ONEOK, Inc. Health Plan

Legal Notices – 2025

Table of Contents

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	NEBRASKA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026

Michelle's Law

Michelle's Law, a federal law passed in 2008, prohibits group health plans from terminating coverage for a dependent child who has lost student status as a result of a medically necessary leave of absence due to serious illness or injury. Plans must continue to provide coverage for up to one year, or until coverage would otherwise terminate under the plan. Plans are allowed to require physician certification of the medical necessity for the leave of absence.

To receive the extension of coverage, your dependent child must be covered under the plans immediately before the leave by reason of being a student at a post-secondary educational institution, and the leave must be for a medically necessary reason and must cause that dependent child to lose student status for purposes of coverage under the plans' terms.

If a dependent child qualifies for the Michelle's Law extension of eligibility, the plans will treat the dependent child as eligible for coverage until the earlier of:

(a) One year after the first day of the leave; or
(b) The date coverage would otherwise terminate under the plans' terms (e.g., due to an age limitation or for reasons other than failure to be a full-time student).

A dependent child whose benefits are continued under Michelle's law is entitled to receive the same benefits under the plans as if the child had continued to be a covered student and had not taken a medically necessary leave of absence. If the coverage provided by the plans is changed during the one-year period of continued coverage, the plans will provide the changed coverage for your dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plans no longer provide coverage for dependent children. If you believe your dependent child is eligible for this continued coverage, the dependent child's treating physician must provide to the plans a written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury and that the leave of absence or other enrolment change that would otherwise cause loss of eligibility is medically necessary).

Coordination with COBRA Continuation Coverage
If your dependent child is eligible for the Michelle's Law continued coverage and loses coverage under the plans at the end of the continued coverage period, continuation coverage under COBRA will be available for the dependent child at the end of the Michelle's Law coverage period and a COBRA election notice will be provided at that time.

Plan Administrator's Contact Information for Michelle's Law
UnitedHealthcare
800-232-8943
Website: www.myuhc.com

ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

For a Michelle's Law form, call HR Solutions at 855-663-6547.

Prescription Drug Coverage and Medicare Notice

Important Notice from ONEOK, Inc. About Your Prescription Drug Coverage and Medicare

For participants currently eligible for Medicare or those who may become eligible for Medicare.
Please read this notice carefully and keep it where you can find it. This notice has information about ONEOK, Inc. Health Plan prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you and your dependents decide whether or not you want to join a Medicare drug plan.

If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about ONEOK, Inc. Health Plan coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. ONEOK, Inc. has determined that the prescription drug coverage offered through your ONEOK, Inc. Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Prescription Drug Plan?
You or your dependents can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you or your dependents lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan? If you decide to join a Medicare drug plan, your current coverage through ONEOK, Inc. will not be affected and will coordinate with the Medicare drug plan. However, if you or your dependents become entitled to Medicare after electing COBRA continuation coverage, your ONEOK, Inc. Health Plan coverage may end.

When Will You Pay a Higher Premium (penalty) to Join a Medicare Prescription Drug Plan? You should also know that if you drop or lose your current coverage through ONEOK, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...
Contact the ONEOK HR Solutions Center at the number listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ONEOK, Inc. changes. You also may request a copy at any time.

For More Information About Your Options Under Medicare Prescription Drug Plans...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You may get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug Plans:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you or your dependents decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact Information

ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

ONEOK, Inc. Group Health Plans Notice of Privacy Practices

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

Background
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") require group health plans to notify plan participants and beneficiaries about their policies and practices to safeguard the privacy and security of their protected health information. This Notice of Privacy Practices ("Notice") is intended to satisfy HIPAA's notice requirement with respect to all protected health information created, received, transmitted or maintained by the group health plans (the "plans") sponsored by ONEOK, Inc. (the "Company"). The plans are required to provide this Notice to you pursuant to HIPAA.

The HIPAA privacy rule protects only certain individually identifiable medical information known as "protected health information" ("PHI"). Generally, PHI includes information provided by you or created, received or maintained by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

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

Plan Responsibilities
The plans are required by law to:

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

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

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

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

How the Plans May Use and Disclose Health Information about You
Although HIPAA generally requires the plans protect the confidentiality of your PHI, there are certain uses and disclosures by the plans allowed under HIPAA and applicable regulations. Those uses and disclosures are allowed in order to

properly operate and administer the plans for your benefit according to their terms. The following categories describe the ways we may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose will fall within one of the categories:

