

**PETER KIEWIT SONS', INC. NON-UNION CRAFT
HEALTH AND WELFARE PLAN**

**SUMMARY PLAN DESCRIPTION SUPPLEMENT
JANUARY 1, 2025**

This Summary Plan Description (SPD) is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded a Plan Participant by the underlying Plan or by any state law that is not pre-empted by ERISA, those legal rights supersede the rights set forth in this SPD. *The information in this Supplement is in addition to, and/or supersedes, the information in the Certificates of Insurance and/or Benefit Summaries for the individual benefits offered under the Peter Kiewit Sons', Inc. Non-Union Craft Health and Welfare Plan (the "Plan"). Collectively, the Certificates/Summaries and this Supplement constitute the Summary Plan Description ("SPD") for the Plan.*

GENERAL INFORMATION

Plan Name: Peter Kiewit Sons', Inc. Non-Union Craft Health and Welfare Plan

Plan Sponsor's Name: Peter Kiewit Sons', Inc.

Plan Sponsor's Address: 1550 Mike Fahey Street
Omaha, NE 68102-4722

Plan Sponsor's Identification Number (EIN): 91-1842817

The Plan Sponsor is referred to in this document as the
"Primary Employer."

Related Employers: Participants and beneficiaries may receive a list of Related Employers from the Plan Administrator, upon written request.

The Primary Employer and the Related Employers are
collectively referred to in this document as the "Employer."

Plan Number: 501

Plan Year End: The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Welfare Benefit Plan Type:

Medical and Prescription Drug
Health Care Flexible Spending Account
Dental
Vision
Employee Assistance Program
Life

Accidental Death and Dismemberment
Long Term Disability
Short Term Disability
Voluntary Life
Voluntary Accidental Death and Dismemberment

Plan Administrator: Peter Kiewit Sons', Inc.
1550 Mike Fahey Street
Omaha, NE 68102-4722
(402) 342-2052

The administration of the Plan is under the supervision of the Plan Administrator. It is a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator has full power to administer the Plan in all of its details, subject to applicable requirements of law, including the power to exercise discretion in interpreting the Plan and in deciding all questions concerning the Plan and the eligibility of any person to participate in it. Any such decision made by the Plan Administrator shall be binding and is intended to be subject to the most deferential standard of judicial review.

Notwithstanding the foregoing, with respect to any benefits that are fully insured through insurance policies purchased from insurance companies (or contracts with similar risk shifting characteristics), the insurer or contract issuer (and not the Plan Administrator) shall have the discretion and authority to construe and interpret the policies or contracts under which it provides any fully insured benefits.

Agent for Service of Legal Process: Peter Kiewit Sons', Inc.
1550 Mike Fahey Street
Omaha, NE 68102-4722
(402) 342-2052

Service of Legal Process may also be made upon the Plan Administrator.

SOURCES OF CONTRIBUTIONS TO THE PLAN AND PLAN FUNDING MEDIUM

The Plan is funded through Employer contributions and, in certain circumstances, employee contributions. The medical and prescription drug, health care flexible spending account program, dental, vision, and short term disability benefits are self-funded, meaning that benefits are paid out of the Employer's general assets. All other benefits are fully insured through insurance policies purchased from insurance companies.

If a health insurance issuer ("Issuer") is responsible in whole or in part for the financing or administration of a benefit, please refer to your Insurance Card for the full name and address of the Issuer. Please refer to the applicable Certificate of Insurance to determine whether and to what extent benefits under the Plan are guaranteed under a contract or policy of insurance issued by the Issuer, and the nature of any administrative services (e.g., claims payment) provided by the Issuer.

ELIGIBILITY FOR PARTICIPATION AND BENEFITS

Newly-Hired Employees

Except as described below with respect to medical and prescription drug benefits (including disease management benefits that are integrated with the medical and prescription drug benefits but provided under a separate contract with a disease management provider) and employee assistance program benefits, newly-hired Eligible Employees (and their eligible dependents, as defined in the applicable Certificates of Insurance and/or Benefit Summaries) shall be eligible for benefits under the Plan as of the first day of the month following their completion of 60 days of continuous employment (or if later, the date they first satisfy the criteria for an Eligible Employee).

Newly-hired Eligible Employees (and their eligible dependents, as defined in the medical and prescription drug benefit summary) shall be eligible for the Plan's medical and prescription drug benefits as of the first day of the month following their completion of 60 days of continuous employment (or if later, the date they first satisfy the criteria for an Eligible Employee); provided, however, that an Eligible Employee's absence from work due to any health factor (including an absence while receiving short term disability benefits under the Plan) shall not be considered an absence for purposes of measuring 60 days of continuous employment. Union Employees shall not be eligible for the integrated disease management benefits.

In addition, Employees who otherwise meet the definition of an "Eligible Employee," but who are not regularly scheduled to work at least 30 hours per week (and their eligible dependents, as defined in the medical and prescription drug benefit summary) will also be eligible for the Plan's medical and prescription drug benefits, but only if (and when) they first meet the definition of "full time employee" under the Affordable Care Act of 2010 (based on the measurement, administrative and stability periods adopted by the Primary Employer from time to time).

