ONEOK, INC.

Summary of Dental Benefits

(Component Benefit of the ONEOK, Inc. Welfare Benefits Wraparound Plan)

Revised effective January 1, 2024

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SECTION I: INTRODUCTION

This Summary of Dental Benefits is a Supplement to the Welfare Benefits Wraparound Plan and SPD. You will find information about Dental Component Benefits in this Summary, including a description and explanations of dental benefit enrollment options, eligibility, covered and excluded dental care services, administration of claims, appeals procedures, and general provisions.

The Dental Component Benefit is intended to be administered as a plan providing separate limited scope dental benefits for purposes of requirements governing portability, additional market reforms, and other similar requirements under the Health Insurance Portability and Accountability Act (HIPAA) and other federal laws and regulations that are applicable to group health plans.

SECTION 2: ENROLLMENT OPTIONS AND ELIGIBILITY

Dental Benefit Options

During the Annual Open Enrollment Period, you may elect:

Delta Dental of Oklahoma (PPO Network and Premier Network), or

No Coverage

Coverage Tiers

Your Dental Benefits cost will vary based on the family members you elect to cover. The Coverage Tiers to choose from are:

Employee Only
Employee + Spouse
Employee + Domestic Partner
Employee + Child(ren)*
Employee + Domestic Partner Child(ren)*
Employee + Child(ren)* + Domestic Partner
Employee + Child(ren)* + Domestic Partner + Domestic Partner Child(ren)*
Employee + Domestic Partner + Domestic Partner Child(ren)*
Employee + Spouse and Child(ren)

* Child(ren) is synonymous with the term Dependent(s)

The Dental Benefit allows an election to be changed during the Plan Year in certain situations, known as Change in Status Events, such as marriage, divorce, termination of Domestic Partner relationship, birth, or adoption of a child. You should refer to CHANGE IN STATUS EVENTS in the Cafeteria Plan document.

Default Enrollment Coverage

If you are a newly Eligible Employee and do not complete the Enrollment process in Workday, you will be automatically Enrolled in the Dental Benefit Option that provides no coverage for you, your Spouse/Domestic Partner, or your eligible Dependent(s). If this occurs, you will not be able to Enroll in Dental Benefits coverage until the next Annual Open Enrollment Period or when you experience a Change in Status Event.

Annual Open Enrollment Period

The Annual Open Enrollment Period is usually during the first half of November for approximately ten (10) days. Employees will be furnished enrollment information and forms by November. Elections made during the Annual Open Enrollment Period become effective the following January 1 and will remain in effect until the following December 31.

Making Dependent Changes During Open Enrollment

If you wish to add or drop a Spouse, Domestic Partner, or Dependent(s) as a Covered Person entitled to Benefits under the Dental Component Benefit who is not already covered, you must complete and submit a Benefits Open Enrollment Form during the Annual Open Enrollment Period to HR Solutions. Dependent

Verification Documents and Social Security Numbers will be due November 30 for the current Annual Open Enrollment Period, if not received by November 30 your Dependents will not be enrolled and you will not be able to enroll your Dependents until the following Annual Open Enrollment Period unless a Change in Status Event occurs.

Note: During the Annual Open Enrollment Period, if your Dependent was covered during the entire preceding Component Benefit Plan Year, you will not be required to provide verification. Generally speaking, if you do not make a Dental Benefits Option election, during the Annual Open Enrollment Period, you will remain on the Dental Benefit Option and Coverage Tier that you are enrolled in on the last day of the prior Plan Year.

Tax Treatment if Covering a Domestic Partner Who Is Not a Dependent

If you elect coverage for a Domestic Partner and the Domestic Partner does not qualify as your Dependent, Company contributions for that Domestic Partner coverage will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported as income on your Form W-2.

If you elect coverage for a Domestic Partner and the Domestic Partner does not qualify as your Dependent the contributions you make to the Dental Component Benefit for that coverage must be made on an after-tax basis.

Tax Treatment if Covering a Domestic Partner Who Is a Qualifying Dependent

If your Domestic Partner is covered under the Dental Component Benefit, and the Domestic Partner is your Dependent, then the Company contributions for that coverage will be excluded from your gross income for federal income tax purposes. In addition, you will be able to pay your Net Benefit Cost on a pre-tax basis under the Cafeteria Plan.

SECTION 3: PLAN BENEFITS

This "Overview of Dental Plan Benefits" shows the covered services included in your dental program. It also indicates the amount of your deductible and to which types of services the deductible applies.

The dental services included in the Dental Component Benefit under the Plan are listed in this Summary under "Description of Covered Services" and are described by classes of service. After an eligible person satisfies the plan benefit year deductible, if any, the Plan will pay a percentage of the lesser of the dentist's submitted fee or the maximum allowable amount. The Plan's percentage payment will be based on the class of dental service provided and the participation status of the dentist providing covered treatment—a Delta Dental PPO Participating Dentist, a Delta Dental Premier Participating Dentist, or a Nonparticipating Dentist (Out-of-Network)—as indicated next to each class of service. *Note: Some benefits are subject to limitations, e.g. age of patient, frequency of procedure, etc., or excluded in some instances. Please review "LIMITATIONS" and "EXCLUSIONS" below.*

Maximum Benefit Payments

The maximum benefit payable for combined Classes I, II, and III covered dental services rendered to an eligible person during the benefit year shall be Two Thousand Dollars ($2,000)The maximum lifetime benefit payable for covered Class IV services rendered to an eligible person shall be Two Thousand Dollars ($2,000). *Note: Benefits paid by the Plan for covered oral evaluations and routine prophylaxis rendered to an eligible person during the benefit year will not reduce such person's maximum benefit for combined Class I, Class II, and Class III covered dental services.*

Deductible

Fifty Dollars ($50) per person per benefit year. Note: The maximum family deductible is three (3) individual deductibles per benefit year. *Note: Deductible is not applicable to Class I or Class IV Services. A separate Fifty Dollar ($50) lifetime deductible applies to Class IV Services rendered to an eligible person.*

Benefit Period

January 1 – December 31 each year

Description of Covered Services (In Area)

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for Covered Services described in the Covered Dental Services section in the amounts as specified in this Schedule of Benefits.

