ONEOK Former Employee Benefits Open Enrollment for 2025

Legal Notices

ONEOK Inc., Health Plan for Former Employees – Pre-65 PPO Plan

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Medicare Part D Creditable Coverage Notice

Important Notice from ONEOK, Inc. About Your Prescription Drug Coverage and Medicare

(For participants currently eligible for Medicare or those who may become eligible for Medicare) Please read this notice carefully and keep it where you can find it. This notice has information about the ONEOK, Inc. Health Plan for Former Employees' prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you and your dependents decide when you want to join a Medicare drug plan.

If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about ONEOK's coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. ONEOK, Inc. has determined the prescription drug coverage offered through your ONEOK Inc. Health Plan for Former Employees is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. **However, the ONEOK Inc. Health Plan for Former Employees is only available to participants who are <u>not</u> Medicare eligible. If you become Medicare eligible you cannot remain on this health plan or enrolled in this prescription drug coverage. Contact HR Solutions 855-663-6547 immediately if you or a dependent become Medicare eligible.**

When Can You Join a Medicare Prescription Drug Plan?
You or your dependents can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you or your dependents lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?
The ONEOK Inc. Health Plan for Former Employees is not available to participants who are Medicare eligible. If you become Medicare eligible you cannot remain on this health plan. If you or a dependent becomes Medicare eligible, you or your dependents will be eligible to join the ONEOK Inc. Retiree Reimbursement Account Plan for Former Employees which is not creditable coverage.

When Will You Pay a Higher Premium (penalty) to Join a Medicare Prescription Drug Plan?
You should also know if you drop or lose your current coverage through ONEOK, Inc. and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

If you or any dependents are Medicare eligible due to a disability or for any other reason than you turned 65, you must notify HR Solutions immediately. Your ONEOK, Inc. health coverage, as administered by UHC, ends on the day before you become Medicare eligible and a gap in coverage may cause penalties. Additionally, if you or a dependent become Medicare eligible and do not notify HR Solutions, you may be required to reimburse ONEOK for any claims paid in error.

For More Information About This Notice or Your Current Prescription Drug Coverage. Contact the ONEOK HR Solutions at the number listed below for further information.

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ONEOK, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Plans
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You may get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug Plans:

- Contact Via Benefits at 855-653-9836 or www.my.viabenefits.com/oneok our third party administrator for Medicare eligible former employees and their dependents.
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you or your dependents decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact Information
ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

Via Benefits - 855-653-9836
www.my.viabenefits.com/oneok

ONEOK, Inc. Group Health Plans Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE 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 health information. This Notice of Privacy Practices ("Notice") is intended to satisfy HIPAA's notice requirement with respect to all protected health information created, received, transmitted or maintained by the group health plans (the "plans") sponsored by ONEOK, Inc. (the "Company"). The plans are required to provide this Notice to you pursuant to HIPAA.

The HIPAA privacy rule protects only certain individually-identifiable medical information known as "protected health information" ("PHI"). Generally, 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 that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information. Note: Genetic information shall be treated as protected health information pursuant to HIPAA. The plans are not permitted to use or disclose PHI that is genetic information about an individual for underwriting purposes.

Plan Responsibilities

The plans are required by law to:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you this Notice of the plans' legal duties and privacy practices with respect to your PHI;
- Follow the terms of this Notice, as amended from time to time; and
- Notify you in the event of a breach of your unsecured PHI.

When using or disclosing PHI or when requesting PHI from another covered entity, the plans will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for compliance with the HIPAA privacy rule; and
- Uses or disclosures made pursuant to an authorization.

How the Plans May Use and Disclose Health Information about You

Although HIPAA generally requires the plans protect the confidentiality of your PHI, there are certain uses and disclosures by the plans allowed under HIPAA and applicable regulations. Those uses and disclosures are allowed in order to properly operate and administer the plans for your benefit according to their terms. The following categories describe the ways we may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and present some examples. Not every use or

disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose will fall within one of the categories:

- For Treatment. The plans 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 plans may advise an emergency room physician about the types of prescription drugs you currently take.
- For Payment. The plans 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 plans' terms. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- For Plan Operations. The plans may use and disclose your PHI to enable the plans to operate or operate more efficiently, or to make certain all of the plan participants receive their plan benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The plans may also combine information about many plan participants and disclose it to the Company in summary fashion so the Company can decide what coverage the plans should provide. The plans will remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning the identity of any specific participant. The amount of health information used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The plans are prohibited from using or disclosing PHI that contains genetic information about an individual for underwriting purposes.
- To the Company. The plans 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 ONEOK, Inc. Benefit Plans Administration Committee (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, Accounting, Finance 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 plans 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 plans sponsored by the Company.
- To a Business Associate. Certain services are provided to the plans by third parties known as business associates. For example, the plans may input information about your treatment into an electronic claims processing system maintained by a plan's business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function, but only after the business associate agrees in writing to contract terms that are designed to appropriately safeguard PHI. HIPAA and the plans require all business associates to safeguard your PHI.
- Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- Plan-Related Benefits and Services. The plans may use and disclose your PHI to tell you about your plan-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 and Personal Representatives. The plans 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 available to you in this enrollment packet or by contacting HR Solutions 855-663-6547. Uses and disclosures of your PHI not described in this Notice will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not withdraw or change any uses or disclosures already made by the plans in reliance on your prior authorization. A 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.

