ONEOK, INC.

RETIREE REIMBURSEMENT ACCOUNT PLAN

FOR

FORMER EMPLOYEES

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE JANUARY 1, 2024

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INTRODUCTION

ONEOK, Inc., (hereinafter referred to as "Company") has established and maintains the ONEOK, Inc. Retiree Reimbursement Account Plan for Former Employees (the "Plan"). The purpose of the Plan is to reimburse Eligible Former Employees, and certain Eligible Dependents, for Eligible Medical Expenses, which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

This document serves as both the Plan document and the Summary Plan Description (hereinafter referred to as the "Plan") and contains the terms and provisions of the Plan and information to explain the rights and obligations of certain former employees who are Plan Participants.

Note that capitalized terms used in this Plan are defined the first time they are used or are defined in the Plan Information Appendix or Plan Terms at the end of this document. Please note that "you," "your" and "my" when used in this Plan refer to you, the Eligible Former Employee.

ONEOK, Inc. is pleased to provide you with this Plan, available to you and your Eligible Dependents under the Plan. It includes summaries of the following:

- Who is eligible,
- Services that are covered, called Eligible Medical Expenses,
- Services that are not covered,
- How claims for benefits are made, submitted and administered,
- How benefits are paid, and
- Your rights and responsibilities under the Plan.

This Plan is designed to meet your information needs and the summary plan description disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

PART I
GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program.

Q-2. Who can participate in the Plan?

Retired employees of the Company are eligible to participate in the Plan if they meet all requirements to be an Eligible Former Employee as defined in Section 1 of the Plan Terms. In addition, certain Eligible Dependents of an Eligible Former Employee can participate (see Q-3). Eligible Former Employees and their Eligible Dependents, who become covered under the Plan, as explained in Q-4, are called "Participants."

Note that certain self-employed persons (such as sole proprietors, partners, and 2% shareholders of an "S" corporation) may not participate in the 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, this Plan, regardless of whether such individual satisfies the eligibility requirements to be an Eligible Former Employee.

Q-3. Can my dependents participate in the Plan?

Your Dependents who meet all requirements to be Eligible Dependents may also become Participants in the Plan. The Company elected to make separate Benefit Credits for your Eligible Dependents, as reflected in Sections 2, 3, 4, 5, 6, and 7 of the Plan Terms. Note the Company requires that the Eligible Former Employee elect coverage for the Eligible Dependent during the Eligible Former Employee's Initial Election Period. The Initial Election Period is 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 (as defined in Section 1 of the Plan Terms), at the time employment is terminated because of Long-Term Disability. See Section 4 of the Plan Terms regarding this rule and how it applies to you and your Eligible Dependents.

Your Eligible Dependents generally include your Spouse, your Domestic Partner, or Dependent Child (including natural children, stepchildren, adopted children, and other persons described in the Plan Terms), each of whom must be both eligible and enrolled in Medicare (when an individual is both eligible and enrolled in Medicare, the individual is considered to be "entitled" to Medicare).

The Plan will allow reimbursement of Eligible Medical Expenses for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Claims Submission Agent will make a determination as to whether the order is a QMCSO in

accordance with the Plan's QMCSO procedures. The Claims Submission Agent will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Claims Submission Agent at the address listed in the Plan Information Appendix.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Former Employee actually becomes a Participant in the Plan on the date that he or she has satisfied all of the following requirements:

- He or she has become eligible for and enrolled in Medicare;
- He or she has obtained an individual health insurance policy through Via Benefits (or any of its approved affiliates) by enrolling through Via Benefits no later than 60 days after becoming entitled to Medicare, or, if permitted by the Company as reflected in Section 5 of the Plan Terms, he or she has provided satisfactory evidence to the Plan Administrator that he or she has other coverage permissible to the Plan Administrator; and
- He or she has completed any enrollment forms or procedures required by the Plan Administrator for enrollment in the Plan.

An Eligible Dependent, as reflected in Sections 2 through 4 of the Plan Terms, becomes a Participant in the ONEOK, Inc. Health Plan for Former Employees ("Health Plan") or this Plan on the date the Eligible Former Employee becomes a Participant if he or she has completed any enrollment forms or procedures required by the Plan Administrator to enroll his/her Eligible Dependents.

Q-5. How does the Plan work?

