ONEOK, INC. CAFETERIA PLAN

Plan Document and Summary Plan Description

As Amended & Restated January 1, 2024

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

ONEOK, Inc. ("ONEOK") has established and maintains this ONEOK, Inc. Cafeteria Plan (the "Cafeteria Plan" or "Plan") to provide pre-tax benefits for Eligible Employees of ONEOK, its affiliates and subsidiaries (the "Company") and their family members within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code").

The ONEOK, Inc. Benefit Plan Administration Committee (the "BPAC" or "Plan Administrator") is pleased to provide you with this document which serves as the Plan Document and Summary Plan Description (the "Cafeteria Plan Document"), which describes the benefits available to you and your covered family members under the Cafeteria Plan.

This Cafeteria Plan Document outlines the terms and conditions of coverage and Benefits available under this Plan. Additional terms and conditions of the Cafeteria Plan's Benefits are contained in the various policies, summaries and booklets provided by UnitedHealthcare (each a "Benefit Summary") and are incorporated into this Plan by reference. You do not have a complete copy of this Cafeteria Plan unless you have each of the Benefits Summaries referenced herein. These Benefit Summaries can be requested from HR Solutions (contact information listed below).

The Cafeteria Plan, along with the documents listed in Section 1: Schedule of Benefit Summaries, are designed to furnish you information consistent with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This Cafeteria Plan and the Benefit Summaries, certificates and other descriptive material provided to you by the Company and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Cafeteria Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed provisions. You may obtain copies of the Cafeteria Plan and its related documents or examine these documents by contacting HR Solutions at 855-663-6547 or at HRSolutions@oneok.com. Every effort has been made to ensure that all these materials contain a consistent description of the Cafeteria Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Cafeteria Plan. No one speaking on behalf of the Cafeteria Plan or the Company can alter the terms of the Cafeteria Plan.

Capitalized words in this document have meaning stated in *SECTION 7 Glossary,* unless indicated otherwise.

ONEOK., at this time, intends to continue the Cafeteria Plan, but reserves the right, in its sole discretion, to modify, amend or terminate the Cafeteria Plan at any time, for any reason. This Cafeteria Plan Document is not to be construed as a contract of or for employment.

Please read this Cafeteria Plan Document thoroughly to learn how the Cafeteria Plan works. If you have questions contact HR Solutions.

How to Use this Cafeteria Plan Document

- Read this entire Cafeteria Plan Document, and the summaries listed under Section 1: Schedule of Benefit Summaries, and share it with your family.
- Many of the sections of this Cafeteria Plan Document are related to other sections. You may need to read more than just one section for all the information.
- You can find this Cafeteria Plan Document and the Benefit Summaries online at www.oneokonline.com or www.myuhc.com. You can also request a printed copy of this this Cafeteria Plan Document by contacting HR Solutions.
- Capitalized words in this Cafeteria Plan Document have defined meanings stated in *SECTION 7: Glossary.*
- If there is a conflict between this this Cafeteria Plan Document and any Benefit Summaries (other than Summaries of Material Modifications) provided to you, this this Cafeteria Plan Document will control.

This Cafeteria Plan Document is the Cafeteria Plan document and replaces any and all summaries, certificates, or benefit booklets previously issued for the Employees with respect to the Cafeteria Plan in effect as of January 1, 2024. The Cafeteria Plan only provides the Benefits described in this document and the applicable Benefit Summaries, and only for Covered Persons.

Table of Contents

SECTION 1: Schedule of Benefit Summaries

Summary Plan Description: ONEOK, Inc. Flexible Spending Account Plan
Summary Plan Description: ONEOK, Inc. Limited Health Care Flexible Spending Account Plan

SECTION 2: INTRODUCTION

Overview

Under the Cafeteria Plan, you may elect to participate in the following Cafeteria Plan components:

- Health Savings Account ("HSA"):
- Health Care Spending Account ("HCSA");
- Limited Purpose Spending Account ("LHCSA");
- Dependent Care Spending Account ("DCSA"); and
- Pre-Tax Contributions.

The Health Savings Account ("HSA") is a savings account for participants on the ONEOK, Inc. Health Plan High Deductible Health Plan ("HDHP"). The HSA is a tax-advantaged bank account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. If you elect coverage under the HDHP, an HSA will be established for you. You can elect to contribute pre-tax dollars to the HSA to reimburse yourself for certain eligible expenses that are not covered under your healthcare coverage –that is, your qualifying medical, dental, prescription drug, and vision care expenses. The use of pre-tax dollars for these eligible expenses reduces your taxes. The funds in your HSA also accumulate interest and can earn investment returns.
Note: HSAs are individual accounts and are not subject to ERISA. Therefore, the portions of this Cafeteria Plan Document that relate only to ERISA-covered plans (such as the claims and appeals provisions) do not apply to the HSA.

The Health Care Spending Account ("HCSA") is a type of flexible spending account used for reimbursement of Eligible Health Care Expenses, including certain medical and dental expenses for you and your Eligible Dependents. Refer to the ONEOK, Inc. Flexible Spending Account Plan Summary Plan Description for additional details.

The Limited Health Care Spending Account ("LHCSA") is a type of flexible spending account used for reimbursement of certain types of Eligible Health Care Expenses only, including certain dental and vision expenses for you and your Eligible Dependents. If you participate in an HSA, you are ineligible for the HCSA but you are eligible for the LHCSA. Once the minimum HDHP deductible has been met, the LHCSA can be used for certain medical expenses. Refer to the ONEOK, Inc. Flexible Spending Account Plan Summary Plan Description for additional details.

The Dependent Care Spending Account ("DCSA") is a type of flexible spending account used for reimbursement of Eligible Dependent Care Expenses such as day care. Refer to the ONEOK, Inc. Flexible Spending Account Plan Summary Plan Description for additional details.

The Pre-Tax Contributions component of the Cafeteria Plan allows you to make Pre-Tax Employee Contributions and receive Company contributions toward the Benefit Options you elect for yourself and your Covered Dependents. See *SECTION 3: Pre-Tax Contributions.*

Eligible Employees

"Eligible Employees" shall include all full-time, salaried and hourly Employees of the Company. For this purpose, "full-time" means regularly scheduled to work twenty (20) hours or more per week. Employees who are members of a collective bargaining unit and nonresident aliens who do not receive U.S. source income are not Eligible Employees.

