

7. AUTHORIZATION AND STATEMENT OF ELIGIBLE DEPENDENTS FOR THE HEALTH AND WELFARE PLANS

The health and welfare plans offered by the company give an eligible employee the opportunity to enroll an eligible dependent(s) under the benefits during specific timeframes. To be eligible for Kiewit benefits, a dependent must meet one of the criteria outlined below.

Your lawful spouse (opposite or same sex) from either a licensed marriage, registered common-law marriage or registered domestic partner relationship.

- Registered common-law marriage is defined by each state. For common-law spouse insurance under this plan, you will need to meet the definition of a common-law marriage for the state in which you reside. You must not be legally separated from your spouse, and you **must be registered with a state or local government common-law registry.**
- Registered domestic partner relationship is defined as a relationship with an individual of the same or opposite sex where both partners must: not be so closely related that marriage would otherwise be prohibited; not be legally married to, or the domestic partner of, another person under either statutory or common law; be at least 18 years old; live together and share the common necessities of life; be mentally competent to enter into a contract; and be financially interdependent. You **must be registered with a state or local government domestic partner registry.**

Your or your spouse’s child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian.

- A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO)

An unmarried child aged 26 or over who is or becomes disabled and dependent upon you and was incapacitated prior to the date on which the insurance would have otherwise ended.

If you are enrolling a spouse, registered domestic partner, registered common-law spouse, stepchild, or child of registered domestic partner/common-law spouse, provide the following information:

- Spouse (Legally Married) Registered as Domestic Partner with any state or local domestic partnership registry Registered as Common-Law with any state that recognizes common-law marriage

County of Marriage, Common Law Registration or Domestic Partnership Registration	City of Marriage, Common Law Registration, or Domestic Partnership Registration	State of Marriage, Common Law Registration or Domestic Partnership Registration	Date of Marriage, Common Law Registration or Domestic Partnership Registration

8. AUTHORIZATION AND SIGNATURE (REQUIRED TO AUTHORIZE CHANGES)

I have read the statement in Section 7 and, if applicable, confirm that I have enrolled only eligible dependents in the health and welfare plans. **I understand that if I knowingly file a statement claim containing any misrepresentation or any false, incomplete, or misleading information, it may result in immediate termination of employment.**

I have also read about my benefits choices under the Kiewit Benefits Plan. I authorize the choices I have made and the payroll deductions necessary for those benefits. I understand these choices will remain in effect for the entire calendar year unless I have a change in family status. If I make contributions to Health Care and/or Dependent Day Care Spending Accounts, I understand expenses must be incurred in the same Plan Year deposits are made and any funds left over after the close of the Plan Year will be forfeited.

Employee Signature: _____ Date: _____

<<<Form will NOT be processed without a signature>>>

9. DECLARATION OF TAX DEPENDENT (REGISTERED DOMESTIC PARTNERS ONLY)

I understand that Peter Kiewit Sons’, Inc. (and its subsidiaries) has not provided tax advice to me on this matter, and that I am responsible for consulting with my own tax advisor regarding this matter, including consequences of making this declaration. I have reviewed IRS Publication 501.

Please check the appropriate box below.

I hereby certify that the above named registered domestic partner (and children if applicable) that I am enrolling for health insurance coverage **does** qualify, and I claim them as dependents under IRC Section 152 for the _____ tax year. **I understand that falsely certifying dependency status could result in disciplinary action up to and including termination of employment.** I further agree to notify Peter Kiewit Sons’, Inc. immediately of any change in this tax status.

I hereby certify that the above named registered domestic partner (and children, if applicable) that I am enrolling in health insurance coverage **does not** qualify, and I do not claim them as dependents under IRC Section 152 for the _____ tax year. I understand that the fair market value of group health insurance coverage provided by Peter Kiewit Sons,’ Inc. to cover my domestic partner will be treated as taxable income to me. I further understand that the portion of premiums I pay for this coverage must be paid for on an after-tax basis.