The Company has elected a Separate Account structure, as reflected in Section 6 of the Plan Terms. A separate account (hereinafter referred to as a Retiree Reimbursement Account (RRA)) will be established for each Participant and Benefit Credits for each Participant will be credited to his or her own RRA.

Benefit Credits will be credited to RRAs by the Company in the amount and at the times determined by the Company in its sole discretion, as specified in Sections 7, 8, and 10 of the Plan Terms, and will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her RRA. Note that the law does not permit Participants to make any contributions to their RRAs.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you or any Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include, but are not limited to:

- Medications (in reasonable quantities as determined by the Third Party Administrator)

NOTE: Effective for expenses incurred in Plan Years beginning after December 31, 2019, certain over the counter medications and menstrual care products are considered Eligible Medical Expenses.

- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this

Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a reimbursement arrangement.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your RRA. Similarly, only Eligible Medical Expenses incurred while your Eligible Dependent is a Participant in the Plan may be reimbursed from his or her RRA. Eligible Medical Expenses are "incurred" when the medical care is provided, not when you or your Eligible Dependent are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an RRA:

- Expenses incurred for qualified long term care services;
- Expenses incurred prior to the date that you became a Participant in the Plan;
- Expenses incurred after the date that you cease to be a Participant in the Plan;
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; or
- Any other expenses specifically identified as excluded in Section 9 of the Plan Terms.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Former Employee, you will cease being a Participant in the Plan on the earlier of:

- The date you cease to be an Eligible Former Employee for any reason;
- The date you are rehired by the Company as an active employee;
- The date you cease to be eligible for Medicare;
- The date your individual health insurance policy through Via Benefits (or any of its approved affiliates) is terminated for any reason;
- Your date of death;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

If you are an Eligible Dependent, you will cease being a Participant in the Plan on the earlier of:

- The date you cease to be an Eligible Dependent for any reason;
- The date the Eligible Former Employee with whom your participation is associated ceases being a Participant except on account of the Eligible Former Employee's death;
- The date you cease to be eligible for Medicare;
- The date your individual health insurance policy through Via Benefits (or any of its approved affiliates) is terminated for any reason;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of "incurred," see Q-6.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, your Eligible Dependents may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Their continuation of coverage rights and responsibilities are described in Q-16 below.

Q-8. What happens if I do not use all of the credits allocated to my RRA during the Plan Year?

If you do not use all of the amounts credited to your RRA during a Plan Year, those amounts will be carried over to subsequent Plan Years, as reflected in Section 10 of the Plan Terms.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement request through your online login at my.viabenefits.com or request a form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing. The address to which the claim form should be mailed will be noted on the claim form you will receive from the Claims Submission Agent.)

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will need to follow the claims procedures in the Claim Procedures Appendix.

Q-11 What happens if I die?

Separate Account

The Company elected a Separate Account structure, as reflected in Section 6 of the Plan Terms, such that if the Eligible Former Employee dies, the RRA of the Eligible Former Employee is forfeited upon death, but the deceased Eligible Former Employee's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Former Employee before his or her death. Claims must be submitted within 180 days of his or her death.

The Company elected to continue making Benefit Credits to Eligible Dependents after the Eligible Former Employee's death, as reflected in Section 11 of the Plan Terms, such that the Eligible Dependents may retain their RRAs and submit claims for Eligible Medical Expenses in the normal course.

In the event an Eligible Dependent who is also a Participant dies, his or her RRA shall be forfeited, but the deceased Eligible Dependent's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Dependent before the Eligible Dependent's death. Claims must be submitted within 180 days of his or her death.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant's taxable income.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my RRA?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your RRA for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to RRAs or to reduce or eliminate any amounts currently credited to a Participant's RRA.

Other companies participating in the Plan other than the Company (such as a related affiliate or Subsidiary of the Company) may terminate their participation in the Plan at any time upon 60 days written notice to the Plan Administrator.

Amendment or Termination of 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, 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 ("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 shall consist of the Company's President and Chief Executive Officer; Executive Vice President and Chief Administrative Officer; Chief Financial Officer and Executive Vice President – Strategic Planning and Corporate Affairs; Senior Vice President – Finance and Treasurer; Senior Vice President, General Counsel and Assistant Secretary; Vice President – Human Resources; Vice President, Secretary and Associate General Counsel; 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 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.