The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Cafeteria Plan, and the Plan Administrator has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Cafeteria Plan.

Employment Eligibility Waiting Period

A new Eligible Employee (*i.e*., a new hire or someone who transitions to an eligible employment status) is eligible for participation in the Cafeteria Plan, effective their employment start date (or date of transition).

Enrollment: When and How You May Enroll

You may elect to participate in the Cafeteria Plan, via Workday, within the two weeks (14 days) of your employment start date. If you do not elect to participate in the Cafeteria Plan, you must wait until the next Annual Open Enrollment Period to elect to participate, unless you have experienced a Change in Status Event (see section below on "Change in Status Events").

If you Enroll in the HCSA, LHCSA or DCSA, you must specify the amount of Pre-Tax Dollars that you wish to contribute. The elections you make in Workday will remain in effect for the entire Plan Year, except as provided in the section below on "Change in Status Events."

You must make an online election through Workday each year during the Annual Open Enrollment Period, even if you Enrolled in the Cafeteria Plan the year before. The Annual Open Enrollment Period is usually during the first half of November for approximately 10 days. Employees will be furnished enrollment information by November. Elections made during the Annual Open Enrollment Period become effective the following January 1 and will remain in effect until the following December 31.

If you are a new Employee or transition to an Eligible Employee and you do not enroll in the Cafeteria Plan, you will automatically make Pre-Tax Employee Contributions and receive Company contributions under any of the Company's Benefit Options that you receive coverage under. You will not be automatically Enrolled in a HCSA, LHCSA or DCSA. Employees that elect HDHP coverage will automatically be signed up for an HSA.

Contributions

Each year, you must decide on the amount of before tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCSA or LHCSA and DCSA, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan year, with limited exceptions.

Change in Status Events

The only time that you are allowed to change an election during the Plan Year is when you have a qualifying Change in Status Event. This is because federal tax laws governing the Cafeteria Plan only permit you to change your Pre-Tax Employee Contribution for coverage under the Company's Benefit Options and your HCSA, LHCSA and DCSA elections in special cases. The following table shows the Change in Status Events and what changes, if any, can be made.

The term "Dependent" in the chart below means Eligible Dependent in the case of the HCSA, Qualified Dependent in case of the DCSA, and Covered Dependent in the case of the Pre-Tax Contributions component. For purposes of a Change in Status Event and the chart below, "Domestic Partner" refers only to Domestic Partners that qualify as a federal tax dependent of the Participant.

Change in Status Event	Permitted Election Changes
A. Change in Employee's Legal Marital Status	
1. **Gain Spouse** (marriage)	Participant may enroll or increase election for newly eligible Spouse and Dependent (and preexisting Dependents also may be enrolled); Participant may revoke Participant's or Dependent's coverage only when such coverage becomes effective under the Spouse's plan
2. **Lose Spouse** (divorce, legal separation, annulment, death of Spouse (see loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation, etc.))	Participant may revoke election only for Spouse; Participant may elect coverage for self or dependents who lose eligibility under Spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment, or death (and any Dependents may be enrolled so long as at least one Dependent has lost coverage under Spouse's plan)
B. Change in Employee's Domestic Partner Relationship Status	
1. **Gain Domestic Partner**	Participant may enroll or increase election for newly eligible Domestic Partner (and preexisting Dependents also may be enrolled); Participant may revoke Participant's or Dependent's coverage only when such coverage becomes effective under the Domestic Partner's plan
2. **Lose Domestic Partner** (termination of Domestic Partner relationship, death of Domestic Partner) (see loss of dependent eligibility below for discussion of dependent eligibility loss following termination of domestic partner relationship, etc.)	Participant may revoke election only for Domestic Partner; Participant may elect coverage for self or dependents who lose eligibility under Domestic Partner's plan if such individual loses eligibility as a result of termination of domestic partner relationship, or death (and any Dependents may be enrolled so long as at least one Dependent has lost coverage under Domestic Partner's plan)
C. Change in the Number of Employee's Dependents	
1. **Gain Dependent** (birth, adoption, foster child; Domestic Partner becomes federal tax dependent of employee)	Participant may enroll or increase coverage for newly eligible Dependent (under eligibility rule, any other Dependents who were not previously covered may also be enrolled). Participant may revoke Participant's or Dependent's coverage if Participant or Dependent becomes eligible under Spouse's or Domestic Partner's plan
a. Issuance of a Qualified Medical Child Support Order (QMCSO)	Participant to enroll Dependent(s) subject to QMCSO
b. Eligibility for Medicaid or State Children's Health Insurance Program (SCHIP)/Children's Health Insurance Program (CHIP) coverage	Participant may enroll Spouse/Domestic Partner and/or Dependent(s) in coverage