Employee Signature: _____ Date: _____

10. 2026 FLEXIBLE SPENDING ACCOUNTS (FSA) WITH FIDELITY

The Plan Year begins on your insurance effective date through Dec. 31 of the current Plan Year. Any changes in the annual contribution, due to a life event, can only be used from the life event date to Dec. 31 of the current Plan Year. **Funds do NOT carry over from one year to another. Any funds left over in this account after the close of the Plan Year will be forfeited.** You can go to www.netbenefits.com to manage your account online. The contribution amount you elect to put into your FSA will be divided by how many pay periods are remaining in the Plan Year. For more information about this plan, refer to the Flexible Spending Account Summary Plan Description found at www.myjobbenefits.com (password: kiewitbenefits).

A) Health Care FSA

(Available if enrolled in the Traditional Plan or waiving coverage)

I elect \$ _____ as my annual contribution amount
(min \$72, max \$3,300)

I do not want a Health Care FSA

B) Limited Purpose FSA

(Available if enrolled in the Health Savings Plan)

I elect \$ _____ as my annual contribution amount
(min \$72, max \$3,300)

I do not want a Limited Purpose FSA

C) Dependent Care FSA

I elect \$ _____ as my annual contribution amount
(min \$72, max \$7,500)

I do not want a Dependent Day Care FSA

11. HEALTH SAVINGS ACCOUNT (HSA) WITH FIDELITY

Available to employees who enroll in the Health Savings Plan (HDHP) and meet listed eligibility criteria:

- Are covered by an HSA-qualified high-deductible health plan (HDHP) on the first day of a given month.
- You cannot be covered by another health insurance plan that is not a qualified HDHP.
- You cannot currently be enrolled in Medicare benefits.
- Are not eligible to be claimed as a dependent on someone else's tax return.
- Do not have a health care flexible spending account (FSA) or health reimbursement account (HRA). Alternative plan designs, such as a limited-purpose FSA or HRA, might be permitted.

Once the HSA account has been opened with Fidelity, Kiewit will receive notification and can then start the employee and /or employer pretax contributions via payroll deduction and remit those contributions to Fidelity.

For 2026, IRS regulations state you can have total HSA contributions up to \$4,400 if you have individual coverage and \$8,750 if you have family coverage. The IRS also allows you to make an extra catch-up deposit of \$1,000 if you are 55 or older. **Kiewit will contribute money to your HSA on a weekly basis once your account is open and ready for funding. For single coverage is \$9.61 and \$19.23 for employee + dependent coverage. These employer contributions count toward the IRS maximum.**

Weekly Contribution \$ _____ (Must enroll in the Health Savings Medical Plan)

By signing below, you agree to the following:

- I am eligible to open a health savings account. I am a U.S. citizen or tax resident with a valid U.S. Street address, and I am of legal age to enter into an agreement in my state of residence. I request to open a new Fidelity HSA® with Fidelity Brokerage Services LLC ("Fidelity") for which Fidelity Personal Trust Company, FSB will serve as custodian. I understand that this request will be processed as soon as administratively feasible upon Fidelity's receipt of required information. A Fidelity HSA opened through this Simple HSA Service will accept contributions and allow me to request distributions, but will otherwise be restricted, and I will not have the ability to place trades, designate beneficiaries, and indicate my communication preferences, until I go to Fidelity's website and provide additional information that is accepted by Fidelity, and will promptly do so. If I already have or open a non-managed Fidelity HSA prior to Fidelity receiving this request, notwithstanding my election below, my request to open a Fidelity HSA through this Simple HSA Service shall be disregarded. I authorize my employer to disclose information about me to Fidelity as needed to open my account. I have provided my employer with current and accurate information about me and agree to promptly update Fidelity with changes thereto. Fidelity may communicate with me based on this information, including electronically to my employer email address.
- I can access, retain, have read, understand and agree to be bound by these terms and the [Fidelity HSA Documents](#), the [Electronic Delivery Agreement](#) and the [Terms and Conditions](#). I have internet access and a web-browser that is Java-script enabled. I can access documents provided in HyperText Markup Language (HTML), Portable Document Format (PDF) or other compatible formats. If I do not have the ability to access or retain these documents, or do not consent to receive them electronically, I will contact Fidelity at **800-544-3716** for a free paper copy. By proceeding I confirm my device is equipped to access these documents.
- My name, legal address, date of birth, and government issued identification number are required by federal law to verify my identity. Fidelity may not open, or may restrict and/or close my Fidelity HSA if it cannot obtain and verify information to confirm my identity. Fidelity will not be responsible for any losses or damages (including, but not limited to, lost opportunities) that may result if my account is restricted or closed.
- I agree to notify Fidelity if I am or become employed by or associated with a broker-dealer, stock exchange, exchange member firm, the Financial Industry Regulatory Authority (FINRA) or a municipal securities dealer. Absent such notice from me, I represent and warrant to Fidelity that this does not apply. If I am so affiliated, I understand that Fidelity must obtain consent and report my trading activity and other account data to my employer or other affiliated company. I understand that my account will continue to be restricted until such consent is received by Fidelity.
- I agree to notify Fidelity if I am or become, or an immediate family/household member is or becomes, a director, corporate officer, or 10% shareholder of a publicly held company or a control person of a public traded company under SEC Rule 144. Absent such notice from me, I represent and warrant to Fidelity that this does not apply.
- Contributions to my Fidelity HSA will be deposited into the FDIC-Insured Deposit Sweep Program, which will generally sweep funds to one or more Program Banks assigned to this account from the HSA Program Bank List provided in the Fidelity HSA Documents above. I understand that such Program Banks may change between the time I request this account and the HSA is actually opened, and if a Program Bank is not available, my funds may be swept to a money market mutual fund as described in the Fidelity HSA Documents.