Q-15. How does the Plan interact with other medical plans?

Only health care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical or pharmacy expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

Q-16. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," Eligible Dependents under the Plan who are the spouse, former spouse or dependent child of an Eligible Former Employee may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant's death or a dependent child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days after the later of the date the qualifying event occurs, and the date on which the qualified beneficiary loses coverage under the terms of the Plan or they will lose the right to continue coverage under the Plan.

If an Eligible Dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her RRA equal to the amounts credited to the RRAs of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their children.

For COBRA purposes, a Domestic Partner will not qualify as a "qualified beneficiary" and will have no equivalent right to elect COBRA continuation coverage. A dependent child of a Domestic Partner may be eligible to elect COBRA continuation coverage, but only if the dependent child qualifies as an Eligible Dependent under the eligibility criteria contained in the Plan Terms.

COBRA continuation coverage is a temporary continuation of coverage. Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's RRA is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Company ceases to provide any group health plan.

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

Q-17. Whom do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the section titled Plan Information Appendix.

PART II
ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your Company, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the

materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III
LEGAL NOTICES

Mothers' And Newborns' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess 48 hours (or 96 hours).

Women's Health And Cancer Rights Act

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas. Call your Plan Administrator for more information.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) includes prohibitions against:

- Requesting or requiring individuals or their family members to undergo genetic testing;
- Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;
- Collecting genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage; and
- Adjusting group premium or contribution amounts on the basis of genetic information.

Health Insurance Portability And Accountability Act

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

Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") require group health plans to notify plans' 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 an individual. It is not individually identifiable health information.

Note: Genetic information shall be treated as health information pursuant to HIPAA. The plans are not permitted to use or disclose PHI that is genetic information about an individual for underwriting purposes.

Plan Responsibilities

The plans are required by law to:

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

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

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

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

How the Plans May Use and Disclose Health Information about You

Although HIPAA generally requires the plans protect the confidentiality of your PHI, there are certain uses and disclosures by the plans allowed under HIPAA and applicable regulations. Those uses and disclosures are allowed in order to properly operate and administer the plans for your benefit according to their terms. The following 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 plans' 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 their business associate so it can perform its claims payment function, but only after the business associate agrees in writing to contract terms that are designed to appropriately safeguard PHI. HIPAA and the plans require all business associates to safeguard your PHI.
- **Treatment Alternatives**. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Plan-Related Benefits and Services**. The plans may use and disclose your PHI to tell you about your plan-related benefits or services that may be of interest to you. However, your PHI will not be used or disclosed for marketing, sales or fundraising purposes without your authorization.
- **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.

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

- **Government Audits**. The plans are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA privacy rule.

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 a Copy of This Notice**. You have the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Contact Information section of this Notice. If you receive this Notice on the plans' website or by electronic mail, you are also entitled to a paper copy of this Notice upon request.
- **Right to Be Notified of a Breach**. You have the right to be notified in the event the plans or a Business Associate discover a breach of your unsecured PHI.

Changes To This Notice

The plans reserve the right to change this Notice at any time and to make the revised or changed Notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The 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 of Total Rewards, Human Resources
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

PLAN INFORMATION APPENDIX

Name of Plan:	ONEOK, Inc. Retiree Reimbursement Account Plan for Former Employees
Effective Date:	January 1, 2019
Name, address, and telephone number of the Plan Sponsor:	ONEOK, Inc. c/o Vice President of Total Rewards, Human Resources 100 W. Fifth Street Tulsa, OK 74103 (918) 588-7000
Name, address, and telephone number of participating Subsidiaries (other than Sponsor):	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.
Name, address, and telephone number of the Plan Administrator:	ONEOK, Inc. Benefit Plan Administration Committee c/o Vice President, Human Resources 100 W. Fifth Street Tulsa, OK 74103 (918) 588-7000 The Health 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 Senior Vice President, Chief Financial Officer and Treasurer, Vice President of Total Rewards – Human Resources, Executive Vice President and Enterprise Services Office, Senior Vice President Corporate Development, and Executive Vice President Chief Legal Counsel and Assistant Secretary, and their

	respective successors in title or duties, authority and function. The Company's Senior Vice President, Chief Financial Officer and Treasurer 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. 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.

