# ONEOK, INC. HEALTH PLAN FOR FORMER EMPLOYEES

## Plan Document and Summary Plan Description

## Restated January 1, 2024

# ONEOK, Inc. Health Plan for Former Employees Plan Document and Summary Plan Description

## General/Introduction

Post-retirement health plan coverage at ONEOK, Inc. ("ONEOK") consists of two plans:

- This ONEOK, Inc. Health Plan for Former Employees ("Health Plan" or "Plan") – This Plan is a group health plan that provides medical and pharmacy benefits ("Benefits") for eligible former employees of ONEOK, its affiliates and subsidiaries (the "Company") and other eligible persons. This Plan features:
    - a traditional PPO design for eligible participants who are not yet eligible for Medicare
    - Medicare Secondary option for Medicare-eligible participants who cannot obtain supplemental coverage under the RRA Plan due to deemed disability prior to age 65 or Medicaid enrollment and ineligibility for guaranteed issue individual coverage
    - Coverage of either option is subject to eligibility requirements.

- The ONEOK, Inc. Retiree Reimbursement Account Plan for Former Employees ("RRA Plan") (Legacy ONEOK Employees Only) – consisting of individual health reimbursement accounts established for all Medicare-eligible participants, including pre-65 participants who become eligible for Medicare due to disability. Under the RRA Plan, Medicare provides primary medical coverage and a third-party administrator assists participants with purchasing individual Medicare supplemental, Medicare advantage, and Part D prescription drug coverage. The terms of the RRA Plan are not detailed in this document and the RRA Plan is a separate plan from this Health Plan. The RRA Plan is only available to legacy Former Employees of the Company who are not Legacy Magellan Employees.

During your retirement, you and one or more family members may be enrolled in different ONEOK health plans, based upon eligibility for those plans. This Health Plan Document and Summary Plan Description ("SPD") and its referenced UnitedHealthcare summary plan documents outlines the terms and conditions of coverage and Benefits available under this Plan. Family members who are eligible for Medicare may have an opportunity to enroll in the RRA Plan and should review the RRA Plan Document and Summary Plan Description. Any family member eligible to enroll in Medicare should do so immediately upon your retirement/separation from the Company.

The Health Plan is operated under a third-party administrative services agreement between the Company and a claims administrator (the "Claims Administrator"). The Claims Administrator administers the payment of Benefits, on behalf of the Company, in accordance with the terms of the Health Plan. It performs certain other services on behalf of the Company. Neither the Health Plan nor the Claims Administrator insure or guarantee payment of Benefits or any other Benefits under any contract or policy of insurance.

This SPD describes the Benefits available to you and your covered family members under the Health Plan. Unlike the health plan maintained for ONEOK's active employees, this Health Plan is not required to comply with many provisions of the Patient Protection and Affordable Care Act ("ACA") and certain other federal laws. Consequently, this Health Plan features different Benefits, terms, conditions and exclusions than the health plan maintained for active employees, and you should only rely on information in this SPD to determine your rights under this Health Plan.

The Company reserves the right, in its sole discretion, to modify, change, revise amend or terminate the Health Plan, in whole or in part, at any time, for any reason, and without prior notice. This SPD is not to be construed as

a contract of or for employment, retirement from employment with the Company or Long-Term Disability qualification.

## Contents

# SECTION 1: GENERAL INFORMATION FOR ALL HEALTH PLAN PARTICIPANTS

**This ONEOK, Inc. Health Plan for Former Employees Plan Document and Summary Plan Description is intended to provide you with an overview of the underlying benefits (the "Component Benefits") that are available under the terms of the Plan. These Component Benefits include a program for retiree participants, a program for long-term disability eligible participants and a Medicare secondary benefit program for certain Medicare-eligible participants.**

The terms and conditions of the Plan's Component Benefits are contained in the various United Healthcare summary plan descriptions (the "Benefit Documents") and are incorporated into this Plan by reference. You do not have a complete copy of this plan unless you have each of the Benefit Documents applicable to your enrollment and referenced in this Plan. These Benefit Documents can be requested from HR Solutions (contact information listed below).

This Plan is also intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 ("ERISA") as well as other important information. In the event of any conflict between the information contained in this Plan and any Benefit Document, the terms of this Plan will control with respect to self-insured benefits and determinations as to eligibility, participant contributions and the rights, duties, and responsibilities reserved to the Benefit Plan Sponsor Committee ("BPSC") or the Benefit Plan Administration Committee ("BPAC").

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

ONEOK, Inc.
Attn: HR Solutions
100 W 5th Street
Tulsa OK 74103
PHONE: 855-663-6547

## Eligibility

Eligible Former Employees: You are eligible to participate in the Health Plan as a Former Employee of the Company if you satisfy one of the criteria below.

Legacy ONEOK Employees:
The following rules apply to Former Employees of the Company who are not Legacy Magellan Employees:

- **As a Retiree Participant**: You are a pre-65 Former Employee who (1) was hired by the Company prior to January 1, 2017; (2) terminated employment at age 50 or older but before age 65; (3) completed sixty (60) or more consecutive months of full-time service (meaning you were regularly scheduled to work forty (40) or more hours per week); (4) at the time of termination or retirement were regularly scheduled to work a minimum of twenty (20) or more hours per week; and (5) elected in writing to participate in and be covered under the Health Plan during your Initial Election Period; or

- **As a Long-Term Disability Participant**: You are a pre-65 Former Employee who (1) was hired by the Company prior to January 1, 2017 and are eligible for benefits under the ONEOK, Inc. Long-Term Disability Plan (LTD Plan); and (2) elected in writing to participate in and be covered under the Health Plan during your Initial Election Period. If your eligibility under the LTD Plan is terminated at any point, to remain a Participant in the Health Plan you must: (1) be between the ages 50 and 65 at the termination of your eligibility for the LTD Plan; and (2) have completed sixty (60) or more consecutive months of full-time service (meaning you were regularly scheduled to work forty (40) or more hours per week) immediately prior to being approved under the LTD Plan.

Legacy Magellan Employees:
The following rules apply to Former Employees who are Legacy Magellan Employees:

- **As a Retiree Participant**: You are a pre-65 Former Employee who (1) was hired prior to September 25, 2023; (2) (i) terminated employment at age 55 or older but before age 65 and completed five (5) or more years of service; or (ii) terminated employment after reaching age 50 if such termination occurred as a result of a reduction-in-force per the terms of the applicable Magellan severance pay plan; (3) at the time of termination was a regular employee and regularly scheduled to work a minimum of twenty (20) or more hours per week; and (4) elected in writing to participate in and be covered under, or deferred enrollment in (on or before December 31, 2023), the Health Plan during your Initial Election Period.

  If you elected to defer enrollment in the Health Plan on or before December 31, 2023, you must contact HR Solutions to request enrollment in the Health Plan. Your coverage will be effective the first day of the month following 90 days after you have properly requested enrollment in the Health Plan.

  If you do not meet the requirements for subsidized retiree medical benefits under this Health Plan (as described below in "Cost of Coverage") and your employment is covered by a collective bargaining agreement, you are not eligible to participate in this Health Plan unless that agreement specifically provides otherwise.

No Current Employee is eligible to participate in this Health Plan. No Former Employee who elects COBRA coverage under the group health plan that provides major medical benefits for active Employees is eligible to participate in this Health Plan. No Former Employee or dependent who is age 65 or greater or entitled to Medicare is eligible to participate in this Health Plan, except as provided in Section 3: Information for Certain Participants Eligible for Medicare.

Independent contractors and other individuals classified by the Company as non-Employees (for example, leased employees) are not eligible to participate in this Health Plan. If any court, administrative body, agency, or other entity, at any time, should determine that any individual classified as an independent contractor or non-Employee by the Company was, in reality, a common law Employee of the Company, or is now a Former Employee of the Company, such individual still shall not be eligible for, nor entitled to, and shall not participate in, the Health Plan.

## If You are Rehired or, Return to Work

If you are rehired, or return to work after retiring from employment with the Company or any other termination of employment, you and your Dependents will lose eligibility under this Health Plan and will not be eligible to participate upon your subsequent termination of employment. If you meet the eligibility requirements, you will be permitted to elect coverage under the ONEOK, Inc. Health Plan that active Employees participate in; however, you may be subject to the Waiting Period under that plan and any other terms and conditions. Please consult those plan documents if you return to work or are rehired.

CAUTION: For purposes of the Company Subsidy, this Health Plan will not credit you with your prior service if you return to work after your initial retirement from or termination of employment with the Company. Thus, if you are eligible for a Company Subsidy, retire from employment or terminate employment for any reason, return to work, you will forfeit your Company Subsidy upon your subsequent retirement or termination.

CAUTION: If you elect to move to part time employment and are regularly scheduled for less than twenty (20) hours per week, you will lose eligibility for this Health Plan at that time or in the future when you subsequently retire.

## No Pre-Existing Condition Exclusions

The Health Plan does not have a pre-existing condition exclusions limitation.

## No Waiting Period

Eligible Former Employees electing coverage under this ONEOK, Inc. Health Plan for Former Employees will not be subject to a Waiting Period.

## Opt-Out Election Is Permanent

If you elect to "Opt Out" of the Health Plan as to initial participation or during any Annual Open Enrollment Period or at any other time, your election will be final, permanent, and irrevocable. You will never be allowed to receive or reinstate any Benefits under the Health Plan after electing to Opt Out of the Health Plan. You will also forfeit all Company provided life insurance, unless you are a Legacy Magellan Employee.

If you elect to decline coverage, a ONEOK, Inc. Health Plan Opt-Out Form or an Open Enrollment Change Form must be completed and submitted to HR Solutions.

## If You Choose No Benefits Coverage

Any Former Employee who does not elect Benefits coverage within 30 days of retirement or termination of employment shall be deemed to have Opted Out of coverage and shall permanently forfeit eligibility to participate in the Health Plan. Failure to timely pay premiums when due also will result in a deemed Opt-Out election.

## Eligible Family Member Eligibility

The only Eligible Family Members you may cover in the Health Plan are those who are enrolled in the Health Plan at the time of your Initial Election Period. If your Eligible Family Member (including any Dependents) is not enrolled at the time of your Initial Election Period you may not enroll them at any future time.

## Annual Open Enrollment Period

The Annual Open Enrollment Period is usually coordinated with the Medicare open enrollment period to begin in October and continue for several weeks. Former Employees will be furnished enrollment information, including benefits and rate information, enrollment forms and the beginning and ending dates of the Annual Open Enrollment Period in early October. Elections made during the Annual Open Enrollment Period become effective the following January 1 and will remain in effect until the following December 31 unless you or an Eligible Family Member become Medicare eligible or reach age 65.

## Make Changes During the Annual Open Enrollment Period

If you wish to drop a Spouse or Dependent as a Covered Person entitled to Benefits under the Health Plan, you must complete and submit a Benefit Open Enrollment Change Form to HR Solutions. Once a Spouse or Dependent is dropped from coverage under this Health Plan, you will never be allowed to receive or reinstate any Benefits or coverage under the Health Plan for that Spouse or Dependent.

## Dependent Eligibility Changes

The Health Plan allows enrolled Dependents of a Former Employee to remain eligible for coverage under this Plan until age 26, regardless of that child's marital, student or dependent status with some exceptions. See "Eligible Family Members" in this section. The Company will continue to require evidence of relationship based on the Verification Document requirements.