Percentage of Covered Services

	ALLOWABLE CHARGE*		
	PPO Network	**Premier Network**	**Out-of-Network**
Class I Services—Diagnostic and Preventive	100%	90%	90%
Class II Services—Basic	80%	70%	70%
Class III Services—Major Restorative	50%	40%	40%
Class IV Services—Orthodontic**	50%	40%	40%

Payment of the percentages above is subject to any applicable Deductible and Maximum Benefit Payment limitation. Out-of-Network benefits are based on the maximum allowable amount for Delta Dental Premier participating dentists.

** Orthodontic services are available to the Eligible Employee and his or her eligible Dependents.

Note: The Allowable Charge for a Covered Service may be less if treatment is provided by a Nonparticipating Dentist. To prevent unexpected out-of-pocket expenses, Predetermination of Benefits is strongly encouraged, particularly if the cost of treatment is to exceed $250.

Deductible

Class I Services	None
Class II Services	$50 Per Covered Person Per Benefit Period*
Class III Services	$50 Per Covered Person Per Benefit Period*
Class IV Services	$50 Per Covered Person Per Lifetime

*The $50 deductible may be met in Class II Services or Class III Services, or any combination of Class II and Class III services. The maximum deductible per family per benefit period shall not exceed $150.

Maximum Benefit Payments

Class I, Class II, and Class III Services Combined	$2,000Per Covered Person Per Benefit Period
Class IV Services	$2,000Per Covered Person Per Lifetime

Note: Benefits payable by the Plan for covered oral evaluations (examinations) and routine prophylaxis (cleaning) will not reduce the maximum benefit per person during the benefit year for combined Class I, Class II, and Class III covered dental services.

Description of Covered Services (Out-of-Area)

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for Covered Services described in the Covered Dental Services section in the amounts as specified in this Schedule of Benefits.

Percentage of Covered Services

	ALLOWABLE CHARGE*		
	PPO Network	**Premier Network**	**Out-of-Network**
Class I Services—Diagnostic and Preventive	100%	100%	100%
Class II Services—Basic	80%	80%	80%
Class III Services—Major Restorative	50%	50%	50%
Class IV Services—Orthodontic**	50%	50%	50%

Payment of the percentages above is subject to any applicable Deductible and Maximum Benefit Payment limitation. Out-of-Network benefits are based on the submitted fee.

** Orthodontic services are available to the Eligible Employee and his or her eligible Dependents.

Note: The Allowable Charge for a Covered Service may be less if treatment is provided by a Nonparticipating Dentist. To prevent unexpected out-of-pocket expenses, Predetermination of Benefits is strongly encouraged, particularly if the cost of treatment is to exceed $250.

Deductible

Class I Services	None
Class II Services	$50 Per Covered Person Per Benefit Period*
Class III Services	$50 Per Covered Person Per Benefit Period*
Class IV Services	$50 Per Covered Person Per Lifetime

*The $50 deductible may be met in Class II Services or Class III Services, or any combination of Class II and Class III services. The maximum deductible per family per benefit period shall not exceed $150.

Maximum Benefit Payments

Class I, Class II, and Class III Services Combined	$2,000 Per Covered Person Per Benefit Period
Class IV Services	$2,000 Per Covered Person Per Lifetime

Note: Benefits payable by the Plan for covered oral evaluations (examinations) and routine prophylaxis (cleaning) will not reduce the maximum benefit per person during the benefit year for combined Class I, Class II, and Class III covered dental services.

Covered Dental Services

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for the following Covered Services in the amounts specified in the Schedule of Benefits.

Class I Services

Diagnostic Services: Procedures performed by properly licensed Dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such covered services include: Oral evaluations (examinations), radiographic images (x-rays), and palliative treatment of dental pain.

Preventive Services: Procedures performed by properly licensed dentists to prevent the occurrence of dental disease. By way of description, such covered services include: Routine prophylaxis (cleaning) and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation; and topical application of fluoride and space maintainers for eligible Dependent children.

Class II Services

Preventive Services: Limited sealants for eligible Dependent children.

Basic Restorative Services: Procedures performed by properly licensed Dentists in the treatment of carious lesions (decay/cavity). By way of description, such services include: Amalgam and composite restorations (fillings); and stainless steel restorations (crowns) for eligible Dependent children.

Oral Surgery Services: Procedures performed by properly licensed Dentists for extractions and other oral surgery, including preoperative and postoperative care.

Endodontic Services: Procedures performed by properly licensed Dentists for the treatment of nonvital teeth. By way of description, such services include: Pulpal therapy and root canal filling.

Periodontic Services: Procedures performed by properly licensed Dentists for the treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance procedures following active therapy. *Note: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation is payable as a Class I covered dental service.*

Adjunctive General Services: Such services include inhalation of nitrous oxide, and occlusal guards.

Class III Services

Major Services: Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. *Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or composite restoration.*

Prosthodontic Services: Procedures for construction of fixed partial dentures (bridges), removable partial dentures, complete dentures, and/or adjustment or repair of an existing prosthodontic device.

Implant Services: Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics.

Class IV Services

Orthodontic Services: The necessary treatment and procedures required for the correction of malposed teeth. Such treatment may consist of Interceptive Therapy, Comprehensive Therapy, Post-treatment Supervision, and Functional/Myofunctional Therapy when in conjunction with full-banded Comprehensive Therapy and when performed by the same dentist.

Limitations and Exclusions

Limitations

The Benefits to be provided to Covered Persons under the Plan shall be limited as follows:

To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed or rendered by your dentist does not make it dentally necessary or eligible under this plan.

For purposes of the Plan, any procedure frequency limitation shall be measured in a period of continuous calendar-year months referred to as a consecutive-month period, which begins on the date of service for which the procedure was last paid.