Agent for Service of Legal Process:	National Registered Agents, Inc. 1833 South Morgan Road Oklahoma City, OK 73128 Legal process may also be served on the Plan Administrator.
Sponsor's federal tax identification number:	73-1520922
Plan Number:	525
Plan Year:	The twelve month period ending each December 31 (i.e., the calendar year)
Third Party Administrator	Willis Towers Watson – Via Benefits 10975 South Sterling View Drive South Jordan UT 84905 (855) 653-9836 www.my.viabenefits.com/funds
Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	Willis Towers Watson PO Box 981155 El Paso, TX 79998-1155 Fax (866) 886-0879
Source of Benefits:	General Assets of the Plan Sponsor; and Voluntary Employees' Benefit Association (VEBA) Trusts
Trusts	ONEOK Inc. Employees' Retiree Medical Benefit Trust (ONEOK VEBA) ONEOK Inc. Employees' Retiree Medical Trust II (Enron VEBA)
Trustee of Trust	The Bank of New York Mellon 500 Grant Street 151-4040 Pittsburg PA 18258

PLAN TERMS

Section 1. Eligible Former Employees

You are eligible to participate in the Plan if, in addition to meeting the requirements of Q-4 of the Section entitled *General Information About the Plan*, you meet the following requirements:

- Retiree:
    - You are a Medicare eligible former employee of the Company ("Former Employee") hired prior to January 1, 2017, (1) who terminated employment at age fifty (50) or older; and (2) when employed you 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); (3) at the time of termination or retirement were regularly scheduled to work a minimum of twenty (20) or more hours per week; and (4) you elected in writing to participate in and be covered by the ONEOK, Inc. Health Plan for Former Employees (the "Health Plan") or this Plan (if eligible) during your Initial Election Period; or

    - You are a Former Employee acquired as part of the Northern Border Northern Plains Purchase Agreement, (1) who terminated employment at age fifty (50) or older; (2) and when employed you 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); (3) at the time of termination or retirement were regularly schedule to work a minimum of twenty (20) or more hours per week: and (4) you elected in writing to participate in and be covered by the Health Plan or this Plan (if eligible) during your Initial Election Period. To be eligible for a Grandfathered group Benefit Credit (previously referred to as the 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, identified in Section 7 of the Plan Terms as Group Number 4, are not eligible for a Benefit Credit (previously referred to as the Defined Dollar Benefit in the case of Enron Trust Participants).

- Long-Term Disability Participant:
    - You are a LTD Participant if you are a Medicare eligible Former Employee hired by the Company prior to January 1, 2017, (1) who has been approved for benefits under the ONEOK, Inc. Long-Term Disability Plan (LTD); (2) you elected in writing to participate in and be covered by the Health Plan or this Plan (if eligible) during your Initial Election Period; and you are eligible for Medicare. If your eligibility for LTD benefits is terminated, you must otherwise meet these eligibility requirements to remain a Participant in the Plan.

No current active employee, Legacy Magellan employee, or Former Employee ineligible for Medicare, is eligible to participate in this Plan.

Certain Eligible Former Employees who do not receive a Benefit Credit under this Plan may have access to services through Via Benefits. See the attached Via Benefits Access Only appendix.

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 an Eligible Former Employee of the Company, such individual still shall not be eligible for, nor entitled to, and shall not participate in, the Health Plan or this Plan.

Section 2. Eligible Dependents[1]

Certain of your Eligible Dependents are eligible to participate in the Plan if, in addition to meeting the requirements of Q-4 of the Section entitled *General Information About the Plan*, they meet the following requirements:

Eligible Dependent[1]	**Verification Document Requirements**
Your *Spouse*, meaning a person who is recognized as your legal Spouse for purposes of federal income tax laws, who is eligible for and enrolled in Medicare. Neither you nor your spouse may be married to anyone else under either statutory or common law. Your Spouse may be under age 65 if eligible for Medicare.	State-issued marriage certificate (or foreign equivalent) For common law marriages: Affidavit of Common Law Marriage (or Certificate of Informal Marriage).
Your *Domestic Partner*, meaning a person with whom you have a committed relationship, but who is not considered your legal spouse for purposes of federal income tax laws, who is eligible for and enrolled in Medicare. Neither of you may be married to or legally separated from anyone else under either statutory or common law. Your Domestic Partner may be under age 65 if eligible for and enrolled in Medicare.	Jointly signed Declaration for Domestic Partnership. Affidavit of Dependent Status for Domestic Partnership. If HR Solutions does not timely receive a properly completed affidavit, the Plan Administrator will assume that neither your domestic partner nor your domestic partner's eligible dependent 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 eligible dependent child(ren). Proof of Joint Ownership includes two of the following: 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.
Your *natural child(ren)*, if eligible for and enrolled in Medicare, until they reach age 26.	State-issued birth certificate[3] (or foreign equivalent) listing Eligible Former Employee as parent.