Change in Status Event	Permitted Election Changes
2. **Lose Dependent** (divorce, legal separation, annulment, termination of domestic partner dependent relationship, death of Dependent)	Participant may drop coverage only for the Dependent(s) who loses eligibility. Reason could be due to age or relative Dependent (such as niece, nephew, grandchild) for whom you have legal guardianship becomes ineligible due to age, marriage, no longer residing with the Participant, employed full-time)
a. Loss of Medicaid or SCHIP/CHIP	Participant may revoke Spouse/Domestic Partner and/or Dependent(s) coverage
b. Revocation of a QMCSO	Participant may revoke Dependent(s) subject to QMCSO
D. Change in Employment Status of Participant, Spouse, Domestic Partner, or Dependent That Affects Eligibility	
1. Commencement of Employment by Employee/Participant or Other Change in Employment Status (e.g., part-time to full-time) **Triggering Eligibility Under Component Plan**	Provided that eligibility was gained for this coverage, Employee/Participant may add coverage for employee/Participant, Spouse/Domestic Partner or Dependents
a. Commencement of Employment by Spouse/Domestic Partner, or Dependent or Other Change in Employment Status Triggering Eligibility Under Spouse's, Domestic Partner's or Dependent's plan	Participant may revoke or decrease election under Participant's, Spouse's, Domestic Partner's or Dependent's coverage if Participant, Spouse/Domestic Partner or Dependent is added to Spouse's, Domestic Partner's or Dependent's plan
2. Termination of Employment by Participant, Spouse/Domestic Partner or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility	
a. Termination of Participant's Employment or Other Change in Employment Status (e.g., unpaid leave, full-time to part-time) Resulting in a Loss of Eligibility	Participant may revoke or decrease election for Participant, Spouse/Domestic Partner or Dependent who loses eligibility under the Plan
b. Termination of Spouse's, Domestic Partner's or Dependent's Employment (or other change in employment status resulting in a loss of eligibility under their employer's plan)	Employee/Participant may enroll or increase election for Employee, Spouse, Domestic Partner, or Dependents who lose eligibility under Spouse's, Domestic Partner's or Dependent's employer's plan. In addition, other previously eligible Dependents may also be enrolled as allowed by regulations.
E. Event Causing Participant's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements	
1. **Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan** (individual becoming a qualified dependent of employee.)	Participant may enroll or increase election for newly eligible Dependent. In addition, other previously eligible Dependents may also be enrolled as allowed by regulations.
2. **Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer's Plan** (attaining a specified age, getting married, ceasing to be domestic partner dependent, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected Dependent

Change in Status Event	Permitted Election Changes
F. Change in Place of Residence of Employee, Spouse/Domestic Partner or Dependent	
1. Move Triggers Eligibility (e.g., employee or dependent moves into service area)	Employee may enroll or increase election for newly eligible employee, Spouse/Domestic Partner or Dependent if the change affects eligibility. Also, other previously eligible Dependents may be enrolled as allowed by regulations
2. **Move Causes Loss of Eligibility** (e.g., employee or dependent moves outside service area)	Employee may revoke election or make new election if the change in residence affects the Employee's, Spouse's, Domestic Partner's or Dependent's eligibility for coverage option
G. Significant Changes in Employee, Spouse/Domestic Partner or Dependent Coverage or Cost	
1. **Cost Changes** – a. **Automatic Changes** (for insignificant cost changes) b. **Significant Cost Changes** (if cost charged to employee significantly increases or decreases)	The Plan will automatically adjust an Employee's election for insignificant cost changes. For a significant increase in cost, Employee may increase election correspondingly or revoke an election and elect coverage under another Benefit Option providing similar coverage for Employee, Spouse/Domestic Partner or Dependent For a significant decrease, Employee may decrease election correspondingly or may elect coverage (even if no prior participation) with decreased cost and drop election for similar coverage option for Employee, Spouse/Domestic Partner or Dependent The Plan Administrator will determine in its discretion whether a change is significant.
2. **Significant Curtailment with Loss of Eligibility** (complete loss of coverage, including elimination of a benefit package)	Employee may revoke election for curtailed coverage and make new prospective coverage election under another similar Benefit Option or drop coverage if a similar Benefit Option is not available for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change
3. **Significant Curtailment with Loss of Eligibility** (e.g. significant increase in deductible or copay)	Employee may revoke election for curtailed coverage and make a new election for coverage under another Benefit Option for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change
4. **Addition or Improvement of a Benefit Package Option**	Employee may revoke existing election and elect newly added or improved Benefit Option for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change

Change in Status Event	Permitted Election Changes
5. **Change in Coverage under Another Employer Plan**	If other employer plan increases coverage, Employee may decrease or revoke election for individuals who have elected or received corresponding increased coverage under the other employer plan If other employer plan decreases or ceases coverage, Employee may enroll or increase election for individuals who have elected or received corresponding decreased coverage under other employer plan If open enrollment under other employer's plan corresponds to a different plan year, corresponding changes can be made under the Plan
6. **Loss of Coverage under Other Group Health Coverage** (loss of coverage under any group health coverage sponsored by a government or educational institution)	Employee may enroll or increase election for Employee, Spouse/Domestic Partner or Dependent if the individual loses group health coverage sponsored by a governmental or educational institution

You must Promptly Report Change in Status Events to Change Elections

When a Change in Status Event occurs, it is your responsibility to complete a Benefits Change in Workday within the allotted time frame after your Change in Status Event occurs. A change in a Domestic Partner's relationship qualifies as a Change in Status only if your

Domestic Partner is your federal tax dependent for health coverage purposes, as defined under Code Section 105(b).

If the Change in Status Event request is for coverage to be added for you, your Spouse/Domestic Partner and/or your Eligible Dependent(s), you must complete a Benefits Change in Workday within thirty (30) days of the Change in Status event. If the Benefits Change is not received within the required timeframe, then a change of coverage election will not be permitted until the next Change in Status Event occurs OR the next Annual Open Enrollment Period. For marriage or Domestic Partner relationship inception, the Benefits Change must be received within thirty (30) days from the date of marriage or inception of Domestic Partner relationship, as applicable. For birth, adoption, or placement for adoption the change must be received within ninety (90) days. For loss of, or eligibility for, Medicaid or SCHIP/ CHIP, the change must be received within sixty (60) days.

If you do not complete the required Benefit Change in Workday, you are not permitted to add the newborn or adopted child, the eligible Spouse/Domestic Partner or Dependent(s) until the next Annual Open Enrollment Period and coverage is not retroactive.

If a requested change for a newborn or adopted child results in a coverage tier change in a Benefit Option, any make-up deductions will be taken on an after-tax basis on your next paycheck, dependent upon payroll administrative processing schedules.

If the Change in Status Event request is for coverage to be discontinued for you, your Spouse/Domestic Partner and/or your Eligible Dependent(s), a completed Benefits Change must be submitted within thirty (30) days of the Change in Status Event. If the Benefits Change is not received within the requested timeframe, then a change of coverage election will not be permitted until the next Change in Status Event occurs OR the next Annual Open Enrollment Period.