Newly-hired Eligible Employees (and their eligible dependents, as defined in the employee assistance benefits benefit summary) shall be eligible for the Plan's employee assistance program benefits as of their date of hire (or if later, the date they first satisfy the criteria for an Eligible Employee).

Reinstatement of Coverage

An Eligible Employee (and the Eligible Employee's eligible dependents) whose benefits under the Plan terminate due to the Eligible Employee's termination of employment shall regain eligibility for such benefits if the terminated Eligible Employee

is subsequently rehired (or, with respect to the Plan's medical and prescription drug benefits, considered to be rehired for purposes of the Affordable Care Act of 2010) within 12 months of their termination. In such circumstances, the rehired Eligible Employee (and the Eligible Employee's eligible dependents) shall regain eligibility for Plan benefits on the first day of the month coincident with or next following the date the Eligible Employee is rehired. If an Eligible Employee's coverage (and that of the Employee's eligible dependents) ends due to termination of employment and the Eligible Employee is not rehired (or, with respect to the Plan's medical and prescription drug benefits, considered to be rehired for purposes of the Affordable Care Act of 2010) within 12 months after such termination, the terminated Eligible Employee will be treated as a new hire and will be required to satisfy the eligibility requirements for newly-hired Employees described above.

Definitions

"Employee" means any person employed by the Employer as a common law employee, but shall not include any person who is providing services as an independent contractor or as a leased employee. In addition, the term "Employee" shall not include any person who in good faith is classified as an independent contractor or leased employee by the Employer, even if such individual is later determined by any court or governmental agency to have been a common law employee.

The term "Eligible Employee" shall mean any non-union manual hourly-paid Employee of the Employer, any union Employee of the Employer employed at Kie-Con Inc. who is covered by the terms of a collective bargaining agreement which requires their participation, or with respect to eligibility for the Plan's employee assistance program benefits only, any union Employee of the Employer; but only if such an Employee is scheduled to work at least 30 hours per week and is Actively at Work; provided, however, that any Employee who is not Actively at Work due to a health factor (such as being absent from work on sick leave or while receiving short term disability benefits the Plan) shall be deemed to be Actively at Work. For purposes of the Plan, an individual is "Actively at Work" only if the individual is actually performing the material duties of the individual's job in the place where, and the manner in which, the job is normally performed, and not on an approved leave of absence or vacation. Individuals on approved military leave shall be considered "Eligible Employees" despite not meeting the 30 hour per week requirement to the extent such individuals are otherwise entitled to benefits under the Plan pursuant to the Employer's military leave policy.

Notwithstanding the foregoing, an Employee who is receiving long term disability benefits under the Plan shall be an Eligible Employee only with respect to the Plan's medical and prescription drug benefits, dental benefits, and vision benefits, and only through the last day of the sixth month following the effective date of the Employee's long term disability benefits.

SUMMARY OF PLAN BENEFITS

Please refer to the attached Certificates of Insurance and/or Benefit Summaries for a description of the Plan's benefits.

SPECIAL PROVISIONS

(Applies Only to Medical/Prescription Drug, Dental, and Vision Benefits)

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for the following information:

- ⇒ A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which the Participant or beneficiary will be responsible;
- ⇒ Any annual or lifetime caps or other limits on benefits under the Plan;
- ⇒ The extent to which preventive services are covered under the Plan;
- ⇒ Whether and under what circumstances existing and new drugs are covered under the Plan;
- ⇒ Whether and under what circumstances coverage is provided for medical tests, devices, and procedures;
- ⇒ Provisions governing the use of network providers;
- ⇒ The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- ⇒ Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- ⇒ Any conditions or limits applicable to obtaining emergency medical care; and
- ⇒ Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for a description of the Plan's provider network. *Provider lists are furnished automatically, without charge, as a separate document or available via a website.*

LOSS OR REDUCTION OF PLAN BENEFITS

Please refer to the applicable Certificate of Insurance and/or Benefit Summaries for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, or reduction of benefits.

THE PLAN SPONSOR'S RIGHT TO TERMINATE THE PLAN, OR AMEND OR ELIMINATE PLAN BENEFITS

The Plan Sponsor has the right, under the terms of the Plan, to modify or amend the Plan at any time. Any modification shall be effective as of the date of the amendment, or

at such later date as the Plan Sponsor shall determine. The Plan Sponsor also has the right to terminate the Plan at any time. Any termination of the Plan shall be effective as of the date of the termination amendment or board resolution, or at such later date as the Plan Sponsor shall determine. Termination of the Plan shall be binding on all Participants of the Plan Sponsor and any Related Employer.

The Certificates of Insurance and/or Benefit Summaries will disclose any Plan provisions governing the benefits, rights and obligations of Participants and beneficiaries upon Plan termination or the amendment or elimination of benefits under the Plan.

To the extent applicable, the Certificates of Insurance and/or Benefit Summaries will disclose any situations where the receipt of benefits is conditioned on the imposition of a fee or charge on a Participant or beneficiary, or on an individual account thereof.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- ⇒ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ⇒ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- ⇒ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage.

- ⇒ Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description Supplement and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights. If your Claim for a welfare 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.

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 annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.