Eligible Dependent[1]	Verification Document Requirements
Your *stepchild(ren)*, meaning your Spouse or Domestic Partner's children, if eligible for and enrolled in Medicare, until they reach age 26 or earlier if your marriage to, or Domestic Partnership with, their natural parent ends other than due to the death of one of you.	State-issued birth certificate[3] (or foreign equivalent) listing Eligible Former Employee's Spouse or Domestic Partner as parent, and the verification documents required above to document the relationship with the Spouse or Domestic Partner, as applicable.
Your *adopted child(ren)*, if eligible for and enrolled in Medicare, meaning you, your Spouse or Domestic Partner have adopted the child(ren), or the child(ren) is placed for adoption with you, your Spouse or Domestic Partner, until they reach age 26. You or your Spouse or Domestic Partner must be one of the adopting parents; the child must have been placed in your (or your Spouse's or your 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, and state-issued birth certificate[3] (or foreign equivalent) or similar information obtained in connection with adoption proceeding.
Your *foster child(ren)*, if eligible for and enrolled in Medicare, meaning child(ren) who are placed with you (or your Spouse or Domestic Partner) by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction until they reach age 26.	Foster placement judgment, decree or order.
Your *child covered by a Qualified Medical Child Support Order* (QMCSO), meaning your child(ren) on whose behalf a QMCSO has been entered or issued, indicating that coverage must be provided by you until the child 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 in the ONEOK, Inc. Health Plan for Former Employees or this Plan at retirement)
Other individual(s) who is not your child(ren), or the child(ren) of your Spouse or Domestic Partner, but to whom you are related, for whom you (or your Spouse or Domestic Partner) have been appointed legal guardian,[2] who is your dependent(s) for federal income tax purposes, who is eligible for and enrolled in Medicare, and who is (i) under age 19, or (ii) under age 24 and a full-time education student.	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.[1] If a new legal guardian is appointed in the current calendar year, no tax return is required.
An *incapacitated person*, meaning your child(ren), or other Eligible Dependent(s), who is physically or mentally incapable of self-support while remaining incapacitated, so long as you remain an Eligible Former Employee and so long as the child(ren) or other Eligible Dependent(s) (i) was enrolled in the Health Plan, the ONEOK, Inc. Health Plan, or this Plan prior to turning 26 years of age (for natural, adopted and stepchildren), or attaining age 24 (for other Eligible Dependents), and remained covered through such age, (ii) is eligible for	To continue coverage for an Eligible Dependent under this provision, proof of disability or incapacity (obtained at your own expense) must be received by HR Solutions within 31 days after coverage would otherwise terminate. The Plan requires annual re-certification of the child's physical or mental condition.

Eligible Dependent[1]	Verification Document Requirements
and enrolled in Medicare, and (iii) satisfies the criteria for eligibility under one of the categories described above but for age.	

[1] Eligible Dependents may participate in the RRA only if you enrolled them in the Health Plan or this Plan at the time of your Initial Election Period. If you did not enroll your Eligible Dependents at that time, you may not enroll the Eligible Dependents in this Plan.

[2] If a Spouse or legal guardian for whom coverage was elected during the Initial Election Period was acquired in the current calendar year, no tax return is required.

[3] If the Eligible Dependent has a name different from the name on a state-issued birth certificate (or foreign equivalent), a state-issued marriage certificate (or foreign equivalent) or social security card is required.

The Plan requires the verification documents outlined above and Spouse/Domestic Partner/Eligible Dependent social security number as conditions to retaining an enrolled Spouse/Domestic Partner/Eligible Dependent on the Plan. If documentation is requested to prove the eligibility status of a person you have enrolled under the Plan and you fail to supply the requested documentation within ninety (90) days, the Plan will terminate enrollment of your Spouse/Domestic Partner/Eligible Dependent retroactively to the enrollment date and pursue reimbursement of claims paid by the Plan.