## Help and Online Information About the Health Plan

If you have questions concerning your Enrollment, participation or Benefits, call HR Solutions at (855) ONEOKHR (855-663-6547). You can find helpful information about the Health Plan and your participation if you log onto www.myuhc.com.

## Coverage Tiers

There are seven Coverage Tiers to choose from:

- Former Employee Only or Surviving Spouse Only
- Former Employee + Spouse/Domestic Partner (DP)
- Former Employee + Child(ren)/DP Child(ren)* or Surviving Spouse and Child(ren)
- Former Employee + Family (Spouse/DP + Child(ren)* / DP Child(ren)*)

- Spouse/Domestic Partner (DP) Only (where the Former Employee is Medicare Eligible**)
- Child(ren)/DP Child(ren)* Only (where the Former Employee is Medicare Eligible** or deceased)
- Spouse/DP + Child(ren)* / DP Child(ren)* Only (where the Former Employee is Medicare Eligible**)

* Child(ren) is synonymous with the term Dependent(s)
** Former Employee is Medicare eligible and enrolled in the RRA Plan, if applicable

## Eligible Family Members and Required Verification Documents

| Spouse/Domestic Partner or Dependent Family Member | Verification Document Requirement |
|---|---|
| **Spouse:** A person who is recognized as your legal spouse for purposes of federal income tax laws. Neither of you is married to anyone else under either statutory or common law. | State-issued marriage certificate. For common law marriages: Proof of joint ownership (or Certificate of Informal Marriage). |
| **Domestic Partner:** A person with whom you have a committed relationship with for 12 months and whom you live with, but who is not considered your legal spouse for purposes of federal income tax laws. Neither of you is married to or legally separated from anyone else under either statutory or common law. | Jointly signed Declaration for Domestic Partnership (must be submitted with initial enrollment) **and** Affidavit of Dependent Status for Domestic Partnership (must be submitted with initial enrollment) **and** two items showing proof of financial interdependence. Proof of financial interdependence includes: joint ownership of an automobile or home; a joint checking, bank or investment account; a joint credit account, mortgage or a lease for a residence identifying both partners as tenants; a will and/or life insurance policies signed and completed to the effect that one domestic partner is the primary beneficiary of the other; a beneficiary designation form for a retirement plan signed and completed to the effect that one domestic partner is the primary beneficiary of the other. Registration of domestic partners if the domestic partners reside in a state that provides for registration. Official recognition of civil union for persons who reside in states that recognize civil unions.<br><br>If HR Solutions does not receive a properly completed affidavit in a timely manner, the plan administrator will assume that neither your domestic partner nor your domestic partner's child(ren) qualify as your tax dependent(s) and will impute income to you for the value of coverage provided to your domestic partner and your domestic partner's child(ren). |
| **Natural Child(ren):** Until they reach 26. | State-issued birth certificate (or foreign equivalent) listing Former Employee as a parent. |

| Spouse/Domestic Partner or Dependent Family Member | Verification Document Requirement |
|---|---|
| **Stepchild(ren):** Your spouse's or domestic partner's child(ren) until they reach age 26 or earlier if your marriage to or domestic partnership with their natural parent ends. | State-issued birth certificate (or foreign equivalent) listing Former Employee's spouse or domestic partner as a parent **and** state-issued marriage certificate proving Former Employee and spouse are married and recorded in legal records **or** domestic partnership registration or Declaration for Domestic Partnership, as applicable, documenting the relationship. |
| **Adopted Child(ren):** Child(ren) you (or your spouse or domestic partner) have adopted or who have been placed for adoption with you until the child(ren) turns age 26. You or your spouse or domestic partner must be one of the adopting parents; the child(ren) must have been placed in your (or your spouse or domestic partner's) custody; and the adoption proceeding must have assigned the responsibility for benefits coverage to you (or your spouse or domestic partner). | Adoption or placement for adoption documents and court granted custody documents, as applicable; state-issued birth certificate (or foreign equivalent) or similar information obtained in connection with adoption proceeding. |
| **Foster Child(ren):** Child(ren) who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction until the child(ren) turns age 26. | Foster placement judgment, decree or order |
| **Child Covered by a Qualified Medical Child Support Order (QMCSO):** Child(ren) on whose behalf a QMCSO has been entered or issued, indicating that coverage must be provided by you until the child(ren) covered by the QMCSO turns 26 years of age, the QMCSO expires or the Plan receives notice from the issuing party that the QMCSO is no longer valid, whichever occurs first in time. | QMCSO (only if enrolled at time of retirement) |
| **Other Eligible Dependent:** A person who is not your child (or the child of your spouse or domestic partner) but to whom you are related; for whom you have been appointed legal guardian and is your Dependent for federal income tax purposes; and is (i) under age 19, or (ii) under age 24 and a full-time student, as defined by the educational institution. Your Other Eligible Dependent continues to be a full-time student during periods of regular vacation established by the educational institution. If your Other Eligible Dependent does not continue as a full-time student immediately following the period of vacation, the full-time student designation will | State issued birth certificate (or foreign equivalent) **and** court legal guardianship documents (if applicable) **and** copy of the first page of your federal tax return filed within the last tax year (income amounts blacked out) **and** proof of full-time education student, if applicable. If a new legal guardian is appointed in the current calendar year, no tax return is required. |

| Spouse/Domestic Partner or Dependent Family Member | Verification Document Requirement |
|---|---|
| end. The period of vacation for full-time student status is reviewed January 1 and August 1, which is after the Christmas holiday and summer break. | |
| **Incapacitated Person:** Continued coverage is provided for your child(ren) or other eligible dependent(s), who is physically or mentally incapable of self-support while remaining incapacitated, as long as you remain an eligible former employee and so long as (i) the child or other eligible dependent was enrolled in the ONEOK Health Plan prior to his or her turning 26 years of age (for natural, adopted and stepchildren), or attaining age 24 (for other eligible dependents), as the case may be, and remained covered through such age; and (ii) the child or other eligible dependent satisfies the criteria for eligibility under one of the categories described above but for his or her age. | To continue coverage for a child under this provision, proof of disability or incapacity (obtained at your own expense) must be received by HR Solutions within 31 days after coverage would otherwise terminate. The Health Plan requires annual re-certification of the child's physical or mental condition.<br><br>Special Note: This plan does not allow Medicare eligible participants to remain enrolled. If an incapacitated family member is eligible for Medicare they will be ineligible for the Health Plan and may be entitled to enroll in our RRA Plan. |

## If You Fail to Provide Dependent Verification Documents

During your Initial Election Period, we require proof of dependency and Spouse/Domestic Partner and Dependent Social Security Number as conditions to enrolling an Eligible Dependent or retaining an enrolled Dependent on the Health Plan. In the course of enrolling an Eligible Dependent, or retaining enrollment of one, you will be required to affirm that any information you provide about an individual's status as your Eligible Dependent is true and correct, and that you understand that the Health Plan relies on your representations. If documentation is requested to prove the eligibility status of one or more persons you have enrolled or are seeking to enroll under the Health Plan, and you fail to supply the requested documentation within ninety (90) days of Enrollment (or such other date as indicated in the Plan Administrator's request), the Health Plan may decline to enroll your Spouse/Domestic Partner or Dependent or may prospectively terminate his or her coverage. By contrast, if in the course of enrolling an individual or retaining his or her enrollment, you instead make a misrepresentation of a material fact or do something, or fail to do something, that constitutes fraud (both as determined by the Plan Administrator or its designee in its sole discretion), then your Eligible Dependent will have a Rescission of Coverage retroactive to the date of that fraud or misrepresentation. No COBRA continuation coverage will be available in either type of case. If the Plan Administrator believes a retroactive termination is appropriate you will receive a Notice of Rescission of Coverage at least 30 days before coverage is terminated and be afforded the opportunity to treat any such adverse action as an Adverse Benefit Determination with respect to a claim and appeal the Health Plan's action under the Health Plan's claims and appeals provisions. Section 4: Claims and Appeals.

## Benefits for an Eligible Family Member of a Deceased Former Employee

### Retiree Participants

In the event of death of a Former Employee participating in the Health Plan on the date of their death such Former Employee's enrolled Eligible Family Members may continue coverage under this Health Plan subject to the Company's general right to amend or terminate the Health Plan at any time. Such coverage will continue until the Eligible Family Member no longer meets the otherwise applicable eligibility requirements under this Health Plan.

### Long-Term Disability Participants (Legacy ONEOK Employees only)

Legacy ONEOK Employees only: In the event of death of a Long-Term Disability Participant enrolled in the Health Plan, all enrolled Eligible Family Members may continue coverage under this Health Plan if the Former Employee had completed sixty (60) or more consecutive months of full-time service (meaning they were regularly scheduled to work forty (40) or more hours per week) with the Company immediately prior to their eligibility for the LTD Plan, subject to the Company's general right to amend or terminate the Health Plan at any time. Such coverage will continue until the Eligible Family Member no longer meets the otherwise applicable eligibility requirements under this Health Plan.

### Benefits for Spouse and/or Dependent(s) of a Deceased Active Employee

The surviving Spouse and/or Eligible Dependents of an individual who at the time of such individual's death was an active Employee are eligible to enroll in and participate in the Health Plan if the following requirements are met:

- On the date of death, the Employee was an active Employee with the Company hired prior to 1/1/2017 (in the case of Legacy Magellan Employees, the Employee was an active Employee with the Company hired prior to 9/25/2023); and
- On the date of death, the Employee had completed sixty (60) or more consecutive months of full-time service (meaning they were regularly scheduled to work forty (40) or more hours per week) with the Company (in the case of Legacy Magellan Employees, the Employee had attained the age 55 and completed five (5) or more years of service with the Company).

In the event the deceased active Employee or Long-Term Disability Participant does not satisfy the requirements above, coverage under this Health Plan is not available to the surviving Spouse or Eligible Dependent(s), except for COBRA Continuation Coverage as described in Section 4: COBRA Continuation.

Any new spouse or domestic partner of a surviving Spouse of a deceased Former Employee shall not be eligible for coverage under this Health Plan. No additional Dependents may be added after the Former Employee's Initial Enrollment Period.

## Cost of Coverage

You will receive information during the Annual Open Enrollment or when eligible during the Plan Year, which will list your Participant contribution requirements, if any, to participate in the Health Plan, and be covered to receive Benefits under the Health Plan.

Your costs under the Health Plan will depend in part on any Company Subsidy available to you. Former Employees (and/or surviving Spouses and eligible Dependents) may be eligible for a Company Subsidy based on a historical matrix maintained by the ONEOK Human Resources Department, but eligibility for a Company Subsidy and the amount thereof is at the Company's sole discretion and may be modified or eliminated at any time. You will be notified regarding any Company Subsidy and any required Eligible Former Employee contribution during the Health Plan's Annual Open Enrollment Period.

Legacy ONEOK Employees:

The rules in this section apply to legacy Company Employees who are not Legacy Magellan Employees. To be eligible for the Grandfathered group Defined Dollar Benefit (in the case of Enron Trust Participants), you must be age fifty-five (55) with five (5) or more years of service or age plus years of credited service is equal to or greater than 75 or higher, as defined in the Northern Border Northern Plains Acquisition Purchase Agreement. Any combination of age plus years of credited service with a total value of 74.5 or greater will be rounded up. All other Eligible Former Employees in this group are not eligible for a Defined Dollar Benefit.

If your monthly pension payment under the Retirement Plan is sufficient to cover the cost of the monthly Participant contribution, it will be deducted from your pension payment if you so elect or are deemed to have elected. If you do not elect to have your Participant contribution deducted from your pension payment or your pension benefit is less than your Participant contribution amount, you will be billed directly by a third-party administrator as selected by the Company.

