOK, Inc. Benefit Plan Sponsor Committee.

Cafeteria Plan – The ONEOK, Inc. Cafeteria Plan, a plan that allows a Participant to pay for health care Benefits on a pre-tax basis.

Change in Status Event - A Change in Status Event specified under the Plan that qualifies a Covered Person to change elected coverage during the Plan Year other than during the Annual Open Enrollment Period. Notification must be provided within thirty (30) days except in the case of birth and/or adoption, which must be provided within ninety (90) days; or Medicaid or State Children's Health Insurance Program (SCHIP)/Children's Health Insurance Program (CHIP) coverage, which must be provided within sixty (60) days.

Claim, Claim for Benefits – A request for a Benefit or Benefits under the Plan made by a claimant in accordance with the Plan's procedure for filing Benefit claims; and includes any Pre-Service Claim and any Post-Service Claim.

Claimant - An individual who makes a Claim for Benefits under the Plan and a claim as provided for in applicable Department of Labor Regulations and this Section. For purposes of this Section references to Claimant include a Claimant's authorized representative.

COBRA -Consolidated Omnibus Budget Reconciliation Act of 1985, as amended

COBRA Continuation Coverage - Coverage under a group health plan that satisfies the provisions of COBRA.

Code - Internal Revenue Code of 1986, amended

Company - ONEOK, Inc. and its subsidiaries and affiliates.

Component Benefits – The underlying benefits available under the terms of this Plan.

Co-pay, Co-payment or Coinsurance Amount - An amount required to be paid by or on behalf of a Covered Person in connection with the delivery of certain Covered Health Services.

Covered Person - Any Eligible Employee covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual's relationship to an Eligible Employee (such as the Employee's spouse, child, or other eligible family member).

Dependent - An individual who is a family member of an Eligible Employee, who comes within the coverage provisions listed and stated under Eligible Family Members in Section 2: Eligibility and General Information and who meets the requirements of Code section 152 as modified by Code sections 105 and 106 and their accompanying regulation.

Dependent Verification Documents – The documentation required by the Plan to confirm proof of Dependent eligibility.

Domestic Partner - Definition of Domestic Partnership - A Domestic Partner does not qualify as a spouse under Federal Law. A Domestic Partner is not a qualified beneficiary, and therefore not able to elect COBRA continuation of coverage. A Domestic Partner's child is not eligible for coverage under the plan as a result of QMCSO (Qualified Medical Child Support Order).

A Domestic Partnership is a relationship between unmarried partners of the same or opposite sex who share a committed and financially interdependent personal relationship. A Domestic Partner of an individual must:

- not be so closely related that marriage would otherwise be prohibited under the laws of the state in which they reside;
- not be legally married to, or the Domestic Partner of, another individual under either statutory or common law;
- be at least 18 years old;
- live together with the individual (other Domestic Partner) and share the common necessities of life;
- be mentally competent to enter into a contract; and
- have a single dedicated relationship of at least 12 months duration; and
- be living together at the same residence; and
- be financially interdependent with the individual (other Domestic Partner) and have furnished documents to support at least 2 of the following conditions of such financial interdependence:

    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; and
    - have a will and/or life insurance policies signed and completed to the effect that

one Domestic Partner is the primary beneficiary of the other; or
- a beneficiary designation form for a retirement plan signed and completed to the effect that one Domestic Partner is the primary beneficiary of the other.

Effective Date - The date when your coverage begins.

Eligible Employee – An Employee who meets the eligibility criteria to participate in one or more of the Component Benefit programs as outlined in Section 2 and Section 4.

The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Plan, and the Plan Administrator has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Plan.

Eligible Family Member - An individual who is a family member of an Eligible Employee and who comes within the coverage provisions and meets all requirements to be eligible for coverage as listed in the Plan or a Component Benefit.

Employee – An individual who is classified as an employee of the Company under the Company's internal policies and procedures. An individual who is classified by the Company as a contingent worker, independent contractor or leased employee shall not be considered an Employee for purposes of the Plan. The term Employee when used in this document shall refer to an Employee eligible to participate in the Plan in accordance with the terms and provisions of this Plan.