I acknowledge that the Fidelity HSA is governed by a pre-dispute arbitration clause, which appears on the last page of the HSA Brokerage Customer Agreement in the Fidelity HSA Documents accessible above, and which I represent having read and agreed to.

Employee Signature: _____ Date: _____

Must sign if enrolling in the Health Savings Medical Plan

12. SUPPLEMENTAL LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

For the purposes of this enrollment form, wherever the term spouse appears, it shall also include registered domestic partner (DP).

A) Supplemental Life Insurance

To qualify for the guaranteed issue amount, you must elect coverage within 31 days of becoming eligible for life insurance or qualifying family status change.

Employee/Spouse Age	Monthly Premiums		
	Employee Monthly Cost Per Unit (1 unit = \$10,000)	Spouse Monthly Cost Per Unit (1 unit = \$5,000)	Child Monthly Cost Per Unit (1 unit = \$2,000)
Under 25	\$0.50	\$0.25	\$0.16
25 to 29	\$0.60	\$0.25	
30 to 34	\$0.80	\$0.25	
35 to 39	\$0.90	\$0.45	
40 to 44	\$1.10	\$0.55	
45 to 49	\$1.80	\$0.90	
50 to 54	\$3.20	\$1.60	
55 to 59	\$4.90	\$2.45	
60 to 64	\$7.90	\$3.95	
65 to 69	\$13.70	\$6.85	
70 & over	\$20.60	\$10.30	

Employee (1 unit = \$10,000)	Spouse (1 unit = \$5,000)	Dependent Child(ren) (1 unit = \$2,000)
The minimum coverage amount is 1 unit and the maximum are 100 units, not to exceed eight times your annual base hourly wage . You can enroll without showing Evidence of Insurability if you elect a coverage amount up to five times your annual base hourly wage, to a maximum of 20 units, anything over that amount would require Evidence of Insurability. <input type="checkbox"/> _____ Units <input type="checkbox"/> Waive	The minimum coverage is 1 unit and the maximum coverage is 50 units, not to exceed one-half of the employee's coverage amounts . You can enroll your spouse without showing Evidence of Insurability if you elect a coverage amounts up to 10 units. Anything over that amount requires Evidence of Insurability. <input type="checkbox"/> _____ Units <input type="checkbox"/> Waive	The dollar amount you indicate will represent the amount for each child. You can elect coverage from 1 unit to 5 units . <input type="checkbox"/> _____ Units <input type="checkbox"/> Waive

B) Supplemental Accidental Death & Dismemberment (AD&D) Insurance

If you select coverage for your family, benefits for family members will be a percentage of yours.

