ONEOK, Inc. Health Plan for Former Employees

Summary of Material Modification

This summary of material modification (SMM) supplements the summary plan description (SPD) for the ONEOK, Inc. Health Plan for Former Employees (the "Plan"). Please review this SMM carefully and keep it with your copy of the SPD for future reference. The changes described in this SMM are effective January 1, 2026.

Cost Sharing. The cost-sharing provisions in the Plan have been consolidated for the non-Medicare benefit options. Section 5 – *Plan Highlights* and Section 15 – *Outpatient Prescription Drugs* have been revised as described in Exhibit A.

Radiology/Cardiology Prior Authorization. The prior authorization requirement for radiology and cardiology services in Section 6 – *Additional Coverage Details* has been eliminated.

Contact Information
If you have any questions regarding the information in this SMM, you may contact the Plan administrator at:

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EXHIBIT A

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum. The Lifetime Maximum Benefit is not included because no changes were made.

Plan Features	Network Amounts	Non-Network Amounts
Copays[1]		
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
▪ Emergency Health Services.	$300	$300
▪ Physician's Office Services - Primary Physician.	$30	Not Applicable
▪ Physician's Office Services - Specialist.	$50	Not Applicable
▪ Urgent Care Center Services.	$65	Not Applicable
▪ Virtual Care Services.	$5	Not Applicable
Copays do not apply toward the Annual Deductible.		
Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible		
▪ Individual.	$1,000	$2,000
▪ Individual +Spouse or Individual +child(ren)	$2,000	$4,000
▪ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).	$3,000	$6,000
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
Annual Out-of-Pocket Maximum		
▪ Individual (single coverage).	$3,500	Unlimited
▪ Individual +Spouse or Individual +child(ren)	$7,000	Unlimited
▪ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).	$10,500	Unlimited
The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.		
The Network Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.		
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.		

1. Copays are paid each time you receive the Covered Health Services. You are responsible for paying the lesser of the Copay, the Eligible Expense or the Recognized Amount when applicable.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	80% after you pay a Copayment of $300 per visit and after you meet the Annual Deductible	Same as Network
Non-Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	80% after you pay a Copayment of $300 per visit and after you meet the Annual Deductible	80% after you pay a Copayment of $300 per visit and after you meet the Annual Deductible
Mental Health Services and Substance-Related and Addictive Disorders Services		
▪ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
▪ Outpatient.	Office visit 100% after you pay a Copayment of $30 per visit All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
▪ Primary Physician.	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
▪ Specialist Physician.	100% after you pay a Copayment of $50 per visit	60% after you meet the Annual Deductible
In addition to the Copayments stated in this section, the Copayments and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office: ▪ Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient. ▪ Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT,		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
PET, MRI, MRA and Nuclear Medicine - Outpatient. ▪ Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic. ▪ Outpatient surgery procedures described under Surgery - Outpatient. ▪ Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.		
Urgent Care Center Services In addition to the Copayment stated in this section, the Copayment and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: ▪ Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient. ▪ Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient. ▪ Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic. ▪ Outpatient surgery procedures described under Surgery - Outpatient. ▪ Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient. ▪ Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment.*	100% after you pay a Copayment of $65 per visit except 80% after you meet the Annual Deductible for all other services	60% after you meet the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $5 per visit	Non-Network Benefits are not available.
All Other Covered Health Services[2,3,4,5,6]	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

1. Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.
2. The Covered Health Services details were not changed.
3. The Benefit description for Covered Health Services that do not specify a coinsurance amount were not changed (for example, see Diabetes Services).
4. The Coinsurance amount for Preventive Care Services is still 100%.
5. If Non-Network Benefits were not available, they are still not available (for example, see Preventive Care Services).
6. If the Coinsurance amount for Non-Network Benefits were the same as Network Benefits, they are still the same as Network Benefits (for example, see Ambulance Services).

Section 15 – Outpatient Prescription Drugs

Schedule of Benefits - Outpatient Prescription Drugs
Benefit Information for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy

Covered Health Services[1,2,3]	**Percentage of Prescription Drug Charge Payable by You (Per Prescription Order or Refill):**	**Percentage of Out-of-Network Reimbursement Rate Payable by You (Per Prescription Order or Refill):**
	Network	**Non-Network[4]**
Retail - up to a 31-day supply[2] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.		
▪ Tier-1	Lesser of $7.50 or actual cost of the drug.	Lesser of $7.50 or actual cost of the drug.
▪ Tier-2	For a Tier 2 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than $25.00 per Prescription Order or Refill and you will not pay more than $75.00 per Prescription Order or Refill.	For a Tier 2 Prescription Drug Product: 30% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. However, you will not pay less than $25.00 per Prescription Order or Refill and you will not pay more than $75.00 per Prescription Order or Refill.
▪ Tier-3	For a Tier 3 Prescription Drug Product: 40% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than $50.00 per Prescription Order or Refill and you will not pay more than $150.00 per Prescription Order or Refill.	For a Tier 3 Prescription Drug Product: 40% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. However, you will not pay less than $50.00 per Prescription Order or Refill and you will not pay more than $150.00 per Prescription Order or Refill.
Specialty Prescription Drug Products[2] - As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.	For a Specialty Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than $100.00 and you will not pay more than $300.00 per Prescription Order or Refill.	Not Covered

Covered Health Services[1,2,3]	Percentage of Prescription Drug Charge Payable by You (Per Prescription Order or Refill):	Percentage of Out-of-Network Reimbursement Rate Payable by You (Per Prescription Order or Refill):
	Network	**Non-Network[4]**
Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.		
Prescription Drug Products on the List of Preventive Medications		
▪ Tiers-1, 2, 3	$0 Copay	$0 Copay
OptumRx home delivery **Mail Order Network Pharmacy** - up to a 90-day supply[2]	100% after you pay a:	Not Covered
▪ Tier-1	Lesser of $22.50 or actual cost of the drug.	Not Covered
▪ Tier-2	For a Tier 2 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than $75.00 per Prescription Order or Refill and you will not pay more than $225.00 per Prescription Order or Refill.	Not Covered
▪ Tier-3	For a Tier 3 Prescription Drug Product: 40% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than $150.00 per Prescription Order or Refill and you will not pay more than $450.00 per Prescription Order or Refill.	Not Covered

1. Please obtain prior authorization from UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features,* under *Prior Authorization Requirements* in this section.
2. The Plan pays Benefits for Specialty Prescription Drug Products and Specialty Prescription Drug Products on the List of Preventive Medications as described in this table.
3. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.
4. Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UnitedHealthcare, as described in your SPD, *Section 9, Claims Procedures*. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product. In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.