ONEOK, INC. HEALTH PLAN

Plan Document and Summary Plan Description

Restated January 1, 2024

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

ONEOK, Inc., (referred to as "Company") has established and maintains the ONEOK, Inc. Health Plan ("Health Plan" or "Plan"), a group health plan, that provides health benefits ("Benefits") for certain Company employees who are eligible to participate in the Health Plan ("Eligible Employees") and their family members ("Eligible Family Members"). This document serves as the Health Plan Document and Summary Plan Description ("SPD") and outlines the terms and conditions of coverage and Benefits available under this Plan. Additional terms and conditions of the Plan's Benefits are contained in the various policies, summaries and booklets provided by UnitedHealthcare (each a "Benefit Summary") and are incorporated into this Plan by reference. You do not have a complete copy of this Plan unless you have each of the Benefits Summaries referenced herein. These Benefit Summaries can be requested from HR Solutions (contact information listed below).

Capitalized words in this document have meaning stated in Sections 9: Glossary, unless indicated otherwise.

The Health Plan is in part administered in conjunction with the ONEOK, Inc. Cafeteria Plan. The Health Plan is operated under a third-party administrative services agreement between the Company and a claims administrator named in the Health Plan ("Claims Administrator").

The Claims Administrator administers the payment of Benefits, on behalf of the Company, in accordance with the terms of the Health Plan. It performs certain other services on behalf of the Company. Neither the Health Plan nor the Claims Administrator insure or guarantee payment of Benefits or any other Benefits under any contract or policy of insurance.

This document, along with the applicable Benefit Summaries, contains the terms and provisions of the Health Plan and information to explain the rights and obligations of Covered Persons under the Health Plan.

This SPD, along with the documents listed in Section 1: Schedule of Benefit Summaries, are designed to furnish you information consistent with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SPD and the Benefit Summaries, certificates and other descriptive material provided to you by the Company and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed provisions. You may obtain copies of this SPD and its related documents or examine these documents by contacting the Plan Administrator.

Every effort has been made to ensure that all these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. No one speaking on behalf of the Plan or the Company can alter the terms of the Plan.

The Company, at this time, intends to continue the Health Plan, but reserves the right, in its sole discretion, to modify, amend or terminate the Health Plan at any time, for any reason. This SPD is not to be construed as a contract of or for employment and does not give you any right to be retained in the Company's employment.

For quick reference:

ONEOK Online – www.oneokonline.com > Departments and Programs > Human Resources > Benefits

How to Use this SPD

- Read this entire SPD, and the summaries listed under Section 1: Schedule of Benefit Summaries, and share it with your family.
- Many of the sections of this SPD are related to other sections. You may need to read more than just one section for all the information.
- You can find the SPD and the Benefit Summaries on ONEOK Online at www.oneokonline.com or request a printed copy of the SPD by contacting HR Solutions.
- Capitalized words in the SPD have defined meanings stated in Sections 9: Glossary.

Please read this SPD thoroughly to learn how the Health Plan works. If you have questions call the number on the back of your ID card or contact HR Solutions at 855-663-6547 or at HRSolutions@oneok.com.

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

Special Notices

Because of some federal laws, changes in the Health Plan, or the operations of the Company, provisions called "Special Notices" may be added to this SPD.

Be sure to check for and read any "notice" or "Special Notice" you receive about the Health Plan. It can include information on changes to the Health Plan and this SPD affecting Benefits coverage or the administration of the Health Plan.

Help and Online Information About the Health Plan

If you have questions concerning your Enrollment, participation or Benefits, call HR Solutions at 855-ONEOKHR (855-663-6547).

Once you are enrolled, you can find helpful information about the Health Plan and your participation online at:

- www.oneokonline.com > Departments and Programs > Human Resources > Benefits
- www.myuhc.com

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SECTION 1: SCHEDULE OF BENEFIT SUMMARIES

Summary Plan Description: ONEOK, Inc. Choice Plus (PPO)

Summary Plan Description: ONEOK, Inc. PPO OOA Plan

Summary Plan Description: ONEOK, Inc. HDHP Plan with HSA

Summary Plan Description: ONEOK, Inc. HDHP OOA Plan with HSA

Progyny ONEOK Member Guide

SECTION 2: Eligibility and General Information

Eligible Employees

Eligibility is open to all salaried and hourly Employees of ONEOK, Inc. (and its affiliates and subsidiaries) who are regularly scheduled to work twenty (20) or more hours per week (“Eligible Employees”). Employees who are nonresident aliens who do not receive U.S. source income and temporary employees such as summer interns are not Eligible Employees.

The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Health Plan, and the Benefit Plan Administration Committee or its designee (the “Plan Administrator”) has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Health Plan. Furthermore, eligibility for certain Benefits under the Health Plan (e.g., Wellness Benefits) may differ from the general eligibility rules for Medical Benefits and Prescription Drug Benefits.

Eligibility

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

Eligibility for Rehired Employees

When you are rehired by the Company, you are treated the same as a new hire for purposes of the Health Plan. That means you would be considered an Eligible Employee as of your date of rehire in order to be eligible. In order to re-enroll your family members you must also provide Dependent Verification Documents (as set forth in this SPD) and Social Security Numbers.

Default Coverage if You Do Not Enroll (“Opt-Out”)

If you are a new Eligible Employee and do not complete the Enrollment process within the two weeks (14 calendar days) of your employment state date or transition to an Eligible Employee and do not complete your enrollment in Workday, you will automatically be enrolled in the PPO Option, Employee Only Coverage Tier. Your coverage will be effective automatic enrollment on your employment state date. You will not be able to change this coverage unless you have a Change in Status Event or until the next Annual Open Enrollment Period.

Coverage Tiers

Your Benefits costs will vary based on the family members you elect to cover. The coverage tiers to choose from are:

- Employee Only
- Employee + Spouse / Domestic Partner
- Employee + Child(ren)* / Domestic Partner Child(ren)*
- Employee + Family

* Child(ren) is synonymous with the term Dependent(s)

Cost of Coverage

Under the Company's Cafeteria Plan you may defer a portion of your salary on a pre-tax basis to purchase coverage under the Health Plan for you and your family members eligible to be Covered Persons.

The Net Participant Cost that you are responsible for each pay period will be provided during the Annual Open Enrollment Period and is also available online – see the heading entitled "Help and Online Information About the Health Plan,".

If You Choose No Benefits Coverage

If you decline Benefits coverage for yourself and/or your Eligible Family Member(s), you may, in the future, be able to enroll yourself and/or your Eligible Family Member(s) in Benefits coverage in the Health Plan, provided that you have a Change in Status which requires notification within thirty (30) days of your Change in Status event. For birth, adoption, or Placement for Adoption, the notification must be received within ninety (90) days. For loss of, or eligibility for, Medicaid or State Children's Health Insurance Program (SCHIP)/Children's Health Insurance Program (CHIP) coverage, the notification must be received within sixty (60) days.

Remember, if you "Opt-Out," you will have no Benefits coverage through the Health Plan or from the Company.

Eligible Family Members

Family members who are eligible to be a Covered Person under the Health Plan and documents that the Plan Administrator may require in order to verify eligibility include:

Spouse/Domestic Partner or Dependent Family Member	Verification Document Requirement
Spouse: A person who is recognized as your legal spouse for purposes of federal income tax laws. Neither of you is married to anyone else under either statutory or common law.	State issued marriage certificate. For common law marriages: Two items showing proof of joint ownership (or Certificate of Informal Marriage).
Domestic Partner: A person with whom you have had a committed relationship with for 12 months and whom you live with, but who is not considered your legal spouse for purposes of federal income tax laws. Neither of you is married to or legally separated from anyone else under either statutory or common law.	Jointly signed Declaration for Domestic Partnership (must be submitted with initial enrollment) **and** Affidavit of Dependent Status for Domestic Partnership (must be submitted with initial enrollment) **and** two items showing proof of financial interdependence. Proof of financial interdependence includes: joint ownership of an automobile or home; a joint checking, bank or investment account; a joint credit account, mortgage or a lease for a residence identifying both partners as tenants; a will and/or life insurance policies signed and completed to the effect that one domestic partner is the primary beneficiary of the other; a beneficiary designation form for a retirement plan signed and completed to the effect that one domestic partner is the primary beneficiary of the other. Registration of domestic partners if the domestic partners reside in a state that provides for registration. Official recognition of civil union for persons who reside in state that recognize civil unions. If you do not provide a completed Affidavit of Dependent Status at time of enrollment, the plan administrator will assume that neither of your domestic partner nor your domestic partner's child(ren) qualify as your tax dependent(s) and will impute income to you for the value of coverage provided to your domestic partner and your domestic partner's child(ren).
Natural Child(ren): Until they reach age 26.	State-issued birth certificate (or foreign equivalent) listing employee as a parent. [1]

Spouse/Domestic Partner or Dependent Family Member	Verification Document Requirement
Stepchild(ren): Your spouse's or domestic partner's child(ren) until they reach age 26 or earlier if your marriage or domestic partnership with their natural parent ends	State-issued birth certificate (or foreign equivalent) listing employee's spouse or domestic partner as a parent **and** state-issued marriage certificate proving employee and spouse are married and recorded in legal records **or** domestic partnership registration or Declaration for Domestic Partnership, as applicable, documenting the relationship. [1]
Adopted Child(ren): Child(ren) you (or your spouse or domestic partner) have adopted or who have been placed for adoption with you until the child(ren) turns age 26. You or your spouse or domestic partner must be one of the adopting parents; the child(ren) must have been placed in your (or your spouse or domestic partner's) custody; and the adoption proceeding must have assigned the responsibility for benefits coverage to you (or your spouse or domestic partner).	Adoption or placement for adoption documents and court granted custody documents, as applicable; state-issued birth certificate (or foreign equivalent) or similar information obtained in connection with adoption proceeding.[1]
Foster Child(ren): Child(ren) who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction until the child(ren) turns age 26	Foster placement judgment, decree or order
Child Covered by a Qualified Medical Child Support Order (QMCSO): Child(ren) on whose behalf a QMCSO has been entered or issued, indicating that coverage must be provided by you until the child(ren) turns 26 years of age, the QMCSO expires or the Plan receives notice from the issuing party that the QMCSO is no longer valid, whichever occurs first in time.	QMCSO
Other Eligible Dependent: A person who is not your child (or the child of your spouse or domestic partner) but to whom you are related; for whom you have been appointed legal guardian and is your Dependent for federal income tax purposes; and is (i) under age 19, or (ii) under age 24 and a full-time student.	State issued birth certificate (or foreign equivalent) **and** court legal guardianship documents (if applicable) **and** copy of the first page of your federal tax return filed within the last tax year (income amounts blacked out) **and** proof of full-time education student, if applicable.[1] If a new legal guardian is appointed in the current calendar year, no tax return is required.

Spouse/Domestic Partner or Dependent Family Member	Verification Document Requirement
Incapacitated Person: Continued coverage is provided for your child(ren) or other eligible dependent(s), who is physically or mentally incapable of self-support while remaining incapacitated, as long as (i) you remain an Eligible Employee, (ii) the Dependent meets the requirements as set out in the section entitled “Coverage of an Incapacitated Person” below, and (iii) the Dependent satisfies the criteria for eligibility under one of the dependent eligibility categories described above but for his or her age.	To continue coverage for a Dependent under this provision, proof of disability or incapacity (obtained at your own expense) must be received by HR Solutions within 31 days after coverage would otherwise terminate (or within 30 days of employee’s employment start date for employees who become Eligible Employees after June 1, 2020). The Health Plan requires annual re-certification of the Dependent’s eligibility. See the section entitled “Coverage of an Incapacitated Person” below for additional requirements.

[1] If the eligible dependent’s name is different than the name on the state-issued (or foreign equivalent) birth certificate, a state-issued marriage certificate or Social Security Card may be required.

Other forms of dependent verification documentation may be accepted, at the Plan Administrator’s sole discretion, on a case-by-case basis.

For the 2024 Annual Open Enrollment Period, legacy Magellan employees have until April 1, 2024, to provide documentation for family member(s)eligible to be Covered Person(s) under the Health Plan. If the documentation is not received by this date, your spouse, domestic partner and/or dependents will be removed from the Plan prospectively and you will not be able to enroll your family members until the following Annual Open Enrollment Period (or until you experience a Change in Status Event).

Tax Treatment of Participant Cost

In general, the Company contributions for coverage under the Health Plan will be excluded from your gross income for federal income tax purposes, except as further described below. Participation in certain voluntary wellness programs that may be offered from time to time (for example, programs where a gift card is offered as an incentive) may result in imputed income to the Employee.

As an active Employee, you will reduce salary equal to your Net Participant Cost each payday with pre-tax dollars — money that is deducted from your pay before federal and state income taxes, and other payroll taxes, are calculated and withheld from your pay.

Coverage of Domestic Partner Not a Dependent

If you elect coverage for a Domestic Partner and the Domestic Partner does not qualify as a Domestic Partner Dependent:

Company contributions for that Domestic Partner coverage will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported as income on your Form W-2; and the contributions you make to the Health Plan for that coverage must be made on an after-tax basis.