Prophylaxis (cleanings) is a benefit twice in a twelve (12) consecutive month period. *Note: Cleanings/prophylaxis of any type, including periodontal maintenance and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation, is limited to any combination of two in a twelve (12) consecutive month period.*

Oral evaluation is a benefit twice in a twelve (12) consecutive month period.

Limited (emergency) oral evaluation is a benefit twice in a twelve (12) consecutive month period. *Note: Benefits for limited (emergency) oral evaluation may be disallowed if other services are performed on the same day.*

Bitewing radiographic images are a benefit once in a twelve (12) consecutive month period. *Note: Benefits may be limited if multiple same-day radiographic images are provided on the same day by the same dentist/dental office.*

Full-mouth radiographic images, a panoramic radiographic image, or multiple same-day radiographic images is a benefit once in a sixty (60) consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury.

Assessment of salivary flow by measurement is a benefit once in any thirty-six (36) consecutive month period.

Topical application of fluoride solutions is a benefit for patients through age eighteen (18), and once in a twelve (12) consecutive month period.

A space maintainer is a benefit for missing primary posterior teeth for persons through age fifteen (15), and not for orthodontic purposes.

Re-cement or re-bond of a space maintainer is a benefit once per space maintainer, per arch.

Removal of a fixed space maintainer is a benefit once per fixed space maintainer, per arch.

Sealants are a benefit for persons through age fifteen (15), limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a sixty (60) consecutive month period.

Stainless steel crowns are a benefit for persons through age eleven (11), and once per tooth in an eighty-four (84) consecutive month period.

General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical condition. Otherwise, the fee for general anesthesia/IV sedation is denied. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed dentist.

Inhalation of nitrous oxide is a benefit with any covered dental service.

Payment is made for a single tooth surface repair once in a twenty-four (24) consecutive month period regardless of the number of combinations of restorations placed therein.

Root canal therapy is a benefit once per tooth in a thirty-six (36) consecutive month period.

Prosthodontics:

An upper or lower denture is a payable benefit once per arch in a sixty (60) consecutive month period.

A removable partial denture or fixed partial denture (bridge) may not be provided under the Plan for any one patient more often than once per arch in a sixty (60) consecutive month period, except where the loss of additional teeth requires the construction of a new appliance.

Reline (process of resurfacing the tissue side of a denture with new base material) and rebase (process of refitting a denture by replacing the base material) is a benefit once in any thirty-six (36) consecutive month period for any one appliance.

Fixed partial dentures (bridges) and removable partial dentures are benefits for persons age sixteen (16) and over.

Pontic is a benefit once per tooth in any sixty (60) consecutive month period for persons sixteen (16) years of age or older.

Retainer crown is a benefit once per tooth in any sixty (60) consecutive month period for persons sixteen (16) years of age or older.

Implant Benefits: The implant and the associated crown over the implant are a benefit for persons sixteen (16) years of age and over, limited to once in an eighty-four (84) consecutive month period. Implant supported retainer, abutment supported retainer, and abutment supported crown are a

benefit for persons sixteen (16) years of age and over, limited to once in a sixty (60) consecutive month period. Some implant procedures or procedures associated with implants are not covered services under the plan and no benefits will accrue or be payable for those excluded procedures.

Single crowns/onlays/veneers are benefits for persons age twelve (12) and over, once in an eighty-four (84) consecutive month period.

Comprehensive Orthodontic Benefits:

Benefits are available to the Eligible Person and the Eligible Person's eligible Dependents.

Treatment must be provided by a licensed dentist.

Benefits are limited to traditional methods; If non-traditional methods are utilized, the patient is responsible for the difference between the non-traditional method charge and the approved amount for the traditional method.

Benefits for comprehensive orthodontic treatment are limited to periodic payments.

The obligation of the Plan to make periodic payments for covered orthodontic services shall cease on the day on which patient receiving comprehensive orthodontic treatment becomes ineligible for coverage under this Plan; treatment is terminated for any reason before completion of the treatment plan, including but not limited to termination of the treatment plan by the dentist; treatment is completed; the maximum orthodontic benefit has been paid; orthodontic benefits are discontinued as a benefit under the Plan; or Plan Agreement is terminated, whichever occurs first.

Limited Orthodontic Benefits:

Benefits are available to the Eligible Person and the Eligible Person's eligible Dependents.

Limited orthodontic treatment must begin on or after the eligible person's effective date of orthodontic coverage under this Plan.

Treatment must be provided by a licensed dentist.

Benefits are limited to traditional methods; If non-traditional methods are utilized, the patient is responsible for the difference between the non-traditional method charge and the approved amount for the traditional method.

Limited orthodontic benefits are limited to a one-time payment.

The obligation of the Plan to make payment for covered limited orthodontic treatment shall cease on the day on which patient receiving limited orthodontic treatment becomes ineligible for coverage under this Plan; the maximum orthodontic benefit has been paid; orthodontic benefits are discontinued as a benefit under the Plan; or the Plan Agreement is terminated, whichever occurs first.

Alternate Benefits/Optional Treatment: The Plan may consider alternate dental services that are suitable for care of a specific condition if those alternate services will produce a professionally acceptable result, as determined by DDPOK. If patient and dentist elect other treatment, patient will be responsible for any charges in excess of the Plan's payment.

The Plan's obligation to provide benefits for covered dental services terminates on the date on which the patient becomes ineligible for benefits under the Plan.

Termination of care due to death will be paid in full, to the limit of the Plan's liability, for services completed or in progress.

When services in progress are interrupted and completed later by another dentist, DDPOK will review the claim to determine the payment to each dentist.

Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.

Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of major medical or comprehensive medical expense benefits plan must first be submitted for payment to the medical carrier. The Plan may benefit as the secondary carrier.

Exclusions

The following shall be excluded from the benefits and services to be provided to Covered Persons under the Plan:

Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.

Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.

Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.

Benefits for services or appliances started prior to the date the patient became eligible under the Plan may be excluded.

Benefits for services when a claim is received for payment more than twelve (12) months after the date of service.

Charges for any professional services performed by a relative of the patient.

