Summary Plan Description

ONEOK, INC.

Limited Health Care Flexible Spending Account Plan

EFFECTIVE DATE: January 1, 2024

CONTRACT NUMBER: 715229

UnitedHealthcare®
A UnitedHealth Group Company

LIMITED HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN

NOTICE TO EMPLOYEES

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2024.

ONEOK, INC. has entered into an arrangement with UnitedHealthcare Services, Inc, Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs") which you fund with before-tax contributions from your salary, and which you then use to reimburse yourself for Eligible Expenses.

Note: If you are enrolled in the HSA Plan offered by ONEOK, INC. you cannot be reimbursed for Eligible Health Care Expenses.

- The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses, such as day care.
- This Flexible Spending Account ("FSA") is a **Limited Health Care Spending Account ("LHCSA")**. The LHCSA is for reimbursement of eligible health care expenses, including certain vision, and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return. Once the minimum High Deductible Health Plan (HDHP) deductible has be met, it can be used for certain medical expenses. Refer to the ONEOK, Inc. Flexible Spending Account Plan Summary Plan Description for additional details.

You can elect to participate in the LHCSA, the DCSA, or both.

Each Plan Year (January 1-December 31) you can contribute to your LHCSA and DCSA, and then, during the Plan Year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. If you are enrolled in the HSA Plan you cannot be reimbursed for Eligible Health Care Expenses from your HCSA Contribution levels are set forth as described under Section, *Contributions*.

Each Plan Year (January 1-December 31) you can contribute to your DCSA and then, during the Plan Year, you can receive reimbursement from the account for Eligible Expenses. Contribution levels are set forth as described under Section, *Contributions*.

LIMITED HEALTH CARE SPENDING ACCOUNT

Eligible Expenses

To be eligible for reimbursement from your LHCSA, the health care expenses must be all of the following:

- Incurred while you are participating in the Plan.
- Incurred during the Plan Year.
- Not reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Please note Any reimbursement you receive through your LHCSA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your LHCSA. Generally, Eligible Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) and include any deductible and copayment amounts.

A more comprehensive list of Eligible Expenses is available at www.myuhc.com. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office or IRS website www.irs.gov or by phone at 1-800-TAX-FORM (1-800-829-3676).

Vision Expenses.

- Routine eye examinations.
- Eyeglasses.
- Contact lenses, including all necessary supplies and equipment.

Dental Expenses.

- Copayments, Coinsurance and Deductible amounts.
- Preventive Care.
- Exams, cleanings, x-rays, root canals and bridges.
- Dentures and fillings.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Insurance premiums and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through your LHCSA can not be claimed as deductions on your income tax retur

DEPENDENT CARE SPENDING ACCOUNT

Eligible Expenses

Eligible Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you can not use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses can not exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- a dependent under federal tax law who is a child under age 13; or
- a spouse or dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such spouse or dependent lives in your home for more than one-half of the 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.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are

claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.

- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

HEALTH CARE SPENDING CARD DEBIT MASTERCARD®

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to deduct Eligible Expenses directly from your LHCSA and/or DCSA. The Health Care Spending Card Debit MasterCard® allows for direct payments to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

Important You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to www.myuhc.com to learn how to get the most out of your Health Care Spending Card Debit MasterCard®.

Receiving Your Health Care Spending Card Debit MasterCard®

You will automatically receive two Health Care Spending Card Debit MasterCard® s. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

Activating Your Health Care Spending Card Debit MasterCard®

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real-time upon activation of the card within the first Plan year. However, for future Plan years the funds will not be available for use until the effective date of the future Plan year.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from ONEOK, INC. or found on www.myuhc.com and as described under Section, Requesting a Reimbursement from Your Flexible Spending Account.

Please Note If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, and retail pharmacy counters.

You may choose to use your Health Care Spending Card Debit MasterCard® for mail order prescriptions or for eligible over the counter (OTC) medicines, supplies and materials by going to an online pharmacy. Additionally, your Health Care Spending Card Debit MasterCard® can be used at

participating retailers as described under the Section, Retailers with Inventory Information Approval System (IIAS).

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS; therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard® because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under Section, *Health Care Spending Account*. A claim number is assigned to the transaction.

Eligible Expenses Reimbursed through the Health Care Spending Card Debit MasterCard®

Your card can be used for certain Eligible Health Care Expenses including copayments deductibles and coinsurance at dental and vision provider locations associated with UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. While in-network provider transactions can be used for coinsurance and deductibles the card does not determine patient responsibility or eligible benefits.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your LHCSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your LHCSA, the LHCSA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. **Note:** not all providers or merchants accept partial authorization.

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and an FSA yearly statement which will include your card activity. You will also be able to view card transactions on www.myuhc.com If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

Getting help 24 hours a day is easy.
Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.