- For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.
- For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid for your benefit according to the plans' terms. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- For Plan Operations. The plans may use and disclose your PHI to enable the plans to operate or operate more efficiently, or to make certain all of the plan participants receive their plan benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The plans may also combine information about many plan participants and disclose it to the Company in summary fashion so the Company can decide what coverage the plans should provide. The plans will remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning the identity of any specific participant. The amount of health information used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The plans are prohibited from using or disclosing PHI that contains genetic information about an individual for underwriting purposes.
- To the Company. The plans may disclose your PHI to designated Company personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the ONEOK, Inc. Benefit Plans Administration Committee (the "Plan Administrator"), the Company's Vice President – Total Rewards (the "Privacy Officer"), personnel of the Company's Human Resources Department and personnel in the Company's Legal, Audit, Accounting, Finance and Information Technology Departments who support the Company's Human Resources Department. These individuals will protect the privacy of your health information and ensure it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the plans to any other Company employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other employee benefit plans sponsored by the Company.
- To a Business Associate. Certain services are provided to the plans by third parties known as business associates. For example, the plans may input information about your treatment into an electronic claims processing system maintained by a plan's business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function, but only after the business associate agrees in writing to contract terms that are designed to appropriately safeguard PHI. HIPAA and the plans require all business associates to safeguard your PHI.
- Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- Plan-Related Benefits and Services. The plans may use and disclose your PHI to tell you about your plan- related benefits or services that may be of interest to you. However, your PHI will not be used or disclosed for marketing, sales or fundraising purposes without your authorization.
- Authorizations and Personal Representatives. The plans may disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide a written authorization and any supporting documents (*e.g.*, power of attorney). A separate authorization is required from you in order to use or disclose psychotherapy notes. To designate an authorized representative, complete and return the Individual Authorization form available to you in this enrollment packet or by contacting HR Solutions 855-663-6547. Uses and disclosures of your PHI not described in this Notice will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not withdraw or change any uses or

disclosures already made by the plans in reliance on your prior authorization. A plan does not have to disclose information to a personal representative if it has a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- Spouses and Other Family Members. With only limited exceptions, the plans will send all mail to the employee. This includes mail relating to a spouse/domestic partner and other dependents who are covered under the plans, and includes mail with information on the use of plan benefits by the spouse/domestic partner and other dependents and information on the denial of any plan benefits to the spouse/domestic partner and other dependents. However, if a person covered under a plan has requested restrictions or confidential communications, and if we have agreed to the request, we will send mail as provided by the request for restrictions or confidential communications.
- As Required by Law. The plans will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

- Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process that requires such use or disclosure.
- Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- Workers' Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and/or other similar programs.
- Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release health information about you as deemed necessary by military command authorities.
- To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes if (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.
- National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law; and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- Organ and Tissue Donation. If you are an organ donor, the plans may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the plans may disclose your PHI to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The

plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

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

- Government Audits. The plans are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA privacy rule.
- Disclosures to you. When you request, the plans are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI is not disclosed pursuant to your individual authorization.

Your Rights Regarding Your Own PHI - Your rights regarding the PHI the plans maintain about you are as follows:

- Right to Inspect and Copy. You have the right to inspect and copy your own PHI. This includes information about plan eligibility, claim and appeal records, and billing records. To inspect and copy your PHI maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your PHI that you request. In limited circumstances, the plans may deny your request to inspect and copy your PHI.If you are denied access to health information, you may request a review of the denial by submitting a written request to the Privacy Officer.
- Right to Amend. If you feel that PHI is incorrect or incomplete, you may ask the plans to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request, in writing, to the Privacy Officer. You must provide the reason(s) to support your request. A plan may deny your request if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask the plan to amend health information that either: (1) is accurate and complete; (2) was not created by the plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the health information kept by or for the plan; or (4) is not information that you would be permitted to inspect and copy.
- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of disclosures of your PHI the plans have made to others, except the accounting will not include (1) those necessary to carry out health care treatment, payment, operations, (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting of disclosures that have occurred since the effective date of this Notice, submit your request, in writing, to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested and which may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask the plans not use or disclose information about a surgery. To request restrictions, make your request in writing to the Privacy Officer. You must advise the Privacy Officer: (1) what health information you want to restrict or limit; (2) whether you want to restrict or limit the plans' use, disclosure, or both; and (3) to whom you want the restriction(s) and limit(s) to apply. *Note*: *A plan may refuse to agree to a requested restriction on uses and disclosures necessary to properly administer the plan. The plan will advise you if it does not agree to follow a restriction you request, or if it terminates a restriction it has previously agreed to follow.*
- Right to Request Confidential Communications. You have the right to request the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential

communications, make your request, in writing, to the Privacy Officer. The plans will take action needed to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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

Changes To This Notice

The plans reserve the right to change this Notice at any time and to make the revised or changed Notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The new notice will be provided to you electronically or by mail. The plans will maintain a copy of the current version of this Notice at all times. You have the right to a paper copy of this notice at any time; simply contact HR Solutions at 855-663-6547.