Legacy Magellan Employees:

The rules in this section apply to Legacy Magellan Employees. To be eligible for the subsidized cost basis retiree medical benefits you must meet all of the following eligibility requirements:

- Your employment must have transferred from Williams to Magellan by January 1, 2005; and
- You must be entitled to an immediate normal retirement, early retirement or disability retirement under the Magellan Pension Plan or the Magellan Pension Plan for USW Employees; and
- You must have been hired on or before December 31, 1991 by The Williams Companies, Inc. as it existed at that time and eligible for participation in the Williams Pension Plan as it existed on that date, and have not had more than a 1-year break-in-service at any time; or
- You must have been hired as an employee covered by a collective bargaining agreement between the Company the United Steel Workers Union Local 5-348 or on before February 1, 1993 and have not had more than a 1-year break-in-service.

If you do not meet the requirements outlined above for the subsidized retiree medical benefits you must meet the following eligibility requirements below to elect retiree medical benefits on a retiree-pay-all cost basis:

- Your employment is not covered by a collectively bargained agreement, unless that agreement specifically provides for this coverage;

Your Participant contributions are subject to review and the Company reserves the right to change your Participant contribution amount from time to time, usually on an annual basis.

If you experience any Change in Status Event (marriage, death, divorce, change in Domestic Partner relationship, birth, adoption, etc.) during the Health Plan Year that results in coverage being dropped for your Spouse and/or your Dependent(s), refunds will not be issued, as it is your responsibility as a Former Employee to notify the Health Plan in a timely manner when the Change in Status Event occurs.

## Change in Status Events

You can change your benefit choices during the Plan Year if you experience a change in family status and proper documentation should be submitted within 30 days of the change.

The following table shows the Change in Status Events and the permitted changes to your enrollment:

CHANGE IN STATUS EVENT

- Marriage /Domestic Partnership: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Divorce, legal separation and annulment/declaration of termination of domestic partnership – date granted: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Death of Spouse/Domestic Partner or Dependent: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Termination/commencement of Spouse/Domestic Partner or Dependent employment: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Eligible for Medicare: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Significant change in Former Employee health care coverage/premiums: Drop coverage for you, your Spouse/Domestic Partner, and/or your Eligible Dependent(s)
- Dependent becomes ineligible due to age, marriage, no longer residing with the Employee, change in student status, employed full-time, similar circumstances: Drop coverage for you, your Eligible Dependent(s)

No other family status change you have, or experience will entitle you to change coverage and benefit elections you have made under the Health Plan. Thus, a change in your marital status by marriage to a Spouse who was not initially elected by you to be covered under the Health Plan, establishment of a DP relationship, the birth, adoption or placement for adoption of a child who was not initially elected by you to be covered under the Health Plan, or the placement of a foster child who was not initially elected by you to be covered under the Health Plan, or any similar circumstance of a Change in Status Event, will not entitle you to add or obtain coverage for the other individual involved in such a Change in Status Event or otherwise change the coverage and Benefits you have elected under the Health Plan.

## You must Promptly Report Change in Status Events to Change Elections

When a Change in Status Event occurs, it is your responsibility to complete the necessary forms and submit them to HR Solutions within the allotted time frame after your Change in Status Event occurs.

You should complete a Change in Status Event Form, including:

- All information requested such as your personal information, your Eligible Family Member's name, birth date(s), Social Security Number(s), reason for ineligibility, etc.;
- Indication of the date the Change in Status Event occurred and provide any necessary documentation;
- Sign and date the Change in Status Event Form and return it to HR Solutions within the given time frame; and
- If the request is for coverage to be discontinued for a Spouse/DP or Dependent(s) who is no longer eligible, the coverage will be discontinued as of the date of the Change in Status Event but the Health Plan will not issue any refund for any changes that result in a Coverage Tier change. Any claims that have been processed by the Claims Administrator for the Spouse/Domestic Partner and/or Dependent after the date that they are no longer eligible must be refunded by the Participant to the Health Plan.

In order for COBRA to be offered to the Spouse or Dependents, per IRS regulations, notification must be received by HR Solutions within sixty (60) days of certain of the Change in Status Events. If the notification of those events is not received within that timeframe, COBRA coverage will not be available to the Spouse or Dependent(s). See Section 4: COBRA Continuation.

## Tax Treatment of Domestic Partner Participant Cost

Coverage of Domestic Partner 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 will be reported as compensation on your Form W-2.

Coverage of a Domestic Partner Dependent: If your Domestic Partner is covered under the Health Plan 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.

## Termination of Benefits

Benefits under the Health Plan end when the Former Employee Participant terminates coverage or his or her Spouse/Domestic Partner or Dependent(s) ceases to be eligible for coverage or premium ceases to be paid. Your coverage under this Health Plan will automatically end when you turn 65 or otherwise become eligible for Medicare. At that point, you will have the opportunity to continue post-retirement health benefits in the RRA Plan, as applicable. In certain limited cases, you may be eligible instead for coverage under the Medicare Secondary Benefit Option referenced in Section 3: Information for Certain Participants Eligible for Medicare. If you wish to end coverage for yourself or for any Eligible Family Member under this Health Plan, you must complete and submit a Retirement Benefit Packet Election and Authorization Form or Benefit Open Enrollment Change Form to HR Solutions. Coverage will end on the date you are no longer eligible. Any claims paid after the Participant contribution stops must be reimbursed to the Health Plan.

PLEASE REMEMBER: If an Eligible Former Employee elects to Opt-Out of health coverage under the Health Plan, that election is final, permanent, and irrevocable. If you elect to Opt-Out of the Health Plan,

you also forfeit all Company provided life insurance, unless you are a Legacy Magellan Employee.

# SECTION 2: HOW THE PRE-MEDICARE HEALTH PLAN WORKS

## Medical Benefit Options for participants not eligible for Medicare

The Health Plan provides a Preferred Provider Organization (PPO) Medical Benefit Option, including Prescription Drug coverage and Preventive Care Benefits.

During your coverage election period or the Annual Open Enrollment Period, you may elect:

- Preferred Provider Organization (PPO); or
- Opt-Out of coverage – Once you Opt-Out of the Health Plan, this decision is final, permanent, and irrevocable. You also forfeit all Company provided life insurance, unless you are a Legacy Magellan Employee.

## Modified Health Plan Benefits for Those Eligible for Medicare

Legacy ONEOK Employees only: As a Former Employee who is a retiree, if you, your Spouse or your covered Dependent are entitled to enroll in Medicare Part A and Part B due to turning age 65, disability, or for any other reason, you become ineligible to participate in the benefits outlined in this Section. Participants granted a valid exception should refer to Section 3: Information for Certain Participants Eligible for Medicare. Participants over the age of 65 will have the opportunity to continue post-retirement health benefits in the RRA Plan, as applicable.

As a retiree, if you, your Spouse or your Dependent(s) are currently eligible for Medicare, or who become eligible for Medicare during the year, you must contact HR Solutions at 855-663-6547 or HRSolutions@oneok.com immediately.

## What Happens If a Family Member Becomes Eligible for Medicare?

The family member eligible for Medicare must work with Via Benefits, ONEOK's third-party plan administrator for post-Medicare eligible retirees, to enroll in an individual Medicare supplemental policy. The Former Employee, Spouse, or Dependent NOT eligible for Medicare may remain enrolled in the PPO Medical Benefit Option.

## Cost Sharing Features of Your Coverage

As a Participant in this Health Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Annual Deductible, Coinsurance, and Co-Payment provisions of your coverage, as well as any charges for which Benefits are not provided. Check with HR Solutions at (855) ONEOKHR (855-663-6547) for specific premium amounts applicable to the Medical Benefit Option you have elected for you, your Spouse and/or your Eligible Dependent(s).

## Special Notices

Because of some federal laws, changes in the Health Plan, or the special needs of the Company, provisions called "Special Notices" may be added to this Summary Plan Description or any Component Program Benefit Documents.

Be sure to check for and read any "notice" or "Special Notice" you receive about the Health Plan. It can change provisions of the Health Plan and this Plan Document and Summary Plan Description affecting Benefits coverage or the administration of the Health Plan.

## Limitation of Liability

The choice of a Provider is solely yours. The Health Plan does not furnish Covered Services but only pays for Covered Services you receive from Providers. Neither the Company, the Plan Sponsor, the Claims Administrator, nor the Health Plan is liable for any act or omission of any Provider, and they have no responsibility for a Provider's failure or refusal to give Covered Health Services to you.

## Foreign Travel

Foreign Travel is defined as traveling outside of the fifty (50) states of the United States. The Health Plan will cover Emergency claims only, which includes Urgent Care facilities.

## Compliance with Applicable Law

The Health Plan is intended to comply with all applicable laws. No limitation or restriction under the Health Plan will be enforced to the extent that it is prohibited by applicable law or would subject the Company, the Plan Administrator or the Health Plan to any excise tax or other penalty under Health Care Reform (to the extent applicable to a group health plan for former employees) or other applicable law.

## Applicable Benefit Documents

**Summary Plan Description: Choice Plus (PPO) Pre-65 (Legacy ONEOK Employees only)**
**Summary Plan Description: PPO Pre-65 OOA (Legacy ONEOK Employees only)**
**Summary Plan Description: Choice Plus Legacy Magellan Pre-65 Retiree (Legacy Magellan Employees only)**
**Summary Plan Description: PPO Magellan Pre-65 Retiree OOA Plan (Legacy Magellan Employees only)**

# SECTION 3: INFORMATION FOR CERTAIN PARTICIPANTS ELIGIBLE FOR MEDICARE

## Medicare Secondary Medical Benefit Option (Legacy ONEOK Employees Only):

The Health Plan provides the Medicare Secondary Benefit Option for Medicare eligible Participants that are unable to obtain a guaranteed issue Medigap policy through Via Benefits (or any of its approved affiliates or successors) due to disability prior to age 65, or Medicaid enrollment. In such cases, Participants will be considered for exceptions to remain in this Medicare Secondary Benefit Option under the Plan until they reach age 65 or can be transitioned to a guaranteed issue policy through Via Benefits.

During your transition period or the Annual Open Enrollment Period, if you become Medicare eligible the following are your options:

1. Medicare Parts A & B are primary; and the Medicare Secondary Benefit Option for Medicare eligible Participants is secondary; or
2. Waive coverage – Once you Opt-Out of the Health Plan, this decision is final, permanent, and irrevocable. You also forfeit all Company provided life insurance.

Note: Any Participant eligible for Medicare Part A or Part B should give careful consideration before deciding not to enroll in both Medicare Part A and Part B when you first become eligible. If you defer enrollment, you may have a lapse in eligibility for Medicare coverage and/or you may have to pay a higher premium when you do enroll later. The Medicare Secondary Benefit Option will not pay the portion of a claim that Medicare would have paid had you enrolled in Medicare Part A and Part B when you became eligible. Additionally, the Medicare Secondary Benefit Option does not offer coverage for outpatient prescription drugs. You should give careful consideration to enrolling in qualified Part D prescription drug coverage when first offered.

Note: This Medicare Secondary Benefit Option for Medicare eligible Participants is only available to Former Employees of ONEOK and is not available to Legacy Magellan Employees.

## Network Option

Under the Medicare Secondary Benefit Option you can choose any health care provider, there are no different coverage levels for In-Network or Out-of-Network.

## Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Medicare Secondary Benefit Option is in effect, determined according to the definition in the applicable UnitedHealthcare Summary Plan Description ONEOK, Inc. Health Plan for Former Employees, Medicare Secondary Benefit Option. For certain Covered Health Services, the Medicare Secondary Benefit Option will not pay these expenses until Medicare has paid and you have met your Annual Deductible.

## No Prescription Drug Benefits

The Health Plan does not offer Prescription Drug coverage to Participants on the Medicare Secondary Benefit Option. Prescription drugs for Medicare eligible individuals enrolled in the Medicare Secondary Benefit Option are available through a Medicare Part D Plan of your choice. You should enroll in a Medicare Part D Drug Plan to obtain pharmacy benefits for your Prescription Drugs.

You should give careful consideration regarding enrollment in Medicare Part D when you first become eligible for Medicare. If you choose not to enroll in Medicare Part D when first eligible, there may be a penalty imposed by Medicare.

## Applicable Benefit Document

**Summary Plan Description: Medicare Secondary Benefit Option**

# SECTION 4: ADDITIONAL GENERAL INFORMATION FOR ALL PARTICIPANTS

## When Coverage Ends - COBRA

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan will still process claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The date the Plan is terminated;
- The date you stop making the required contributions;
- The date you are no longer eligible (for instance, when you become Medicare-eligible and are able to enroll in coverage under the RRA Plan);
- The date UnitedHealthcare receives written notice from the Company to end your coverage, or the date requested in the notice, if later;
- The date of your death; or
- The date your eligibility for the ONEOK, Inc. Long-Term Disability Plan ends and you had not completed sixty consecutive months of full-time service prior to qualification.

Coverage for your Eligible Family Member(s) will end on the earliest of:

- The date your coverage ends under this Health Plan or the RRA Plan (as applicable), unless coverage ends due to attainment of age 65, becoming eligible for Medicare or death;
- The date you are no longer eligible under this Health Plan or the RRA Plan (as applicable), unless loss of eligibility is due to attainment of age 65, becoming eligible for Medicare or death;
- The date the Plan is terminated;
- The date you (or your Eligible Family Member(s)) stop making the required contributions;
- The date UnitedHealthcare receives written notice from the Company to end your coverage, or the date requested in the notice, if later; or
- The day your Eligible Family Member loses eligibility (11:59 p.m. on the last day of coverage).

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- You permit an unauthorized person to use your ID Card or you use another person's ID Card;
- You knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Spouse or Dependent;
- You commit an act of physical or verbal abuse that poses a threat to the Company's staff, UnitedHealthcare's staff, a Provider or another Covered Person;
- You violate any terms of the Health Plan; or
- Fraud, misrepresentation or false information - occurs when there has been fraud or misrepresentation, or the Participant knowingly gave UnitedHealthcare or the Company false material information. Examples include false information relating to another person's eligibility or status as a Spouse or Dependent.

If your coverage is terminated for any of the above reasons, you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

UnitedHealthcare and the Health Plan reserve the right to demand that you pay back Benefits, which the Company paid to you, or paid in your name, during the time you were incorrectly covered under the Health Plan.

## Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Health Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability;
- The child depends mainly on you for support;
- You provide to the Company proof of the child's incapacity and dependency within thirty-one (31) days after coverage would have otherwise terminated; and
- You provide proof, upon the Company's request, that the child continues to meet these conditions.

The proof might include medical examinations at your expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within thirty-one (31) days, the Health Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Health Plan.

## COBRA CONTINUATION

If you lose your Health Plan coverage, you may have the right to continue it under the Consolidated Budget Reconciliation Act of 1985 (COBRA).

Much of the language in this Section comes from the federal law and regulations that govern COBRA Continuation Coverage. You should call HR Solutions at (855) ONEOKHR (855-663-6547) if you have questions about your right to continue coverage.

In order to be eligible for COBRA Continuation Coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Health Plan on the day before a Qualifying Event:

- A Former Employee covered under the Health Plan; or
- A covered Former Employee's enrolled Spouse or Dependent, including with respect to the Former Employee's children, a child born to or Placed for Adoption with the Former Employee during a period of continuation coverage under federal law.

If you continue coverage under the Health Plan under COBRA, account balances, Annual Deductibles and maximums will remain intact.

## Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under the Health Plan pursuant to COBRA for yourself, your Spouse and/or your Eligible Family Member(s), and the maximum length of time you can receive continued coverage. These situations are considered "Qualifying Events".

| **If the Health Plan coverage ends because of the following Qualifying Events:** | **You May Elect COBRA Continuation Coverage:** | | |
|---|---|---|---|
| | **For Yourself** | **For Your Spouse** | **For Your Child(ren)** |
| You or your family member become eligible for Social Security disability Benefits at any time within the first sixty (60) days of losing coverage[1] | 29 months | 29 months | 29 months |
| Your death | N/ | 36 months | 36 months |
| Your divorce (or legal separation) | N/ | 36 months | 36 months |
| Your Dependent child is no longer an Eligible Family Member (e.g. reaches the maximum age limit) | N/ | N/ | 36 months |
| The Company files for bankruptcy under Title 11, United States Code.[2] | 36 months | 36 months[3] | 36 months[3] |

[1]Subject to the following conditions:

(i) Notice of the disability must be provided within the latest of sixty (60) days after a. The determination of the disability,
   b. The date of the Qualifying Event,
   c. The date the Qualified Beneficiary would lose coverage under the Health Plan, and in no event later than the end of the first eighteen (18) months;

(ii) The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven (11) months over the original eighteen (18) months; and

(iii) If the Qualified Beneficiary entitled to the eleven (11) months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven (11) months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within thirty (30) days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than thirty (30) days after the date of that determination.

[2]This is a Qualifying Event for any Former Employee and his or her enrolled Spouse and/or Dependent(s) if there is a substantial elimination of coverage within one year before or after the date, the bankruptcy was filed.

[3]From the date of the Former Employee's death if the Former Employee dies during the COBRA Continuation Coverage.

## How Your Medicare Eligibility Affects Spouse or Dependent COBRA Coverage

The table below outlines how your Spouse or Dependent'(s) COBRA coverage is impacted if you become entitled to Medicare.

| If Spouse or Dependent Coverage Ends When: | You May Elect COBRA Continuation Coverage for Up To: |
|---|---|
| You become entitled to Medicare and do not experience any additional Qualifying Events. | 18 months |
| You become entitled to Medicare, after which you experience a second Qualifying Event that is your termination of employment or reduced work hours before the initial eighteen (18) month period expires. | 36 months |
| You experience a Qualifying Event that is your termination of employment or reduced work hours, after which you become entitled to Medicare before the initial eighteen (18) month period expires; and, if absent this initial Qualifying Event, your Medicare entitlement would have resulted in loss of Spouse or Dependent coverage under the Health Plan. | 36 months |

## Getting Started/Notice to You of COBRA Eligibility

You will be notified by the Company, as Plan Administrator, by mail if you become eligible for COBRA Continuation Coverage. The notification will give you instructions for electing COBRA Continuation Coverage and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee and other cost as permitted by law.

## Your COBRA Election Period

You will have up to sixty (60) days from the date you receive notification or sixty (60) days from the date your coverage ends to elect COBRA Continuation Coverage, whichever is later. You will then have an additional forty-five (45) days to pay the cost of your COBRA Continuation Coverage, retroactive to the date your Health Plan coverage ended.

During the sixty (60) day election period, the Health Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA Continuation Coverage, retroactive to the date your COBRA eligibility began.

While you are a Participant in the Health Plan under COBRA, you have the right to change your coverage election:

- During Annual Open Enrollment Period; and
- Following a change in family status, as described under Section 1.

## Your COBRA Notification Requirements for Qualifying Events

If your covered Spouse or Dependent(s) lose coverage under the Health Plan eligibility provisions due to divorce, legal separation, or loss of Spouse or Dependent status, you, your Spouse or your Dependent(s) must notify the Plan Administrator within sixty (60) days of the latest of:

- The date of the divorce, legal separation or an enrolled Spouse or Dependent's loss of eligibility

as an enrolled Spouse or Dependent;
- The date enrolled Spouse or Dependent would lose coverage under the Health Plan; or
- The date on which you, your enrolled Spouse or Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You, your Spouse or your Dependent(s) must also notify the Plan Administrator when a Qualifying Event occurs that will extend continuation coverage.

If you are receiving COBRA Continuation Coverage under federal law, you must notify the Plan Administrator within sixty (60) days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA, as described above under the heading "Getting Started/Notice To You of COBRA Eligibility."

If you, your Spouse or your Dependent(s) fail to notify the Plan Administrator of these events within the sixty (60) day period, the Plan Administrator is not obligated to provide COBRA Continuation Coverage to the affected Qualified Beneficiary.

### Your COBRA Notification Requirements for Disability Determination

If you extend your COBRA Continuation Coverage beyond eighteen (18) months because you are eligible for disability Benefits from Social Security, you must provide the Claim 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 in Section 4: Important Administrative Information: ERISA. 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.

### Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

### When COBRA Continuation Coverage Ends

COBRA Continuation Coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that You, your Spouse or your covered Dependent(s) becomes covered under another group health plan, as long as the other health plan does not limit your coverage due to a preexisting condition; or if the other health plan does exclude coverage due to your preexisting condition, your COBRA Benefits would end when the exclusion period ends;

- The date, after electing continuation coverage, that You, your Spouse or your covered Dependent(s) first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium (premium is not paid within forty-five (45) days);
- The date coverage ends for failure to make any other monthly premium (premium is not paid within thirty (30) days of its due date);
- The date the Health Plan is terminated; or
- The date coverage would otherwise terminate under the Health Plan as described in Section 4: When Coverage Ends

Note: If you selected COBRA Continuation Coverage under a prior health plan, which was then replaced by coverage under this Health Plan, continuation coverage will end as scheduled under the prior health plan or in accordance with the terminating events listed in this Section, whichever is earlier.

**IMPORTANT HEALTH PLAN INFORMATION**

## Marketplace Coverage under Health Care Reform

There may be other coverage options available to you. In the Health Care Reform Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You can access the Marketplace for your state at www.HealthCare.gov. Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

## Health Plan Contact Information

You can obtain information about the Health Plan on request from:

ONEOK, Inc. Health Plan for Former Employees
Attention: ONEOK, Inc. Benefit Plan Administration Committee c/o Vice President, Human Resources
100 West Fifth Street
Tulsa, OK 74103-4298
Telephone (918) 588-7000

You can obtain information about COBRA Continuation Coverage by contacting UnitedHealthcare at (877) 797-7475, Business Hours: 7 a.m. to 7 p.m. CST.

## PLAN REIMBURSEMENT: SUBROGATION

The Health Plan has a right to subrogation and reimbursement, as defined below.

### Right of Recovery

The Health Plan has the right to recover Benefits or other amounts it has paid to you, or on your Spouse's or your Dependent(s)' behalf that were:

- Made in error;
- Due to a mistake in fact;
- Advanced during the time period of meeting the calendar year Annual Deductible;
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year; or
- Not authorized or provided for under the terms of the Health Plan.

Benefits paid because you, your Spouse or your Dependent(s) misrepresented facts are also subject to recovery. If the Health Plan provides a Benefit for you, your Spouse or your Dependent(s) that exceeds the amount that should have been paid, the Health Plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future Benefit payment for you, your Spouse or your Dependent(s) by the amount of the overpayment.