If any court, administrative body, agency, or other entity should determine that any individual classified as a contingent worker, independent contractor, leased employee or other non- Employee by the Company was, in reality, a common law employee of the Company, such individual still shall not be eligible for, nor entitled to, and shall not participate in, the Plan.

ERISA - Employee Retirement Income Security Act of 1974, as amended.

Exclusion(s) - Covered Health Services that the Plan does not pay claims for, even if they are recommended or prescribed by a Provider, or are the only available treatment for your condition.

Explanation of Benefits (EOB) – A statement provided from a healthcare provider to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any);
- The eligible reimbursement amounts;
- Coinsurance;
- Any other reductions taken;
- The net amount paid by the Plan; and
- The reason(s) why the service or supply was not covered by the Plan.

FMLA - Family and Medical Leave Act of 1993, as amended

Former Employee – A Former Employee means, as applicable:

- For legacy ONEOK Employees who are not Legacy Magellan Employees, an Employee who (1) was hired prior to January 1, 2017; (2) terminated employment at age 50 or older but before

age 65; (3) completed sixty (60) or more consecutive months of full-time service (meaning they were regularly scheduled to work forty (40) or more hours per week) and (4) at the time of termination or retirement were regularly scheduled to work a minimum of twenty (20) or more hours per week and elected in writing to participate in and be covered under the Former Employee Health Plan during the Employee's initial election period.

- For Legacy Magellan Employees, an Employee who (1) terminated employment at age 50 or older but before age 65; and (2) elected in writing to participate in and be covered under the Former Employee Health Plan during the Employee's initial or deferred election period, as applicable.

Former Employee LTD Participant – a legacy ONEOK Employee who (1) was hired prior to January 1, 2017 and is eligible for benefits under the ONEOK, Inc. Long-Term Disability Plan (LTD Plan) and elected in writing to participate in and be covered under the Former Employee Health Plan. For the avoidance of doubt, no Legacy Magellan Employee is (or can become) a Former Employee LTD Participant.

Former Employee Health Plan – post-retirement health benefits consist of two health plans based on Medicare eligibility. The ONEOK, Inc. Health Plan for Former Employees is available to any Former Employee or Eligible Family Member who is not Medicare eligible and the ONEOK, Inc. Retiree Reimbursement Account Plan is available to any legacy ONEOK Former Employee or Eligible Family Member who is Medicare eligible. For the avoidance of doubt, no Legacy Magellan Employee or Eligible Family Member of a Legacy Magellan Employee is (or can become) eligible for benefits through the ONEOK, Inc. Retiree Reimbursement Account Plan.

Foster Child – A foster child meaning your child(ren) who is an individual who is a child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time Student (Full-time Education Student) – A person who is enrolled in and attending, full-time, a recognized course of study or training at:

- An accredited high school;
- An accredited college or university; or
- A licensed vocational, technical, automotive, beautician school, or similar training school.

GINA - Genetic Information Nondiscrimination Act of 2008

Guardianship - A guardianship is a legal relationship created when a person is assigned by the court to take care of minor children or incompetent adults.

HIPAA - Health Insurance Portability and Accountability Act of 1996, as amended

HITECH - Health Information Technology for Economic and Clinical Health Act

Incurred – A charge is incurred on the date you receive a service or supply for which the charge is made.

Legacy Magellan Employee – A current or former employee of Magellan Midstream Holdings GP, LLC ("Magellan") or a Magellan affiliate who, as of September 25, 2023, was either (1) participating in the Term Life and AD&D Insurance Benefits component of the Magellan Health and Welfare Plan, or (2) eligible to retire and receive life insurance benefits through the Term Life and AD&D Insurance

Benefits component of the Magellan Health and Welfare Plan. A current or former employee of Magellan or a Magellan affiliate who was not participating (or eligible to retire and receive benefits) in the Term Life and AD&D Insurance Benefits component of the Magellan Health and Welfare Plan as of September 25, 2023 shall not be a Legacy Magellan Employee and no person may become a Legacy Magellan Employee after September 25, 2023.