Coverage of a Domestic Partner Dependent

If your Domestic Partner is covered under the Health Plan, and the Domestic Partner qualifies as a Domestic Partner Dependent, then the Company contributions for that coverage will be excluded from your gross income for federal income tax purposes. In addition, you will be able to pay your Net Benefit Cost on a pre-tax basis under the Cafeteria Plan.

Change in Status Events; After-Tax Treatment

If you experience any Change in Status Event (marriage, birth, adoption, etc.) during the Health Plan Year that results in a change in Coverage Tiers, any retroactive Net Participant Cost will be withheld from your pay on an after-tax basis (money that is deducted from your pay after federal and state income taxes are withheld). Prospective Net Participant Costs will be withheld from your pay on a pre-tax basis.

Coverage of an Incapacitated Person

Coverage under the Health Plan may be provided for a Dependent with a mental or physical disability who reaches an age when coverage would otherwise end, as long as the Dependent meets the following requirements:

1. The Dependent was enrolled in the Health Plan prior to his or her turning 26 years of age (for natural, adopted, foster and stepchildren), or attaining age 24 (for other eligible dependents), as the case may be, and remained covered through such age;

2. The Dependent is unable to be self-supporting due to a severe mental or physical handicap or disability, depends mainly on you for support and is considered a Dependent under the terms of this Plan;

3. The Dependent is unmarried; and

4. Proof of the Dependent’s incapacity and status as a Dependent is provided to HR Solutions within thirty-one (31) days after coverage would have otherwise terminated and at any time upon the Health Plan’s request.

The proof might include medical examinations at your expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within thirty-one (31) days, the Health Plan will no longer pay Benefits for that dependent.

In the case of a newly Eligible Employee, the requirements in (1) and (4) above are modified to require enrollment in the applicable group health plan of the Eligible Employee’s former employer immediately prior to date of hire with the Company and proof of coverage and the child’s incapacity and dependency must be provided within 30 days from your date of hire and before coverage can commence. These requirements are subject to the Plan Administrator’s discretion.

Coverage will continue, as long as the enrolled Dependent meets the foregoing requirements and you remain an Eligible Employee, or, unless coverage is otherwise terminated in accordance with the terms of the Health Plan.

Enrollment – When an Employee, Spouse/Domestic Partner and/or Dependent(s) becomes covered

Within two weeks (14 days) of your employment start date, you must complete your elections in Workday, indicating your Benefit elections and which family members who can be Covered Persons are to be covered for Benefits under the Health Plan. Provided you timely submit your election, the coverage for your family members will be effective on your employment start date.

You elect the Medical Benefit Option and Coverage Tier you want and then the Company will deduct your portion of the contribution for cost of that coverage from your paychecks for the twenty-four (24) annual pay periods. Note that since contributions are paid each pay period and not pre-paid for the month, coverage is provided on a pay period basis.

In order to enroll your family members, you must also provide Verification Documents (as set forth in this this SPD) and Social Security Numbers within 90 days of your employment start date. If these items are not received by this date, your spouse, domestic partner and/or dependents will be removed from the Plan prospectively and you will not be able to enroll your family members until the following Annual Open Enrollment Period (or until you experience a Change in Status Event).

For the 2024 Annual Open Enrollment Period, legacy Magellan employees have until April 1, 2024, to provide documentation for family member(s) eligible to be Covered Person(s) under the Health Plan.

If You Fail to Provide Dependent Verification Documents

In all cases, we require proof of dependency (where applicable) and Social Security Number as conditions to enrolling an Eligible Family Member or retaining an enrolled Eligible Family Member on the Health Plan. In the course of enrolling an Eligible Family Member, or retaining enrollment of one, you will be required to affirm that any information you provide about an individual's status as your Eligible Family Member is true and correct, and that you understand that the Health Plan relies on your representations. The Plan Administrator may request you verify eligibility in order to re-enroll or maintain enrollment of an Eligible Family Member at any time. If documentation is requested to prove the eligibility status of one or more persons you have enrolled or are seeking to enroll under the Health Plan, and you fail to supply the requested documentation within ninety (90) days of employment start date (or such other date as indicated in the Plan Administrator's request), the Health Plan may decline to enroll your Eligible Family Member or may prospectively terminate his or her coverage. By contrast, if in the course of enrolling an individual or retaining his or her enrollment, you instead make a misrepresentation of a material fact or do something, or fail to do something, that constitutes fraud (both as determined by the Plan Administrator or its designee in its sole discretion), then your Eligible Family Member will have a Rescission of Coverage retroactive to the date of that fraud or misrepresentation. No COBRA continuation coverage will be available in either type of case. If the Plan Administrator believes a retroactive termination is appropriate you will receive a Notice of Rescission of

Coverage at least 30 days before coverage is terminated and be afforded the opportunity to treat any such adverse action as an Adverse Benefit Determination with respect to a claim and appeal the Health Plan's action under the Health Plan's claims and appeals provisions. See Section 8: Claims Procedures.

Change in Status Events

The only time that you are allowed to change a Benefits election during the Plan Year is when you have a qualifying Change in Status Event. This is because federal tax laws governing the Cafeteria Plan only permit you to change a pre-tax contribution for coverage under the Health Plan in special cases. The following table shows the Change in Status Events and what changes, if any, can be made in your Coverage Tiers.

Change in Status Events Table:

Change in Status Event	Permitted Election Changes
A. Change in Employee's Legal Marital Status	
1. Gain Spouse (marriage)	Participant may enroll or increase election for newly eligible Spouse and Dependent (and preexisting Dependents also may be enrolled); Participant may revoke Participant's or Dependent's coverage only when such coverage becomes effective under the Spouse's plan
2. Lose Spouse (divorce, legal separation, annulment, death of Spouse (see loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation, etc.))	Participant may revoke election only for Spouse; Participant may elect coverage for self or dependents who lose eligibility under Spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment, or death (and any Dependents may be enrolled so long as at least one Dependent has lost coverage under Spouse's plan)
B. Change in Employee's Domestic Partner Relationship Status	
1. Gain Domestic Partner	Participant may enroll or increase election for newly eligible Domestic Partner (and preexisting Dependents also may be enrolled); Participant may revoke Participant's or Dependent's coverage only when such coverage becomes effective under the Domestic Partner's plan
2. Lose Domestic Partner (termination of Domestic Partner relationship, death of Domestic Partner) (see loss of dependent eligibility below for discussion of dependent eligibility loss following termination of domestic partner relationship, etc.)	Participant may revoke election only for Domestic Partner; Participant may elect coverage for self or dependents who lose eligibility under Domestic Partner's plan if such individual loses eligibility as a result of termination of domestic partner relationship, or death (and any Dependents may be enrolled so long as at least one Dependent has lost coverage under Domestic Partner's plan)

Change in Status Event	Permitted Election Changes
C. Change in the Number of Employee's Dependents	
1. Gain Dependent (birth, adoption, foster child; Domestic Partner becomes federal tax dependent of employee)	Participant may enroll or increase coverage for newly eligible Dependent (under eligibility rule, any other Dependents who were not previously covered may also be enrolled). Participant may revoke Participant's or Dependent's coverage if Participant or Dependent becomes eligible under Spouse's or Domestic Partner's health plan
a. Issuance of a QMCSO	Participant to enroll Dependent(s) subject to QMCSO
b. Eligibility for Medicaid or SCHIP/CHIP coverage	Participant may enroll Spouse/Domestic Partner and/or Dependent(s) in coverage
2. Lose Dependent (divorce, legal separation, annulment, termination of domestic partner dependent relationship, death of Dependent)	Participant may drop coverage only for the Dependent(s) who loses eligibility. Reason could be due to age or relative Dependent (such as niece, nephew, grandchild) for whom you have legal guardianship becomes ineligible due to age, marriage, no longer residing with the Participant, employed full-time)
a. Loss of Medicaid or SCHIP/CHIP coverage	Participant may revoke Spouse/Domestic Partner and/or Dependent(s) coverage
b. Revocation of a QMCSO	Participant may revoke Dependent(s) subject to Order
D. Change in Employment Status of Participant, Spouse, Domestic Partner, or Dependent That Affects Eligibility	
1. Commencement of Employment by Employee/Participant or Other Change in Employment Status (e.g., Part-time to Full-time) Triggering Eligibility Under Component Plan	Provided that eligibility was gained for this coverage, Employee/Participant may add coverage for employee/Participant, Spouse/Domestic Partner or Dependents
a. Commencement of Employment by Spouse/Domestic Partner, or Dependent or Other Change in Employment Status Triggering Eligibility Under Spouse's, Domestic Partner's or Dependent's health plan	Participant may revoke or decrease election under Participant's, Spouse's, Domestic Partner's or Dependent's coverage if Participant, Spouse/Domestic Partner or Dependent is added to Spouse's, Domestic Partner's or Dependent's plan
2. Termination of Employment by Participant, Spouse/Domestic Partner or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility	

Change in Status Event	Permitted Election Changes
a. Termination of Participant's Employment or Other Change in Employment Status (e.g., unpaid leave, Full-time to Part- time) Resulting in a Loss of Eligibility	Participant may revoke or decrease election for Participant, Spouse/Domestic Partner or Dependent who loses eligibility under the Plan
b. Termination of Spouse's, Domestic Partner's or Dependent's Employment (or other change in employment status resulting in a loss of eligibility under their employer's plan)	Employee/Participant may enroll or increase election for Employee, Spouse, Domestic Partner, or Dependents who lose eligibility under Spouse's, Domestic Partner's or Dependent's employer's plan. In addition, other previously eligible Dependents may also be enrolled as allowed by regulations
E. Event Causing Participant's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements	
1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (individual becoming a qualified dependent of employee)	Participant may enroll or increase election for newly eligible Dependent. In addition, other previously eligible Dependents may also be enrolled as allowed by regulations
2. Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer's Plan (attaining a specified age, getting married, ceasing to be domestic partner dependent, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected Dependent
F. Change in Place of Residence of Employee, Spouse/Domestic Partner or Dependent	
1. Move Triggers Eligibility (e.g., employee or dependent moves into service area)	Employee may enroll or increase election for newly eligible employee, Spouse/Domestic Partner or Dependent if the change affects eligibility. Also, other previously eligible Dependents may be enrolled as allowed by regulations
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside service area)	Employee may revoke election or make new election if the change in residence affects the Employee's, Spouse's, Domestic Partner's or Dependent's eligibility for coverage option

Change in Status Event	Permitted Election Changes
G. Significant Changes in Employee, Spouse/Domestic Partner or Dependent Coverage or Cost	
1. Cost Changes – a. Automatic Changes (for insignificant cost changes) b. Significant Cost Changes (if cost charged to employee significantly increases or decreases)	The Plan will automatically adjust an Employee's election for insignificant cost changes. For a significant increase in cost, Employee may increase election correspondingly or revoke an election and elect coverage under another Medical Benefit Option providing similar coverage for Employee, Spouse/Domestic Partner or Dependent For a significant decrease, Employee may decrease election correspondingly or may elect coverage (even if no prior participation) with decreased cost and drop election for similar coverage option for Employee, Spouse/Domestic Partner or Dependent
2. Significant Curtailment with Loss of Eligibility (complete loss of coverage, including elimination of a benefit package)	Employee may revoke election for curtailed coverage and make new prospective coverage election under another similar Medical Benefit Option or drop coverage if a similar Medical Benefit Option is not available for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change
3. Significant Curtailment with Loss of Eligibility (e.g. significant increase in deductible or Copay)	Employee may revoke election for curtailed coverage and make a new election for coverage under another Medical Benefit Option for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change
4. Addition or Improvement of a Benefit Package Option	Employee may revoke existing election and elect newly added or improved Medical Benefit Option for Employee, Spouse/Domestic Partner or Dependent based upon the applicable change
5. Change in Coverage under Another Employer Plan	If other employer plan increases coverage, Employee may decrease or revoke election for individuals who have elected or received corresponding increased coverage under the other employer plan If other employer plan decreases or ceases coverage, Employee may enroll or increase election for individuals who have elected or received corresponding decreased coverage under other employer plan If open enrollment under other employer's plan corresponds to a different plan year, corresponding changes can be made under the Plan

Change in Status Event	Permitted Election Changes
6. Loss of Coverage under Other Group Health Coverage (loss of coverage under any group health coverage sponsored by a government or educational institution)	Employee may enroll or increase election for Employee, Spouse/Domestic Partner or Dependent if the individual loses group health coverage sponsored by a governmental or educational institution.

You must Promptly Report Change in Status Events to Change Elections

When a Change in Status Event occurs, it is your responsibility to complete a Benefits Change in Workday within the allotted time frame after your Change in Status Event occurs.

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

There is NO automatic coverage under the Health Plan. Newborns are NOT automatically covered under the Health Plan even if you are already enrolled in a Coverage Tier with Dependent(s) coverage. You must complete a Benefit Change within 90 days from birth to enroll your newborn in the Health Plan.

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

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

To complete a Benefit Change:

Login to Workday > Benefits and Pay > Change Benefits

You should complete a Benefit Change, including:

- All information requested such as your personal information, your Spouse's/Domestic Partner's or your Dependent(s)' name, birth date(s), Social Security Number(s), reason for ineligibility, etc.;
- Indication of the date the Change in Status Event occurred and provide any necessary documentation;
- Submit the Benefit Change within the given time frame; and

- Dependent Verification Documents and Social Security Numbers are required and must be received by HR Solutions within ninety (90) days of the Change in Status Event.