If the Health Plan provides an advancement of Benefits to you, your Spouse or your Dependent(s) during the time period of the Annual Deductible, the Health Plan will send you, your Spouse or your Dependent(s) a monthly statement identifying the amount you owe with payment instructions. The Health Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you, your Spouse or your Dependent(s) that details any outstanding balance owed to the Health Plan; and
- Conducting courtesy calls to you, your Spouse or your Dependent(s) to discuss any outstanding balance owed to the Health Plan.

### Right to Subrogation

The right to subrogation means the Health Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third-party for Benefits that the Health Plan has paid. Subrogation applies when the Health Plan has paid on your behalf Benefits for a Sickness or Injury for which a third-party is considered responsible, e.g. another automobile driver who was negligent (or his/her insurance carrier) if you are involved in an auto accident.

The Health Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and Benefits the Health Plan has paid on your behalf relating to any Sickness or Injury caused by any third-party.

### Right to Reimbursement

The right to reimbursement means that if a third-party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery; you must use those proceeds to fully return to the Health Plan 100% of any Benefits you received for that Sickness or Injury. Thus, the third-party effectively pays for your Sickness or Injury expense, not you or the Company.

### Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- The Company in workers' compensation cases, if applicable to a Former Employee participating in the Health Plan; or
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
    - Underinsured or uninsured motorist insurance;
    - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise); Workers' compensation coverage; or
    - Any other insurance carrier or third-party administrator.

### Subrogation and Reimbursement Provisions

As a Covered Person, you agree by participating in the Health Plan to the following:

- The Health Plan has a first priority right to receive payment on any claim against a third-party before you receive payment from that third-party.
- The Health Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Health Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Health Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Health Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
    - Complying with the terms of this Section;
    - Providing any relevant information requested;
    - Signing and/or delivering documents at its request;
    - Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
    - Obtaining the Health Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third-party as a result of a Sickness or Injury, and the Health Plan alleges some or all of those funds are due and owed to it,

you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Health Plan has paid.

- If the Health Plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by you or your representative, the Health Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Health Plan, without its written approval.
- You will assign to the Health Plan all rights of recovery against third parties to the extent of Benefits the Health Plan has provided for a Sickness or Injury caused by a third-party.
- The Health Plan's rights will not be reduced due to your own negligence.
- The Health Plan may file suit in your name and take appropriate action to assert its rights under this Section. The Health Plan is not required to pay you part of any recovery it may obtain from a third-party, even if it files suit in your name.
- The provisions of this Section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third-party.
- In case of your wrongful death, the provisions of this Section to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Health Plan or its agents is considered a breach of contract. As such, the Health Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Health Plan has paid relating to any Sickness or Injury caused by any third-party, to the extent not recovered by the Health Plan, due to you or your representative not cooperating with the Health Plan.
- If a third-party causes you to suffer a Sickness or Injury while you are covered under this Health Plan, the provisions of this Section continue to apply, even after you are no longer a Covered Person.
- The Health Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

## Plan Contact Information

You can obtain information about the Plan on request from:

ONEOK, Inc. Health Plan for Former Employees
Attention: ONEOK, Inc. Benefit Plan Administration Committee c/o Vice President, Human Resources
100 West Fifth Street
Tulsa, OK 74103-4298
Telephone (918) 588-7000

You can obtain information about COBRA Continuation Coverage by contacting UnitedHealthcare at (877) 797-7475, Business Hours: 7 a.m. to 7 p.m. CST.

## IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This Section includes information on the administration of the Health Plan, as well as information required to be stated in the SPD by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

### Type of Administration

The Plan is a self-funded group health plan

### Plan Administrator and Plan Fiduciary

The Plan is administered by the ONEOK, Inc. Benefit Plan Administration Committee (hereinafter referred to as the "Plan Administrator"), a committee consisting of the Company's Chief Financial Officer Chief Financial Officer, most senior officer with day-to-day responsibility for the Human Resources function, most senior officer with day-to-day responsibility for the Treasury function and their respective successors in title or duties, authority and function. The Company's Chief Financial Officer shall serve as Chair of such committee and may appoint additional members in his sole discretion. Each of the members of such committee may from time to time designate an alternate who shall have full power to act in his/her absence or inability to act. The Plan Administrator shall serve as the "plan administrator" within the meaning of Section 3(16)(A) of ERISA and as the Plan's "named fiduciary" within the meaning of Section 402 of ERISA.

The Plan Administrator may delegate authority and responsibility for administration of the Plan to other persons, including but not limited to the Company and its Employees, pursuant to a duly adopted resolution or memorandum of consent, and all discretionary actions taken pursuant to any such delegation shall be entitled to the same deference as if taken by the Plan Administrator. The discretionary authority and duties of the Plan Administrator include interpreting the Plan; prescribing forms; establishing claims and other administrative procedures and rules; determining rights to and the amount of Benefits; reviewing determinations on claims for Benefits and other determinations and actions; authorizing other Benefit payments; obtaining and transmitting information necessary for the administration of the Plan; employing agents, counsel, accountants, actuaries, consultants, record keepers and other service providers, including the appointment of investment managers under Section 402(c)(3) of ERISA to manage any assets of the Plan; opening, closing and managing accounts at one or more commercial banks, investment banks, trust companies, insurance companies, broker-dealers, investment advisers, investment managers, registered investment companies, investment funds and other financial institutions; depositing and withdrawing money, securities or other property in and from such accounts and providing written or oral instructions with respect to the administration and management of such accounts; making, signing, furnishing, delivering or filing reports, returns, forms or other instruments with respect to, on behalf of or for the Plan or any trustee; and otherwise having authority to control and manage the operation and administration of the Plan.

In carrying out its responsibilities under the Plan, the Plan Administrator (or such other designated Plan fiduciaries or persons to whom it has delegated authority) has discretionary authority to interpret the terms of this Plan and to determine eligibility for and entitlement to Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and conclusive, binding on all persons and entities and be given full force and effect. To the extent permitted by law, the Plan Administrator and other designated or functional Plan fiduciaries who

are employees of the Company shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of the Plan.

You may contact the Plan Administrator at:
ONEOK, Inc.
Plan Administrator - Vice President, Human Resources
100 W. 5th Street Tulsa, OK 74103 (918) 588-7000

## Reliance on Participant Information

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

## Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Health Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited to the Health Plan following two (2) years after the date that any such payment first became due.

## Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Former Employee or the amount of Benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 105, the regulations issued there under, or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the Benefits to which he or she is properly entitled under the Health Plan. Such action by the Plan Administrator may include directing the Company with respect to the withholding of any amounts due to the Health Plan or the Company from amounts paid to the Participant by the Company.

## Compensation of Plan Administrator

Unless otherwise determined by the Company and permitted by law, any agent, member or representative of the Plan Administrator who is also an Employee of the Company shall serve without compensation for services rendered in such capacity.

## Payment of Plan Administration Expenses

All reasonable expenses of administering the Health Plan shall be paid by the Company to the extent not

paid out of Plan assets at the direction of the Plan Administrator or its duly authorized representatives. To the extent that a trust serves as a funding vehicle for more than one plan, expenses paid by such trust may be fairly allocated among such plans at the reasonable discretion of the Plan Administrator or its duly authorized representatives.

## Claims Administrator

Claims are processed on behalf of the Health Plan and Plan Administrator by the Claims Administrator, UnitedHealthcare; PO Box 305555, Salt Lake City, UT 84130, Telephone: (800) 232-8943. The Claims Administrator for the Health Plan is classified as an insurance issuer under federal law.

The role of the Claims Administrator is to handle the day-to-day administration of the Health Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Health Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Health Plan.

Under the Health Plan, Benefits claims are paid directly from the general assets of the Company and certain trust assets. No Benefits under the Health Plan are guaranteed or paid under a contract or policy of insurance issued by the Claims Administrator.

You may contact the Claims Administrator by the telephone number above or in writing at:
UnitedHealthcare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450

## Health Plan Funding and Payments

The Health Plan is funded by contributions and payments from the general assets of ONEOK, Inc. The Health Plan is also funded by contributions from a voluntary employees' beneficiary association (VEBA) trust that provides for the payment of Benefits to Participants under the Health Plan. Participants in the Health Plan make contributions to the Health Plan based on an elected Medical Benefit Option and Coverage Tier, in accordance with the Health Plan.

Payments are made pursuant to the Health Plan to reimburse eligible Former Employees, Spouses and Dependent(s) for health care expenses, and for other authorized purposes in accordance with the Health Plan.

## Insurance Contracts

The Company shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Health Plan; and (b) to replace any of such insurance companies or contracts. To the extent that such amounts are less than aggregate Company contributions toward such insurance, any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall be the property of the

Company.

## Amendment or Termination of Health Plan

ONEOK, Inc., as the Plan Sponsor, has and retains the right to amend, change, cancel, discontinue, or terminate the Plan at any time without the consent of employees, former employees, or participants in the Plan, or any other person covered by the Plan. Except for those authorities and responsibilities which are expressly reserved to the Board of Directors herein, the ONEOK, Inc. Benefit Plan Sponsor Committee shall possess and exercise all non-fiduciary "settlor" authority to act on behalf of the Company with respect to the Plan. The ONEOK, Inc. Benefit Plan Sponsor Committee ("Sponsor Committee") shall consist of the officers designated as members of the ONEOK, Inc. Benefit Plan Sponsor Committee pursuant to the management committees list maintained by the Company's Corporate Secretary and their respective successors in title or duties, authority and function. The Company's Chief Executive Officer, acting in his sole discretion in his capacity as Sponsor Committee Chair, may appoint, remove or replace Sponsor Committee members at any time by executing a written instrument setting forth his desired changes in Sponsor Committee membership. Any such appointment, removal or replacement shall become effective as of the date prescribed in such written instrument, even if not memorialized in the governing Plan documents until a later date. Sponsor Committee members shall serve until their resignation, retirement or removal.

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

## Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Health Plan. The Health Plan's Agent of Service is:

ONEOK, Inc. Health Plan for Former Employees
National Registered Agents, Inc.
1833 South Morgan Road
Oklahoma City, OK 73128

Legal process may also be served on the Plan Administrator.

## Other Plan Information

This Section of the Plan Document and Summary Plan Description contains information about how the Health Plan is administered as required by ERISA.

| | |
|---|---|
| Health Plan Name: | ONEOK, Inc. Health Plan for Former Employees |
| Plan Number: | 516 |
| Employer/Plan Sponsor: | ONEOK, Inc. and Subsidiaries<br>100 West Fifth Street<br>Tulsa, Oklahoma 74103 |
| Employer ID: | 73-1520922 |
| Plan Type: | Welfare benefit plan |
| Plan Year: | January 1 – December 31 |
| Plan Administrator: | ONEOK, Inc. Benefit Plan Administration Committee<br>c/o Vice President, Human Resources<br>100 West Fifth Street<br>Tulsa, Oklahoma 74103 (918) 588-7000 |
| Third-party Claims Administrator: | UnitedHealthcare<br>P.O. Box 30555<br>Salt Lake City, Utah 84130-0555<br>(800) 232-8943 between 8 a.m. to 8 p.m. CT except for major holidays |
| Agent of Service of Legal Process: | ONEOK, Inc. Health Plan for Former Employees<br>National Registered Agents, Inc.<br>1833 South Morgan Road<br>Oklahoma City, OK 73128 |
| Source of Plan Contributions: | Company and Former Employees |
| Source of Benefits: | General Assets of the Plan Sponsor; and Voluntary Employees' Benefit Association (VEBA) Trust— ONEOK Inc. Employees' Retiree Medical Benefit Trust (VEBA) and ONEOK Inc. Employee Retirement Medical Trust II |
| Trustee of Trust: | The Bank of New York Mellon<br>500 Grant Street 151-4040<br>Pittsburg PA 18258State Street Bank and Trust Company<br>1200 Crown Colony Drive, Quincy, MA 02169 |

## YOUR ERISA RIGHTS

As a Participant in the Health Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Health Plan Participants shall be permitted to:

- Receive information about the Health Plan and Benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, summary annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all documents governing the operation of the Health Plan and other Health Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest annual report, Form 5500 Series and updated Summary Plan Description, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- Receive a summary annual report of the Health Plan's financial activities. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

You can continue health care coverage for yourself, your Spouse and/or your Dependent(s) if there is a loss of coverage under the Health Plan as a result of a Qualifying Event. You, your Spouse or your Dependent(s) may have to pay for such coverage. Review this Summary Plan Description and the Health Plan documents to understand the rules governing your COBRA Continuation Coverage rights.
In addition to creating rights for Health Plan Participants, ERISA imposes duties on the people who are responsible for the operation of the Health Plan. The people who operate your Health Plan, who are called "fiduciaries" of the Health Plan, have a duty to do so prudently and in the interest of you and other Health Plan Participants and beneficiaries. No one, including your Employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Health Plan Benefit or exercising your rights under ERISA.