MHPA - Mental Health Parity Act of 1996

MHPAEA - Mental Health Parity and Addiction Equity Act of 2008

Michelle's Law - The law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

Named Fiduciary - ONEOK, Inc. Benefit Plan Administration Committee, and its duly authorized representatives and fiduciaries.

NMHPA - Newborns' and Mothers' Health Protection Act of 1996, as amended

Notice (or Notification) - The delivery or furnishing of information to an individual in a manner that satisfies the standards of Department of Labor Regulations applicable to the Plan as appropriate with respect to material required to be furnished or made available to an individual.

Open Enrollment – The period of time, determined by ONEOK, Inc., during which Eligible Employees may enroll themselves, their Spouse/Domestic Partner and/or their Dependent(s) under the Plan.

Participant - An Eligible Employee, Spouse, Domestic Partner, or Dependent(s) who elects to participate in the Plan.

Plan - ONEOK Inc. Welfare Benefits Wraparound Plan Document

Plan Administrator - ONEOK, Inc. Benefit Plan Administration Committee or its designee.

Plan Document & Summary Plan Description (SPD) - This document that describes the Benefits available to you and your covered family members under the Plan.

Plan Sponsor – The ONEOK, Inc. Benefit Plan Sponsor Committee.

Plan Year – The calendar year period beginning January 1 and ending December 31.

PPACA - Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010

Prescription Drug - Drugs and medicine lawfully prescribed by a Hospital, Physician, or other licensed Provider.

Qualified Beneficiary - An Employee covered under the Plan; a covered Employee's enrolled Spouse or Dependent, including with respect to the Employee's children, a child born to or Placed for Adoption with the Employee during a period of continuation coverage under federal law; or a covered Employee’s Spouse/Domestic Partner.

Qualifying Event - An event that may give rise to a right to elect COBRA Continuation Coverage.

Relevant - A document, record, or other information shall be considered Relevant for purposes of the Plan if such document, record or other information (1) was relied upon in making the Benefit Determination, (2) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination, (3) demonstrates compliance with the administrative processes and safeguards required pursuant to the Plan and applicable Department of Labor Regulations in making the Benefit Determination.

Rescission of Coverage - A cancellation or discontinuance of coverage under the Plan that has retroactive effect, including a cancellation that treats coverage under the Plan as void from the time of the individual's enrollment, or a cancellation that voids benefits paid up to a year before the cancellation. Provided, a cancellation or discontinuance of coverage is not a Recession of Coverage if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extend it is attributable to a failure to timely pay required contributions toward the cost of coverage under the Plan.

Social Security Number (SSN) - A nine-digit number issued to U.S. citizens, permanent residents, and temporary (working) residents under section 205(c)(2) of the Social Security Act.

SPD – Summary Plan Description

Spouse – An individual to whom an Eligible Employee is legally married for purposes of federal income tax laws. Evidence of a spousal relationship may be State Issued Marriage Certificate, Affidavit of Common Law Marriage.

State Issued Birth Certificate – an official document issued by the state in which the person was born. Hospital issued birth certificates do not qualify as State Issued Birth Certificates.

State Issued Marriage Certificate - an official document issued to record a person's marriage, including such identifying data as name, date of marriage, place of marriage and court record.

USERRA - Uniformed Services Employment and Reemployment Rights Act of 1994

WHCRA - Women's Health and Cancer Rights Act of 1998

Workday - The online platform used to house enrollment data.

SECTION 11: SCHEDULE OF BENEFIT DOCUMENTS

Summary of Dental Benefits (Dental)

ONEOK, Inc. Group Dental Plan Summary Plan

Description (Dental)

Group Vision Benefits Overview (Vision)

Certificate of Insurance (Vision)

Group Policy (Vision

Certificate Riders – January 1, 2021 and January 1, 2022

Group Life Insurance Certificate (Life)

Group Life Insurance Policy (Life)

Group Accident Insurance Certificate (AD&D)

Group Accident Insurance Policy (AD&D)

Blanket Accident Policy (Business Travel)

Certificate of Insurance (LTD)

Summary of Employee Assistance Program (EAP)

Summary of Chemical Dependency Treatment Program (CDTP)

Applicable Company Policies and Forms (EAP, CDTP)