Charges for treatment by other than a properly licensed dentist (unless allowed by state law), except radiographic images (x-rays) ordered by a dentist, cleaning and scaling of teeth, and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.

Charges for completion of forms or submission of documentation required by DDPOK for a benefit determination. Such charges are not billable to the patient when services are provided by a Delta Dental Participating Dentist, and the patient cannot be charged by the participating dentist. Such charges are denied if submitted by a nonparticipating dentist and may be charged to the patient by a nonparticipating dentist.

Charges for house calls, hospital calls, or office visits.

Charges for missed or cancelled appointments, hospitalization or additional fees charged for hospital treatment.

Charges for bleaching of teeth.

Charges for placement of intra-socket biological dressing to aid in hemostasis or clot stabilization. Such procedure is considered part of the extraction and/or post-operative procedure and a separate fee is not billable to the patient when procedure is provided by a Delta Dental Participating Dentist. Charges are denied if submitted by a nonparticipating dentist and may be charged to the patient by a nonparticipating dentist.

Prescription drugs, pre-medications, and relative analgesia.

Experimental procedures.

Benefits or services for orthodontic treatment, except as specifically provided within this Summary.

Charges for repair of an orthodontic appliance.

Charges for replacement of lost or missing crowns or appliances, or for replacement of stolen appliances.

Benefits or services to correct congenital or developmental malformations, including, but not limited to, congenitally-missing teeth and cleft palate.

Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).

Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.

Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).

All other benefits and services not specified in this Dental Wrap Plan or by the Plan Administrator, including but not limited to the specific excluded procedure codes (CDT) listed in Exhibit 1.

SECTION 4: CLAIMS PROCEDURES

Delta Dental Networks of Participating Dentists

You may visit the properly licensed dentist of your choice, because your plan provides for in-network as well as limited out-of-network benefit coverage. However, Delta Dental Plan of Oklahoma uses two nationwide networks of dentists—the Delta Dental Premier network and the Delta Dental PPO network—through Delta Dental Plan of Oklahoma's membership in a nationwide system known as Delta Dental Plans Association. These networks are among the largest in the dental benefits industry, both locally and nationwide, providing you easy access to participating dentists in most geographical areas.

Delta Dental Plans have unique "participating agreements" with those dentists in the networks described above. In most cases, these agreements mean you simply present your identification card to the dentist at the time of treatment and he or she will file your claim for you. Delta Dental Plan of Oklahoma will pay the participating dentist direct for any covered services.

Benefit Payment Procedure for Participating Dentists

Under the Delta Dental Plans participating agreements with participating dentists, 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 in accordance with the Participating Agreement applicable to the plan. Participating dentists accept the maximum allowable amount as payment in full.

If a Delta Dental PPO Participating Dentist provides treatment, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental PPO Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

If treatment is provided by a Delta Dental Premier Participating Dentist, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental Premier Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

For a list of Delta Dental Participating Dentists, you may contact DDPOK at 405-607-2100 or toll-free at 800-522-0188. You may also obtain a customized list of Participating Dentists within your geographic area or nationwide by searching the internet at www.DeltaDentalOK.org.

Nonparticipating Dentists: Out-of-Network Services

If you obtain treatment from a dentist who has not signed a participating agreement with Delta Dental, 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 for filing your own claim.

Employee-Filed Claims

When you must file a Dental Component Benefit claim yourself, you may obtain claim forms from ONEOK HR Solutions, the Claims Administrator or the ONEOK, Inc. portal; **www.oneokonline.com** > Employee Resources > Benefits > Dental > Forms.

Emergency Care and Claim Predetermination

If you require emergency care, there is no preauthorization requirement. If the cost of the dental care you need is less than $250, your participating dentist will probably proceed with treatment. If the cost estimate is more than $250 and the treatment is not emergency care, your dentist can determine the treatment needed and submit a treatment plan to DDPOK for predetermination of benefits. This procedure will enable you and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by your dental component benefit, and how much of the cost you will be responsible for paying.

This plan does not require any preauthorization for any dental services; however, said services are subject to the plan's specific limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over your plan maximum.

Note: Please keep in mind, the Predetermination of Benefits is only an estimate and not a guarantee of payment. The patient must be eligible for Benefits at the time services are actually rendered, and the procedure must be a Covered Service on the date of service.

Eligibility and Cost of Coverage Claims

Either you or your authorized representative may file a claim regarding eligibility for coverage under the Component Dental Benefit or cost of coverage with the Plan with HR Solutions. If the claim is denied, you will receive a written notice 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.

Claim Filing

You or someone in the dental office must complete the information portion of the claim form with the Covered Person's full name, the Employee's ONEOK OKE identification number, the name and date of birth of the person receiving dental care, and the group name and number.

If you have any questions about the plan, please check with HR Solutions or contact Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154-1709. You may also contact Delta Dental Plan of Oklahoma by email at CustomerService@DeltaDentalOK.org. All correspondence with DDPOK should include the group name and group number; the Employee's ONEOK OKE identification number, telephone number, and address; name of patient; and date of service. Once treatment is completed, the participating dentist will submit the claim form to Delta Dental Plan of Oklahoma for payment. Participants and beneficiaries can obtain, without charge, the necessary claim filing forms from DDPOK.

It is important that all information requested on the claim form be given; otherwise, the claim form may be returned to you for additional information, which will delay payment. A separate claim form must be filled out for each Covered Person along with that person's expenses. A separate claim form must accompany each group of statements (if filed at different times). Cancelled checks, cash register receipts, personal itemizations, and statements that show only the balance due are not acceptable. When you file claims, be sure to keep copies of all bills and receipts for your own personal records. The Claims Administrator may request additional information needed in connection with the processing of your claim.

Direct Claims Line

The Claims Administrator has a special toll-free number for your inquiries. You may call Delta Dental of Oklahoma at (800) 522-0188 between 7:30 a.m. and 5:00 p.m., CT, Monday through Friday.

Claim Filing Deadline

The Plan is not obligated to pay any claim submitted later than 12 months following the date of service. *WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony*.