1) How much AD&D coverage do you want? _____ Units (Max of 50 units)	2) Who are you covering? <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family <input type="checkbox"/> Waive	Monthly Premiums (Can elect coverage in increments of 1 unit) 1 unit = \$10,000	
		Employee	Employee and Family
		\$0.26 per 1 unit	\$0.42 per 1 unit

C) Beneficiary(ies)

<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Supplemental AD&D				
	Full Name	Percentage	Address	Relationship
Primary (First in line to receive)				
Contingent (Second in line to receive if primary is unable)				

I will be my family members' beneficiary unless I notify Kiewit otherwise in writing. Benefits will not be paid to my registered domestic partner if he/she is not specifically designated. I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or my family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

Employee Signature: _____ Date: _____

13. VOLUNTARY PROTECTION PLANS

You must elect coverage within 31 days of becoming eligible for the protection plans or qualifying family status change, otherwise you cannot enroll until the next open enrollment period. No one can be a dependent of more than one employee.

A) VOLUNTARY ACCIDENT PROTECTION PLAN (check one box)

<input type="checkbox"/> Employee Only \$9.73/month	<input type="checkbox"/> Employee + Spouse \$15.54/month	<input type="checkbox"/> Employee + Child(ren) \$12.42/month	<input type="checkbox"/> Family \$18.23/month	<input type="checkbox"/> Waive Coverage
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B) VOLUNTARY CRITICAL ILLNESS PROTECTION PLAN

Voluntary Critical Illness Protection Benefit Options			
	Option 1	Option 2*	Option 3*
Employee	\$5,000	\$10,000	\$20,000
Spouse	\$2,500	\$5,000	\$10,000
Child(ren)	\$1,250	\$2,500	\$5,000

*Employee may choose from lower coverage options for spouse and Child(ren)

Employee Monthly Premiums per \$1,000		
Employee Age	Non-Tobacco	Tobacco
Under 25	\$0.22	\$0.25
25 to 29	\$0.31	\$0.34
30 to 34	\$0.39	\$0.46
35 to 39	\$0.52	\$0.68
40 to 44	\$0.72	\$1.06
45 to 49	\$1.20	\$2.24
50 to 54	\$1.83	\$3.24
55 to 59	\$2.63	\$4.80
60 to 64	\$4.08	\$7.99
65 to 69	\$5.67	\$10.99
70 to 74	\$8.26	\$16.99
75 +	\$10.50	\$19.63

Spouse Monthly Premiums per \$1,000		
Spouse Age	Non-Tobacco	Tobacco
Under 25	\$0.21	\$0.22
25 to 29	\$0.29	\$0.32
30 to 34	\$0.38	\$0.43
35 to 39	\$0.53	\$0.63
40 to 44	\$0.79	\$1.02
45 to 49	\$1.17	\$1.69
50 to 54	\$1.60	\$2.54
55 to 59	\$2.14	\$3.70
60 to 64	\$3.04	\$5.63
65 to 69	\$4.36	\$8.46
70 to 74	\$6.01	\$11.19
75 +	\$8.33	\$14.20

Child(ren) Monthly Premiums per \$1,000
\$0.16
The premium amount will represent the amount for each child.

Employee must purchase coverage to purchase on spouse and/or child(ren). **Coverage for spouse and/or children cannot be higher than the employee coverage.** Check the appropriate boxes:

Who are you enrolling in Vol. Critical Illness Plan?	Indicate the protection option you want to buy (1,2, or 3)	Indicate tobacco usage	If you don't want coverage, check waive
Employee	_____ Option	<input type="checkbox"/> Tobacco <input type="checkbox"/> Non-Tobacco	<input type="checkbox"/> Waive Coverage
Spouse	_____ Option	<input type="checkbox"/> Tobacco <input type="checkbox"/> Non-Tobacco	<input type="checkbox"/> Waive Coverage
Dependent child(ren)	_____ Option	N/A	<input type="checkbox"/> Waive Coverage

C) HOSPITAL INDEMNITY PLAN (check one box)

<input type="checkbox"/> Employee Only \$16.42/month	<input type="checkbox"/> Employee + Spouse \$42.72/month	<input type="checkbox"/> Employee + Child(ren) \$33.89/month	<input type="checkbox"/> Family \$64.15/month	<input type="checkbox"/> Waive Coverage
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D) Beneficiary(ies)

<input type="checkbox"/> Accident Plan <input type="checkbox"/> Critical Illness Plan <input type="checkbox"/> Hospital Indemnity Plan				
	Full Name	Percentage	Address	Relationship
Primary (First in line to receive)				
Contingent (Second in line to receive if primary is unable)				

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued. All statements made by me are representations and, not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless it is contained in a written statement signed by me and, a copy of the statement is furnished to me or my beneficiary.