If your claim for a Health Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the Health Plan, and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Health Plan, you may file suit in a state or federal court. In addition, if you disagree with the Health Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that, the Health Plan's fiduciaries misuse the Health Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Health Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

## Health Plan Benefits and Rights

Participation in the Health Plan provides Participants and Covered Persons with Benefits in accordance with the terms and provisions of the Health Plan. The Health Plan is a welfare benefit plan for Former Employees established and maintained by the Company. The Health Plan is not a contract. Benefits, rights and features of the Health Plan are not vested for any Participant and are subject to change, in whole or in part, at any time and for any reason. The permitting of Benefits provided under the Health Plan is not permanent and is subject to the authority of the Company to amend, modify, or terminate the Health Plan in the future, as provided in the Health Plan.

## No Guarantee of Retirement or Long-Term Disability Benefits

The Health Plan shall not be construed to give any Former Employee the right to retain entitlement to post-retirement benefits or Long-Term Disability by the Company nor any right or claim to a benefit, payment, or compensation unless the right to such a benefit is in accordance with the terms of the Health Plan.

## No Guarantee of Tax Consequences

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

## Governing Law

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

## Headings

The headings of the various Parts of this Health Plan are stated for convenience of reference and are not

to be regarded as indicating or controlling the meaning or construction of any provisions.

## Severability

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

The Health Plan's Benefits are administered by the Company, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Health Plan and provides appeal services; however, UnitedHealthcare and the Company are not responsible for any decision you, your Spouse and/or your Dependents make to receive treatment, services or supplies, whether provided by a Provider. UnitedHealthcare and the Company are neither liable nor responsible for the treatment, services or supplies provided by the Providers.

## GENERAL INFORMATION

### General

The Health Plan shall be considered to provide relevant Notices in a culturally and linguistically appropriate manner if the Health Plan meets all the requirements of this Section with respect to the applicable non-English languages described herein.

The Health Plan shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing Claims and Appeals (including External Review) in any applicable non- English language.

The Health Plan shall provide, upon request, a Notice in any applicable non-English language. The Health Plan shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Health Plan.

### Applicable Non-English Language

With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of Health and Human Services.

### Limitation of Action

You cannot bring any legal action against the Company, the Plan Administrator, or the Claims Administrator to recover reimbursement until ninety (90) days after you have properly submitted a claim for Benefits and all required reviews of your claim have been completed. If you want to bring a legal action against the Company, the Plan Administrator or the Claims Administrator, you must do so within one (1) year after an adverse determination (or deemed adverse determination) on appeal.

By participating in the Plan, you are deemed to have waived any right to participate in any class action involving the Health Plan or to accept any personal recovery (equitable, monetary or otherwise) from any such proceeding.

### Jurisdiction and Venue

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

### Designating an Authorized Representative

The Health Plan has established procedures for you to designate an individual to act on your behalf with respect to a health Benefit claim or an appeal of an Adverse Benefit Determination. Contact UnitedHealthcare by calling the toll-free number on the back of your ID Card for help if you wish to designate an authorized representative. In the case of a Pre-certification Claim Involving Urgent Care, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative. The Health Plan reserves the right to limit the person(s) who may act as your authorized representative, and a person's status as your authorized representative does not convey any independent legal or equitable rights to such person as a Participant, third-party beneficiary, assignee,

subrogee or otherwise.

### Assignment of Benefits—No Right to Assign Benefits

You may not assign your Benefits under the Health Plan to an Out-of-Network Provider without consent of the Health Plan Claims Administrator. When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the Out-Of-Network Provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the Out-Of-Network Provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the Out-Of-Network Provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to an Out-Of-Network Provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to an Out-Of-Network Provider, you remain the sole beneficiary of the payment, and the Out-Of-Network Provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although the Claims Administrator may in its discretion send information concerning the Benefits to the Out-Of-Network Provider as well. If payment to an Out-Of-Network Provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the Provider owes the Plan, pursuant to Refund of Overpayments in Section 4: Plan Reimbursement: Subrogation.

When you assign your Benefits under the Health Plan to an Out-of-Network Provider with our consent, and the Out-of-Network Provider submits a claim for payment, you and the Out-of-Network Provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate. To be recognized as a valid assignment of Benefits under the Health Plan, the assignment must reflect the Covered Person's agreement that the Out-of-Network Provider will be entitled to all the Covered Person's rights under the Health Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the Out-of-Network Provider, the Claims Administrator may in its discretion make payment of the benefits directly to the Out-of-Network Provider for your convenience, but will treat you, rather than the Out-of-Network Provider, as the beneficiary of your claim. If Benefits are assigned or payment to an Out-of-Network Provider is made, the Health Plan and the Company reserves the right to offset Benefits to be paid to the provider by any amounts that the Out-of-Network Provider owes the Health Plan or the Company pursuant to Refund of Overpayments.

The Claims Administrator will pay Benefits to you unless:

(1) The Out-of-Network Provider submits a claim form to the Claims Administrator that you have provided signed authorization to assign Benefits directly to that Out-of-Network Provider.
(2) You make a written request for the Out-of-Network Provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or, with written authorization by you, your Out-of-Network Provider, and not to a third-party, even if your Out-of-Network Provider purports to have assigned Benefits to that third-party.

# HIPAA PRIVACY NOTICE AND POLICY ONEOK, INC. HEALTH PLAN FOR FORMER EMPLOYEES

**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 Clinic Health Act ("HITECH") require group health plans to notify plan participants and beneficiaries about their policies and practices to safeguard the privacy and security of their protected health information. This Notice 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 speaking, PHI includes information provided by you or created, received or maintained by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan 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 and 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; and
- Follow the terms of this Notice, as amended from time to time.
- 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 are the most common ways the plans may use and disclose your PHI:

- **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 plans 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 – Human Resources (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. 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.
- **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. 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.
- **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.

## 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. Generally, if you are denied access to health information, you may request a review of the denial.
- **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 you ask the plan to amend health information that either: (1) is accurate and complete; (2) was not created by the plan; (3) is not part of the health information kept by or for the plan; or (4) is not information that you would be permitted to inspect and copy.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures. This is a list of disclosures of your PHI the plans have made to others, except for those necessary to carry out health care treatment, payment, operations, disclosures made to you, or in certain other situations. To request an accounting of disclosures that have occurred since the effective date of this Notice, submit your request, in writing, to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.
- **Right to Request Restrictions**. You have the right to request a restriction on the health information the 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 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 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 Secretary 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, Human Resources
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

# CLAIMS AND APPEALS PROCEDURES

## General

As part of the claims administration process, the Claims Administrator will:

- pay claims for benefits due under the Health Plan;
- provide written explanations of the reasons for denied claims;
- handle claimant requests for reviews of most denied claims; and
- make the final decision on most denied claims.

The claims and appeals procedure described in this SPD is generally required by federal law, but the procedure used by the Plan's Claims Administrator may differ in certain ways. If the procedure described in a Benefit Document differs from the procedure described here, you should follow the procedure described in the Benefit Document. The Claims Procedure for the Health Plan is intended to provide reasonable procedures consistent and in compliance with governing federal law and regulations and include a description of all claims procedures, including any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames which are stated and included in this Summary Plan Description and Plan Document.

The Claims Procedures are intended to contain no provision, and are not to be administered in a way, that unduly inhibits or hampers the initiation or processing of Claims for Benefits. The Claims Procedures do not preclude an Authorized Representative of a Claimant from acting on behalf of the Claimant in pursuing a Benefit Claim or Appeal of an Adverse Benefit Determination. However, the Health Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant. In the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the Authorized Representative of the Claimant.

The Claims Procedures are intended to contain administrative processes and safeguards designed to ensure and to verify that Benefit Determinations are made in accordance with the Health Plan and this Summary Plan Description and that, where appropriate, Health Plan provisions have been applied consistently with respect to similarly situated Claimants.

The Claims Procedures of the Health Plan provide that, in the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Health Plan's procedures for filing a Pre-Service Claim, the Claimant or Authorized Representative shall be notified of the failure and the proper procedures to be followed in filing a Benefit Claim. This notification shall be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure for a Pre-Service Claim, and not later than twenty-four (24) hours following the failure in the case of a failure to file a Claim Involving Urgent Care. Such notification may be oral, unless written notification is requested by the Claimant or authorized representative.

The notification of failure to follow Health Plan procedures for Pre-Service Claims and Claims Involving Urgent Care shall apply only in the case of a failure that is (1) a communication by a Claimant or an Authorized Representative of a Claimant that is received by a person or organizational unit customarily

responsible for handling benefit matters, and (2) is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

## Special Rules for the Healthcare Benefits

Special timelines apply to claims and appeals for the medical benefits (the "Healthcare Benefits"). These timelines are based on whether your claim is an "urgent care claim," a "pre-service claim," or a "post-service claim."

- An *urgent care claim* is a claim for which application of the pre-service or post-service timelines could jeopardize your life, health, or ability to regain maximum function, or, in your doctor's opinion, would subject you to severe pain.
- A *pre-service claim* is a claim for a service or supply that must be pre-certified before it is performed.
- A *post-service claim* is any other claim. For example, a post-service claim includes a claim where you request reimbursement after treatment has been performed.

Additionally, special rules apply for certain "concurrent care claims," which are claims that relate to a previously-approved ongoing course of treatment to be provided over a period of time or number of treatments. A decision by the Health Plan to reduce or terminate a course of treatment (other than by Health Plan amendment or termination) will be treated as a claim denial. The notification of the denial will meet the "written notice of denial" requirements described in this SPD and will be provided sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

If you request to extend a course of treatment beyond the previously-approved period of time or number of treatments and your request is an urgent care claim (see above), your request will be decided as soon as possible, taking into account the medical needs. The Claims Administrator will notify you of that benefit determination within 24 hours after the Health Plan receives the claim if the claim is made to the Health Plan at least 24 hours before the end of the previously-approved period of time or number of treatments. Appeals of concurrent care decisions are governed by the rules and timeframes described below based on the underlying claim involved (i.e., urgent care, pre-service or post-service). For example, an appeal of a concurrent care decision involving urgent care will be governed by the rules and timeframes that apply to appeals of urgent care claims.