Benefit Determination: Explanation of Benefits

Anytime you or a dentist file a claim, you will receive a form called an Explanation of Benefits (EOB) from Delta Dental Plan of Oklahoma 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, as well as in this Summary Plan Description. *Note: If the "Patient Pays" amount on an EOB is $0.00, the EOB will not be mailed to you unless DDPOK is requesting additional information to finalize the claim. A copy of any of your applicable EOBs may be obtained from DDPOK's online system.*

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 Component Dental 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 Component Dental Benefit 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.

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 Component Dental Benefit, you have a right to appeal that determination. The procedure for appealing an Adverse Benefit Determination, and time within which you can appeal, is set forth below in the section entitled, APPEAL PROCEDURES.

Designating an Authorized Representative

The Plan has established procedures for you to designate an individual to act on your behalf ("Authorized Representative") with respect to a Dental Benefit claim or an appeal of an Adverse Benefit Determination. Contact HR Solutions for help if you wish to designate an Authorized Representative.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) personal representative form for the Claims Administrator is available on www.oneokonline.com > Employee Resources > Benefits > Dental > Health Insurance Portability and Accountability Act (HIPAA) >
Delta Dental HIPAA Authorization Form.

You may print the form and mail or fax it to the Claims Administrator. You may also be required to complete a ONEOK HIPAA authorization form.

SECTION 5: 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)
Or
Appeals@DeltaDentalOK.org (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 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 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)
Or
Appeals@DeltaDentalOK.org (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, Human Resources
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 Appeals

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 Benefit Plan Administration Committee (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.

SECTION 6: GENERAL PROVISIONS

No Assignment of Benefits

Services to eligible persons are for the personal benefit of such persons and cannot be transferred or assigned. Any attempt to do so shall automatically terminate all rights of the eligible person, except in those states where assignment is required by law.

Determination of Benefits and Utilization Review

The Plan Administrator has delegated discretionary authority to the Claims Administrator to interpret the terms and conditions of the Plan and to determine its Dental Benefits. Such determination by the Claims Administrator as to whether dental health care services you receive are eligible for Dental Benefits under the Plan may be made by a panel of Dentists appointed by the Claims Administrator at its election. *The fact that a Dentist or other Provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it Medically Necessary or a Covered Service, even if it is not specifically listed as an exclusion under the Plan*.

To assist the Claims Administrator in its review of your claims, the Claims Administrator may request that:

You arrange for dental records to be provided to the Claims Administrator; and/or

You submit to a professional evaluation by a Dentist selected by the Claims Administrator, at the Dental Plan's expense; and/or

A Dentist consultant or panel of Dentists or other Providers appointed by the Claims Administrator review the claim.

Failure of the Covered Person to comply with the request for dental records or dental evaluation may result in Benefits being partially or wholly denied.

To determine how the terms of this Summary Plan Description shall be applied and implemented, DDPOK may, without the consent of or notice to any eligible person, release to or obtain from any insurance company, group hospitalization plan, or dental care plan any information with respect to payments or benefits which it deems to be necessary for such purposes.

Any eligible person claiming benefits under this plan shall furnish DDPOK such information as may be necessary to implement this provision.

Coordination with other Dental Plans – Coordination of Benefits (COB)

If coverage is provided to a person under two (2) or more dental care plans, Coordination of Benefits (COB) rules are applied by Component Dental Benefit. The COB rules are provided in the Plan so that the total amount payable for you or a dependent does not exceed the amount that would be paid under the Component Dental Benefit paying the larger benefit. If a dental plan is considered "primary" under COB provisions, it will be deemed to pay benefits before another dental plan that is considered "secondary" under COB. If the Component Dental Benefit is considered the secondary plan and another plan is considered primary, the primary plan will pay its Benefits first. Under non-duplication of benefits, as the secondary payer, the Component Dental Benefit will not reimburse more than it would have paid if it had been the primary payer.

This means that if the primary plan paid claims in amounts equal to or greater than what the secondary plan would pay on its own, no benefit will be payable by the secondary plan. Therefore, if both primary and secondary dental plans have the same benefit plan design and structure there will be no benefit to having and paying for dual dental coverage.

For purposes of the COB rules of the Component Dental Benefit, the term “dental plan” means an employee benefit plan sponsored by an employer that provides for payment for dental care of eligible employees and dependents.

Determining Which Dental Plan is Primary

If you are covered by two (2) or more dental plans, the Benefit payment follows the rules below in this order:

The Component Dental Benefit will always be secondary to dental payment coverage or personal Injury protection coverage under any auto liability or no-fault insurance policy;

When you have coverage under two (2) or more dental plans and only one (1) has COB provisions, the dental plan without COB provisions will pay benefits first;

A dental plan that covers a person as an employee pays benefits before a dental plan that covers the person as a dependent;

If you are receiving COBRA Continuation Coverage under another dental plan, the Component Dental Benefit will pay benefits first;

Your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the dental plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- The parents are married or living together whether or not they have ever been married and not legally separated; or

- A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage;

If two (2) or more dental plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for dental care, the child will be covered under the dental plan of:

- The parent with custody of the child; then
- The Spouse/Domestic Partner of the parent with custody of the child; then
- The parent not having custody of the child; then
- The Spouse/Domestic Partner of the parent not having custody of the child;

Dental plans for active Employees pay before dental plans covering laid-off or retired employees;

The dental plan that has covered the individual claimant the longest will pay first; only expenses normally paid by the Dental Plan will be paid under COB; the expenses must be covered in part under at least one (1) of the plans; and

Finally, if none of the above rules determines which dental plan is primary or secondary, the Eligible Expenses shall be shared equally between the plans meeting the definition of the Plan. In addition, the Plan will not pay more than it would have paid had it been the primary dental plan.

The following examples illustrate how the Component Dental Benefit determines which dental plan pays first and which dental plan pays second.