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

If the request is for coverage to be discontinued for a Spouse, Domestic Partner, or Dependent(s) who is no longer eligible, any claims that have been processed by the Plan Administrator for the Spouse, Domestic Partner, and/or Dependent after the date that they are no longer eligible must be reimbursed to the Health Plan.

In order for COBRA Continuation Coverage under the Health Plan to be offered to the Spouse or Dependents, per IRS regulations, notification must be received within sixty (60) days of the Change in Status Event. If the notification is not received within that timeframe, COBRA Continuation Coverage will not be available to the Spouse or Dependent(s). Refer to When Coverage Ends in the applicable Benefit Summary listed under Section 1: Schedule of Benefit Summaries.

Annual Open Enrollment Period

The Annual Open Enrollment Period is usually during the fall and continues for a period of time determined each year by the Plan which will be communicated to you in advance of the Annual Open Enrollment Period. During the Annual Open Enrollment Period you will have the opportunity to enroll or make changes to your benefit elections (see *Make Changes In Open Enrollment Period*, below). **All Eligible Employees must complete Annual Open Enrollment online via the Workday system by the announced deadline.**

Make Changes in Open Enrollment Period

If you wish to add or drop an Eligible Family Member as a Covered Person entitled to Benefits under the Health Plan, you must complete and submit an Open Enrollment change in Workday during the Annual Open Enrollment Period. If you are adding an Eligible Family Member required Verification Documents and Social Security Numbers will be required and if not returned within the timeframe specified, your Spouse/Domestic Partner/Dependents will not be enrolled and you will not be able to enroll them until the following Annual Open Enrollment Period unless a Change in Status Event occurs.

For the 2024 Annual Open Enrollment Period, legacy Magellan employees have until April 30, 2024, to provide documentation for family member(s) eligible to be Covered Person(s) under the Health Plan.

Note: During the Annual Open Enrollment Period, if your Eligible Family Member was covered during the entire preceding Plan Year, you will not be required to provide verification unless requested by the Plan Administrator.

PLEASE REMEMBER: If you do not make a Medical Benefits Option election, during the Annual Open Enrollment Period, you will remain on the Medical Benefit Option and Coverage Tier that you are enrolled in on the last day of the prior Plan Year.

When Eligibility Continues

Eligibility for Benefits under the Health Plan may continue, as follows:

- Sickness or Injury – eligibility will continue as long as you are in a Short-Term Disability status as defined in ONEOK Policies and Procedures (and which is defined to include approved FMLA Leave). For more information on FMLA Leave and continuation of coverage see the heading Paying Contributions While on Family or Medical Leave of Absence
- Temporary Layoff– eligibility terminates as of the date the layoff
- Military Leave of Absence –
    - Annual and/or Periodic Training: (eighteen (18) days per year of annual active duty training with any United States National Guard of Reserve Military Unit) – eligibility will continue throughout the period of leave.
    - Emergency Call-Out Duty – Regular Employees who are members of the armed forces of the United States, US Reserves, or National Guard going on active emergency call-out duty for periods up to but not exceeding thirty (30) days in any government fiscal year are granted emergency military leave for call-out duty. Eligibility for the Health Plan will continue for up to the thirty (30) day period.
    - Extended Active Duty – Employees who are called to active duty, asked to volunteer for active duty as a result of Presidential or Congressional order, or who enlist in any branch of the armed forces of the United States for an extended military duty assignment of longer than thirty (30) days are allowed extended active duty military leave of absence.
    - Uniformed Services Employment and Reemployment Rights Act (USERRA) – Employees who are Participants in the Health Plan during leaves of absence for active military duty are entitled to elect to continue coverage under the Health Plan for a period up to twenty-four (24) months.
    - See COMPANY POLICY "MILITARY LEAVE" on www.oneokonline.com and "USERRA AND MILITARY SERVICE," in the applicable Benefit Summary listed in Section 1: Schedule of Benefit Summaries.

Paying Contributions While on a Family or Medical Leave of Absence

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

Your Health Plan coverage will be continued during your FMLA leave, with the Company paying the same portion of the costs it normally pays. You will be responsible for paying your portion of the cost of these benefits. To continue this coverage, you will be required to make the appropriate monthly contributions. If you fail to make a timely contribution, coverage under the Health Plan will be cancelled effective the last day of the payroll period for which you did make the required contribution on time. Please note, however, that if a leave starts mid-payroll period, and a contribution is never made, coverage under the Plan will be cancelled effective back to the date the leave started. If you fail to make payments while on FMLA leave, the Company

will recoup any missed payments on an after-tax basis when you return from FMLA leave.

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

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

SECTION 3: HOW THE HEALTH PLAN WORKS

No Pre-Existing Condition Exclusions

The Health Plan does not have a pre-existing condition exclusions limitation.

Medical Benefit Options

The Health Plan provides coverage through a Preferred Provider Organization (PPO) option and a High Deductible Health Plan (HDHP) option, both of which include Prescription Drug coverage and Preventive Care Benefits. In addition, the Health Plan also provides access to near-site medical clinics. See Section 5: Near-Site Medical Clinics. Refer to the applicable Benefit Summary listed under Section 1: Schedule of Benefit Summaries for plan details.

During your New Hire Period or the Annual Open Enrollment Period, you may elect:

- Preferred Provider Organization (PPO), or
- High Deductible Health Plan (HDHP), or
- No Benefits Coverage (Opt-Out)

Preferred Provider Organization (PPO) Option

The Preferred Provider Organization (PPO) Option offers Copayments. This option provides for a sharing of the cost of health care services between you and the Health Plan starting day one. You should refer to the appropriate PPO Benefit Summary listed in Section 1: Schedule of Benefit Summaries for a description and explanation of the PPO Option.

High Deductible Health Plan (HDHP) Option

The High Deductible Health Plan (HDHP) Option does not use Co-payments and features higher Annual Deductibles and Annual Out-of-Pocket Maximums. This option provides for a sharing of the cost of health care services between you and the Health Plan starting day one. You should refer to the appropriate HDHP Benefit Summary listed in Section 1: Schedule of Benefit Summaries for a description and explanation of the HDHP Option.

Out-of-Area Benefits

If you live and seek treatment in an area designated as an Out of Area location (generally meaning it is an area that is not served by UnitedHealthcare's Networks and that you do not have at least one Primary Care Physician (Family Practice, General Practice, and Internal Medicine) Provider within thirty (30) miles and one Hospital within thirty (30) miles), you may be eligible to Enroll in the PPO or HDHP and receive In-Network Benefits, regardless of the Provider you choose. Please see the applicable Out of Area Benefit Summary listed under Section 1: Schedule of Benefit Summaries for details. The Company reserves the right, in its sole discretion, to designate any and all locations as Out-of-Area and to revoke any areas status as Out-of-Area at any time and for any reason.

SECTION 4: WELLNESS PROGRAM

The Company offers as a part of the Health Plan the ONEOK, Inc. Wellness Program (the "Wellness Program"). The Wellness Program is intended to provide wellness benefits to Health Plan Participants and their Spouses/Domestic Partners and Dependents. The Wellness Program is a component of, and offered pursuant to, the Health Plan. To the extent that this Wellness Program conflicts with the Health Plan, the Health Plan shall govern.

The Health Plan may change any of the Wellness Program vendors at any time and for any reason, which may result in changes to applicable forms and procedures. The Health Plan will notify you of any different or additional actions that may be required to remain eligible for a reward.

Legal Status

This Wellness Program generally is intended to provide nontaxable employer-provided health coverage under Code Section 106 and the regulations issued there under and shall be interpreted to accomplish that objective. The Benefits provided under the Wellness Program generally are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b). However, participation in certain Wellness Programs (for example, receipt of a gift card offered as an incentive) may result in actual or imputed income to an Employee.

Wellness Benefits

Tobacco Cessation Program

This voluntary wellness program provides a comprehensive program to assist in quitting tobacco use. Enrolled Employees, Spouses/Domestic Partners, and Dependents (18 and over), qualify for the Tobacco Cessation Program. The Health Plan will pay for the cost for participation in the Tobacco Cessation Program by Health Plan Participants, regardless of the tobacco use election. The Company will pay the costs for persons who do not participate in the Health Plan.

The Company is committed to providing a tobacco cessation program to all Plan Participants who wish to stop using tobacco products.

The Company has contracted with Quit for Life by Optum, endorsed by the American Cancer Society to provide:

- Individualized assessment and planning for specific quit date;
- Telephonic and Web-based individual coaching (initiated by participant or cessation coach), which includes unlimited inbound phone support;
- Nicotine Replacement Therapy (nicotine patch/gum supply);
- Text2Quit texting support tool;
- Relapse prevention coaching; and
- Tools, including telephonic Quit Coach, available in multiple languages.

To enroll in the Quit For Life program, please call 1-866-QUIT-4-LIFE (1-866-784-8454) or www.quitnow.net.

For more information about tobacco cessation, contact HR Solutions at 855-ONEOKHR (855- 663-6547) or email hrsolutions@oneok.com.

Omada

Omada is an innovative online health program that surrounds the participant with everything needed to lose weight, build healthy habits, and help reduce the risk for certain chronic diseases.

With Omada, high-tech meets human touch. Once accepted into the program, participants will be guided and inspired by a dedicated health coach, get access to weekly online lessons, and have the support of a small group of fellow participants. Participants also get tools delivered to the home address, starting with a wireless scale that's automatically linked to a personal account.

Participants will receive:

- Full-time health coach;
- Wireless scale;
- Interactive program;
- Weekly online lessons; and
- A supportive peer group

Omada participants lose, on average, more than 10 pounds and continue to engage in the program over the 16 weeks, which may reduce the risk for type 2 diabetes and heart disease.

Omada is available to Employees and Spouses/Domestic Partners, that are enrolled in the Health Plan, at no cost, if eligible.

To find out eligibility for Omada, visit omadahealth.com/ONEOK.

Livongo

Livongo combines the latest technology with coaching – all with a goal of better monitoring and regulating medical conditions.

Diabetes Management

Participants will receive:

- Livongo meter
- Unlimited strips at no cost
- Full-time coaching by a diabetes educator

Livongo Diabetes Management is available to Employees, Spouses / Domestic Partners and Dependents age 13 and older, that are enrolled in the Health Plan, if eligible.

To find out eligibility for Livongo Diabetes Management visit https://welcome.livongo.com/ONEOK.

Hypertension Management

Participants will receive:

- Livongo blood pressure meter
- Full-time personalized health coaching

Livongo Hypertension Management is available to Employees, Spouses / Domestic Partners and Dependents age 18 and older, that are enrolled in the Health Plan, if eligible.

To find out eligibility for Livongo Hypertension Management visit https://ready.livongo.com/ONEOK/register.

Hinge Health

Hinge Health is an exercise therapy program designed to address chronic back, knee, hip, neck or shoulder pain. The program includes:

- Personalized exercise therapy to improve strength and mobility
- Personal care team to provide care, motivation and support virtually
- Interactive education to each you how to manage your specific condition, treatment options and more

Hinge Health is available to Employees, Spouses / Domestic Partners and Dependents age 18 and older, that are enrolled in the Health Plan.

Active Release Techniques (ART)

ART is a patented soft-tissue management approach for treating aches, pains or discomforts without medications or surgery. It is a hands-on technique that targets and breaks up scar tissue to correct muscle function and free nerve entrapments in muscles. ART is available to active Employees that are enrolled in the Health Plan at select ONEOK locations.

ART is available to active Employees that are enrolled in the Health Plan only. ART is not available for individuals receiving COBRA Continuation Coverage from the Health Plan and ART is not available for Spouses / Domestic Partners and Dependents.

Additional Wellness Benefits

The Health Plan may offer additional Wellness Benefits from time to time, including but not limited to, complimentary or discounted flu shots, diagnostic testing, routine medical examinations, access to health and fitness education, group and individual counseling with dietitians, nutritionists and other wellness professionals, and other wellness-oriented products and services.

The Company reserves the right to offer different Wellness Benefits to different groups of employees based upon any reasonable and nondiscriminatory classification, including but not limited to primary work location, corporate subsidiary, job title, job function, pilot program participation, random selection, legal compliance, business necessity or participation (or non- participation) in any other Company-sponsored employee benefit program. To the extent that these Wellness Benefits utilize Out-of-Network Providers, the Plan Administrator

will determine the extent to which any cost-sharing obligations will apply under this Health Plan. The

Company reserves the right to amend or terminate any such Wellness Benefit, in whole or in part, at any time and for any reason.

Your participation in any Wellness Program is entirely voluntary and will not affect your employment status or your eligibility for coverage or benefits under the Health Plan.

Alternative Methods of Participation May Be Available

The Health Plan is committed to helping you achieve your best health. Rewards for participating in a Wellness Program are available to all Participants. If you think you might be unable to meet a standard for a reward under a Wellness Program, you might qualify for an opportunity to earn the same reward by different means. Contact HR Solutions, and we will work with you (and, if you wish, with your doctor) to find an alternative wellness program with the same reward that is right for you in light of your health status.