If the request is for coverage to be discontinued for a Spouse, Domestic Partner or Dependent(s) who is no longer eligible, the coverage will be discontinued as of the date of the Change in Status Event but the Company will not issue any refund for any changes that result in a coverage tier change. Any claims that have been processed by the Plan Administrator for the Spouse, Domestic Partner, and/or Dependent after the date that they are no longer eligible must be reimbursed to the Plan.

In order for COBRA Continuation Coverage under the Cafeteria Plan to be offered to the Spouse or Dependents, per IRS regulations, notification must generally be received within sixty (60) days of the Change in Status Event. If the notification is not received within that timeframe, COBRA Continuation Coverage will not be available to the Spouse or Dependent(s). *For more information, see the Benefits Summary: Summary Plan Description: ONEOK, Inc. Flexible Spending Account Plan*

To Complete a Benefit Change:

Login to Workday > Menu > Benefits and Pay

You should complete a Benefit Change, including:

- All information requested such as your personal information, your Spouse's/Domestic Partner's or your Dependent(s)' name, birth date(s), Social Security Number(s), reason for ineligibility, etc.;
- Indication of the date the Change in Status Event occurred and provide any necessary documentation.
- Submit the Benefit Change within the given time frame; and
- Dependent Verification Documents and Social Security Numbers are required and must be received by HR Solutions within ninety (90) days of the Change in Status Event.

SECTION 3: PRE-TAX CONTRIBUTIONS

Pre-Tax Employee Contributions

If you file a Benefits Option Election you are agreeing to reduce your unearned compensation during the Plan Year by the amount of Pre-Tax Dollars needed to cover the employee costs of the Benefit Options you have elected. Your Pre-Tax Employee Contributions will be made in approximately equal amounts over payroll periods applicable to you during the Plan Year, according to schedules determined and administered by the Plan Administrator.

If you have insufficient unearned compensation to support the employee costs of your Benefit Elections, you will be required to pay the appropriate monthly contributions with After-Tax Dollars by sending contributions to UnitedHealthcare. If you fail to make a timely contribution, coverage under the Cafeteria Plan (and applicable components) will be cancelled effective the last day of the payroll period for which you did make the required contribution on time.

Benefit Options

The following Benefit Options are available under the Cafeteria Plan:

- ONEOK, Inc. Health Plan;
- ONEOK, Inc. Wraparound Welfare Benefit Plan (including separate elections for certain underlying Component Benefits in the form of Dental, Vision Insurance, Life Insurance*, Accidental Death and Dismemberment Insurance and Long Term Disability Insurance*);
- ONEOK, Inc. Flexible Spending Account Plan (including the HCSA, LHCSA and the DCSA); and
- Health Savings Account (HSA).

Each Benefit Option under the Cafeteria Plan that is provided by the Company under a separate benefit plan are described and controlled by the terms and provisions of such separate plan, and the related summary plan descriptions, documents, and descriptive materials.

The HSA Benefit Option is described and controlled by the terms of an individual agreement between you and an HSA custodian selected by the Company from time to time. Contributions to the HSA through this Cafeteria Plan are subject to rules, limitations, conditions and forms prescribed by the Company and the HSA custodian from time to time.

The Benefit Options available under the Cafeteria Plan are limited to those coverages and benefits available to you under the terms and conditions of the plans listed above. The Cafeteria Plan will not offer any Benefit Option that defers your compensation from one taxable year to a subsequent taxable year. The Benefit Options provided under the Cafeteria Plan will not include any nonqualified benefits that are not permitted to be offered under Code Section 125 and applicable Treasury Regulations.

The Benefit Costs of each Benefit Option for each Plan Year will be determined and communicated by the Company to Eligible Employees within a reasonable period of time prior to the beginning of the applicable Plan Year. The Benefit Costs for each Benefit Option for a Plan Year will be determined by the Company in its sole discretion.

* If you elect any of the following Benefit Options, you will pay Benefit Costs with After-Tax Dollars:

- Family coverage and Employee coverage (in excess of $50,000 basic coverage) under the Life Insurance Component Benefit under the ONEOK, Inc. Wraparound Welfare Benefit Plan; and

- Employee coverage under the Long-Term Disability Insurance Component Benefit under the ONEOK, Inc. Wraparound Welfare Benefit Plan.

SECTION 4: CLAIMS PROCEDURES FOR HCSA, LHCSA AND DCSA

Claim Denials and Appeals

If a claim for benefits under the HCSA, LHCSA or DCSA is denied in part or in whole, you may call UnitedHealthcare at the number on your Health Care Spending Card Debit MasterCard® card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim under the HCSA, LHCSA or DCSA, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:
the patient's name and ID number as shown on the ID card;

- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:
an appropriate individual(s) who did not make the initial benefit determination; and
a health care professional who was not consulted during the initial benefit determination process.
Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. ONEOK, Inc. will review all claims in accordance with the rules established by the U.S. Department of Labor. ONEOK, Inc.'s decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

HCSA, LHCSA and DCSA Eligibility Coverage Claims and Appeals

Either you or your authorized representative may file a claim regarding eligibility for coverage under the Cafeteria Plan (rather than a claim for benefits under the HCSA, LHCSA or DCSA) with HR Solutions. If the claim is denied, you will receive a written notice from HR Solutions within 90 days after the claim was received, as long as all needed information was provided with the claim. If a time extension is necessary to process your claim, written notice of the extension will be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Cafeteria Plan expects to render the determination.

If your claim regarding eligibility for coverage under the Cafeteria Plan is denied, you have the right to appeal this denial to the Plan Administrator. There is only one level of appeal for denied eligibility claims.

You have 180 days from receipt of the notice of denial to file an appeal. All appeals must be in writing. You may submit, within two weeks of the date the appeal is filed, written comments, documents, records, and any other information that supports the position(s) taken in the appeal.

The Plan Sponsor will provide a full and fair review of a claim and any supporting documentation submitted, including all comments, documents, records, and other information either not previously submitted or not considered in the initial decision. Upon request and free of charge, a Claimant will also be provided reasonable access to and copies of all documents, records, and information relevant to the claim.
You will be notified of any decision on appeal within 60 days after the Plan Sponsor receives the appeal request and all other supporting documentation. If you wish to pursue the claim further after exhausting the administrative remedies under the Cafeteria Plan, you will have the right to bring a civil action in a federal court under Section 502(a) of ERISA within 90 days of receiving a notice on appeal.