Section 3. Benefit Credits for Eligible Dependents:

(a) X Yes

(b) ☐ No

An Eligible Dependent for whom the Company elects to make a Benefit Credit is eligible to be a Participant under the Plan.

Section 4. Eligible Dependent: An Eligible Dependent may be a Participant in the Plan:

(a) ☐ only if and when the Eligible Former Employee becomes a Participant

(b) X if the Eligible Former Employee has elected coverage for the Eligible Dependent during the Eligible Former Employee's Initial Election Period. Eligible Dependents are eligible only if they meet the Participant requirements outlined in Q-4 of Part I above. An Eligible Dependent may also participate in this Plan if the Eligible Former Employee elected coverage in the Health Plan. For example, the Eligible Dependent may be Medicare-eligible but the Eligible Former Employee may not yet be eligible for Medicare and continue to be enrolled in the Health Plan. The Eligible

Dependent may not participate simultaneously in both this Plan and another group health plan sponsored by the Company.

Section 5. Insurance Coverage Exception: In lieu of obtaining an individual health insurance policy through Via Benefits, an Eligible Former Employee or Eligible Dependent may establish that he or she:

(a) ☐ Has health coverage under TRICARE

(b) ☐ Has health coverage under a policy or plan provided by his or her spouse's Company

(c) ☐ Resides outside the United States

(d) X Is eligible for and enrolled in Medicaid and is not eligible to obtain a guaranteed issue individual health insurance Medigap policy through Via Benefits, Inc. (or any of its approved affiliates).

(e) ☐ Not Applicable

Section 6. Account Structure:

(a) ☐ Combined Account. Only one RRA will be established for all Participants in a single family and all credits for such family members will be credited to such RRA.

(b) X Separate Accounts. A separate RRA will be established for each Participant within a single family.

Section 7. Benefit Credit:

An amount determined by the Company, in its sole discretion, may be credited each month on behalf of Participants who are Eligible Former Employees, Eligible Spouses/Domestic Partners or Eligible Dependents Child(ren). You will be notified prior to each Plan Year, typically during Open Enrollment, of the amount of Benefit Credit you are eligible to receive for the Plan Year.

Section 8. Timing of Benefit Credit: Benefit Credits will be credited to RRAs as follows:

(a) ☐ One time on (insert date):

(b) ☐ On the first day of each Plan Year

(c) ☐ On the first day of each calendar quarter (i.e., one-fourth of the annual Benefit Credit 9 will be credited each quarter)

(d) X On the first day of each calendar month

Section 9. Eligible Medical Expense Exclusion: Eligible Medical Expenses do not include dental and vision insurance premiums.

Section 10. Carryover of Accounts: Credits remaining in an RRA at the end of a Plan Year (after the expiration of the claims run-out period) shall:

(a) ☐ be forfeited on April 1 of the following Plan Year

(b) X be carried over to the following Plan Year to reimburse Participants for Eligible Medical Expenses incurred during subsequent Plan Years

(c) ☐ be carried over to the following Plan Year, up to a limit of $_____

Section 11. Death:

The account remains open for 180 days from the date of death for claim submission for expenses incurred prior to the date of death.

In the event of death of an Eligible Former Employee participating in the Plan, Eligible Dependents of the Eligible Former Employee may continue coverage under the Plan subject to the following conditions:

- Surviving Spouse / Domestic Partner:
    - Spouse / Domestic Partner must be covered under the Plan on the date of the Eligible Former Employee's death; and
    - If the surviving Spouse / Domestic Partner should remarry or establish a new Domestic Partner relationship, the individual the surviving Spouse marries (or establishes a Domestic Partner relationship with) will not be eligible for coverage under this Plan.
- All other Eligible Dependents:
    - Dependent(s) must be covered under the Plan on the date of the Eligible Former Employee's death; and
    - Must continue to meet all applicable Eligible Dependent requirements, as set out in this document.

A surviving Eligible Dependent enrolled in the Health Plan is eligible to participate in this Plan upon eligibility for Medicare and satisfaction of all other eligibility requirements under this Plan, subject to the conditions above.