Confidentiality Disclosure

Confidential information received or created by the Health Plan in connection with the Wellness Programs will be used and disclosed only for the purposes identified in this Section 4: Wellness Program. Except as permitted under existing federal regulations or as needed to administer the Health Plan, information obtained in connection with the Wellness Programs will only be provided to the Company in aggregate terms that do not disclose, or are not reasonably likely to disclose, the identity of any employee. Any protected health information received or created by the Health Plan will be safeguarded in accordance with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996, as amended.

Wellness Claims and Appeals Procedure

If a claim for any Wellness Benefit under this Wellness Program is wholly or partially denied, claims shall be administered in accordance with the terms and provisions of the claims procedure set forth in this SPD for the Health Plan in Section 8: Claims Procedures, which are incorporated herein by reference. For purposes of the Wellness Program, the Claims Administrator shall be HR Solutions, which may be contacted at 855-663-6547 or hrsolutions@oneok.com.

SECTION 5: NEAR-SITE MEDICAL CLINICS

Access to Medical Clinics

The Company may provide subsidized or unsubsidized access to one or more near-site medical clinics (each, a "Clinic"). Access to any such Clinic shall be a component Benefit under the Health Plan. Any such Clinic will supplement other medical coverage available under the Health Plan. The Company will contract with one or more third-party vendors that will be responsible for the staffing and day-to-day operation of each Clinic.

Eligibility for Clinic Benefits

An individual is eligible for Clinic Benefits if he or she is an Eligible Employee, Spouse, Domestic Partner or Dependent who is a Participant in the Health Plan as of the date of the Clinic visit.

An individual will lose his or her eligibility for Clinic benefits upon the earliest to occur of:

- the date that the individual ceases to be a Participant under the Health Plan (including any periods of qualifying FMLA or USERRA leave or any extension of coverage pursuant to COBRA or any similar law);
- the date the Health Plan terminates; or
- the date the Company eliminates access to the Clinics as a Benefit under the Health Plan.

Summary of Clinic Benefits

The Clinics are intended to provide Participants with convenient access to a licensed physician or nurse practitioner for the treatment of certain medical conditions. Participants may use a Clinic for primary care services including, but not limited to, acute care, chronic disease management, diagnostic testing and screenings, administration of adult immunizations and vaccinations, preventative care and comprehensive physical exams. Additional information about the specific services available at each Clinic may be communicated to Participants from time to time by Company or the third-party vendor that operates the Clinic. Participants also may inquire directly with a Clinic about available services or to schedule an appointment.

When a service is not available at a Clinic, the health care providers at such Clinic may assist Participants with a referral to an appropriate in-network or out-of-network provider under the Health Plan.

Costs of Clinic

The Clinics are available to PPO Participants free of charge. PPO Participants are not required to make any co-payment for a Clinic visit, and the Company will pay the entire cost of services provided at the Clinic. A Clinic visit will not apply towards a PPO Participant's annual deductible or out-of-pocket maximum under the Health Plan, and there are no annual or lifetime limits on the services a PPO Participant can receive at a Clinic.

HDHP Participants receive eligible preventive care services from the Clinics free of charge but must pay a fair market charge for non-preventive care received from the Clinics. HDHP Participants may file receipts from their Clinic visits with UHC and count the fair market charges toward satisfaction of their Annual Deductible and Annual Out-of-Pocket Maximum.

Participants will not be charged anything extra for the cost of certain medications maintained in stock at each Clinic and dispensed by a Clinic Physician. However, Participants will be required to pay for the normal cost of obtaining any medications from a pharmacy in accordance with the terms of the Health Plan. Likewise, if a Clinic is unable to provide a particular service and refers a Participant to another provider, the cost of visiting the other provider will be subject to the normal cost-sharing rules of the Health Plan.

Limitations on Clinic Benefits

The services provided at the Clinics may be more limited than the services available from other Health Plan providers and are not intended to replace other coverage or benefits under the Health Plan. A Clinic will only provide medical treatment to the extent that such treatment is covered under the Health Plan. A clinic will not provide treatment for emergency medical services. A Clinic may only dispense or prescribe a medication to the extent that the Health Plan otherwise covers such medication. In addition, a Clinic is not permitted to dispense or prescribe certain medications (e.g., certain specialty pharmaceuticals) even though such medications are covered under the Health Plan.

The services available at a Clinic may be limited further by written agreement between the Company and the operator of such Clinic. In addition, the health care providers at each Clinic are entitled to exercise their independent professional judgment in determining whether to provide or deny any particular service.

Claims and Appeals Procedures

If a claim for Clinic benefits is denied in whole or in part, claims shall be administered in accordance with the claims and appeals procedures set forth in the Plan and Summary Plan Description for the Health Plan; provided, however, that the Claims Administrator for the purpose of filing a claim for Clinic benefits shall be an HR Benefits Representative, who may be contacted in writing at ONEOK, Inc., 100 W. 5th St., Tulsa, OK 74103, or by telephone at (918) 588-7000. UnitedHealth will not process any claims for Clinic benefits.

Company's Right to Amend or Terminate

The Company reserves the right to amend or terminate the Clinic benefit, in whole or in part, at any time and in its sole discretion, without prior notice to participants. Such right shall include, but shall not be limited to, the ability to impose cost-sharing or other limits on use of, or services available at, any of the Clinics. Moreover, the Company reserves the right to add or remove any or all of the Clinics that are available to Participants under the Health Plan, or to change the third-party vendor that is responsible for operating a Clinic.

Additional Information

For additional information about the location of the nearest Clinic and/or an explanation of available Clinic services, contact HR Solutions at 1-855-ONEOKHR (1-855-663-6547) or HRSolutions@oneok.com.

Additional information also is available directly from the third-party vendor responsible for the day- to-day operation of each Clinic. Currently, the third-party vendor for each of the Clinics is:

CareATC
4500 S 129th E Ave, Tulsa, OK 74134-5891
Phone: 800-993-8244
www.careatc.com

Legal Disclosures

The Clinics are intended to qualify as "excepted benefits" under the Health Insurance Portability and Accountability Act ("HIPAA"). Accordingly, the Clinics are not subject to HIPAA's portability rules and are intended to be exempt from certain requirements of the Patient Protection and Affordable Care Act ("PPACA"). However, to the extent that a Clinic exchanges certain protected health information with the Health Plan or the Company, such information would become subject to the privacy and security provisions of HIPAA and would be safeguarded to the same extent as any other protected health information created, maintained, received or transmitted under the Health Plan. Likewise, each third-party vendor is expected to provide Clinic benefits in accordance with PPACA to the extent required by law.

Each Clinic is independently operated by a third-party vendor, CareATC. CareATC (including its employees and professionals) is not owned, controlled, endorsed, recommended or guaranteed by the Company or the Health Plan. Furthermore, the Company specifically disclaims any responsibility or liability for actions of Clinic and its employees, professionals, agents, affiliates and subcontractors. Company makes no warranty, express or implied, with respect to the services available at any Clinic.

The Clinics are available to employees of entities that are not related to the Company. The Company's role with respect to the design and operation of these Clinics is limited, and the services that are available at these Clinics may be only those services that the third-party vendor elects to make available to all users of such Clinic. The Company specifically disclaims any responsibility for the provision of Clinic benefits to the employees of any entity that is not within the same controlled group of corporations or under common control with the Company.

Participants are solely responsible for deciding whether or not to utilize a Clinic. No adverse employment decision will result from a Participant's decision whether to utilize a Clinic. Moreover, the Clinics will be operated in a manner that is intended to avoid discrimination with respect to any Health Plan Participant.

SECTION 6: Expert Medical Opinion

Expert Medical Opinion program, provided by Teladoc Medical Experts, is provided at no cost for employees and their Eligible Dependents enrolled in the Health Plan. Note that employees must be enrolled in the Health Plan to have access to this service under the Health Plan. Eligible Dependents do not have to be enrolled or eligible for the Health Plan to access this service.

Eligible Dependents for the purposes of this section include:

- The employee's Spouse or Domestic Partner
- The employee's, Spouse's or Domestic Partner's children under the age of 26
- The employee's parents and parents-in-law

Expert Medical Opinion is: a way to get an independent opinion from a leading medical specialist, to help you choose the best care possible.

You register securely online and submit your medical records, or Teladoc Medical Experts will obtain your medical records. A specialist reviews your individual situation and provides a second opinion comprehensive report, securely online. Physicians are available for follow-up. Service is voluntary, completely confidential, and offered at no cost to you.

Expert Medical Opinion is NOT: a substitute for direct medical care.

Expert Medical Opinion is NOT: a resource for confirming every medical diagnosis, a physician referral service, or an alternative means for certifying a disability.

Additional Resources: For more information, please call (888)251-4158 or visit https://www.teladoc.com/Medical-Experts/

SECTION 7: WHEN COVERAGE ENDS, COBRA AND OTHER CONTINUATION RIGHTS

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Health Plan will still process claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Health Plan will end on the earliest of:

- The date your employment with the Company ends (11:59 p.m. of the last day of employment);
- The date the Health Plan is terminated;
- The date you stop making the required contributions;
- The date you are no longer eligible;
- The date UnitedHealthcare receives written notice from the Company to end your coverage, or the date requested in the notice, if later; or
- The date you retire from the Company or commence benefits under the ONEOK, Inc. Long Term Disability Plan.

Coverage for your Eligible Family Members(s) will end on the earliest of:

- The date your coverage ends;
- The last day you stop making the required contributions;
- The last day UnitedHealthcare receives written notice from the Company to end your coverage, or the date requested in the notice, if later;
- The day your Dependent loses eligibility (11:59 p.m. on the last day of coverage), or
- The day your Dependent child turns age twenty-six (26); or
- The day you fail to provide the required Verification Documents; or
- The day your Other Eligible Dependent, is over age nineteen (19) and under age twenty-four (24); and
    - Is no longer enrolled as a Full-time Student, as defined by the educational institution; or
    - Has graduated from the educational institution.

Your Other Eligible Dependent continues to be a Full-time Student during periods of regular vacation established by the educational institution. If your Other Eligible Dependent does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above. Full-time Student status is reviewed January 1 and August 1.

The Health Plan may terminate your coverage by providing written notice to you that your coverage has ended if any of the following occur:

- You permit an unauthorized person to use your ID Card or you use another person's ID Card;
- You knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Spouse or Dependent;
- You commit an act of physical or verbal abuse that imposes a threat to the Company's staff, UnitedHealthcare's staff, a Provider or another Covered Person;
- You violate any terms of the Health Plan; or
- Fraud, misrepresentation, or false information - occurs when there has been fraud or misrepresentation, or the Employee knowingly gave UnitedHealthcare or the Company false material information. Examples include false information relating to another person's eligibility or status as a Spouse or Dependent.

If your coverage is terminated for any of the above reasons you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

In the event of a rescission, UnitedHealthcare and the Health Plan reserve the right to demand that you pay back Benefits that the Health Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Health Plan.

COBRA Continuation Coverage under Federal Law

If you lose your Health Plan coverage, you may have the right to continue it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 9: Glossary.

Much of the language in this section comes from the federal law and regulations that govern COBRA Continuation Coverage. You should call HR Solutions if you have questions about your right to continue coverage.

In order to be eligible for COBRA Continuation Coverage under federal law, you must meet the definition of a "Qualified Beneficiary.” A Qualified Beneficiary is any of the following persons who were covered under the Health Plan on the day before a Qualifying Event:

- An Employee covered under the Health Plan; or
- A covered Employee's enrolled Spouse or Dependent child, including with respect to the Employee's Dependent children, a child born to or Placed for Adoption with the Employee during a period of continuation coverage under federal law.

Please note that Domestic Partners are not eligible for COBRA Continuation Coverage under federal law. If an employee terminates employment with the Company and elects COBRA continuation coverage for 18 months, the employee may elect to continue the Domestic Partner’s

coverage for 18 months also, subject to all other requirements applicable to COBRA continuation coverage. However, if an employee on COBRA continuation coverage dies or becomes entitled to Medicare, or the Domestic Partner relationship terminates, the Domestic Partner may not elect additional continuation coverage on the grounds of a second qualifying event. Dependent children of the Domestic Partner may be eligible to elect COBRA continuation coverage, but only if they qualify as a dependent under the dependent eligibility criteria of the applicable benefit plan or insurance contract.

If you continue coverage under the Health Plan under COBRA, account balances, Annual Deductibles and maximums will remain intact.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under the Health Plan pursuant to COBRA for yourself, your Spouse and/or your Dependent(s), and the maximum length of time you can receive continued coverage. These situations are considered "Qualifying Events."

If the Health Plan coverage ends because of the following Qualifying Events:	You May Elect COBRA Continuation Coverage:		
	For Yourself	For Your Spouse[4]	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability Benefits at any time within the first sixty (60) days of losing coverage[1]	29 months	29 months	29 months
Your death	N/A	36 months	36 months
Your divorce (or legal separation)	N/A	36 months	36 months
Your Dependent child is no longer an eligible family member (e.g. reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
The Company files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions:

(i) Notice of the disability must be provided within the latest of sixty (60) days after

a. The determination of the disability,

b. The date of the Qualifying Event,

c. The date the Qualified Beneficiary would lose coverage under the Health Plan, and in no event later than the end of the first eighteen (18) months;

(ii) The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven (11) months over the original eighteen (18) months; and

(iii) If the Qualified Beneficiary entitled to the eleven (11) months of coverage has non- disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven (11) months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within thirty (30) days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than thirty (30) days after the date of that determination.