Limitation of Action

You cannot bring any legal action against the Company, the Plan Administrator, or the Claims Administrator for any purpose until ninety (90) days after you have exhausted the administrative procedures described in this section. If you want to bring a legal action against the Company, the Plan Administrator or the Claims Administrator, you must do so within one (1) year after an adverse determination (or deemed adverse determination) on appeal.

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

Jurisdiction and Venue

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

SECTION 5: WHEN PARTICIPATION ENDS

Duration of Participation

Except to the extent provided under the Benefits Summary: *Summary Plan Description: ONEOK, Inc. Flexible Spending Account Plan "COBRA Continuation Coverage,"* you will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates;
- The date you cease to be an Eligible Employee, except that your eligibility may continue, if you are in a sickness benefit status as defined in ONEOK Policies and Procedures (and which is defined to include approved FMLA Leave.)
- The date you fail to make a required contribution under the terms of the Plan.

Paying Contributions While on a Family or Medical Leave of Absence

Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible for up to 12 weeks of unpaid leave each year if you have a serious illness; adopt or have a child; or need to care for a seriously ill spouse, child or parent.

Your Cafeteria Plan coverage will be continued during your FMLA leave, with the Company paying the same portion of the costs it normally pays. You will be responsible for paying your portion of the cost of these benefits. You can also elect to end your coverage under the Cafeteria Plan during the FMLA leave. To continue this coverage, you will be required to pay the appropriate monthly contributions with After-Tax Dollars by sending contributions to UnitedHealthcare. If you fail to make a timely contribution, coverage under the Cafeteria Plan (and applicable components) will be cancelled effective the last day of the payroll period for which you did make the required contribution on time. Please note, however, that if a leave starts mid-payroll period, and a contribution is never made, coverage under the Cafeteria Plan will be cancelled effective back to the date the leave started. If you fail to make payments while on FMLA leave, the Company will recoup any missed payments with After-Tax Dollars when you return from FMLA leave.

When you begin FMLA leave you will receive a notification from UnitedHealthcare Benefit Services explaining that you are now being "direct billed" for your coverage costs. This notification will explain how, where and when to remit payment for your coverage.

If your coverage under the Cafeteria Plan or Benefit Option ceases while on FMLA leave, you will be permitted to re-enter the Cafeteria Plan upon return from such FMLA leave on the same basis in which you were participating in the Cafeteria Plan prior to leave, or as otherwise required by the FMLA.

Contact HR Solutions for more information on eligibility and coverage under the Family and Medical Leave Act.

SECTION 6: IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all summary plan descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note
Pre-Tax Contributions and the DCSA are not subject to ERISA. Only the HCSA and LHCSA is subject to **ERISA and the terms** described below.

Plan Administrator and Named Fiduciary

The Plan is administered by the Plan Administrator, which is the BPAC. The Plan Administrator shall serve as the "plan administrator" within the meaning of Section 3(16)(A) of ERISA and as the Plan's "named fiduciary" within the meaning of Section 402 of ERISA.

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

In carrying out its responsibilities under the Plan, the Plan Administrator (or such other designated Plan fiduciaries or persons to whom it has delegated authority) has discretionary authority to interpret the terms of this Plan and to determine eligibility for and entitlement to Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and conclusive, binding on all persons and entities and be given full force and effect. To the extent permitted by law, the Plan Administrator and other designated or functional Plan fiduciaries who are employees of the Company shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of the Plan.

You may contact the Plan Administrator at:

ONEOK, Inc. Benefit Plan Administration Committee
c/o Vice President, Total Rewards
100 W. 5th Street
Tulsa, OK 74103
(918) 588-7000

Reliance on Participant Information

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

Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Cafeteria Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited to the Cafeteria Plan following 1 year after the date that any such payment first became due.

Effect of Mistake

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

Compensation of Plan Administrator

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

Correction of Overpayment

In the event the payment or reimbursement of claims or benefits exceed or do not conform to the terms and provisions of this Cafeteria Plan, including the failure of a Participant or other person to properly substantiate the entitlement to payment or reimbursement or the amount involved, the Company or Plan Administrator may:

- Require a Participant or other person to pay back an amount equal to any improper payment;
- Withhold from the Participant's salary or wages the amount of an improper payment to the extent permissible under applicable law;
- Establish and utilize a claims substitution, offset or other arrangement to resolve an improper claim or payment; or
- Otherwise take administrative or legal action to recover an improper payment as allowed under applicable law.

Waiver

Failure by the Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances will not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan will be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

No Assignment of Benefits

Participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any Benefit payable under the Plan or the right to assert legal or equitable rights, including an administrative claim, action under state law or lawsuit against any of the following: the Plan, the Plan Administrator, the Claims Administrator, or any Plan fiduciary, or the Company, or their officers, shareholders, or employees. For example, Participants may not assign their right to receive Benefits and legal rights relating to the Plan to any other party, including any care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction) or to bring any administrative claim, action under state law or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

Claims Administrator

Claims (other than eligibility claims) are processed on behalf of the Cafeteria Plan and the Plan Administrator by the Claims Administrator: UnitedHealthcare. The Claims Administrator for the Cafeteria Plan is classified as an insurance issuer under federal law.

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

Under the Cafeteria Plan, benefit claims are paid directly from the general assets of the Company. No benefits under the Cafeteria Plan are guaranteed or paid under a contract or policy of insurance issued by the Claims Administrator.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Cafeteria Plan Funding and Payments

The Cafeteria Plan is funded by Participant contributions and, if necessary, payments from the general assets of ONEOK, Inc. Participants in the Cafeteria Plan make contributions to the Cafeteria Plan based on a Benefit Options Election, in accordance with the Cafeteria Plan.

Payments are made pursuant to the Cafeteria Plan to reimburse Eligible Employees, Spouses, Domestic Partners (if your Domestic Partner is your federal tax dependent) and Dependent(s) for Eligible Expenses, and for other authorized purposes in accordance with the Cafeteria Plan.

