

Summary Plan Description

Peter Kiewit Sons', Inc. Flexible Spending Account Plans

Effective: January 1, 2023

Plan Number: 82409

FLEXIBLE SPENDING ACCOUNT PLAN

Notice To Employees

This booklet describes the Employer-sponsored Flexible Spending Account Plans ("Plans") as of January 1, 2023.

Peter Kiewit Sons', Inc. has entered into an arrangement with Fidelity Investments ("Fidelity") under which Fidelity will process reimbursements and provide certain other administrative services to the Plans.

Fidelity Investments does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under these Plans, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses. **Note:** Please be aware that if you are enrolled in a Health Spending Account (HSA), you are only eligible to enroll in the Limited Health Care Spending Account ("LHCSA"). The **Health Care Spending Account ("HCSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the *Health Care Spending Account* section), including certain medical, vision and dental expenses for you, your spouse, your dependent children, and any other dependents as determined by Peter Kiewit Sons', Inc. and in compliance with the Internal Revenue Code (IRC).

The **Limited Health Care Spending Account ("LHCSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the *Limited Health Care Spending Account* section), including certain vision, dental and preventive care expenses for you, your spouse, your dependent children, and any other dependents as determined by Peter Kiewit Sons', Inc. and in compliance with the Internal Revenue Code (IRC).

Note for LHCSA only: If you are enrolled in the Choice Plus HSA Plan offered by Peter Kiewit Sons' Inc. you cannot be reimbursed for Eligible Health Care Expenses until AFTER you meet the annual deductible under your Choice Plus HSA Plan.

The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the *Dependent Care Spending Account* section), such as day care.

You can elect to participate in either the HCSA, the LHCSA and/or the DCSA.

Each Plan year (January 1 through December 31) you can contribute to your HCSA, LHCSA and/or DCSA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. **(For LHCSA only:** If you are enrolled in the Choice Plus HSA Plan you cannot receive reimbursement for Eligible Health Care Expenses from your HCSA until AFTER you meet the annual deductible under your Choice Plus HSA Plan.) Contribution levels are set forth as described under Section, *Contributions*.

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

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

A regular active full-time non-union hourly/salaried staff employee, non-union hourly craft employee and/or union hourly employee of KieCon, who is scheduled to work at least 30 hours per week.

When You May Enroll

You may elect to participate during your first 31 days of employment or during any subsequent annual enrollment period. If timely elected, the Plan will be effective on the day you become eligible for medical benefits (even if you choose not to elect medical benefits offered through Peter Kiewit Sons', Inc. If you do not elect to participate in the Plan during your first 31 days of employment, you must wait until the next annual Open Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) **You will need to enroll each year, even if you enrolled in the Plan the year before.**

How to Enroll

You elect to participate in the Plan by completing an enrollment form and submitting it to the Benefits Department or online through the Employee Self-Service within 31 days of the date you first become eligible to participate in the Plan. You must specify the amount of before-tax dollars you wish to contribute to the HCSA, the LHCSA and/or the DCSA. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to participate in the Plan.

You will need to enroll each year, even if you enrolled in the Plan the year before. During annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both. Any changes you make during Open Enrollment will become effective the following January 1.

CONTRIBUTIONS

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCSA, LHCSA and/or DCSA, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you **forfeit any unused funds** remaining in either account after the end of the Plan year. **(For LHCSA only:** If you are enrolled in the Choice Plus HSA Plan you cannot receive reimbursement for Eligible Health Care Expenses from your HCSA until AFTER you meet the annual deductible under on your Choice Plus HSA Plan.) You should consider this when deciding on the amount to contribute to your LHCSA or HCSA.

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

You have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following

your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. Any such Eligible Dependent Care Expenses must be submitted on or before March 31 of the Plan year following your termination.

For the Health Care Spending Account or the Limited Health Care Spending Account, you may elect to contribute up to \$2,850 a year.