[2]This is a Qualifying Event for any Retired Employee and his or her enrolled Spouse and/or Dependent child if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the COBRA Continuation Coverage.

[4]As noted above, for COBRA purposes, a Domestic Partner will not qualify as a “qualified beneficiary” and will have no equivalent right to elect COBRA continuation coverage. If an employee terminates employment with the Company and elects COBRA continuation coverage for 18 months, the employee may elect to continue the Domestic Partner’s coverage for 18 months also, subject to all other requirements applicable to COBRA continuation coverage. However, if an employee on COBRA continuation coverage dies or becomes entitled to Medicare, or the Domestic Partner relationship terminates, the Domestic Partner may not elect additional continuation coverage on the grounds of a second qualifying event. Dependent children of the Domestic Partner may be eligible to elect COBRA continuation coverage, but only if they qualify as a dependent under the dependent eligibility criteria of the applicable benefit plan or insurance contract.

How Your Medicare Eligibility Affects Spouse or Dependent COBRA Coverage

The table below outlines how your Spouse or Dependent’(s) COBRA coverage is impacted if you become entitled to Medicare.

If Spouse or Dependent Coverage Ends When:	You May Elect COBRA Continuation Coverage for Up To:
You become entitled to Medicare and do not experience any additional Qualifying Events	18 months
You become entitled to Medicare, after which you experience a second Qualifying Event that is your termination of employment or reduced work hours before the initial eighteen (18) month period expires	36 months
You experience a Qualifying Event that is your termination of employment or reduced work hours, after which you become entitled to Medicare before the initial eighteen (18) month period expires; and, if absent this initial Qualifying Event, your Medicare entitlement would have resulted in loss of Spouse or Dependent coverage under the Health Plan	36 months

Getting Started/Notice to You of COBRA Eligibility

You will be notified by the Plan Administrator by mail if you become eligible for COBRA Continuation Coverage. The notification will give you instructions for electing COBRA Continuation Coverage and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Company costs, plus a 2% administrative fee and other cost as permitted by law.

Your COBRA Election Period

You will have up to sixty (60) days from the date you receive notification or sixty (60) days from the date your coverage ends to elect COBRA Continuation Coverage, whichever is later. You will then have an additional forty-five (45) days to pay the cost of your COBRA Continuation Coverage, retroactive to the date your Health Plan coverage ended.

During the sixty (60) day election period, the Health Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA Continuation Coverage, retroactive to the date your COBRA eligibility began.

While you are a Participant in the Health Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment; and
- Following a Change in Status, as described under Section 2: Eligibility and General Information.

Your COBRA Notification Requirements for Qualifying Events

If your covered Spouse or Dependent(s) lose coverage under the Health Plan eligibility provisions due to divorce, legal separation, or loss of Spouse or Dependent status, you, your Spouse or your

Dependent(s) must notify the Plan Administrator within sixty (60) days of the latest of:

- The date of the divorce, legal separation, or termination of an IRS-qualified Domestic Partner Dependent relationship, or an enrolled Spouse or Dependent's loss of eligibility as an enrolled Spouse or Dependent;
- The date enrolled Spouse or Dependent would lose coverage under the Health Plan; or
- The date on which you, your enrolled Spouse or Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You, your Spouse or your Dependent(s) must also notify the Plan Administrator when a Qualifying Event occurs that will extend continuation coverage.

If you are receiving COBRA Continuation Coverage under federal law, you must notify the Plan Administrator within sixty (60) days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA, as described above under the heading "Getting Started/Notice To You of COBRA Eligibility."

If you, your Spouse or your Dependent(s) fail to notify the Plan Administrator of these events within the sixty (60) day period, the Plan Administrator is not obligated to provide COBRA Continuation Coverage to the affected Qualified Beneficiary.

Your COBRA Notification Requirements for Disability Determination

If you extend your COBRA Continuation Coverage beyond eighteen (18) months because you are eligible for disability Benefits from Social Security, you must provide the Claim Administrator with notice of the Social Security Administration's determination within sixty (60) days after you receive that determination, and before the end of your initial eighteen (18) month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 11: Important Administrative Information: ERISA. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and Qualified Beneficiary(ies), the Qualifying Event or disability, and the date on which the Qualifying Event occurred.

Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage (including any COBRA-equivalent coverage provided to a Domestic

Partner) will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other another group health plan.
- The date, after electing continuation coverage, that you, your Spouse/Domestic Partner or your covered Dependent(s) becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium (premium is not paid within forty-five (45) days).
- The date coverage ends for failure to make any other monthly premium (premium is not paid within thirty (30) days of its due date).
- The date the Health Plan is terminated.
- The date coverage would otherwise terminate under the Health Plan as described in the beginning of this section.

Note: If you selected COBRA Continuation Coverage under a prior health plan that was then replaced by coverage under this Health Plan, continuation coverage will end as scheduled under the prior health plan or in accordance with the terminating events listed in this section, whichever is earlier.

Marketplace Coverage under Health Care Reform

There may be other coverage options available to you. In the Health Care Reform Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You can access the Marketplace for your state at www.HealthCare.gov. Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than thirty (30) days by reason of service in the Uniformed Services may elect to continue Health 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 of the United States in time of war or national emergency.

An Employee who is a Participant qualified to continue coverage pursuant to the USERRA, may elect to continue coverage under the Health Plan by notifying the Plan Administrator in advance,

and providing payment of any required contribution for the coverage. This will include the amount the Plan Administrator normally pays on an Employee Participant’s behalf. If an Employee Participant’s Military Service is for a period of time less than thirty-one (31) days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee Participant may continue Health Plan coverage under USERRA for up to the lesser of:

- The twenty-four (24) month period beginning on the date of his or her absence from work; or
- The day after the date on which he or she fails to apply for, or return to, a position of employment.

Regardless of whether a participating Employee continues health coverage under USERRA on account of Military Service, if the Employee returns to a position of employment, the Employee's Health Plan coverage and that of the Employee's eligible Spouse/Domestic Partner and/or Dependent(s) will be reinstated under the Health Plan. No exclusions or Waiting Period may be imposed on an Employee or the Employee's eligible Spouse/Domestic Partner and/or Eligible Dependent(s) 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 health coverage or reinstatement under USERRA.

Health Plan Contact Information

You can obtain information about the Health Plan on request from:

ONEOK, Inc. Health Plan
Attention: ONEOK, Inc. Benefit Plan Administration Committee
100 West Fifth Street, Tulsa, OK 74103-4298
Telephone (918) 588-7000

You can obtain information about COBRA Continuation Coverage by contacting UnitedHealthcare at (877) 797-7475, Business Hours: 7 a.m. to 7 p.m. CT.

Medically Necessary Leave of Absence for Dependent Student Status – Applicable to Other Eligible Dependent, as defined in Eligible Family Members Section

If a Dependent Enrolled in the Health Plan on the basis of being a student at a postsecondary education institution leaves the institution due to a Medically Necessary Leave of Absence the Health Plan coverage for the Dependent will not terminate because of the absence from the institution. This continued coverage will apply if the Plan Administrator has received written notification by a treating physician of the Dependent, which states that the Dependent is suffering

from a serious illness or Injury. The continued coverage will not end before the earlier of:

- The date that is one (1) year after the first day of Medically Necessary Leave of Absence; or
- The date on which the Dependent's coverage would otherwise terminate under the terms of the Health Plan.

A Dependent whose Benefits are continued under the Health Plan shall be entitled to the same Benefits as if the Dependent continued to be a covered student at the institution of higher education.

Benefits End

For a description of when Benefits end, see the applicable Benefit Summary, listed in Section 1: Schedule of Benefit Summaries.

Generally, your coverage and/or the coverage of your Eligible Family Member under the Health Plan may be rescinded, after the Health Plan provides you and/or your Eligible Family Member with 30 days advance written notice of that Rescission of Coverage (a "Notice of Recession of Coverage"), if either you and/or your Eligible Family Member (i) perform an act, practice or omission that constitutes fraud; or (ii) make an intentional misrepresentation of a material fact. The Plan Administrator or its designee has the right to determine, in its sole discretion, whether there has been an act, practice or omission constituting fraud, or an intentional misrepresentation of a material fact. A Rescission of Coverage is a retroactive cancellation of coverage, which means the cancellation will be effective back to the date that you and/or your Eligible Family Member (s) should not have been covered by the Health Plan. However, retroactive cancellations for these

two reasons are not considered rescissions of coverage and do not require 30 days advance written notice:

- Normal administrative delays;
- Your failure to make required payments on time

"Normal administrative delay" means the time needed by the Health Plan to receive and process information concerning loss of Health Plan coverage. A normal administrative delay is 60 days or less from the time you and/or your Dependent(s) technically lose coverage under terms of the Health Plan. If you incur claims after you and/or your dependent(s) lose coverage under the Health Plan, you will be required to repay the cost of claims incurred and processed.

For any other unintentional mistakes or errors under which you or your Dependents were covered by the Health Plan when you should not have been covered, your coverage will be cancelled prospectively, once the mistake is identified. Such a cancellation will not be considered a Rescission of Coverage and does not require that you be provided with 30 days advance written notice.

SECTION 8: CLAIMS PROCEDURES

General

As part of the claims administration process, the Claims Administrator will:

- pay claims for benefits due under the Health Plan;
- provide written explanations of the reasons for denied claims;
- handle Claimant requests for reviews of most denied claims; and
- make the final decision on most denied claims.

The claims and appeals procedure described in this SPD is generally required by federal law, but the procedure used by the Plan's Claims Administrator may differ in certain ways. If the procedure described in a Benefit Summary differs from the procedure described here, you must follow the procedure described in the Benefit Summary. The Claims Procedure for the Health Plan is intended to provide reasonable procedures consistent and in compliance with governing federal law and regulations and include a description of all claims procedures, including any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames which are stated and included in this SPD.

The Claims Procedures are intended to contain no provision, and are not to be administered in a way, that unduly inhibits or hampers the initiation or processing of Claims for Benefits. The Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of the Claimant in pursuing a Benefit Claim or Appeal of an Adverse Benefit Determination. However, the Health Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant. In the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant. The Health Plan reserves the right to limit the person(s) who may act as your authorized representative, and a person's status as your authorized representative does not convey any independent legal or equitable rights to such person as a Participant, third-party beneficiary, assigned, subrogate or otherwise.

The Claims Procedures are intended to contain administrative processes and safeguards designed to ensure and to verify that Benefit Determinations are made in accordance with the Health Plan and this SPD and that, where appropriate, Health Plan provisions have been applied consistently with respect to similarly situated Claimants.

The Claims Procedures of the Health Plan provide that, in the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Health Plan's procedures for filing a Pre-Service Claim, the Claimant or authorized representative shall be notified of the failure and the proper procedures to be followed in filing a Benefit Claim. This notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days following the failure for a Pre-Service Claim, and not later than twenty-four (24) hours

following the failure in the case of a failure to file a Claim Involving Urgent Care. Such notification may be oral, unless written notification is requested by the Claimant or authorized representative.

The notification of failure to follow Health Plan procedures for Pre-Service Claims and Claims Involving Urgent Care shall apply only in the case of a failure that is (1) a communication by a Claimant or an authorized representative of a Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters, and (2) is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Special Rules for the Healthcare Benefits

Special timelines apply to claims and appeals for the medical benefits (the "Healthcare Benefits"). These timelines are based on whether your claim is an "urgent care claim," a "pre-service claim," or a "post-service claim."

- An urgent care claim is a claim for which application of the pre-service or post-service timelines could jeopardize your life, health, or ability to regain maximum function, or, in your doctor's opinion, would subject you to severe pain.
- A pre-service claim is a claim for a service or supply that must be precertified before it is performed.
- A post-service claim is any other claim. For example, a post-service claim includes a claim where you request reimbursement after treatment has been performed.

Additionally, special rules apply for certain "concurrent care claims," which are claims that relate to a previously-approved ongoing course of treatment to be provided over a period of time or number of treatments. A decision by the Health Plan to reduce or terminate a course of treatment (other than by Health Plan amendment or termination) will be treated as a claim denial. The notification of the denial will meet the "written notice of denial" requirements described in this SPD and will be provided sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

If you request to extend a course of treatment beyond the previously-approved period of time or number of treatments and your request is an urgent care claim (see above), your request will be decided as soon as possible, taking into account the medical needs. The Claims Administrator will notify you of that benefit determination within 24 hours after the Health Plan receives the claim if the claim is made to the Health Plan at least 24 hours before the end of the previously-approved period of time or number of treatments. Appeals of concurrent care decisions are governed by the rules and timeframes described below based on the underlying claim involved (i.e., urgent care, pre-service or post-service). For example, an appeal of a concurrent care decision involving urgent care will be governed by the rules and timeframes that apply to appeals of urgent care claims.

Filing Claims

You must file a claim for benefits with the Claims Administrator for that benefit. In some cases, your doctor or service provider automatically files a claim for you. In other cases, you need to submit a claim form by mail, by fax, or online. Each Benefit Summary describes the procedure for filing claims, which may include the date by which a claim must be filed and the information to be included with the claim.