Payment of Plan Administration Expenses

All reasonable expenses of administering the Cafeteria Plan shall be paid by the Company (to the extent not paid out of a trust) at the direction of the Plan Administrator or its duly authorized representatives. To the extent that a trust serves as a funding vehicle for more than one plan, expenses paid by such trust may be fairly allocated among such plans at the reasonable discretion of the Plan Administrator or its duly authorized representatives.

Amendment or Termination of Cafeteria 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 (the "BPSC") shall possess and exercise all non-fiduciary "settlor" authority to act on behalf of the Company with respect to the Plan.

The procedure for amending the Plan and for identifying the persons who have authority to amend the Plan shall be for the BPSC to adopt, authorize, approve, and/or ratify amendment of the Plan by action duly approved by the BPSC. The BPSC may amend the Plan at a meeting of the BPSC, or without a meeting in a written memorandum of action signed by all the members of the BPSC, 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 BPSC. 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 BPSC, which may, without limitation, be a duly adopted resolution of the BPSC 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 BPSC designated by it, or a written instrument signed by an officer of the Company or an authorized representative of the BPSC 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 BPSC or its designated authorized representatives. Amendment of the Plan pursuant to such procedure shall not require approval or action of the Board of Directors of the Company; provided, the Board of Directors is also authorized to, at any time, amend, modify, or change the Plan by resolution approved by it. The Company may cancel, discontinue, or terminate the Plan by either (i) a written instrument signed by the Chief Executive Officer of the Company, or (ii) a resolution approved by the Board of Directors of the Company.

Agent for Service of Legal Process

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

Agent for Legal Process – ONEOK, Inc. Cafeteria Plan
National Registered Agents, Inc.
1833 South Morgan Road
Oklahoma City, OK 73128

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of the Cafeteria Plan Document contains information about how the Cafeteria Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	ONEOK, Inc. Cafeteria Plan
Plan Number:	508
Employer ID:	73-1520922
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	ONEOK, Inc. Benefit Plan Administration Committee; Third Party Claims Administrator
Source of Plan Contributions and Funding:	The Plan is funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees

Your ERISA Rights

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

- Receive information about Plan benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the HCSA and LHCSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 series) and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- Obtain copies of all documents that govern the operations of the HCSA and LHCSA and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual reports (Form 5500), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue HCSA or LHCSA benefits for yourself, Spouse, Domestic Partner (if your Domestic Partner is your federal tax dependent) or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse, your Domestic Partner (if your Domestic Partner is your federal tax dependent) or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan benefit under the HCSA or LHCSA is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See *SECTION 4: Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Document or the latest annual report 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, 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, you may file suit in federal court. If it should happen that the Plan's 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; for example, if it finds your claim is frivolous.

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

No Guarantee of Employment

The Cafeteria Plan shall not be construed to give any Employee the right to be retained in employment by the Company nor any right or claim to a benefit, payment, or compensation unless the right to such a benefit is in accordance with the terms of the Cafeteria Plan.

No Guarantee of Tax Consequences

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

Governing Law

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

Headings

The headings of the various parts of this Cafeteria Plan are stated for convenience of reference and are not to be regarded as indicating or controlling the meaning or construction of any provisions.

Severability

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

The Cafeteria Plan is administered by the Company and the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Cafeteria Plan and provides appeal services; however, UnitedHealthcare, the Plan Administrator and the Company are not responsible for any decision you, your Spouse, Domestic Partner (if your Domestic Partner is your federal tax dependent) and/or your Dependents make to receive treatment, services or supplies.

SECTION 7: GLOSSARY

Many of the terms used throughout this Cafeteria Plan Document may be unfamiliar to you or have a specific meaning with regard to the way the Cafeteria Plan is administered and how reimbursements are made. This section defines terms used throughout this Cafeteria Plan Document, but it does not describe the benefits provided by the Cafeteria Plan.

After-Tax Dollars – The dollar amount a Participant has elected to have deducted from his compensation on an after-tax basis to pay Benefit Costs under the Cafeteria Plan.

Amendment – Any Amendment of the terms and provisions of the Cafeteria Plan that is made in accordance with the procedures stated in *SECTION 6: Important Administrative Information: ERISA*, under the heading *"*Amendment or Termination of Cafeteria Plan."

Annual Open Enrollment Period – The annual period of time during which current Eligible Employees may Enroll in the Cafeteria Plan. To participate in the HCSA or DCSA, you must Enroll each year.

Benefit Cost – The cost of each Benefit Option.

Benefit Plan Administration Committee or Committee – ONEOK, Inc. Benefit Plan Administration Committee, the Plan Administrator of the Cafeteria Plan.

Benefit Options – Coverage or benefits available that a Participant may elect to contribute Pre-Tax Dollars under the Cafeteria Plan and as outlined in *SECTION 3: Pre-Tax Contributions.*

Benefit Options Election – A election completed by the Eligible Employee in Workday to Enroll in the Cafeteria Plan.

Cafeteria Plan – The Cafeteria Plan for Employees of ONEOK, Inc. and Subsidiaries, a plan that allows a Participant to receive Company contributions toward health care benefits and to pay for health care Benefits on a *pre-tax* basis.

Claims Administrator – United Healthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Cafeteria Plan.

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

COBRA Continuation Coverage – Coverage under a group health plan that satisfies the provisions of COBRA.

Code – Internal Revenue Code of 1986, as amended.

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

Component Benefit – One of the underlying benefit options available to participants through the ONEOK, Inc. Wraparound Welfare Benefit Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – Provisions of federal law that require companies to offer continued health insurance coverage to certain Employees, their Spouse and/or Dependent(s) whose group health insurance has been terminated.

Covered Dependent – An individual who is a family member of an Eligible Employee and who is covered under the applicable Benefit Option.

Dependent – An individual who is a Covered Dependent, Eligible Dependent or Qualifying Dependent, as appropriate, under the terms of this Cafeteria Plan.

Dependent Care Spending Account (DCSA) – An account established by an Employee under the Cafeteria Plan for Employees of ONEOK, Inc. and Subsidiaries to reimburse Eligible Dependent Care Expenses.