Determining Primary and Secondary Dental Plan Examples

You and your Spouse or Domestic Partner both have family dental coverage through your respective employers. You are not well and go to see a Dentist. Since you are covered as an Employee under the Component Dental Benefit, and as a Dependent under your Spouse's or Domestic Partner's dental plan, the Component Dental Benefit will pay Benefits for the Dentist's visit first.

In another example, you and your Spouse or Domestic Partner both have family dental coverage through your respective employers. You take your Dependent child to see a Dentist. The Component Dental Benefit will look at your birthday and your Spouse's or Domestic Partner's birthday to determine which dental plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's or Domestic Partner's dental plan will pay first, and the Dental Component Benefit will pay second.

When the Dental Component Benefit is Secondary

If the Dental Component Benefit is the secondary plan, it determines the amount it will pay for a Covered Dental Service by following the steps below:

- The Dental Component Benefit determines the amount it would have paid based on the primary dental plan's Eligible Expense.
- If the Dental Component Benefit would have paid less than the primary dental plan paid, the Dental Component Benefit pays no Benefits.
- If the Dental Component Benefit would have paid more than the primary dental plan paid, the Dental Component Benefit will pay the difference.

The Dental Component Benefit will only pay on claims that are of lesser value or not paid by the primary dental plan at all. *The maximum combined payment you can receive from all dental plans may be less than 100% of the total Eligible Expense. See the "Glossary" for* the definition of *"Eligible Expenses."*

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these Coordination of Benefits (COB) rules and to determine Benefits payable under the Dental Component Benefit and other dental plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under the Dental Component Benefit and other dental plans covering the person claiming Benefits. The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming Benefits under the Dental Component Benefit must give the Claims Administrator any facts needed to apply those rules and determine Benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Help and Online Information

If you have questions concerning your Enrollment, participation or Benefits, call HR Solutions at 855-ONEOKHR and/or 855-663-6547.

Once you are enrolled, you can find helpful information about the Component Dental Benefit and your participation if you log onto:

www.oneokonline.com > Employee Resources > Benefits > Dental OR www.deltadentalok.org

SECTION 7: GLOSSARY

This section defines terms that have special meanings under the Summary of Dental Benefits. Terms not defined below shall have the meaning set forth in the Plan.

Adverse Benefit Determination - A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for Dental Benefits, including, but not limited to, any such action based on a determination of a person's eligibility to participate in the Dental Component Benefit, 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.

Annual Open Enrollment Period -The annual period of time during which current Eligible Employees may Enroll in the Dental Component Benefit or change their coverage elections for the following Plan 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.

Authorized Representative - A person duly authorized by a Covered Person to act on behalf of the Covered Person with respect to a claim or appeal.

Benefit(s) - The payment, reimbursement, and indemnification of any kind for dental care that you will receive from and through the Dental Component Benefit.

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

Benefit Period - The period of time during which you, your Spouse/Domestic Partner and/or Dependent(s) receive Covered Services paid for by the Dental Component Benefit. A Dental Benefit Period begins when a newly Eligible Employee Enrolls in the Dental Component Benefit. For a current Eligible Employee, the Dental Benefit Period is generally the Calendar Year, but may be shorter if a current Eligible Employee Enrolls or changes his election during a Calendar Year due to a Change in Status Event.

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

Calendar Year - The period of 12 months commencing on the first day of January and ending on the last day of the following December.

Change in Status Event - A change in status event specified under the Cafeteria 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 received within 30 days except in the case of birth and/or adoption which notification must be received within 90 days. For loss of, or eligibility for, Medicaid or State Children's Health Insurance Program (SCHIP)/Children's Health Insurance Program (CHIP) coverage, the notification must be received within sixty (60) days.

Claims Administrator - The person or organization appointed or designated by the Plan Administrator to process claims.

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

Coverage Tier - The level of coverage that may be elected by Covered Persons under the Dental Component Benefit.

Covered Service - A customary and necessary service or supply as defined in the Dental Component Benefit and given by a Provider for which the Dental Component Benefit will provide Dental Benefits.

Deductible - A specified amount of the cost of Covered Services that you must Incur before the Dental Component Benefit will start to pay its share of the remaining Covered Services.

Denied – If the fee for a procedure or service is denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The submitted amount is not payable by the Planl, but is collectable from the patient.

Dental Benefit(s) - The payment, reimbursement, and indemnification of any kind for dental care that you will receive from and through the Dental Component Benefit.

Dental Benefit Option - An amount and type of Dental Benefit coverage elected by a Covered Person from the optional coverage plans or programs provided under the Schedule of Benefits of the Plan and this Summary Plan Description.

Dentist - A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Dependent – (i) your spouse; (ii) natural child, stepchild, legally adopted child, or eligible foster child who has not reached age 26; or (iii) your federal tax dependent under the Code, including a relative child for whom you have legal guardianship who has not reached age 19 or is a full-time student who has not reached age 24.

Eligible Employee – All full-time, salaried and hourly Employees of ONEOK, Inc. (and its affiliates and subsidiaries) who are regularly scheduled to work twenty (20) hours or more per week ("Eligible Employees") and have completed the Employment Waiting Period. For this purpose, "full-time" means. Employees who are members of a collective bargaining unit and nonresident aliens who do not receive U.S. source income are not Eligible Employees.

Eligible Expenses - Those expenses that are part of a treatment plan and included in the Covered Services section of the Plan. The Eligible Expense is either the negotiated fees or the Reasonable and Customary Charges Incurred for dental services and supplies provided by any licensed Dentist practicing within the scope of his/her profession.

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 Dental Component Benefit.

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

Employment Waiting Period - A newly Eligible Employee (i.e., a new hire or someone who transitions to an eligible employment status) is eligible for participation in the Dental Component Benefit, effective the date his or her employment starts. ***Exception:*** *A newly Eligible Employee hired December 2 through December 31 of any calendar year is eligible for participation in the Dental Component Benefit effective January 1 of the calendar year immediately following the date his or her employment starts.*

Enrollment (or Enroll) - To become covered for Dental Benefits under the Plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required to Enroll for coverage.