Employee Signature: _____ Date: _____

Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **within 31 days** after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have new dependents because of marriage, birth, adoption or placement for adoption, you may be able to enroll your eligible dependents if you are already enrolled. However, you must request enrollment **within 31 days** after the marriage, birth, adoption or placement for adoption.

If you or your dependents lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible to participate in a Medicaid or CHIP premium assistance program, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment **within 60 days** after your or your dependents' other coverage ends or after becoming eligible for premium assistance.

To request special enrollment or obtain more information, contact the Benefits Department at 855-329-7907 or benefits@kiewit.com

Information Regarding Taxation of Health Benefits for Registered Domestic Partners

If you have a registered domestic partner, the tax treatment of the health insurance coverage that is provided to your domestic partner (or his/her dependent child) depends on whether such individual qualifies as your "dependent" under Section 152 of the Internal Revenue Code. If such individual qualifies as an Internal Revenue Code Section 152 dependent, then the health insurance coverage provided by your employer is not subject to federal income tax. Additionally, your portion of the cost of such coverage can be provided on a pretax basis through your employer's Section 125 plan and claims for expenses not covered by the health insurance can be reimbursed through a health care flexible spending account.

If such individual does not qualify under Section 152, then the value of employer provided health care coverage must be taxed, and premiums for your portion of the cost of the coverage must be paid on an after-tax basis.

A plan can be disqualified if health coverage is paid for on a pretax basis for a domestic partner (or his or her child) that is not a Section 152 dependent of the employee, or if the employer pays the premiums for such health coverage without imputing income to the employee. Generally, to qualify as an IRC Section 152 dependent of an employee during a given tax year, the registered domestic partner (or his or her child, if applicable) must be a "qualifying relative" of the employee. To be a "qualifying relative," the registered domestic partner (or child) must meet the following requirements:

1. Have the same principal place of residence as the employee for the full tax year, except for temporary absences such as vacation, military service or education. Unless the domestic partnership commences precisely on Jan. 1, the registered domestic partner or their child (if applicable) cannot be considered a Section 152 dependent during the first year of the relationship. Similarly, if the Domestic Partnership dissolves other than on Dec. 31, for reasons other than the death of the domestic partner, the tax exclusion is lost for the entire year. If the relationship terminates due to the death of the domestic partner, the domestic partner will continue to be treated as a dependent for the entire tax year.
2. Be a member of the employee's household for the entire calendar year (and the relationship must not violate local law)
3. Receive more than half of his or her support from the employee*
4. Not be the employee's (or anyone else's) "qualifying child" under Code Section 152, and
5. Be a U.S. citizen, U.S. national or resident of the U.S., Canada or Mexico.

*The rules for determining whether the registered domestic partner receives more than half of his or her total support from the employee is complicated and more involved than just determining who the "primary breadwinner" is. Total support includes amounts spent to provide food, lodging, clothing, education, medical and dental care, recreation, transportation, and similar necessities. In IRS Publication 501, the IRS provides a worksheet that can be used to determine whether an individual meets the support test required to be a qualifying relative. This worksheet is available at <http://www.irs.gov/pub/irs-pdf/p501.pdf>.

NOTE: The foregoing information is only general guidance and does not represent tax planning advice to employees. Employees are responsible for consulting with a tax advisor to determine and understand whether the above requirements are met and any other tax planning or consequences relating to this matter.

HOW TO RETURN YOUR COMPLETED AND SIGNED FORMS TO THE BENEFITS DEPARTMENT

• Email to benefits@kiewit.com

• Fax to 402-271-2965

• Mail to Kiewit Corporation – Attn: Benefits
1550 Mike Fahey St., Omaha, NE 68102