For the Dependent Care Spending Account, you may each elect to contribute up to \$5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to \$2,850 a year. If you or your spouse's earned income is less than \$5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you meet one of the following conditions:

- A. With regard to LHCSA, HCSA and a DCSA, one of the following changes in status events occurs:
- An event that results in a change in your legal marital status, including your marriage, registered domestic partnership, the death of your spouse, or your divorce, legal separation or annulment.
 - An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
 - An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
 - An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the LHCSA, HCSA or DCSA.
- B. For individuals who participate in a LHCSA or HCSA, the following additional events will enable you to change your election:
- If you become entitled to Medicare or Medicaid, you may elect to revoke your LHCSA or HCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
 - If the FSA Plan Sponsor and/or Peter Kiewit Sons', Inc. receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator and/or Peter Kiewit Sons', Inc. may:
 - ◆ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the LHCSA or HCSA, or
 - ◆ Permit you to cancel your child's coverage under the LHCSA or HCSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Peter Kiewit Sons', Inc. within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your LHCSA or HCSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts made during the Plan year are effective as of the qualified event date that you timely notify Peter Kiewit Sons', Inc. of the change in status.

LIMITED HEALTH CARE SPENDING ACCOUNT / HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your LHCSA or HCSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred AFTER you meet the annual deductible under the Choice Plus HSA Plan, if you are enrolled in that plan.
- Incurred while you are participating in the LHCSA or HCSA.
- Incurred during the Plan year.

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

Below is a partial list of the types of health care expenses eligible for reimbursement from your LHCSA or HCSA. **(For LHCSA only:** If you are enrolled in the Choice Plus HSA Plan you cannot receive reimbursement for Eligible Health Care Expenses from your HCSA until AFTER you meet the annual deductible under your Choice Plus HSA Plan.) Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

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

Eligible Expenses available alongside your Choice Plus HSA Plan For LHCSA only:

- If you are enrolled in the Choice Plus HSA Plan all Eligible Expenses described below and Eligible Expenses available through your Choice Plus HSA Plan described in a separate SPD provided by Peter Kiewit Sons', Inc. can be reimbursed from your HCSA only AFTER you meet the annual deductible under your Choice Plus HSA Plan.

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

Eligible Medical Expenses for HCSA only

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses for HCSA only

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

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

Eligible Prescription Drugs for HCSA only

- Copayments, Coinsurance and Deductible amounts;
- Cost for allowable prescription drugs.

Eligible Preventive Care Expenses for LHCSA only

- Copayments, Coinsurance and Deductible amounts;
- Physician Office Services;
- Lab, X-ray or Other Preventive Tests.

Ineligible Expenses

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

- Expenses incurred BEFORE you meet the annual deductible under your Choice Plus HSA Plan.
- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your LHCSA or HCSA cannot be claimed as deductions on your income tax return.

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

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

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

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

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

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

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

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

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.

- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

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

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

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

To be reimbursed from your LHCSA, HCSA and/or DCSA simply submit a reimbursement form to the Claims Administrator, called a request for withdrawal, for the Eligible Expenses that have been incurred. A request for withdrawal form is available from Peter Kiewit Sons', Inc. or can be found on www.netbenefits.com.

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

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

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following

your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your LHCSA, HCSA or DCSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You can also complete a Recurring Dependent Care Request Form available at www.netbenefits.com so you can receive recurring reimbursement of your dependent care expenses.

If you have established a LHCSA or HCSA, your total annual contribution amount is available immediately, unless you are enrolled in the Choice Plus HSA Plan. **(For LHCSA only:** If you are enrolled in the Choice Plus HSA Plan your annual contribution will be available once you meet the annual deductible under your Choice Plus HSA Plan.) You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

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

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

Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. Any such Eligible Dependent Care Expenses must be submitted on or before March 31 of the Plan year following your termination.

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

Important Resources

Visit www.netbenefits.com for features and resources including the option to:

- View a summary of your contributions and the balance in your FSA, claims and transaction details
- Access an FSA savings calculator, forms, and additional resources and information to help you manage your account(s)

CLAIMS PROCEDURES

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call Fidelity Investments at the number on your ID card before requesting a formal appeal. A representative will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

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

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

Fidelity Investments
Attn: Fidelity Reimbursement Accounts Services
PO Box 2703
Fargo, ND 58108

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

Review of an Appeal

Fidelity Investments will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if Fidelity Investments upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Fidelity Investments within 60 days from receipt of the first level appeal. Fidelity Investments must notify you of the benefit determination within 30 days after receiving the completed appeal.

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

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

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

Claim Denial and Appeals	
Type of Claim or Appeal	Timing
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Fidelity Investments must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

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

WHEN PARTICIPATION ENDS

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

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

Limited Health Care Spending Account / Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year of employment termination, as long as those expenses were incurred prior to the date of your termination. **(For LHCSA only:** If you are enrolled in the Choice Plus HSA Plan you cannot submit a claim for reimbursement of Eligible Expenses until AFTER you meet the annual deductible under the Choice Plus HSA Plan expenses.) Any such claims must be submitted on or before March 31 of the next Plan year.