Experimental or Investigational - For benefit options where Delta Dental is the Claims Administrator: A procedure or service that does not meet generally accepted standards of dental practice in the United States as determined by the Claims Administrator.

Identification Card - The Identification Card that is provided to a Covered Person by the Dental Component Benefit for use in obtaining Covered Services in accordance with the Dental Component Benefit.

Incur(red) - A charge is incurred on the date you receive a service or supply for which the charge is made.

Medical Necessity or Medically Necessary - For benefit options where Delta Dental is the Claims Administrator: A dental service or supply given by a licensed Dentist that the Claims Administrator determines is appropriate and necessary as determined by the standards of generally accepted dental practice and the Claims Administrator.

Network Provider - A Dentist or other Provider of dental services, who has entered into an agreement with the Claims Administrator at a discounted rate.

Not billable to the patient – If the fee for a procedure or service is not billable to the patient, it is not benefited by the Plan nor collectable from the patient by a Delta Dental Participating Dentist.

Open Enrollment Period - The period of time during which current Eligible Employees may Enroll in the Dental Component Benefit or change their coverage elections for the following Plan Year.

Out-of-Network Provider - A Dentist or other Provider of dental services that has not entered into an agreement with the Claims Administrator to be a Network Provider.

Participant - An Eligible Employee who participates in the Dental Component Benefit.

Placement for Adoption (or Placed for Adoption) - The assumption and retention of an obligation by Court Order of a court of competent jurisdiction for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan or "The Plan" - The Welfare Benefits Wraparound Plan and SPD.

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

Predetermination - Determination from the Claims Administrator before the services are rendered that, based upon the information presented by the Covered Person or his/her Provider at the time Predetermination is requested; the proposed treatment meets the Plan's guidelines for Medical Necessity.

Predetermination does not guarantee that the care and services a Covered Person receives are eligible for Dental Benefits under the Dental Component Benefit. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Plan.

Preventive Service(s) - Preventive dental care services covered by the Plan as described in the COVERED SERVICES section of the Plan.

Provider - A Dentist or other practitioner or Provider of dental services or supplies licensed to render Covered Services and performing within the scope of such license.

Reasonable and Customary Charges - The amounts which the Claims Administrator determines, in its sole discretion, should be paid for any service, which may (but do not have to be) based on the

prevailing charge for a Covered Service or supply made by providers of a similar expertise in a particular geographic area.

Welfare Benefits Wraparound Plan and SPD – The ONEOK, Inc. Welfare Benefits Wraparound Plan and SPD consolidates consistent language for ONEOK, Inc. component welfare benefits into a single plan. This document supplements applicable insurance policies and certificates to provide information about ONEOK, Inc.'s component benefits to comply with ERISA.

EXHIBIT 1

Note: Some excluded procedure codes listed below are preceded by one or more asterisks. Following is a brief explanation of what the asterisk(s) preceding an excluded code means:

> **** Indicates an orthodontic procedure. Orthodontic services will be allowed if the plan stipulates orthodontic coverage.***
>
> ***** Indicates the fee for the procedure or service is not billable to the patient, which means it is not benefited by the plan, nor is the charge collectable from the patient if the service is provided by a Delta Dental Participating Dentist.***
>
> ****** Indicates the procedure is not billable to the patient when submitted by a Delta Dental Participating Dentist for periodontal probing and/or laser disinfection (laser charges) in conjunction with other services. The procedure may be denied when submitted for other miscellaneous periodontal procedures or as a stand-alone procedure.***

Excluded Procedure Code	Description of Excluded Procedures
D0171	Re-evaluation-post operative office visit
D0190/D0191	Screening of a patient/Assessment of a patient
D0250/D0251	Extra-oral radiographic images
D0310	Sialography
D0320-D0322	TMJ radiographic images and tomographic survey
*D0340/D0350	Cephalometric radiographic image/2D oral-facial photographic images
D0364-D0368	Cone beam CT - image capture and interpretation
D0369	Maxillofacial MRI capture and interpretation
D0370	Maxillofacial ultrasound capture and interpretation
D0371	Sialoendoscopy capture and interpretation
D0372-D0374	Intraoral tomosynthesis radiographic images
D0380-D0384	Cone beam CT
D0385	Maxillofacial MRI image capture
D0386	Maxillofacial ultrasound image capture
**D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – capture only
**D0388	Intraoral tomosynthesis – bitewing radiographic image – capture only
**D0389	Intraoral tomosynthesis – periapical radiographic image – capture only
D0391	Interpretation of diagnostic image by practitioner not associated with capture of the image, including report
D0393-D0395	Post processing of image or image sets
**D0396	3D printing of a 3D dental surface scan
D0411	HbA1c In-office point of service testing
D0412	Blood glucose level test – in office using a glucose meter
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report
D0415/D0416	Bacteriologic studies/Viral culture
D0417/D0418	Collection and preparation of saliva sample for laboratory diagnostic testing/Analysis of saliva sample
D0422	Collection and preparation of genetic sample material for laboratory analysis and report
D0423/D0425	Genetic test for susceptibility to diseases–specimen analysis/Caries susceptibility test
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities
*D0470	Diagnostic cast
**D0472-D0474	Accession of tissue