Complaints

If you believe your HIPAA privacy rights described in this Notice have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may make a complaint to the Office of Civil Rights of the U.S. Department of Health and Human Services, generally within 180 days of when the act or omission complained of occurred. You will not be penalized or retaliated against for filing a complaint.

Contact Information

If you have any questions or want further information about this Notice, please contact:

ONEOK, Inc.
Attn: Vice President, Total Rewards
P.O. Box 871
Tulsa, OK 74102
855-ONEOKHR (855-663-6547)

This notice is effective October 28, 2024

Notice of Special Enrollment Rights

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for a dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage and within 90 days after the birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request Special Enrollment or obtain more information, contact HR Solutions at 855-ONEOKHR (855-663-6547).

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Your Rights Under USERRA

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed services;
- Have applied for membership in the uniformed services; or

- Are obligated to serve in the uniformed services;

then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., preexisting condition exclusions) except for service-connected illnesses or injuries.
- Please refer to the specific ONEOK health and/or dental plan documents for further information regarding USERRA and Military Service issues.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Wellness Program Disclosure

From time to time, ONEOK may offer an incentive or reward for participation in a wellness program. Participation in any wellness program is completely voluntary, and you will not be discriminated against or subject to retaliation if you choose not to participate. Each wellness program is intended to comply with all applicable laws, including the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and the Health Insurance Portability and Accountability Act. ONEOK is committed to maintaining the privacy and security of your personally identifiable information and will never use personal information collected as part of any wellness program to make employment decisions, nor will it be sold to any third party or used for any other purpose without your consent. All wellness program vendors are required to abide by the same confidentiality standards and maintain adequate precautions to avoid any data breach. You will be notified as soon as administratively practicable in the event of a data breach involving your personal information. If you think you may be unable to meet the standard to qualify for an incentive or reward, please contact HR Solutions to find an alternative wellness program with the same reward that is right for you in light of your health status. Please contact HR Solutions at 855-ONEOKHR (855-663-6547) with any questions about this legally required notice.

♦ Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans sponsored by employers that offer mastectomy coverage to provide coverage for certain services relating to the mastectomy. In the case of a participant or beneficiary who is receiving benefits under the ONEOK, Inc. Health Plan in connection with a mastectomy, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of themastectomy, including lymphedemas.

This coverage is subject to the same deductibles, coinsurance, other cost-sharing and limitations (in-network or out- of-network) applicable to other medical and surgical benefits provided by the ONEOK, Inc. Health Plan.

If you would like more information on WHCRA benefits, please contact HR Solutions at 855- ONEOKHR (855-663-6547).

♦ Newborns' and Mothers' Health Protection Act of 1996

(Coverage Applies to Employee/Spouse Only)

The Newborns' and Mothers' Health Protection Act of 1996 requires plans that offer maternity stay coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

A plan may not require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 to 96 hours after delivery.

Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Employer Name:	ONEOK INC
Employer State of Situs:	OKLAHOMA
Name of Issuer:	ONEOK INC
Plan Marketing Name:	ONEOK, INC. HEALTH PLAN
Plan Year:	2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	YES, Partially	Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.
2	Allergy Injections and Testing	Ambulatory	Pg. 11	YES	
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	YES, Partially	The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the coverage are not covered, other than for malfunctions.
4	Durable Medical Equipment	Ambulatory	Pg. 13	YES	
5	Hospice	Ambulatory	Pg. 28	YES, Partially	Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	YES	
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	YES	
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	YES	
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	YES	
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	YES, Partially	If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	YES	
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	YES	
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	YES	
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	YES	
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	YES	
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	YES	

17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	YES	
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	YES	
19	Skilled Nursing Facility	Hospitalization	Pg. 21	YES	
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	YES	
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	YES	
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	NO	
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	YES	
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	NO	
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	YES	
26	Tele-Psychiatry	MH/SUD	Pg. 11	YES	
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	YES	
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes, Partially	Only as covered under Accidental Injury - Dental
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes, Partially	Routine vision examinations, including refractive examinations to determine the need for vision correction.
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	YES	Full Coverage is only available to employee and spouse/domestic partner
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	YES	
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	YES	
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	YES	
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	YES	
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	YES	
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	YES	
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	YES	
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	YES	
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	YES	
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	YES	
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	YES	
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	YES, Partially	Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

This is not a plan, plan amendment, summary plan description (SPD) or contract to provide the benefis described. Any benefits provided are governed by the formal written plan documents adopted by ONEOK. While every effort is taken to report benefits accurately, discrepancies or errors are always possible. In the event any conflict between this information and the written plan document, the written plan document will govern. This information does not constitute tax advice or an employment contract or guarantee to continue employment for any period of time. ONEOK reserves the right to change the plans' provisions, in whole or in part, at any time for any reason.