- Spouses and Other Family Members. With only limited exceptions, the plans will send all mail to the employee. This includes mail relating to a spouse/domestic partner and other dependents who are covered under the plans and includes mail with information on the use of plan benefits by the spouse/domestic partner and other dependents and information on the denial of any plan benefits to the spouse/domestic partner and other dependents. However, if a person covered under a plan has requested restrictions or confidential communications, and if we have agreed to the request, we will send mail as provided by the request for restrictions or confidential communications.
- As Required by Law. The plans 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 plans 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 plans 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 plans 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 plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and/or other similar programs.
- Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release health information about you as deemed necessary by military command authorities.
- To Avert Serious Threat to Health or Safety. The plans 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 plans 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 plans 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 plans 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 plans 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 plans may release health 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 plans 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 plans 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 plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

The plans will require the use or disclosure of your PHI under the following circumstance:

- Government Audits. The plans are 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.

- Disclosures to you. When you request, the plans are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI is not disclosed pursuant to your individual authorization.

Your Rights Regarding Your Own PHI - Your rights regarding the PHI the plans maintain about you are as follows:

- Right to Inspect and Copy. You have the right to inspect and copy your own PHI. This includes information about plan eligibility, claim and appeal records, and billing records. To inspect and copy your PHI maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your PHI that you request. In limited circumstances, the plans may deny your request to inspect and copy your PHI. If you are denied access to health information, you may request a review of the denial by submitting a written request to the Privacy Officer.
- Right to Amend. If you feel that PHI is incorrect or incomplete, you may ask the plans to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request, in writing, to the Privacy Officer. You must provide the reason(s) to support your request. A plan may deny your request if your request is not in writing or does not include a reason to support the request. In addition, we 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, unless the person or entity that created the information is no longer available to make the amendment; (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 the plans have made to others, except the accounting will not include (1) those necessary to carry out health care treatment, payment, operations, (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. 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 years prior to the date the accounting was requested and which may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you 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 plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask the plans not use or disclose information about a surgery. 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 plans' 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 the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask the plans 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 plans will take action needed to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have the right to request a paper copy of this Notice at any time by contacting the person(s) or office identified under Contact Information section of this Notice. If you receive this Notice on the plans' website or by electronic mail, you are also entitled to a paper copy of this Notice upon request.
- Right to Be Notified of a Breach. You have the right to be notified in the event the plans or a Business Associate discover a breach of your unsecured PHI.

Changes To This Notice

The plans reserve the right to change this Notice at any time and to make the revised or changed Notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The new notice will be provided to you electronically or by mail. The plans will maintain a copy of the current version of this Notice at all times. You have the right to a paper copy of this notice at any time; simply contact HR Solutions at 855-663-6547.

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 Office for Civil Rights of the U.S. Department of Health and Human Services, generally within 180 days of when the act or omission complained of occurred. 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:

ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871, Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

This notice is effective October 28, 2024.

COBRA General Notice

Important Information About Your COBRA Continuation Coverage Rights

Introduction
You are receiving this notice because you have coverage under the ONEOK, Inc. Health Plan for Former Employees (Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to ONEOK, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide written notice and a Family Change Form to: HR Solutions at 855-663-6547 or HRSolutions@oneok.com

ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

How is COBRA continuation coverage provided?
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 continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

You must provide the Plan Administrator with notice of the Social Security Administration's determination within sixty (60) days after you receive that determination, and before the end of your initial eighteen (18) month continuation period. The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated above. The contents of the notice must be such that the Plan Administrator is able to determine the covered former employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred. Contact the UnitedHealthcare Customer Support Center at (866) 747-0048 or email cobra_kyoperations@uhc.com for more information.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

When and how must payment for continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the "Notice of Right to Elect COBRA Continuation Coverage". However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact UnitedHealthcare Customer Support Center at (866) 747-0048 or email cobra_kyoperations@uhc.com to confirm the correct amount of your first payment.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA information you will receive from UnitedHealthcare Benefit Services. The periodic payments are made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any breaks.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to:

UnitedHealthcare
P.O. Box 713082
Cincinnati, OH 45271-3082

For more information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan descriptions, you should contact UnitedHealthcare Customer Support Center at (866) 747-0048 or email cobra_kyoperations@uhc.com.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Officers are available through EBSA's website. For more information about the Health Insurance Marketplace, visit www.HealthCare.gov.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of 1) The month after your employment ends; or 2) The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. **This plan pays as if secondary to Medicare, even if you are not enrolled in Medicare**.

For more information visit https://www.medicare.gov/medicare-and-you.

Keep your Plan informed of address changes.
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:
UnitedHealthcare Customer Support Center
Phone: (866) 747-0048
Email: cobra_kyoperations@uhc.com

UnitedHealthcare
Division: Benefit Services
P.O. Box 740221
Atlanta, GA 30374-0221

Plan Sponsor contact information
ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

OMB Control Number 1210-0123 (expires 1/31/2026)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**

Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)