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

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

Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

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

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

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

Uniformed Services Employment and Reemployment Rights Act

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

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

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the LHCSA or

HCSA. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the LHCSA or HCSA.

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

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

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

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

Fidelity Investments is not Peter Kiewit Sons', Inc.'s designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date, against what is in your DCSA balance at the time of termination. Any such claims must be submitted on or before March 31 of the next Plan year.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note

The DCSA is not subject to ERISA. Only the LHCSA and HCSA is subject to ERISA.

Plan Sponsor and Administrator

Peter Kiewit Sons', Inc. is the Plan Sponsor and Plan Administrator of the Peter Kiewit Sons', Inc. Health and Welfare Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

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

Claims Administrator:

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

Fidelity Investments
Attn: Fidelity Reimbursement Accounts Services
PO Box 2703
Fargo, ND 58108

Agent for Service of Legal Process

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

Agent for Legal Process - FSA Plan

Peter Kiewit Sons', Inc.
1550 Mike Fahey Street

Omaha, NE 68102
(402) 342-2052

Legal process may also be served on the Plan Administrator.

Other Administrative Information

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

Type of Administration

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

Plan Name:	Peter Kiewit Sons', Inc. Health and Welfare Plan
Plan Number:	501
Employer ID:	91-1842817
Plan Type:	Welfare benefits plan
Plan year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions and Funding:	The Plan is funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees

Your ERISA Rights

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

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the LHCSA or HCSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series), filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all documents that govern the operations of the LHCSA or HCSA and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual reports (Form 5500), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- You can continue LHCSA or HCSA benefits for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your

Dependents may have to pay for such coverage. Review this Summary Plan Description and the governing the Plan documents to understand the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800)-998-7542.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the

nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800)-998-7542. If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in

ATTACHMENT I – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT II – GETTING HELP IN OTHER LANGUAGES OR FORMATS

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

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

Language	Translated Taglines
1.→ Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2.→ Amharic	የሉምንም ከፍተኛ ብቻን ብቻ ለርዳታና መረጃ የማግኘት መብት አላቸው። ለስተርጓሚ ለንዲቀርብልዎ ከፈለጉ በጤና ጥላን መታወቂያዎት ላይ ባለው ብተጸ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3.→ Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة معرف العضوية الخاصة بخطتك الصحية. (TTY 711) واضغط على 0. الهاتف النصي
4.→ Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր ստորագրված պահանջարկի ծրագրի ինքնուրույն (ID) ստույի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY-711
5.→ Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomeroya ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6.→ Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7.→ Bengali-Bangala	অনুবাদের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আইডি কার্ড এ তালিকাভুক্ত ও কল

	und drücken Sie die 0. TTY-711 □
18. •Greek □	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διορθωμένα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισής, πατήστε 0. TTY-711 □
19. •Gujarati □	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. જુલાધિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY-711 □
20. •Hawaiian □	He pono ke kōkua 'ana aku iā 'oe ma ka maopopo 'ana o kēia 'ike ma loko o kōu 'ōlelo pono 'i me ka uku 'ole 'ana. ✖ E kama 'ilio 'oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki 'ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY-711. □
21. •Hindi □	आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिण के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फोन करें, 0 दबाएं। TTY-711 □
22. •Hmong □	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY-711. □
23. •Ibo □	Inwere ikike inweta enyemaka nakwa imuta asusu gi n'efu n'akwughi ugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekwentị nke di nákwukwọ njinimara gi nke emere maka ahụike gi, pia 0. TTY-711. □
24. •Ilocano □	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY-711 □
25. •Indonesian □	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY-711 □
26. •Italian □	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711 □

Fakatonga	he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe aweweti non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	اب کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 تکیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל צו פארלאנגען א דאלמעטשער, דרופט קארטל, דרוקט ID צום טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן. TTY 711
63. Yoruba	O ní ẹ̀tọ̀ lati ní iranwo àti ifitonilétí gbà ní èdè ẹ̀ lǎìsanwó. Látí bá ògbufo kan sọrọ̀, pè sọrí nọmbà ẹ̀rọ̀ ibánisọrọ̀ lǎìsanwó ibodè tí a tò sọrí kádì idánimọ̀ tí ètò ilera ẹ̀, tẹ 0'. TTY 711

***Inside Back Cover