If a pre-service claim for Healthcare Benefits does not follow the required procedures, the Claims Administrator will notify you of the error, and what you must do to correct the error, within 5 days (or within 24 hours, in the case of an urgent care claim), as long as:

- The claim is received by a person or unit of the Plan Administrator or Claims Administrator that is generally responsible for handling benefit matters; and
- The claim submission names the Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

In such cases, notification of your filing error may be oral, unless you request written notification. Below is the name and contact information for the Claims Administrator:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555
(800) 232-8943 between 8 a.m. to 8 p.m. CT except for major holidays

In certain circumstances, the Health Plan may offer claims assistance or provide claim-related notifications in non-English languages. If you have any questions about the language assistance options that may be available to you, contact the Plan Administrator.

Claim Denials

The Claims Administrator must respond to your claim within a certain number of days or hours following its receipt of your claim. The requirement for each benefit is as follows:

Urgent Care	Pre-Service	Post-Service	Disability claims
72 hours	15 days	30 days	45 days

If your claim is incomplete or if the Claims Administrator needs additional time to review your claim, the timeframes described above may change.

Missing Information

If the Claims Administrator asks you for additional information to complete your claim, the amount of time you have to provide the requested information for each benefit is as follows:

Urgent Care	Pre-Service	Post-Service	Disability claims
48 hours	45 days	45 days	45 days

Necessary Extension

If the Claims Administrator needs additional time to review your claim or review the additional information you are requested to provide, the timeframe for deciding your claim may be extended. If the Claims Administrator needs an extension, you will receive a notice before the end of the initial claim denial period explaining when you can expect to receive your decision. The Claims Administrator may take a second extension with claims involving disability determinations. The extension period cannot last longer than a certain number of days after the end of the initial claim determination period specified above or, if earlier, after the earlier of receipt of your additional information or your deadline for submitting that additional information. The maximum extension period for each benefit is listed in the following table:

Urgent Care	Pre-Service	Post-Service	Disability claims
48 hours	15 days	15 days	30 days

Written Notice of Denial

If your claim for benefits is wholly or partially denied, you will receive a written notice containing the following information:

- for medical claims, information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount;
- the specific reasons for the determination, including any denial code applicable to a medical claim and its corresponding meaning;
- a reference to the specific Health Plan provisions on which the determination is based;
- a statement describing additional material or information necessary to complete the claim and why such information is necessary;
- a statement describing Health Plan procedures and time limits for appealing the determination, as well as details regarding any available external review and the right to sue in federal court under Section 502(a) of ERISA;
- for medical claims or disability claims, any internal rule, standard, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying Health Plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification;

- for medical claims, a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process; and for disability claims:
    - a discussion of the decision, including an explanation as to why the Claims Administrator disagreed with or did not follow (i) any evidence you submitted regarding the views of health care professionals who provided treatment to you and/or vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination, or (iii) any Social Security Administration disability determination that you submitted;
    - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Health Plan relied upon in making the determination (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist); and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Upon your request and free of charge, the Claims Administrator will also provide you with the diagnosis and treatment codes (and their corresponding meanings) applicable to your medical claim.

Filing Appeals

If you believe your claim was denied in error, you may appeal this decision. You must submit your appeal request to the Claims Administrator within a certain number of days following your receipt of the written denial notice. The requirement for each benefit is listed in the following table:

Urgent Care	**Pre-Service**	**Post-Service**	**Disability claims**
As soon as possible	180 days	180 days	180 days

You may submit written comments, documents, or other information in support of your appeal and you will be provided, upon request, reasonable access to and copies of all relevant documents, records, and other information, free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review and will not be influenced by the initial claim decision.

If your appeal concerns a medical claim or a disability claim, and if the reviewer considers any evidence or rationale that was not considered as part of the initial claim, the reviewer will provide you with that evidence and/or rationale and give you an opportunity to respond before making its determination.

If the appeal concerns Healthcare Benefits or disability benefits, a different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Health Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the Health Plan in connection with the denial of your claim, we will provide you with the names of each such expert upon your request, regardless of whether the advice was relied upon. If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Health Plan and you by telephone, fax, or other similar method.

Appeal Denials

The Claims Administrator must respond to your appeal within a certain number of days following its receipt of your appeal request. The requirement for each benefit is listed in the following table:

Urgent Care	Pre-Service	Post-Service	Disability claims
72 hours	15 days	30 days	45 days

If a Benefits Summary for the medical benefit provides that the Claims Administrator uses a single level of appeal, the Claims Administrator will have additional time to respond. The Claims Administrator may have an additional 15 days to respond to an appeal regarding a pre-service claim and an additional 30 days to respond to an appeal regarding a post-service claim.

If your appeal is denied, the denial notice will contain the following information:

- for medical claims, information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount;
- the specific reasons for the determination, including any denial code applicable to a medical claim and its corresponding meaning;
- a reference to the specific Health Plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the Health Plan and your right to obtain information about these procedures;
- for medical claims, information regarding the external review process and instructions on how to request an external review;
- a statement describing your right to bring a civil lawsuit under Section 502(a) of ERISA and, for disability claims, a statement describing the deadline for filing such a lawsuit;
- for medical claims or disability claims, a statement disclosing any internal rule, standard, guidelines, protocol or similar criterion relied on in making the adverse determination (or

a statement that such information will be provided free of charge upon request);

- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying Health Plan terms to your medical condition (or a statement that such information will be provided free of charge upon request);
- for medical claims, a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process; and for disability claims:
  - a discussion of the decision, including an explanation as to why the Claims Administrator disagreed with or did not follow (i) any evidence you submitted regarding the views of health care professionals who provided treatment to you and/or vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination, or (iii) any Social Security Administration disability determination that you submitted; and
  - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Health Plan relied upon in making the determination (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist).

Upon your request and free of charge, the Claims Administrator will also provide you with the diagnosis and treatment codes (and their corresponding meanings) applicable to your medical claim.

The appeal determination notice may be provided in written or electronic form. If it is provided in electronic form, you have the right to request and receive it on a written paper document at no charge. Both the electronic and paper versions will contain the same style, format and content.

Second Level Appeals

Unless a Benefit Summary provides otherwise, medical (pre-service and post-service claims) benefits provide a second level of appeal. Therefore, if you disagree with the determination made in the first appeal, you can submit a request for a second level appeal to the Plan Administrator within 60 days of the date you receive the first-level appeal determination notice.

The same procedures and timeframes that applied to your first level appeal will also apply to your second level appeal.

If the Benefit Summary for your medical benefit does not provide for a second level of appeal, you will have exhausted the appeals process after completing your initial appeal.

Effect of Final Appeal Determination

Once you have submitted a claim and completed all available levels of appeal described above, you will have exhausted the appeals process. Once you exhaust the appeals process, you will have no further recourse with the Claims Administrator or the Company. If you want to further challenge a benefit denial, you may have the right to request an external review and you will have the right to sue the Health Plan in federal court.

For medical claims and disability claims, if the Claims Administrator (or Plan Administrator for second level appeals) does not comply with all of the procedures described above, you will generally be treated as though you had exhausted the internal appeals process. As a result, you may request an external review (if applicable) or sue the Health Plan even though you have not completed all required levels of appeal.

However, if the violation of these procedures is "de minimis," you will not be treated as though you exhausted the internal appeals process. The violation will be considered de minimis if it is not likely to cause prejudice or harm to your claim, it was for good cause or due to matters beyond the Health Plan's control and was in the context of an ongoing, good faith exchange of information between you and the Health Plan.

External Review

External reviews are available for medical claims that involve rescissions or medical judgment and claims subject to the No Surprises Act. Once you have submitted a medical claim and exhausted the available levels of appeal described above, you can request that your claim be reviewed by an independent review organization ("IRO"). You may also request an external review of your urgent care claim if exhaustion of the appeal process described above would seriously jeopardize your life or health or ability to regain maximum function. Instructions regarding the process for requesting an external review will be provided in your claim and appeal determination notices.

The external review will be conducted within 45 days after receipt of the request and notice of the decision will be provided to you. The notice will include:

- a general description of the reason for the request for external review,
- the date the IRO received the request for review,
- the date of the IRO's decision,
- references to the evidence or documentation considered in the determination, including the specific coverage provisions and evidence-based standards,
- a discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon,
- a statement that the determination is binding except to the extent that other relief is available under state or federal law,
- a statement regarding your right to file suit in federal court, and

- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Legal Action

You may sue the Health Plan in federal court under Section 502(a) of ERISA 90 days after you have exhausted the administrative procedures as described in this Plan (or the applicable Benefit Summary) and all required reviews of your claim have been completed. You do not need to request an external review before filing suit. If you decide to sue the Health Plan, you must do so within one year after the date of service giving rise to the claim or within the period specified in the applicable Benefit Summary, whichever is longer. Any legal proceeding in connection with the Health Plan can only be filed in the United States District Court for the Eastern District of Oklahoma, located in Tulsa, Oklahoma.

Eligibility and Cost of Coverage Claims and Appeals

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

If a claim regarding eligibility for coverage under the Health Plan or the cost of coverage under the Health Plan is denied, the Claimant has the right to appeal this denial to the Benefit Plan Administration Committee. There is only one level of appeal for denied eligibility and cost of coverage claims.

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

The Benefit Plan Administration Committee will provide a full and fair review of a claim and any supporting documentation submitted, including all comments, documents, records, and other information either not previously submitted or not considered in the initial decision. Upon request and free of charge, a Claimant will also be provided reasonable access to and copies of all documents, records, and information relevant to the claim.

The Claimant will be notified of any decision on appeal within 60 days after the Benefit Plan Administration Committee receives the appeal request and all other supporting documentation.

Special Notices

Because of some federal laws, changes in the Health Plan, or the special needs of the Company, provisions called “Special Notices” may be added to this SPD.

Be sure to check for and read any “notice” or “Special Notice” you receive about the Health Plan. It can describe changed provisions of the Health Plan and this SPD affecting Benefits coverage or the administration of the Health Plan.

SECTION 9: GLOSSARY

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

The decision about whether such a service can be deemed a Covered Health Service is solely at the Plan Administrator's discretion. Other apparently similar promising but Unproven Services may not qualify.

Addendum – any attached written description of additional or revised provisions to the Health Plan. The Benefits and Exclusions of this SPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and as well as any Rescission of Coverage, whether or not, in connection with the Rescission of Coverage, there is an adverse effect on any particular Benefit at that time.

Affidavit of Common Law Marriage – A Legal document showing a relationship between you and your Spouse.

Amendment - Any Amendment of the terms and provisions of the Health Plan that is made in accordance with the procedures stated in Section 11: Important Administrative Information: ERISA, under the heading "Amendment or Termination of Health Plan."

Annual Deductible (or Deductible) – The amount you must pay for Covered Health Services in a calendar year before the Health Plan will begin paying Benefits in that calendar year.

Annual Open Enrollment Period - The annual period of time during which current Eligible Employees may Enroll in the Health Plan or change their coverage elections for the following Health Plan Year.

Appeal (or Internal Review Appeal) - An appeal or internal appeal means review by the Health Plan of an Adverse Benefit Determination, as required by the Health Plan and applicable Department of Labor Regulations.

Benefit Change – A task completed in Workday to Enroll in the Health Plan or to change an employee's elections as a result of a Change in Status Event.

Benefit Determination - A determination made by the Claims Administrator as to providing or making payment of Benefits under the provisions of the Health Plan.

Benefit Plan Administration Committee - ONEOK, Inc. Benefit Plan Administration Committee, the Plan Administrator of the Health Plan.

Benefit Summary—The additional terms and description of Benefits provided by UnitedHealthcare, or other applicable component program vendor which are incorporated herein as further described in Section 1: Schedule of Benefit Summaries.

Benefit(s) – Health Plan payments for Covered Health Services, subject to the terms and conditions of the Health Plan and any Addendums and/or Amendments.

Benefits Open Enrollment Period - The Annual Open Enrollment Period for Company sponsored Benefit plans coordinated and administered with its Benefits Cafeteria Plan.

Cafeteria Plan - The ONEOK, Inc. Cafeteria Plan, a plan that allows a Participant to receive Benefits Dollars and to pay for health care Benefits on a pre-tax basis.

Change in Status Event - A Change in Status Event specified under the Health Plan that qualifies a Covered Person to change elected coverage during the Health Plan Year other than during the Annual Open Enrollment Period. Notification must be provided within thirty (30) days except in the case of birth and/or adoption, which must be provided within ninety (90) days; or Medicaid or State Children's Health Insurance Program (SCHIP)/Children's Health Insurance Program (CHIP) coverage, which must be provided within sixty (60) days.

Claim, Claim for Benefits – A request for a Benefit or Benefits under the Health Plan made by a Claimant in accordance with the Health Plan's procedure for filing Benefit claims; and includes any Pre-Service Claim and any Post-Service Claim.

Claimant - An individual who makes a Claim for Benefits under the Health Plan and a claim as provided for in applicable Department of Labor Regulations and this Section.

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

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

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

Code – Internal Revenue Code of 1986, as amended.

Coinsurance - The charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

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

Copay, Copayment - The charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Coverage Tier - The level of coverage that may be elected by Covered Persons under the Health Plan.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in the applicable document listed in Section 1: Schedule of Benefit Summaries.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Section 2: Eligibility and General Information.
- Not otherwise excluded in the Benefit Summaries under Section 1: Schedule of Benefit Summaries.