**D0475-D0479	Oral pathology tests and examinations
**D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
**D0481-D0483	Oral pathology laboratory procedures
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source
**D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report
D0502	Oral pathology procedures
**D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum
D0604-D0606	Testing for a public health related pathogen, including coronavirus
**D0701	Panoramic radiographic image – image capture only
**D0702	2-D cephalometric radiographic image – image capture only
**D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
**D0705	Extra-oral posterior dental radiographic image – image capture only
**D0706	Intraoral – occlusal radiographic image – image capture only
**D0707	Intraoral – periapical radiographic image – image capture only
**D0708	Intraoral – bitewing radiographic image – image capture only
**D0709	Intraoral – complete series of radiographic images – image capture only
D0801/D0802	3D dental surface scan – direct/3D dental surface scan – indirect
D0803/D0804	3D facial surface scan – direct/3D facial surface scan – indirect
D1301	Immunization counseling
D0999	Unspecified diagnostic procedure
D1310	Nutritional counseling
D1320	Tobacco counseling regarding oral disease
D1321	Counseling for control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330	Oral hygiene instructions
D1355	Caries preventive medicament application – per tooth
D1701-D1714	COVID 19 vaccine administration
D1781-D1783	Vaccine administration – human papillomavirus
D1999	Unspecified preventive procedure, by report
D2410-D2430	Gold foil restorations
**D2949	Restorative foundation for an indirect restoration
**D2953	Each additional cast post-same tooth
**D2957	Each additional prefab post-same tooth
D2975	Coping
D2981	Inlay repair, necessitated by restorative material failure
**D2989	Excavation of a tooth resulting in a determination of non-restorability
D2990	Resin infiltration of incipient smooth surface lesions
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure
**D3110-D3120	Pulp caps
**D3331	Treatment of root canal obstruction
D3333	Internal root repair of perforation defects
D3355-D3357	Pulpal regeneration; does not include final restoration
D3428-D3429	Bone graft in conjunction with periradicular surgery
D3460	Endodontic endosseous implant
D3470	Intentional reimplantation
**D3910	Isolation of tooth with rubber dam
**D3911	Intraorifice barrier
D3921	Decoronation or submergence of an erupted tooth
**D3950	Canal preparation and fitting of post
D3999	Unspecified endodontic procedure
D4230-D4231	Anatomical crown exposure

**D4286	Removal of non-resorbable barrier
D4322-D4323	Splint – intra-coronal; natural teeth or prosthetic crowns/Splint – extra-coronal; natural teeth or prosthetic crowns
D4381	Localized delivery of antimicrobial agents via release vehicle into diseased crevicular tissue, per tooth
**D4920	Unscheduled dressing change
D4921	Gingival irrigation with medicinal agent – per quadrant
***D4999	Unspecified periodontal procedure
D5810-D5811	Interim complete dentures
D5862	Precision attachment, by report
D5867	Replacement of replaceable part of semi- precision or precision attachment, per attachment
D5876	Add metal substructure to acrylic full denture, per arc
D5899	Unspecified removable prosthodontic procedure, by report
D5911-D5999	Maxillofacial prosthetics
**D6011	Surgical access to an implant body (second stage implant surgery)
D6040-D6050	Implant services
D6051	Interim implant abutment placement
D6089	Accessing and retorquing loose implant screw – per screw
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6103	Bone graft for repair of periimplant defect
D6104	Bone graft at time of implant placement
D6118-D6119	Implant/abutment supported interim fixed denture for edentulous arch
D6190	Radiographic/surgical implant index, by report
**D6198	Remove interim implant component
D6199	Unspecified implant services
**D6253	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression
D6548	Retainer-porcelain/ceramic
D6600-D6607	Inlays
D6624	Inlay-titanium
**D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression
D6920/D6940	Connector bar/Stress breaker
D6950	Precision attachment
D6985	Pediatric partial denture, fixed
D6999	Unspecified fixed prosthodontic procedure
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth re-implantation and/or stabilization
D7272	Tooth transplantation
*D7280	Surgical exposure of unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
*D7283	Placement of device to facilitate eruption of impacted tooth
D7285-D7286	Incisional biopsy of oral tissue
D7287	Cytology sample collection
*D7290	Surgical repositioning of teeth
*D7291	Transseptal fiberotomy, by report
D7292-D7294	Placement of temporary anchorage device
D7295	Harvest of bone for use in autogenous grafting procedure
D7296-D7297	Corticotomy
D7298-D7300	Removal of temporary anchorage device
**D7310/D7311	Alveoloplasty in conjunction with extractions
D7320-D7321	Alveoloplasty not in conjunction with extractions
D7340-D7350	Vestibuloplasty
D7410-D7465	Surgical excision of soft tissue/intra-osseous lesions

D7471-D7490	Excision of bone tissue
D7509	Marsupialization of odontogenic cyst
**D7511	Incision and drainage of abscess-intraoral soft tissue-complicated
D7520-D7560	Surgical incision
D7610-D7780	Treatment of fractures
D7810-D7899	Reduction of dislocation & mgmt. of TMJ
**D7910	Suture of recent small wounds up to 5 cm
D7911-D7912	Complicated suturing
D7920-D7921	Other repair procedures
**D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7961-D7962	Other repair procedures
**D7963	Frenuloplasty
**D7970-D7971	Other repair procedures
D7972-D7999	Other repair procedures
*D8000-D8670	Orthodontic services
**D8680-D8681	Other orthodontic services
D8695	Removal of fixed orthodontic appliance(s) – other than at the conclusion of treatment
D8696-D8697	Repair of orthodontic appliance
**D8698-D8699	Re-cement or re-bond fixed retainer
**D8701-D8702	Repair of fixed retainer
*D8703-D8704	Replacement of lost or broken retainer
D8999	Unspecified orthodontic service
D9130	Temporomandibular joint dysfunction, non-invasive physical therapies
**D9210-D9215	Anesthesia
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia
D9248	Non-intravenous moderate (conscious) sedation
**D9311	Consultation with a medical health care professional
D9410-D9450	Professional visits
D9610-D9630	Drugs
D9910-D9911	Miscellaneous services
**D9912	Pre-visit patient screening
D9920-D9930	Miscellaneous services
D9932-D9935	Cleaning and inspection of dentures/partials
D9938-D9939	Fabrication of a custom removable clear plastic temporary aesthetic appliance / Placement of a custom removable clear plastic temporary esthetic appliance
D9947-D9943	Miscellaneous services
**D9990	Certified translation or sign language services, per visit
**D9991-D9992	Dental case management –addressing appointment compliance barriers/Dental case management – care coordination
D9993-D9994	Dental case management – motivational interviewing/patient education to improve oral health literacy
**D9995	Teledentistry – synchronous; real-time encounter
**D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
**D9997	Dental case management- patients with special health care needs
D9999	Miscellaneous service