A surviving Eligible Dependent of an individual who at the time of such individual's death was an active employee of the Company or one of its Subsidiaries (as defined in the Plan Information Appendix) not represented by a collective bargaining unit is eligible to participate in this Plan subject to the conditions above if, at the time of the employee's death, such Eligible Dependent is

eligible for Medicare and satisfies all other eligibility requirements under this Plan. In addition, the following requirements must be met:

- On the date of death, the employee was an active employee with the Company or one of its Subsidiaries (as defined in the Plan Information Appendix) and was regularly scheduled to work forty (40) hours or more per week; and

- On the date of death, the employee had completed sixty (60) or more consecutive months of full-time service with the Company or one of its Subsidiaries (as defined in the Plan Information Appendix).

Section 12. Collective Bargaining Agreement

The Plan is not subject to a collective bargaining agreement.

Section 13. Opt-Out Election Is Permanent

Any Eligible Former Employee who does not elect coverage through Via Benefits shall not ever be eligible to participate again in the Health Plan or this Plan after making that Opt-Out Election.

CLAIM PROCEDURES APPENDIX

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Claims Submission Agent's receipt of the claim. For a disability claim, you are entitled to notification no later than 45 days after receipt of the claim. This 30 (or 45) day period, as applicable may be extended by an additional period of up to 15 days (30 days, in the case of a claim for disability) if the extension is necessary due to conditions beyond the control of the Claims Submission Agent. The Claims Submission Agent is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Claims Submission Agent will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Submission Agent will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Claims Submission Agent will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review.
- If the Claims Submission Agent relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in

making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

- In the case of a denial concerning a claim for disability filed after April 1, 2018,

    - A discussion of the decision, including an explanation as to why the Claims Submission Agent's 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 Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination , or (iii) the Social Security Administration's disability determination that you submitted; and

    - Either the specific rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the determination (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist).

C. Do I have the right to appeal a denied claim?

Yes, you have the right to an appeal.

D. Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, the Company, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your appeal rights.

E. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Claims Submission Agent, and must include the following information:

- Your name and address;

- The fact that you are disputing a denial of a claim or the Claims Submission Agent's act or omission;

- The date of the notice that the Claims Submission Agent informed you of the denied claim; and

- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Submission Agent's act or omission.

You should also include any documentation that you have not already provided to the Claims Submission Agent.

F. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Claims Submission Agent within 180 days after receiving the denial notice or the Claims Submission Agent's act or omission. *If you do not file your appeal within this 180-day period, you lose your right to appeal.* Your appeal will be heard and decided by the Claims Submission Agent (or its designee).

G. How will my appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Submission Agent. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Claims Submission Agent will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Claims Submission Agent receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claims Submission Agent's notice of final adverse benefit determination. Similarly, if the Claims Submission Agent identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Claims Submission Agent's notice of final adverse benefit determination. If your appeal concerns a disability claim filed after April 1, 2018, and if the Claims Submission Agent considers any evidence or rationale that was not considered as part of the initial claim, the Claims Submission Agent's will provide you with that evidence and/or rationale and give you an opportunity to respond before making its determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the appeal determination will be based on the medical judgment of a health care professional retained by the Claims Submission Agent, the health care professional retained for purposes of the appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

H. When will I be notified of the decision on my appeal?

The Claims Submission Agent must notify you of the decision on your appeal within 60 days (or 45 days in the case of a claim for disability) after receipt of your request for review.

I. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Claims Submission Agent will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA § 502(a).

VIA BENEFITS ACCESS ONLY APPENDIX

This Appendix does not describe a benefit under this Plan. However, Company wanted to make Eligible Former Employees aware of this option. Company has offered access to Via Benefits's service of assisting Medicare-eligible Eligible Former Employees in evaluating coverage options that are right for them. While certain Eligible Former Employees do not receive a Company contribution toward the cost of purchasing coverage, the Eligible Former Employees can utilize Via Benefits's coverage evaluation services.

In addition, Medicare-eligible Eligible Former Employees must enroll in retiree medical plans through Via Benefits in order to maintain coverage of their company paid life insurance policy or of their supplemental life insurance and Accidental Death and Dismemberment insurance, if applicable. The only exceptions are the Eligible Former Employees who have been approved for Medicaid and have completed the requirements outlined in Section 5.