## Filing Claims

You must file a claim for benefits with the Claims Administrator for that benefit. In some cases, your doctor or service provider automatically files a claim for you. In other cases, you need to submit a claim form by mail, by fax, or online. Each Summary describes the procedure for filing claims, which may include the date by which a claim must be filed and the information to be included with the claim.

If a pre-service claim for Healthcare Benefits does not follow the required procedures, the Claims Administrator will notify you of the error, and what you must do to correct the error, within 5 days (or within 24 hours, in the case of an urgent care claim), as long as:

- The claim is received by a person or unit of the Health Plan Administrator or Claims Administrator that is generally responsible for handling benefit matters; and
- The claim submission names the claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

In such cases, notification of your filing error may be oral, unless you request written notification.

Below is the name and contact information for the Claims Administrator:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555
(800) 232-8943 between 8 a.m. to 8 p.m. CT except for major holidays

In certain circumstances, the Health Plan may offer claims assistance or provide claim-related notifications in non-English languages. If you have any questions about the language assistance options that may be available to you, contact the Health Plan Administrator.

## Claim Denials

The Claims Administrator must respond to your claim within a certain number of days or hours following its receipt of your claim. The requirement for each benefit is as follows:

| **Urgent Care** | **Pre-Service** | **Post-Service** | **Disability claims** |
|---|---|---|---|
| 72 hours | 15 days | 30 days | 45 days |

If your claim is incomplete or if the Claims Administrator needs additional time to review your claim, the timeframes described above may change.

## Missing Information

If the Claims Administrator asks you for additional information to complete your claim, the amount of time you have to provide the requested information for each benefit is as follows:

| **Urgent Care** | **Pre-Service** | **Post-Service** | **Disability claims** |
|---|---|---|---|
| 48 hours | 45 days | 45 days | 45 days |

## Necessary Extension

If the Claims Administrator needs additional time to review your claim or review the additional information you are requested to provide, the timeframe for deciding your claim may be extended. If the Claims Administrator needs an extension, you will receive a notice before the end of the initial claim denial period explaining when you can expect to receive your decision. The Claims Administrator may take a second extension with claims involving disability determinations. The extension period cannot last longer than a certain number of days after the end of the initial claim determination period specified above or, if earlier, after the earlier of receipt of your additional information or your deadline

for submitting that additional information. The maximum extension period for each benefit is listed in the following table:

| Urgent Care | Pre-Service | Post-Service | Disability claims |
|---|---|---|---|
| 48 hours | 15 days | 15 days | 30 days |

## Written Notice of Denial

If your claim for benefits is wholly or partially denied, you will receive a written notice containing the following information:

- for medical claims, information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount;
- the specific reasons for the determination, including any denial code applicable to a medical claim and its corresponding meaning;
- a reference to the specific Health Plan provisions on which the determination is based;
- a statement describing additional material or information necessary to complete the claim and why such information is necessary;
- a statement describing Health Plan procedures and time limits for appealing the determination, as well as details regarding any available external review and the right to sue in federal court under Section 502(a) of ERISA;
- for Healthcare Benefit claims or disability claims filed before April 2, 2018, any internal rule, standard, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying Health Plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification;
- for medical claims, a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process; and
- for disability claims filed after April 1, 2018,
    - a discussion of the decision, including an explanation as to why the Claims Administrator disagreed with or did not follow (i) any evidence you submitted regarding the views of health care professionals who provided treatment to you and/or vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination, or (iii) any Social Security Administration disability determination that you submitted;
    - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Health Plan relied upon in making the determination (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist); and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Upon your request and free of charge, the Claims Administrator will also provide you with the diagnosis and treatment codes (and their corresponding meanings) applicable to your medical claim.

## Filing Appeals

If you believe your claim was denied in error, you may appeal this decision. You must submit your appeal request to the Claims Administrator within a certain number of days following your receipt of the written denial notice. The requirement for each benefit is listed in the following table:

| Urgent Care | Pre-Service | Post-Service | Disability claims |
|---|---|---|---|
| As soon as possible | 180 days | 180 days | 180 days |

You may submit written comments, documents, or other information in support of your appeal and you will be provided, upon request, reasonable access to and copies of all relevant documents, records, and other information, free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review and will not be influenced by the initial claim decision.

If your appeal concerns a medical claim or a disability claim filed after April 1, 2018, and if the reviewer considers any evidence or rationale that was not considered as part of the initial claim, the reviewer will provide you with that evidence and/or rationale and give you an opportunity to respond before making its determination.

If the appeal concerns Healthcare Benefits or disability benefits, a different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Health Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the Health Plan in connection with the denial of your claim, we will provide you with the names of each such expert upon your request, regardless of whether the advice was relied upon.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Health Plan and you by telephone, fax, or other similar method.

## Appeal Denials

The Claims Administrator must respond to your appeal within a certain number of days following its receipt of your appeal request. The requirement for each benefit is listed in the following table:

| Urgent Care | Pre-Service | Post-Service | Disability claims |
|---|---|---|---|
| 72 hours | 15 days | 30 days | 45 days |

If a Summary for the medical benefit provides that the Claims Administrator uses a single level of appeal, the Claims Administrator will have additional time to respond. The Claims Administrator may

have an additional 15 days to respond to an appeal regarding a pre-service claim and an additional 30 days to respond to an appeal regarding a post-service claim.

If your appeal is denied, the denial notice will contain the following information:

- for medical claims, information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount;
- the specific reasons for the determination, including any denial code applicable to a medical claim and its corresponding meaning;
- a reference to the specific Health Plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the Health Plan and your right to obtain information about these procedures;
- for medical claims, information regarding the external review process and instructions on how to request an external review;
- a statement describing your right to bring a civil lawsuit under Section 502(a) of ERISA and, for disability claims filed after April 1, 2018, a statement describing the deadline for filing such a lawsuit;
- for Healthcare Benefit claims or disability claims filed before April 2, 2018, a statement disclosing any internal rule, standard, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying Health Plan terms to your medical condition (or a statement that such information will be provided free of charge upon request);
- for medical claims, a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process; and
- for disability claims filed after April 1, 2018,
    - a discussion of the decision, including an explanation as to why the Claims Administrator disagreed with or did not follow (i) any evidence you submitted regarding the views of health care professionals who provided treatment to you and/or vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination, or (iii) any Social Security Administration disability determination that you submitted; and
    - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Health Plan relied upon in making the determination (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist).

Upon your request and free of charge, the Claims Administrator will also provide you with the diagnosis and treatment codes (and their corresponding meanings) applicable to your medical claim.

The appeal determination notice may be provided in written or electronic form. If it is provided in electronic form, you have the right to request and receive it on a written paper document at no charge. Both the electronic and paper versions will contain the same style, format and content.

## Second Level Appeals

Unless a Benefit Document provides otherwise, medical (pre-service and post-service claims) benefits provide a second level of appeal. Therefore, if you disagree with the determination made in the first appeal, you can submit a request for a second level appeal to the Plan Administrator within 60 days of the date you receive the first-level appeal determination notice.

The same procedures and timeframes that applied to your first level appeal will also apply to your second level appeal.

If the Benefit Document for your medical benefit does not provide for a second level of appeal, you will have exhausted the appeals process after completing your initial appeal.

## Effect of Final Appeal Determination

Once you have submitted a claim and completed all available levels of appeal described above, you will have exhausted the appeals process. Once you exhaust the appeals process, you will have no further recourse with the Claims Administrator or the Company. If you want to further challenge a benefit denial, you may have the right to request an external review and you will have the right to sue the Health Plan in federal court.

For medical claims and disability claims filed after April 1, 2018, if the Claims Administrator (or Plan Administrator for second level appeals) does not comply with all of the procedures described above, you will generally be treated as though you had exhausted the internal appeals process. As a result, you may request an external review (if applicable) or sue the Health Plan even though you have not completed all required levels of appeal.

However, if the violation of these procedures is “de minimus,” you will not be treated as though you exhausted the internal appeals process. The violation will be considered de minimus if it is not likely to cause prejudice or harm to your claim, it was for good cause or due to matters beyond the Health Plan’s control and was in the context of an ongoing, good faith exchange of information between you and the Health Plan.

## External Review

External reviews are available only for medical claims that involve rescissions or medical judgment. Once you have submitted a medical claim and exhausted the available levels of appeal described above, you can request that your claim be reviewed by an independent review organization ("IRO"). You may also request an external review of your urgent care claim if exhaustion of the appeal process described above would seriously jeopardize your life or health or ability to regain maximum function. Instructions regarding the process for requesting an external review will be provided in your claim and appeal determination notices.

The external review will be conducted within 45 days after receipt of the request and notice of the decision will be provided to you. The notice will include:

- a general description of the reason for the request for external review,
- the date the IRO received the request for review,
- the date of the IRO's decision,
- references to the evidence or documentation considered in the determination, including the specific coverage provisions and evidence-based standards,
- a discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon,
- a statement that the determination is binding except to the extent that other relief is available under state or federal law,
- a statement regarding your right to file suit in federal court, and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

## Legal Action

If you exhaust or are treated as having exhausted all levels of the claims appeal process, you may sue the Health Plan in federal court under Section 502(a) of ERISA. You do not need to request an external review before filing suit. If you decide to sue the Health Plan, you must do so within one year after the date of service giving rise to the claim or within the period specified in the applicable Benefit Document, whichever is longer. Any legal proceeding in connection with the Health Plan can only be filed in the United States District Court for the Eastern District of Oklahoma, located in Tulsa, Oklahoma.

# SECTION 5: GLOSSARY OF TERMS AND DEFINITIONS

Many of the terms used throughout this Plan Document Summary Plan Description (SPD) have a specific meaning with regard to the way the Health Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Health Plan. In addition, some terms are described within the Component Program SPD and such definitions are incorporated herein by reference.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and the Plan Administrator's discretion.

**Addendum** – any attached written description of additional or revised provisions to the Health Plan. The Benefits and Exclusions of this SPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

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

**Affiliate** – Any business organization or entity (including, without limitation, a corporation, general partnership, limited partnership, or limited liability company) that is in one or more chains of such organizations conducting trades or businesses connected through ownership of a 100 percent ownership interest in which (i) ONEOK, Inc., an Oklahoma corporation, is the common parent business organization and (ii) a 100 percent ownership interest in each of the organizations, except ONEOK, Inc., is owned directly by one or more of the other organizations, and (iii) ONEOK, Inc. owns a 100 percent ownership interest in at least one of the other organizations. For purposes of the foregoing provisions of this definition, "100 percent ownership interest" means, in the case of an organization, which is a partnership or limited liability company, ownership of 100 percent of the profits interest or capital interest of such partnership or limited liability company.

**Annual Open Enrollment Period** (or Open Enrollment Period) – The annual period of time during which current Eligible Former Employees receive benefit plan updates and pricing information and may change their coverage elections for the following Health Plan Year.

**Applicable Premium for COBRA** – The applicable premium required to be paid for COBRA Continuation Coverage, which shall be the cost to the Health Plan for coverage for similarly situated Covered Persons for whom a COBRA Qualifying Event has not occurred plus an administrative fee of 2%.

**Benefit(s)** – Health Plan payments for Covered Health Services, subject to the terms and conditions of the Health Plan and any Addendums and/or Amendments.

**Benefit Claim** – A request for a Benefit made by a Claimant in accordance with the procedures of the Health Plan for making and filing claims for Benefits; and includes a Benefit Claims that are Pre-Service

Claims and Post-Service Claims (as such are defined in the Claims Procedures).