Covered Person – Either the Employee, their Spouse/Domestic Partner or Dependent(s) only while enrolled and eligible for Benefits under the Health Plan; References to "you" and "your" throughout this SPD are references to a Covered Person.

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

Definition of Domestic Partner Dependent -

Spouse - A Domestic Partner does not qualify as a spouse under Federal Law. A Domestic Partner is not a qualified beneficiary, and therefore not able to elect COBRA continuation of coverage. A Domestic Partner's child is not eligible for coverage under the Plan as a result of a QMCSO (Qualified Medical Child Support Order).

A Domestic Partner of an individual must:

- not be so closely related that marriage would otherwise be prohibited under the laws of the state in which they reside;

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

Dependent (or Eligible Dependent) - An individual who is a family member of an Eligible Employee, who comes within the coverage provisions listed and stated under Eligible Family Members in Section 2: Eligibility and General Information and who meets the requirements of Code section 152 as modified by Code sections 105 and 106 and their accompanying regulation.

Dependent Verification Documents – The documentation required by the Health Plan to confirm proof of Dependent eligibility.

Effective Date - The date when your coverage begins.

Eligible Employee – An Employee who is eligible to participate in the Health Plan as defined in Section 2: Eligibility and General Information. The Company has sole authority as Plan Sponsor to determine the classes of Eligible Employees who may participate in the Health Plan, and the Plan Administrator has sole discretionary authority to determine whether an individual falls within one of the eligible classes and otherwise satisfies the eligibility criteria to participate in the Health Plan. Eligibility to participate in certain component Benefits offered under the Health Plan (e.g., Wellness Benefits) may differ from the general eligibility rules for Medical Benefits and Prescription Drug Benefits.

Eligible Expenses – Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Eligible Family Member - An individual who is a family member of an Eligible Employee and who comes within the coverage provisions listed and stated under Eligible Family Members in Section 2: Eligibility and General Information.

Employee – An individual who is classified as an employee of the Company under the Company's internal policies and procedures. An individual who is classified by the Company as a contingent worker, independent contractor or leased employee shall not be considered an Employee for purposes of the Health Plan. The term Employee when used in this document shall refer to an Employee eligible to participate in the Health Plan in accordance with the terms and provisions of this Health Plan. If any court, administrative body, agency, or other entity should determine that any individual classified as a contingent worker, independent contractor, leased employee or other non-Employee by the Company was, in reality, a common law employee of the Company, such individual still shall not be eligible for, nor entitled to, and shall not participate in, the Health Plan.

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

Enrollment (or Enroll) - To become covered for Benefits under the Health Plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

Enrollment Date - The first day of coverage if an Eligible Employee elects coverage under the Health Plan. For new Employees, this is their employment start date. For current Eligible Employees, it is the date the new coverage takes effect, such as January 1 after an Annual Open Enrollment or a Change in Status where notification has been provided in accordance with Health Plan provisions.

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

Explanation of Benefits (EOB) – A statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any);
- The eligible reimbursement amounts;

- Coinsurance;
- Any other reductions taken;
- The net amount paid by the Health Plan; and
- The reason(s) why the service or supply was not covered by the Health Plan.

FMLA - the Family and Medical Leave Act of 1993, as amended.

Foster Child – A foster child meaning your child(ren) who is an individual who is a child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time Student (Full-time Education Student) – A person who is enrolled in and attending, full-time, a recognized course of study or training at:

- An accredited high school;
- An accredited college or university; or
- A licensed vocational, technical, automotive, beautician school, or similar training school.

Guardianship - A guardianship is a legal relationship created when a person is assigned by the court to take care of minor children or incompetent adults.

Health Care Flexible Spending Account (HCFSA) – An account established by an Employee under the ONEOK, Inc. Cafeteria Plan, Health Care Flexible Spending Account.

Health Plan (or Plan) – ONEOK, Inc. Health Plan

Health Plan Year – January 1 through December 31 of any given year.

Identification Card (ID Card) – The Identification Card is provided to a Covered Person by the Health Plan for use in obtaining Covered Health Services in accordance with the Health Plan.

Incurred – A charge is incurred on the date you receive a service or supply for which the charge is made.

Medical Benefit Option - An amount and type of Benefits coverage elected by a Covered Person from the optional coverage plan provided under the Schedule of Benefits of the Health Plan.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provide medical Benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary Leave of Absence - This term applies to Dependent loss of coverage in Section 7: When Coverage Ends, COBRA and Other Continuation Rights. A leave of absence from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), that commences while the Dependent is suffering from a serious illness or Injury, and is Medically Necessary.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Net Participant Cost - The cost of the Benefits coverage elected by a Participant in excess of the Company's contribution used for such coverage that is paid and contributed by the Participant in the Health Plan.

Network Benefits (Network) - A Network of Providers who have contracted with UnitedHealthcare to provide services at a discounted rate.

New Hire - A new Employee eligible for participation in the Health Plan.

Notice (or Notification) - The delivery or furnishing of information to an individual in a manner that satisfies the standards of Department of Labor Regulations applicable to the Health Plan as appropriate with respect to material required to be furnished or made available to an individual.

Open Enrollment – The period of time, determined by ONEOK, Inc., during which Eligible Employees may enroll themselves, their Spouse/Domestic Partner and/or their Dependent(s) under the Health Plan.

Opt-Out - If you "Opt-Out," you will have no Benefits coverage through the Health Plan or from the Company.

Out-of-Pocket Maximum (or Annual Out-of-Pocket Maximum) - This is the maximum amount you pay every calendar year.

Participant - An Eligible Employee, Spouse, Domestic Partner, or Dependent(s) who elects to participate in the Health Plan.

Placement for Adoption (or Placed for Adoption) - The assumption and retention of an obligation by Court Order of a Court of competent jurisdiction for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

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

Plan Document & Summary Plan Description (SPD) - The document that describes the health Benefits available to you and your covered family members under the Health Plan, including the applicable Benefit Summary.

Plan Fiduciary - ONEOK, Inc. Benefit Plan Administration Committee, and its duly authorized representatives and fiduciaries.

Plan Sponsor – ONEOK, Inc.

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

PPACA - The Patient Protection and Affordable Care Act, including the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act enacted in 2010.

Preferred Provider Organization (PPO) Medical Benefit Option - A Preferred Provider Organization consisting of a group of Hospitals, doctors and others that contract to provide

Covered Health Services at specified or reduced rates. See Section 3: How the Health Plan Works for Medical Benefit Options provided under the Health Plan.

Prescription Drug - Drugs and medicine lawfully prescribed by a Hospital, Physician, or other licensed Provider

Proof of Financial Interdependency – Documents that show a relationship between you and your Spouse/Domestic Partner such as a mortgage, lease, bank statement, credit card statement or utility statement listing both you and your Spouse, Domestic Partner's names, at the same address, as the responsible party.

Qualifying Event – For purposes of Section 2: Eligibility and General Information, an event that may give rise to a right to elect COBRA Continuation Coverage. Also may be used in reference to events described in the Cafeteria Plan, the occurrence of which may permit a change of a Covered Person's coverage.

Qualified Beneficiary - An Employee covered under the Health Plan; a covered Employee's enrolled Spouse or Dependent, including with respect to the Employee's children, a child born to or Placed for Adoption with the Employee during a period of continuation coverage under federal law; or a covered Employee's Spouse/Domestic Partner.

Rescission of Coverage - A cancellation or discontinuance of coverage under the Health Plan that has retroactive effect, including a cancellation that treats coverage under the Health Plan as void from the time of the individual's enrollment, or a cancellation that voids benefits paid up to a year before the cancellation. Provided, a cancellation or discontinuance of coverage is not a Rescission of Coverage if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage under the Health Plan.

Retired Employee – an Employee who retires from ONEOK, Inc. while covered under the Health Plan (also known as Former Employee).

Social Security Number (SSN) - SSN is a nine-digit number issued to U.S. citizens, permanent residents, and temporary (working) residents under section 205(c) (2) of the Social Security Act.

SPD – Summary Plan Description.

Special Notices - It can describe changed provisions of the Health Plan and this Plan Document and Summary Plan Description affecting Benefits coverage or the administration of the Health Plan.

Spouse – An individual to whom an Eligible Employee is legally married for purposes of federal income tax laws. Evidence of a spousal relationship may be State Issued Marriage Certificate, Affidavit of Common Law Marriage.

State Issued Birth Certificate - an official document issued to record a person's birth, including such identifying data as name, gender, date of birth, place of birth, and parentage.

State Issued Marriage Certificate - an official document issued to record a person's marriage, including such identifying data as name, date of marriage, place of marriage and court record.

Status Change Form – A form completed by an Eligible Employee to change his or her coverage election as a result of a Change in Status Event.

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

Wellness Benefits – The wellness benefits described in Section 4: Wellness Program.

Wellness Program - The ONEOK, Inc. Wellness Program as set forth in Section 4: Wellness Program, as amended from time to time.

Wellness Program Participant - An individual who is an Eligible Employee or other person (Spouse, Domestic Partner, Dependent) and who is participating in the Wellness Program in accordance with the provisions of Section 4: Wellness Program.

Workday – The online platform used to house enrollment data

SECTION 10: HIPAA PRIVACY NOTICE AND POLICY

ONEOK, INC. HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

Background:

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

The Health Plan needs to create, receive and maintain records that contain protected health information about you to administer the Health Plan and provide you with health care Benefits. This Notice describes the Health Plan’s health information privacy policy and practices with respect to your Health, Prescription Drug, Dental, Vision and/or Health Care Flexible Spending Arrangement (“HCFSA”) Benefits. The Notice tells you the ways the Health Plan may use and disclose protected health information about you, describes your rights and the obligations the Health Plan has regarding the use and disclosure of your protected health information. However, this Notice does not state the policies or practices of your health care Providers (such as doctors, Hospitals or laboratories) with respect to privacy of health information.

Health Plan Policy on Privacy of Your Health

The privacy policy and practices of the Health Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as “protected health information” (“PHI”). Generally speaking, PHI includes information provided by you or created, received or maintained by a health care Provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan. Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal and state health information privacy laws.

HIPAA Plan Privacy Requirements

The Health Plan is required by law to:

- Maintain the privacy of PHI about you;
- Provide you with certain rights with respect to your PHI;

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

How the Health Plan may Use and Disclose Health Information about You

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

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

- For treatment. The Health Plan may disclose your PHI to a health care Provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Health Plan may advise an emergency room Physician about the types of Prescription Drugs you currently take.
- For payment. The Health Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care Providers may be paid for your Benefit according to the Health Plan's terms. For example, the Health Plan may receive and maintain information about Surgery you received to enable the Health Plan to process a Hospital's claim for reimbursement of surgical expenses Incurred on your behalf.
- For health care operations. The Health Plan may use and disclose your PHI to enable the Health Plan to operate or operate more efficiently, or to make certain that all of the Health Plan's Participants receive their Benefits. For example, the Health Plan may use your PHI for Case Management or to perform population-based studies designed to reduce health care costs.

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

- To the Company. The Health Plan may disclose your PHI to designated Company personnel so they can carry out their Health Plan related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the Plan Administrator, the Company's Vice President, Human Resources (the "Privacy Officer"),

personnel within the Company's Human Resources Department, and personnel in the Company's Legal, Audit and Information Technology Departments who support those functions. 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 Health Plan to any other Company Employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other Employee Benefit Plan Sponsored by the Company.

- To a business associate. Certain services are provided to the Health Plan by third-party administrators known as "business associates." For example, the Health Plan may input information about your health care treatment into an electronic claims processing system maintained by the Claims Administrator of the Health Plan so your claim may be paid. In so doing, the Health Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Health Plan will require all its business associates, through contract, to appropriately safeguard your health information.
- Treatment alternatives. The Health Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- Health-related Benefits and services. The Health Plan may use and disclose your PHI to tell you about health-related Benefits or services that may be of interest to you.

However, your PHI will not be used or disclosed for marketing, sales or fundraising purposes without your authorization.

Authorizations

The Health Plan may disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide a written authorization and any supporting documents (e.g., power of attorney). A separate authorization is required from you in order to use or disclose psychotherapy notes. To designate an authorized representative, complete and return the Individual Authorization form is available to you at www.oneokonline.com > Departments and Programs > Human Resources > Benefits. If you authorize the Health Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Health Plan will not withdraw or change any uses or disclosures already made by the Health Plan in reliance on your prior authorization. The Health Plan does not have to disclose information to a personal representative if it has a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

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

Spouses and Other Family Members

With only limited exceptions, the Health Plan will send all mail to the employee. This includes mail relating to a Spouse/Domestic Partner and other Dependents who are covered under the Health Plan, and includes mail with information on the use of Benefits by the Spouse/Domestic Partner and other Dependents and information on the denial of any Benefits to the Spouse/Domestic Partner and other Dependents. However, if a person covered under the Health Plan has requested restrictions or confidential communications, and if the Health Plan has agreed to the request, the Health Plan will send mail as provided by the request for restrictions or Confidential communications.