Domestic Partner - Definition of Domestic Partnership
A Domestic Partnership is a relationship between unmarried partners of the same or opposite sex who share a committed and financially interdependent personal relationship. A Domestic Partner of an individual must:

- not be so closely related that marriage would otherwise be prohibited under the laws of the state in which they reside;
- not be legally married to, or the Domestic Partner of, another individual under either statutory or common law;
- be at least 18 years old;
- live together with the individual (other Domestic Partner) and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent with the individual (other Domestic Partner) and have furnished documents to support at least 2 of the following conditions of such financial interdependence:
  - have a single dedicated relationship of at least 12 months duration; and
  - have at least 2 of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; and
    - have a will and/or life insurance policies signed and completed to the effect that one Domestic Partner is the primary beneficiary of the other; or
    - 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.

Eligible Dependent – "Eligible Dependents" means: (i) your Spouse; (ii) your natural child, stepchild, legally adopted child, or eligible foster child who has not reached age 27 as of the end of the calendar year; or (iii) your tax dependent under the Code, including a relative child for whom you have legal guardianship who has not reached age 19 or is a full-time student who has not reached age 24 as of the end of the calendar year. For purposes of this Cafeteria Plan, an individual generally qualifies as a federal tax dependent under Code if:

- During the calendar year in question, your provide more than half of his or her total support;
- The individual is related to you, or for the entire calendar year in question, he or she lives with you and is a member of the household you maintain and occupy;
- The individual is a citizen of the United State or a resident of Mexico or Canada; and
- The relationship between you and the individual does not violate local law.

Eligible Employee – "Eligible Employees" shall include Employees who are regularly scheduled to work twenty (20) hours or more per week. Employees who are members of a collective bargaining unit and nonresident aliens who do not receive U.S. source income are not Eligible Employees.

The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Cafeteria Plan, and the Plan Administrator has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Cafeteria Plan.

Employee – An individual who is classified as an employee of the Company under the Company's internal policies and procedures. An individual who is classified by the Company as a contingent worker, independent contractor or leased employee shall not be considered an Employee for purposes of the Cafeteria Plan. The term Employee when used in this document shall refer to an Employee eligible to participate in the Cafeteria Plan in accordance with the terms and provisions of this Cafeteria Plan.

If any court, administrative body, agency, or other entity should determine that any individual classified as a contingent worker, independent contractor, leased employee or other non-Employee by the Company was, in reality, a common law employee of the Company, such individual still shall not be eligible for, nor entitled to, and shall not participate in, the Cafeteria Plan.

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

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

Enrollment (or Enroll) – To elect to make contributions under the Cafeteria Plan, without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

FMLA – The Family and Medical Leave Act of 1993, as amended.

Health Care Spending Account (HCSA) – An account established by an Employee under the ONEOK, Inc. Cafeteria Plan to reimburse Eligible Health Care Expenses.

Health Plan – The ONEOK, Inc. Health Plan, a plan that allows Participants to receive health care benefits.

Limited Purpose Spending Account (LHCSA) – An account established by an Employee under the Cafeteria Plan to reimburse Eligible Health Care Expenses for dental and vision. Once the HDHP medical plan deductible has been met it can be used for eligible medical expenses.

Participant – An Eligible Employee, Spouse, Domestic Partner (if your Domestic Partner is your federal tax dependent), or Dependent(s) who elects to participate in the Cafeteria Plan.

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

Plan Sponsor – ONEOK, Inc.

Plan Year – The calendar year period beginning January 1 and ending December 31.

Pre-Tax Dollars – The dollar amount a Participant has elected to have deducted from his compensation on a pre-tax basis to pay Benefit Costs and/or contribute to his HCSA or DCSA under the Cafeteria Plan. Pre-Tax Dollars are deducted from a Participant's paycheck before Federal income, Social Security and state income tax, where applicable.

Qualified Dependent – A “Qualified Dependent” is as defined as “qualifying individual” in Code Section 21(b)(1), which means:

- A dependent under federal tax law who is a child under age 13; or
- A Spouse, if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Spouse – An individual to whom an Eligible Employee is legally married for purposes of federal income tax laws.

Evidence of a spousal relationship may be State Issued Marriage Certificate or Affidavit of Common Law Marriage.

UnitedHealthcare or UHC (also known as United HealthCare Services, Inc.) – a health plan administration firm that provides certain claims administration services for the Cafeteria Plan.

USERRA – the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

APPENDIX A: HIPAA NOTICE OF PRIVACY PRACTICES

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

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") require group health plans to notify plan participants and beneficiaries about their policies and practices to safeguard the privacy and security of their protected health information. This notice ("Notice") is intended to satisfy HIPAA's notice requirement with respect to all protected health information created, received, transmitted or maintained by the Cafeteria Plan.

The Cafeteria Plan needs to create, receive and maintain records that contain protected health information about you to administer the Cafeteria Plan and provide you with benefits. This Notice describes the Cafeteria Plan's health information privacy policy and practices. The Notice tells you the ways the Cafeteria Plan may use and disclose protected health information about you, describes your rights and the obligations the Cafeteria Plan has regarding the use and disclosure of your protected health information. However, this Notice does not state the policies or practices of your health care providers (such as doctors, Hospitals or laboratories) with respect to privacy of health information.

CAFETERIA PLAN POLICY ON PRIVACY OF YOUR HEALTH

The privacy policy and practices of the Cafeteria Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is 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. Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal and state health information privacy laws.

HIPAA PLAN PRIVACY REQUIREMENTS

The Cafeteria Plan is required by law to:

- Maintain the privacy of PHI about you;
- Provide you with certain rights with respect to your PHI;
- Provide you this Notice of the Cafeteria Plan's legal duties and privacy practices with respect to your PHI; and,
- Follow the terms of this Notice that are currently in effect, as amended from time to time.

HOW THE CAFETERIA PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Although HIPAA generally requires that the Cafeteria Plan protect the confidentiality of your PHI, there are certain uses and disclosures by the Cafeteria Plan allowed under HIPAA and applicable regulations. Those uses and disclosures are allowed in order to properly operate and administer the Cafeteria Plan for your Benefit according to its terms.