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

**Benefit Documents** – The applicable UnitedHealthcare summary plan description of the terms and conditions of coverage and Benefits available under the Plan which are incorporated into this Summary Plan Description by reference.

**Benefit Election Form** – A form completed by the Eligible Former Employee to Enroll in the Health Plan. The form is provided by the Company and must be completed in accordance with Health Plan procedures.

**Benefit Period** – The period of time during which you, your Spouse and/or your Dependent(s) receive Covered Health Services that are paid for by the Health Plan. A Benefit Period begins when a new Former Employee enrolls in the Health Plan. For a current Eligible Former Employee, the Benefit Period is generally the calendar year, but may be shorter if a current Eligible Former Employee Enrolls or changes his election during a calendar year due to a Change in Family Status Event.

**Benefit Plan Administration Committee** – ONEOK, Inc. Benefit Plan Administration Committee, the Plan Administrator of the Health Plan.

**Change in Status Event**– A Change in Status Event specified under the Health Plan that qualifies a Covered Person to change elected coverage during the Health Plan Year other than during the Annual Open Enrollment Period. Notification must be provided within thirty (30) days.

**Claimant** -An individual who makes a claim under the Health Plan. References to "Claimant" include a claimant's authorized representative.

**Claims Administrator** – UnitedHealthcare (also known as UnitedHealthcare Insurance Company) and its affiliates, which provide certain claim administration services for the Health Plan.

**Claim Involving Urgent Care** – A claim for Medical Care or treatment with respect to which the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant to regain maximum function, or in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**COBRA** – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

**Coinsurance** – The percentage of eligible charges for Covered Health Services for which the Covered Person is responsible.

**Company** – ONEOK, Inc., and its subsidiaries and affiliates.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** – Provisions of federal law that require employers to offer continued health insurance coverage to certain former employees, their spouse and/or dependent(s) whose group health insurance has been terminated.

**Coverage Tier** – The level of coverage that may be elected by Covered Persons under the Health Plan.

**Covered Health Services** – Those health services, including services, supplies, or Pharmaceutical Products, which the Health Plan determines Covered Health Services as defined within the Component Benefit Program documentation.

**Covered Person** – Either the Former Employee, or his or her Spouse or Dependent(s) *only while enrolled and eligible f*or Benefits under the Health Plan; References to "you" and "your" throughout this SPD are references to a Covered Person.

**Creditable Coverage** – Coverage of an individual from a wide range of specified sources, including group health plans, health insurance coverage, Medicare and Medicaid. The Health Plan does not require Creditable Coverage.

**Current Employee** - An individual who is a current employee of the Company within the meaning of such term and words as used in Code Section 9831(a)(2) and ERISA Section 732(a), which the Company and Plan Administrator have determined, and the Plan shall apply to mean for purposes of the Plan, an individual who (i) is currently employed as an employee of the Company and (ii) regularly and actively performs scheduled duties and services as an employee for the Company in its business and operations or is on an approved sickness benefits and/or FMLA leave from such employment. An individual who does not satisfy the criteria and conditions stated in the preceding sentence shall not be considered to be a Current Employee under and for purposes of the Plan even if such individual is receiving compensation or benefits from the Company, or compensation or benefits from or under another employee benefit plan established and maintained by the Company, or is receiving deemed or constructive credit for service as an employee or otherwise for purposes of accruing benefits, or is nominally designated, classified or referred to as an employee of the Company under a collective bargaining agreement or otherwise in another context or for another purpose with respect to his or her prior employment by the Company or his or her prior or present relationship with the Company.

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

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

**Effective Date** – The date when your coverage begins.

**Eligible Family Member** - An individual who is a family member of an Eligible Former Employee and who comes within the coverage provisions listed and stated under Eligible Family Members in Section 1: General Information, Eligible Family Members and required Verification Documents, above.

**Eligible Former Employee** – Former Employees who meet the eligibility criteria listed in Section 1: General Information, Eligibility

**Employee** – An employee of ONEOK, Inc., its subsidiaries and affiliates.

**Employer** – ONEOK, Inc., its subsidiaries and affiliates.

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

are required in order to Enroll for coverage.

**Enrollment Date** – It is the move from the ONEOK, Inc. Health Plan to the ONEOK, Inc. Health Plan for Former Employees. The date the new coverage takes effect, in accordance with Health Plan provisions.

**ERISA - Employee Retirement Income Security Act of 1974, as amended,** federal law that imposes coverage, administration, reporting and disclosure requirements on employer-provided group health and welfare, savings and pension plans.

**External Review** - A review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to an applicable external review process provided for under the Health Plan pursuant to ERISA and governing regulations under such law.

**Final External Review Decision -** A determination by an Independent Review Organization at the conclusion of an External Review.

**Final Internal Adverse Benefit Determination -** An Adverse Benefit Determination that has been upheld by the Health Plan at the completion of the Internal Review appeals process applicable under the Health Plan (or an Adverse Benefit Determination with respect to which the Internal Review appeals process has been exhausted under the deemed exhaustion rules of governing regulations under ERISA.

**Former Employee(s)** – An individual who is not a Current Employee and who meets the eligibility criteria for *Eligible Former Employees* listed in Section 1: General Information for all Health Plan Participants.

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

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

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

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

**Health Plan** or Plan – ONEOK, Inc. Health Plan for Former Employees.

**Independent Review Organization (or IRO)** -An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to the Health Plan, and governing provisions of ERISA and regulations there under.

**Initial Election Period** – The one-time period prescribed by the Company during which the Eligible Former Employee irrevocably elects coverage for himself or herself and/or his or her eligible Dependents at the time of retirement, or, in the case of a Long-Term Disability Participant at the time employment is terminated because of Long-Term Disability.

**In-Network** – A service or supply provided by a Provider under contract with UnitedHealthcare.

**In-Network Provider** – When used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those Providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network Provider for only some products. In this case, the Provider will be an In-Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of Providers will change from time to time.

**Internal Review** - Review by the Health Plan of an Adverse Benefit Determination, as required under the Plan and governing regulations under ERISA.

**Legacy Magellan Employee –** A current or former employee of Magellan Midstream Holdings GP, LLC ("Magellan") or a Magellan affiliate who, as of September 25, 2023, was either (1) participating in the Group Medical Benefits Program for Retirees component of the Magellan Health and Welfare Plan, or (2) eligible to elect to participate in the Group Medical Benefits Program for Retirees component of the Magellan Health and Welfare Plan upon retirement. A current or former employee of Magellan or a Magellan affiliate who was not participating (or eligible to elect to participate upon retirement) in the Group Medical Benefits Program for Retirees component of the Magellan Health and Welfare Plan as of September 25, 2023 shall not be a Legacy Magellan Employee and no person may become a Legacy Magellan Employee after September 25, 2023**.**

**Medical Benefit Option** – A type of Benefits coverage elected by a Covered Person from the optional coverage plan provided under the Schedule of Benefits of the Health Plan

**Medical Care** – Professional services given by a Physician or other Provider to treat illness or Injury.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments that provide medical Benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medicare** – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Open Enrollment** – The period of time, determined by ONEOK, Inc., during which Eligible Former Employees are provided benefit and pricing information and may change elections for themselves, their Spouse and/or their Dependent(s) under the Health Plan.

**Opt-Out (Opt-Out Election)** – An election by a Former Employee, who otherwise could meet the definition of Eligible Former Employee. If you "Opt-Out", you will not be a participant in the Health Plan or receive Benefits under the Health Plan.

**Out-of-Pocket Maximum** – A specified dollar amount of Covered Health Services, which a Covered Person must pay during a Benefit Period.

**Participant** – An Eligible Former Employee, who is enrolled in and elects to participate in the Health Plan pursuant to the terms thereof.

**Physician** – Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you, your Spouse and/ or your Dependent(s) under the Health Plan.

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

**Plan Fiduciary** – ONEOK, Inc. Benefit Plan Administration Committee, and its authorized representatives.

**Plan Document and Summary Plan Description (SPD)** – The SPD is a document which describes the health Benefits available to you and your covered family members under the ONEOK, Inc. Health Plan for Former Employees.

**Plan Sponsor** – ONEOK, Inc.

**Plan Year** – January 1 through December 31 of any given year.

**Preferred Provider Organization (PPO) Medical Benefit Option** – A Preferred Provider Organization consisting of a group of Hospitals, doctors and others that contract to provide Covered Health Services at specified or reduced rates.

**Pre-certification or Pre-authorization** - Certification 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 Pre-certification is requested; the proposed treatment meets the Health Plan's guidelines for Medical Necessity. Pre-certification does not guarantee that the care and services a Covered Person receives are eligible for Benefits under the Health Plan. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Health Plan.

**Pre-certification Request** – Any request for medical treatment that is subject to Pre-certification under the Health Plan.

**Pre-certification Claim Involving Non-Urgent Care** – Any request for medical treatment that is subject to Pre-certification under the Health Plan and that is not a Pre-certification Request Involving Urgent Care.

**Pre-certification Claim Involving Urgent Care** – Any request for Medical Care or treatment with respect

to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of a Covered Person or the ability of a Covered Person to regain maximum function; or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Pre- certification Request.

**Proof of Financial Interdependency** – Documents that show a financial commitment between you and your Domestic Partner, such as a mortgage, lease, bank statement, credit card statement or utility statement listing both you and your Domestic Partner's names, at the same address, as the responsible party.

**Proof of Joint Ownership** – Documents that show a relationship between you and your Spouse such as a mortgage, lease, bank statement, credit card statement or utility statement listing both you and your Spouse's names, at the same address, as the responsible party.

**Properly Filed Claim** – A claim made by or for a Covered Person to the Health Plan that complies with the requirements of the Health Plan, as determined by the Claims Administrator of the Health Plan.

**Provider** – A Hospital, Physician, or other practitioner or Provider of medical services or supplies licensed to render Covered Health Services and performing within the scope of such license.

**Qualifying Event** – Internal Revenue Service's defined events which could result in the change or loss of a Covered Person's coverage.

**Qualified Beneficiary** – A Former Employee covered under the Health Plan; a covered Former Employee's enrolled Spouse or Dependent, including with respect to the Former Employee's children, a child born to or Placed for Adoption with the Former Employee during a period of continuation coverage under federal law; or a covered Former Employee's Spouse.

**Retirement Plan** – The ONEOK, Inc. Retirement Plan (also referred to as "Pension").

**Schedule of Benefits** – The Schedule of Benefits stated for the Health Plan in this Plan Document and Summary Plan Description.

**Sickness** – Physical illness, disease or Pregnancy. The term Sickness as used in this Plan Document and Summary Plan Description includes Mental Illness or substance use, regardless of the cause or origin of the Mental Illness or substance use.

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

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

**State Issued Birth Certificate** – an official document issued to record a person's birth, including such identifying data as name, gender, date of birth, place of birth, and parentage.

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

**Subsidiary** – Any corporation that is in one or more chains of includible corporations connected through stock ownership in which (i) ONEOK, Inc., an Oklahoma corporation, is the common parent corporation (ii) ONEOK, Inc. owns directly stock in at least one (1) of the other includible corporations possessing not less than 100 percent of the total voting power of such corporation, or having a value equal to 100 percent of the total value of the stock of such corporation ("applicable ownership level"), and (iii) stock at such applicable ownership level in each of the includible corporations (except said ONEOK, Inc.) is owned directly by one (1) or more of the other includible corporations.

**UnitedHealthcare (also known as UnitedHealthcare Insurance Company)** – Serves as Claims Administrator for the Health Plan.