COLORADO
Family and Medical Leave Insurance Program (FAMLI)
Department of Labor and Employment

FAMLI Program Notice

Updated December 2023 | famli.colorado.gov

Deductions from Employee Wages start January 1, 2023

- The employee share of FAMLI premiums is set at 0.45% of employee wages through 2024. For 2025 and beyond, the director of the FAMLI Division sets the premium rate according to a formula based on the monetary value of the fund each year. Employers with a total of ten or more employees nationwide must also contribute an additional 0.45% of wages for a total of 0.9%, but employers with nine or fewer employees are only responsible for sending the 0.45% employee share to the FAMLI Division.
- **Starting in 2023, employers may begin deducting up to 0.45% from employees' wages for FAMLI contributions.** This can be done through a simple payroll deduction, and employees will notice the deduction on their regular paychecks. Employers are responsible for collecting those deductions and sending them into the FAMLI Division on behalf of their employees once a quarter.

Benefits start January 1, 2024

- Starting in 2024, paid family and medical leave benefits are available to most Colorado employees who have a qualifying condition and who earned $2,500 over the previous year for work performed in Colorado.
- The qualifying conditions for paid family and medical leave are:
  - Caring for a new child during the first year after the birth, adoption, or foster care placement of that child.
  - Caring for a family member with a serious health condition.
  - Caring for your own serious health condition.
  - Making arrangements for a family member's military deployment.
  - Obtaining safe housing, care, and/or legal assistance in response to domestic violence, stalking, sexual assault, or sexual abuse.
- Covered employees are entitled to up to 12 weeks of paid family and medical leave per year. Individuals with serious health conditions caused by pregnancy complications or childbirth complications are entitled to up to 4 more weeks of paid family and medical leave per year for a total of 16 weeks.
- Leave may be taken continuously, intermittently, or in the form of a reduced schedule.
- Leave will be paid at a rate of up to 90% of the employee's average weekly wage, based on a sliding scale. Employees may estimate their benefits by using the benefits calculator available at famli.colorado.gov.
- You don't have to work for your employer a minimum amount of time in order to qualify for paid family and medical leave benefits.
- If FAMLI leave is used for a reason that also qualifies as leave under the federal FMLA, then the leave will also count as FMLA leave used.
- Employees may choose to use sick leave or other paid time off before using FAMLI benefits, but they are not required to do so.
- Employers and employees may mutually agree to supplement FAMLI benefits with sick leave or other paid time off in order to provide full wage replacement.

Filing Claims

- Benefits will be available starting January 2024. Instructions on how to apply for benefits are available at **famli.colorado.gov**.
- Employees or their designated representatives apply for FAMLI benefits by submitting an application and any required documentation through My FAMLI+, available at **famli.colorado.gov**.
- Applications may be submitted in advance of the absence from work, and in some circumstances, they may be submitted after the absence has begun.
- Approved applications will be paid by the FAMLI Division within two weeks after the claim is properly filed, and weekly thereafter for the duration of the approved leave.
- Employees can appeal claim determinations to the FAMLI Division.
- Individuals who attempt to defraud the FAMLI program may be disqualified from receiving benefits.

Job protection and continued benefits

- Employers may not interfere with employees' rights under FAMLI, and may not discriminate or retaliate against them for exercising those rights, including taking FAMLI leave, talking to others about FAMLI, and filing complaints of FAMLI violations.
- An employee who has worked for the employer for at least 180 days is entitled to return to the same position, or an equivalent position, upon their return from FAMLI leave.

Retaliation, Discrimination, and Interference Prohibited

- Employers may not interfere with employees' rights under FAMLI, and may not discriminate or retaliate against them for exercising those rights.
- Employees who suffer retaliation, discrimination, or interference may file suit in court, or may file a complaint with the FAMLI Division.

Other Important Information

- An employer may offer a private plan that provides the same benefits as the state FAMLI plan, and imposes no additional costs or restrictions. Private plans must be approved by the FAMLI Division.
- Employees and employers are encouraged to report FAMLI violations to the FAMLI Division.