The following are the most common ways the Cafeteria Plan may use and disclose your PHI:

- **For treatment**. The Cafeteria Plan 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 Cafeteria Plan may advise an emergency room Physician about the types of Prescription Drugs you currently take.

- **For payment**. The Cafeteria Plan 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 Cafeteria Plan's terms. For example, the Cafeteria Plan may receive and maintain information about Surgery you received to enable the Cafeteria Plan to process a Hospital's claim for reimbursement of surgical expenses Incurred on your behalf.

- **For health care operations**. The Cafeteria Plan may use and disclose your PHI to enable the Cafeteria Plan to operate or operate more efficiently, or to make certain that all of the Cafeteria Plan's participants receive their benefits. For example, the Cafeteria Plan may use your PHI for Case Management or to perform population-based studies designed to reduce health care costs.

  In addition, the Cafeteria Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Cafeteria Plan may also combine health information about many Cafeteria Plan participants and disclose it to the Company in summary fashion so the Company can decide what coverages the Cafeteria Plan should provide. The Cafeteria Plan will remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning who the specific participants are. The amount of PHI used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Cafeteria Plan is prohibited from using or disclosing PHI that contains genetic information about an individual for underwriting purposes.

- **To the Company**. The Cafeteria Plan may disclose your PHI to designated Company personnel so they can carry out their Cafeteria Plan related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the Plan Administrator, the Company's Vice President, Human Resources (the "Privacy Officer") and/or the personnel of the Company's Human Resources Department and personnel in the Company's Legal and Information Technology Departments who support the 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 Cafeteria Plan 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 Plan Sponsored by the Company.

- **To a business associate**. Certain services are provided to the Cafeteria Plan by third party administrators known as "business associates." For example, the Cafeteria Plan may input information about your health care treatment into an electronic claims processing system maintained by the Claims Administrator of the Cafeteria Plan so your claim may be paid. In so doing, the Cafeteria Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Cafeteria Plan will require all its business associates, through contract, to appropriately safeguard your health information.

- **Treatment alternatives.** The Cafeteria Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-related benefits and services**. The Cafeteria Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you. However, your PHI will not be used or disclosed for marketing, sales or fundraising purposes without your authorization.

- **Authorizations.** The Cafeteria Plan 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 which is available to you at www.oneokonline.com. If you authorize the Cafeteria Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Cafeteria Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Cafeteria Plan will not withdraw or change any uses or disclosures already made by the Cafeteria Plan in reliance on your prior authorization. The Cafeteria 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.

  Any other uses and disclosures of health information that are not described above in this Notice, or allowed by the laws that apply to the Cafeteria Plan, will be made only with your prior written authorization.

- **Spouses and Other Family Members.** With only limited exceptions, the Cafeteria Plan will send all mail to the employee. This includes mail relating to a spouse, domestic partner (if your domestic partner is your federal tax dependent) and other dependents who are covered under the Cafeteria Plan, and includes mail with information on the use of benefits by such spouse, domestic partner and other dependents and information on the denial of any benefits to such spouse, domestic partner and other dependents. However, if a person covered under the Cafeteria Plan has requested restrictions or confidential communications, and if the Cafeteria Plan has agreed to the request, the Cafeteria Plan will send mail as provided by the request for restrictions or Confidential communications.

- **Individual involved in your care or payment of your care**. The Cafeteria Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Cafeteria Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the Hospital), or death.

- **As required by law**. The Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Cafeteria Plan may release medical information about you as deemed necessary by military command authorities.

- **To avert serious threat to health or safety.** The Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan may release medical 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 Cafeteria Plan 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 Cafeteria Plan 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 Cafeteria Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

- **Government Audits.** The Cafeteria Plan is 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 HEALTH INFORMATION ABOUT YOU

Your rights regarding the protected health information the Cafeteria Plan maintains about you are as follows:

- **Right to inspect and copy**. You have the right to inspect and copy your PHI. This includes information about your Cafeteria Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

  To inspect and copy your PHI maintained by the Cafeteria Plan, submit your request in writing to the Privacy Officer. The Cafeteria Plan may charge a fee for the cost of copying and/or mailing your PHI that you request. In limited circumstances, the Cafeteria Plan 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 health information the Cafeteria Plan has about you is incorrect or incomplete, you may ask the Cafeteria Plan to amend it. You have the right to request an Amendment for as long as the information is kept by or for the Cafeteria Plan.

  To request an Amendment, send a detailed request, in writing, to the Privacy Officer. You must provide the reason(s) to support your request. The Cafeteria Plan may deny your request if you ask the Cafeteria Plan to amend health information that either: (1) is accurate and complete, (2) was not created by the Cafeteria Plan; (3) is not part of the health information kept by or for the Cafeteria 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 that the Cafeteria Plan has made to others, except for those necessary to carry out health care treatment, payment, or 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 (6) 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 Cafeteria Plan uses 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 Cafeteria Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Cafeteria Plan not use or disclose information about a Surgery you had.

  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 Cafeteria Plan's 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 that the Cafeteria Plan communicate with you about health matters in a certain way or at a certain

location. For example, you can ask that the Cafeteria Plan 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 Cafeteria Plan will take action needed to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to be notified of a breach.** You have the right to be notified in the event that the Cafeteria Plan or a business associate discovers a breach of your unsecured PHI.

- **Right to a paper copy of this Notice**. You have the right to a paper copy of this Notice. You may access this Notice at www.oneokonline.com or write to the Privacy Officer to request a written copy of this Notice at any time.

CHANGES TO THIS NOTICE

The Cafeteria Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Cafeteria Plan already has about you, as well as any information the Cafeteria Plan receives in the future. The Cafeteria Plan will post a copy of the current Notice on ONEOK online (www.oneokonline.com) at all times.

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 one-hundred eighty (180) days of when the act or omission complained of occurred.

Note: **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:

Privacy Officer
Vice President, Human Resources
ONEOK, Inc.
P.O. Box 871
Tulsa, Oklahoma 74102-0871
Telephone Number: (918) 588-7000