- Learn your account balance.
- Report a lost or stolen card.
- Order extra cards and more.

Go onto www.myuhc.com anytime.

- Learn your account balance.

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your Health Care Spending Card Debit MasterCard® or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your LHCSA and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from your Employer or on the Internet at www.myuhc.com.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

For reimbursement from your LHCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice or an Explanation of Benefits (EOB) from any group dental or vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group dental plans.

Only expenses which are incurred while you are a participant in the Plan under the LHCSA or under the DCSA may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your LHCSA and/or DCSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily.

Your total annual contribution is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a LHCSA, your total annual contribution is available immediately, unless you are enrolled in the HSA Plan. If you are enrolled in the LHSA your annual contribution will be available once you meet the annual deductible under your HSA Plan other than for dental, or vision or preventive care expenses. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan year

In accordance with IRS regulations, amounts contributed to your LHCSA and/or DCSA **during the Plan Year but remaining in your account at the end of the processing period (March 31 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited.**

> **Important**
> **www.myuhc.com** includes many features such as the options to:
> - View Explanation of Benefits/Health Statements.
> - Utilize a savings calculator for FSA.
> - View your FSA summary page detailing contributions and amount left in your FSA.
> - View your FSA Claims Summary including claim transaction details.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID 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, 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 dental, vision or Preventive 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 740380
Atlanta, GA 30374

All LHCSA claims will be treated as post-treatment claims.

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.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible under the plan.

Limited Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31of the year after the Plan Year of termination.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Limited Health Care Spending Account Plan. You should call ONEOK, INC. to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Limited Health Care Spending Account (COBRA)".

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred during that Plan year before your termination date against what is in your DCSA when you leave employment.

Any such claims must be submitted on or before March 31 of the next Plan year.

OPTIONAL CONTINUATION COVERAGE UNDER YOUR Limited HEALTH CARE SPENDING ACCOUNT (COBRA)

This optional continuation coverage only applies if it has been made available by ONEOK, INC. ONEOK, INC. may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask ONEOK, INC. to find out if and how this continuation coverage under USERRA described below applies.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if ONEOK, INC. or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's LHCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and coverage cannot be continued beyond such date. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by ONEOK, INC. on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the LHCSA. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the LHCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the LHCSA, if the employee returns to a position of employment, the employee's LHCSA and that of the employee's eligible dependents will be

reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the LHCSA under USERRA.

UnitedHealthcare is not ONEOK, INC..'s designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

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 The DCSA is not subject to ERISA. Only the LHCSA is subject to ERISA and the terms described below.

Plan Sponsor and Administrator:

ONEOK, INC. is the Plan Sponsor and ONEOK, Inc. Benefit Plan Administration Committee is the Plan Administrator of the ONEOK, Inc. Cafeteria Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

ONEOK, Inc. Benefit Plan Administration Committee

c/o Vice President, Total Rewards
Plan Administrator – FSA Plan
100 W. 5th Street
Tulsa, OK 74103
918-588-7401

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the 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.

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

United HealthCare Services, Inc
185 Asylum Street
Hartford, CT 06103-3408

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 Plan. The Plan's Agent of Service is:

Agent for Legal Process – FSA Plan.

ONEOK, INC.
100 W. 5th Street

Tulsa, OK 74103
918-588-7401

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the 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 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 LHCSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series), filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all documents that govern the operations of the 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 LHCSA benefits for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the governing the Plan documents 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 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, Claim 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 (800)-998-7542.

ATTACHMENT I – Nondiscrimination and Accessibility Requirements

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters.
- Information written in other languages.

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. **Civil Rights Coordinator** UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT II – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	
2. Amharic	
3. Arabic	
4. Armenian	
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	
8. Burmese	
9. Cambodian-Mon-Khmer	
10. Cherokee	

11. Chinese	
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	
16. French Creole-Haitian Creole	
17. German	
18. Greek	
19. Gujarati	
20. Hawaiian	
21. Hindi	
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	
28. Karen	
29. Korean	

30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	
32. Laotian	
33. Marathi	
34. Marshallese	
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	
37. Nepali	
38. Nilotic-Dinka	
39. Norwegian	
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
41. Persian-Farsi	
42. Punjabi	
43. Polish	
44. Portuguese	
45. Romanian	
46. Russian	
47. Samoan-Fa'asamoa	
48. Serbo-Croatian	
49. Spanish	
50. Sudanic-Fulfulde	
51. Swahili	
52. Syriac-Assyrian	
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	
55. Thai	
56. Tongan-Fakatonga	
57. Trukese(Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.

58. Turkish	
59. Ukrainian	
60. Urdu	
61. Vietnamese	
62. Yiddish	
63. Yoruba	