Individual involved in your care or payment of your care

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

As required by law

The Health Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

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

- Lawsuits and disputes. If you become involved in a lawsuit or other legal action, the Health Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process that requires such use or disclosure.
- Law enforcement. The Health Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime’s location or victims, or the identity, description, or location of the person who committed the crime.
- Workers’ compensation. The Health Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers’ compensation laws or other similar programs.
- Military and Veterans. If you are or become a member of the U.S. armed forces, the Health Plan may release medical information about you as deemed necessary by military command authorities.

- To avert serious threat to health or safety. The Health Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- Public health risks. The Health Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, Injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- Health oversight activities. The Health Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- Research. Under certain circumstances, the Health Plan may use and disclose your PHI for medical research purposes if (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.
- National security, intelligence activities, and protective services. The Health Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- Organ and tissue donation. If you are an organ donor, the Health Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Health Plan may disclose your PHI to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Coroners, medical examiners, and funeral directors. The Health Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Health Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.
- Government Audits. The Health Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA privacy rule.

Your Rights Regarding Health Information About You

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

Right to inspect and copy

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

To inspect and copy your PHI maintained by the Health Plan, submit your request in writing to the Privacy Officer. The Health Plan may charge a fee for the cost of copying and/or mailing your PHI that you request. In limited circumstances, the Health Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to amend

If you feel that health information the Health Plan has about you is incorrect or incomplete, you may ask the Health Plan to amend it. You have the right to request an Amendment for as long as the information is kept by or for the Health Plan.

To request an Amendment, send a detailed request, in writing, to the Privacy Officer. You must provide the reason(s) to support your request. The Health Plan may deny your request if you ask the Health Plan to amend health information that either: (1) is accurate and complete, (2) was not created by the Health Plan; (3) is not part of the health information kept by or for the Health Plan; or (4) is not information that you would be permitted to inspect and copy.

Right to an accounting of disclosures

You have the right to request an “accounting of disclosures.” This is a list of disclosures of your PHI that the Health Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures that have occurred since the Effective Date of this Notice, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested.

Right to request restrictions

You have the right to request a restriction on the health information the Health Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Health Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Health Plan not use or disclose information about a Surgery you had.

To request restrictions, make your request in writing to the Privacy Officer. You must advise the Privacy Officer: (1) what health information you want to restrict or limit; (2) whether you want to restrict or limit the Health Plan's use, disclosure, or both; and (3) to whom you want the restriction(s) and limit(s) to apply.

Note: A Plan may refuse to agree to a requested restriction on uses and disclosures necessary to properly administer the Plan. The Plan will advise you if it does not agree to follow a restriction you request, or if it terminates a restriction it has previously agreed to follow.

Right to request confidential communications

You have the right to request that the Health Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Health Plan send you Explanation of Benefits (EOB) forms about your Benefit claims to a specified address.

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

Right to be notified of a breach

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

Right to a paper copy of this Notice

You have the right to a paper copy of this Notice. You may access this Notice at www.oneokonline.com > Departments and Programs > Human Resources > Benefits or write to the Privacy Officer to request a written copy of this Notice at any time.

Changes to This Notice

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

Complaints

If you believe your HIPAA privacy rights described in this Notice have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may make a complaint to the Secretary of the U.S. Department of Health and Human Services, generally within one-hundred eighty (180) days of when the act or omission complained of occurred.

Note: You will not be penalized or retaliated against for filing a complaint.

CONTACT INFORMATION

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

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

SECTION 11: IMPORTANT ADMINISTRATIVE INFORMATION

This section includes information on the administration of the Health Plan, as well as information required to be stated in the SPD by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Administrator and Named Fiduciary

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

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

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

You may contact the Plan Administrator at:

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

Reliance on Participant Information

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

Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Health Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited to the Health Plan following two (2) years after the date that any such payment first became due.

Effect of Mistake

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

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Health Plan, the Health Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Health Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Health Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

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

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

Compensation of Plan Administrator

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

Claims Administrator

Claims are processed on behalf of the Health Plan and Plan Administrator by the Claims Administrator, UnitedHealthcare. The Claims Administrator for the Health Plan is classified as an insurance issuer under federal law.

The role of the Claims Administrator is to handle the day-to-day administration of the Health 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 Health Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Health Plan.

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

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

United HealthCare Services, Inc.
450 Columbus Boulevard
Hartford, CT 06115-0450

Health Plan Funding and Payments

The Health Plan is funded by Participant contributions and payments from the general assets of ONEOK, Inc. Participants in the Health Plan make contributions to the Health Plan based on an elected Medical Benefit Option and Coverage Tier, in accordance with the Health Plan.

Payments are made pursuant to the Health Plan to reimburse Eligible Employees, Spouses, Domestic Partners and Dependent(s) for health care expenses, and for other authorized purposes in accordance with the Health Plan.

Payment of Plan Administration Expenses

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

Insurance Contracts

The Company shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Health Plan; and (b) to replace any of such insurance companies or contracts. To the extent that such amounts are less than aggregate Company contributions toward such insurance, any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall be the property of the Company. For avoidance of doubt, with respect to any insurance company rebate received by the Company that is subject to the Medical Loss Ratio ("MLR") provisions of the PPACA, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Health Plan or applied to the benefit of Participants; which Participants need not be the same Participants who made contributions under the policy that issued the rebate.

PPACA

Notwithstanding anything in this SPD to the contrary, the Health Plan complies with the PPACA. Specifically:

- *Lifetime or Annual Limits*. The Health Plan does not impose a lifetime or annual limit on the dollar value of Essential Health Benefits provided. Essential Health Benefits are health-related items and services that fall into ten categories, as defined in the PPACA and further determined by the Secretary of HHS.
- *No Rescission of Coverage*. The Health Plan will not cancel or discontinue medical benefits with a retroactive effect with respect to you or your covered dependents except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc.
- *No Pre-Existing Condition Exclusion*. The Health Plan will not impose a pre-existing condition exclusion on medical benefits.
- *No Cost Sharing on Recommended Preventive Care*. The medical benefits under the Health Plan will not require Participant cost-sharing on recommended Preventive Care provided by in-network providers.
- *Coverage of Clinical Trials*. Medical benefits under the Health Plan shall not deny participation in an approved clinical trial for which a Covered Person is a "qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Covered Person participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms "qualified individual," "life threatening disease or condition," approved clinical trial" and "routine patient costs" shall have the same meaning as found in Section 2709 of the Public Health Services Act.
- *Cost Sharing Limits*. Medical benefits under the Health Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the PPACA. For purposes of this provision, cost-sharing includes deductibles, coinsurance, copays or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Health Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Health Plan. Notwithstanding the foregoing, the Company reserves the right to maintain bifurcated out-of-pocket maximums as permitted by law.
- *Patient Protections*. To the extent applicable, medical benefits under the Plan shall comply with the patient protections regarding choice of health care professionals and Medical Emergency care services under Public Health Services Act Section 2719A.

Surprise Medical Billing

Issued as part of the Consolidated Appropriations Act of 2021, the No Surprises Act prevents surprise medical bills in connection with claims for services to treat an emergency medical condition that are performed by out-of-network providers, and limits the amount you may be required to pay. For more information on the No Surprises Act, please visit: www.oneok.com/careers/benefits.

Mental Health Parity

Notwithstanding anything in this SPD to the contrary, the Health Plan will provide parity between mental health or substance use disorder benefits (including treatment for alcoholism as described below) and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder. Specifically:

- *Lifetime or Annual Dollar Limits*. The Health Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.
- *Financial Requirement or Treatment Limitations*. The Health Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- *Criteria for medical necessity determinations*. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Health Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

Waiver

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

Amendment or Termination of Health Plan

ONEOK, Inc., as the Plan Sponsor, has and retains the right to amend, change, cancel, discontinue, or terminate the Plan at any time without the consent of employees, or participants in the Plan, or any other person covered by the Plan. Except for those authorities and responsibilities which are expressly reserved to the Board of Directors herein, the ONEOK, Inc. Benefit Plan Sponsor Committee shall possess and exercise all non-fiduciary “settlor” authority to act on behalf of the Company with respect to the Plan. The ONEOK, Inc. Benefit Plan Sponsor Committee shall consist of the officers designated as members of the ONEOK, Inc. Benefit Plan Sponsor Committee

pursuant to the management committees list maintained by the Company's Corporate Secretary and their respective successors in title or duties, authority and function.

The procedure for amending the Plan and for identifying the persons who have authority to amend the Plan shall be for the ONEOK, Inc. Benefit Plan Sponsor Committee (the "Sponsor Committee") to adopt, authorize, approve, and/or ratify amendment of the Plan by action duly approved by the Sponsor Committee. The Sponsor Committee may amend the Plan at a meeting of the Sponsor Committee, or without a meeting in a written memorandum of action signed by all the members of the Sponsor Committee, or by electronic transmission. The minutes or record of the meeting, or writing or writings or electronic transmission or transmissions, shall be filed and maintained in the records of the Company by the Sponsor Committee. An amendment of the Plan pursuant to this procedure shall be stated and incorporated in the governing written documents of the Plan in such form and manner as authorized and approved by the Sponsor Committee, which may, without limitation, be a duly adopted resolution of the Sponsor Committee approving such Plan amendment or restatement, a written amended and restated plan document containing the amendment signed by an officer of the Company or an authorized representative of the Sponsor Committee designated by it, or a written instrument signed by an officer of the Company or an authorized representative of the Sponsor Committee designated by it with the form of an amended and restated plan document containing the amendment that is not signed attached as an exhibit thereto. Such an amendment may be made a part of or referred to in a summary plan description or other documents related to the Plan from time to time in the form and manner determined by the Sponsor Committee or its designated authorized representatives. Amendment of the Plan pursuant to such procedure shall not require approval or action of the Board of Directors of the Company; provided, the Board of Directors is also authorized to, at any time, amend, modify, or change the Plan by resolution approved by it. The Company may cancel, discontinue, or terminate the Plan by either (i) a written instrument signed by the Chief Executive Officer of the Company, or (ii) a resolution approved by the Board of Directors of the Company.

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 Health Plan. The Health Plan's Agent of Service is:

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

Legal process may also be served on the Plan Administrator.

Other Plan Information

This section of the Plan Document and Summary Plan Description contains information about how the Health Plan is administered as required by ERISA.

Health Plan Name:	ONEOK, Inc. Health Plan
Plan Number:	501
Company ID:	73-1520922
Plan Type:	Welfare benefit plan
Health Plan Year:	January 1 – December 31
Plan Administration:	ONEOK, Inc. Benefit Plan Administration Committee; Third-Party Claims Administrator
Source of Plan Contributions:	Company and Employees
Source of Benefits:	General Assets of the Company

Your ERISA Rights

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

- Receive information about Health Plan Benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, summary annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all documents governing the operation of Health Plan and other Health Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest annual report, Form 5500 Series and updated Summary Plan Description, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- Receive a summary annual report of the Health Plan's financial activities. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

You can continue health care coverage for yourself, your Spouse/Domestic Partner and/or your Dependent(s) if there is a loss of coverage under the Health Plan as a result of a Qualifying Event. You, your Spouse/Domestic Partner or your Dependent(s) may have to pay for such coverage. Review this Summary Plan Description and the Health Plan documents to understand the rules governing your COBRA Continuation Coverage rights.

In addition to creating rights for Health Plan Participants, ERISA imposes duties on the people who are responsible for the operation of the Health Plan. The people who operate your Health Plan, who are called "fiduciaries" of the Health Plan, have a duty to do so prudently and in the interest of you and other Health Plan Participants and beneficiaries. No one, including your Company or

any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Health Plan Benefit or exercising your rights under ERISA.

If your claim for a Health Plan Benefit 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 8 Claims Procedures, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the Health Plan, and do not receive them within thirty (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 Health Plan, you may file suit in a state or federal court. In addition, if you disagree with the Health 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 Health Plan's fiduciaries misuse the Health 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 Health Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Legal Notices

Health Plan Benefits and Rights

Participation in the Health Plan provides Covered Persons with Benefits in accordance with the terms and provisions of the Health Plan. The Health Plan is an employee benefit plan established and maintained by the Company. The Health Plan is not a contract. Benefits, rights and features of

the Health Plan are not vested for any Participant and are subject to change, in whole or in part, at any time and for any reason. The permitting of Benefits provided under the Health Plan is not permanent and is subject to the authority of the Company to amend, modify, or terminate the Health Plan in the future, as provided in the Health Plan.

No Guarantee of Employment

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

No Guarantee of Tax Consequences

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

Governing Law

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

Headings

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

Legal Action

You may sue the Health Plan in federal court under Section 502(a) of ERISA 90 days after you have exhausted the administrative procedures as described in this Plan (or the applicable Benefit Summary) and all required reviews of your claim have been completed. If you decide to sue the Health Plan, you must do so within one year after the date of service giving rise to the claim or within the period specified in the applicable Benefit Summary, whichever is longer. Any legal proceeding in connection with the Health Plan can only be filed in the United States District Court for the Eastern District of Oklahoma, located in Tulsa, Oklahoma.

Severability

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

The Health Plan's Benefits are administered by the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Health Plan and provides appeal services; however, UnitedHealthcare, the Health Plan, the Plan Administrator and the Company are not responsible for any decision you, or your Eligible Family Member(s) make to receive treatment, services or supplies, whether provided by an In- Network or Out-of-Network provider. UnitedHealthcare, the Health Plan, the Plan Administrator and the Company are neither liable nor responsible for the treatment, services or supplies provided by In-Network or Out-of-Network Providers.