EMPLOYER REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a medical expense reimbursement program for you and other eligible employees. Under this program, you will be able to receive reimbursement for the cost of eligible medical, dental or other similar expenses without taxation to you individually. The purpose of this Summary Plan Description is to briefly describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of our Plan is that the cost of all benefits being offered to you within this Plan are entirely paid for by us, the Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

PART A
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information The Kier Corporation Health Reimbursement Arrangement is the name of the Plan.

2. The provisions of your Plan became effective on 1/1/2009, which is called the Effective Date of the Plan.

3. Your Plan’s records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial Plan begins on January 1 and ends on December 31

4. Your Employer has assigned Plan Number 535 to your Plan.

5. Employer Information

Your Employer's name, address, and identification number are:

Kier Construction Corporation
3710 Quincy Ave
Ogden, UT 84403
87-0435003

The Plan shall be governed under the laws of the State of UT.

6. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator is:

Director of Human Resources
3710 Quincy Ave
Ogden, UT 84403
801-627-1414

The Administrator keeps the records for the Plan and is responsible for the Plan. The administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

7. Service of Legal Process

The Administrator is the Plan's agent for service of legal process.

8. Type of Administration

The type of Administration is Employer Administration.

9. Eligibility Requirements.

All Employees are considered eligible to participate in this Plan except:

Employees not eligible under Employer's group Medical Plan.

For purposes of determining continued eligibility under the Plan, **Retirees** shall not be eligible to continue participation in the Plan.

10. Entry Date. The Entry Date for eligible Employees shall be:

Same as Employer's group Medical Plan.

11. Benefits. The Plan shall reimburse Eligible Employees for the cost of Eligible Medical and Dental Expenses (as defined under Internal Revenue Code Section 213 and as further described below), subject to an annual limit of $1750/3500, none of this amount can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred).

Eligible Medical Expenses. The following categories of expenses qualify for reimbursement under the Plan:

X Bridge. Only those expenses that are covered under insurance, but subject to a deductible. Coverage will be provided for out-of-pocket costs of up to $1750/3500 of the total deductible limit.

Benefits under this Plan shall be paid AFTER the employee's portion of the deductible limit is paid.

12. Contributions. Other than for Retiree/COBRA continues, the employer shall make all contributions for this Plan. The employer shall make contributions to the plan in the following manner:

On an annual basis at the beginning of the Plan Year.

For new hires on a pro rata basis, coordinating with employee pay dates, within the Plan Year.

13. Order of Benefit Payments. If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:

Eligible Medical must be paid under the Section 125 Plan before this Plan;

PART B
QUESTIONS & ANSWERS

I-1. What is the purpose of the Plan?

The purpose of the Plan is to provide a source of funds to reimburse you or your dependents that are covered under the Plan for some or all of the uninsured medical and dental expenses you incur in the course of each year while you are employed with the Company and the Plan remains in effect.

I-2. When did the Plan take effect?

Please refer to Part A, "General Information About Our Plan," subsection (2), of this document for a description of the "effective date" for our Plan.

I-3. Who can participate in the Plan?

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the Eligibility Requirements under this Plan. Please refer to Part A, "General Information About Our Plan," subsection (9), of this document for a description of our eligibility requirements.

I-4 Who shall make all of the contributions to the Plan?

As your employer, we will make all of the contributions necessary to fund the Plan. Please refer to Part A. “General Information About Your Plan” of this document for description of our contribution schedule.

I-5. How much of my uninsured medical and dental expenses may be reimbursed each year?

Please refer to Part A, “General Information About Our Plan,” subsection (11), of this document for a description of the “reimbursement amount” for our Plan. To the extent provided for in Part A, all or a portion of any unused amounts remaining at the end of the calendar year may be carried over for use in future periods in which you remain eligible under the Plan.

I-6. How do I become a Participant?

Before you become a member or a “participant” in the Plan, there are certain rules which you must satisfy. First, you must meet the “eligibility requirements.” Please refer to Part A, “General Information About Our Plan” of this document for a description of our eligibility requirements.

Once you have met the eligibility requirements, your entry date will be the first day you met the eligibility requirements.

I-7. How do I receive my benefits under the Plan?

When you incur an eligible medical or dental expense, you must submit a claim reimbursement request to the Plan's Administrator within the time frames specified under Part C, Section 3 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. You may submit a claim for any eligible medical or dental expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit the Company has provided plus any unused carryover amounts from the previous calendar year. If your claim arises while you have COBRA continuation coverage (see Answer I-16), all required premiums for the

coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Company prior to the request for reimbursement of otherwise allowable expenses.

To have your claims processed as soon as possible, please read the *Claims Instructions* that have been furnished to you by the Plan Administrator. Please note that it is *not* necessary that you have actually paid an amount due for an eligible medical or dental expense—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have "incurred" an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

I-8. What is an "eligible expense?"

An "eligible expense" means any expense identified as an Eligible Medical and Dental Expense that is further described under subsection 11 of Part A, "General Information About our Plan" described above. However, you may not submit a claim for an amount that has been deducted on your prior year's personal tax return or that was incurred prior to the time that you became a participant under the Plan, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement. Please review the list of any other eligible medical and dental expenses included with the *Claims Instructions* for assistance in determining what is generally accepted as an "eligible expense."

I-9. When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

I-10. Does the Plan also provide benefits for my family?

The Plan provides reimbursement for expenses incurred for you, your spouse, and any other person you could claim as a dependent on your federal income tax return.

I-11. What happens if my claim for benefits is denied?

You will be notified in writing by the Plan's Administrator within 30 days of the date you submitted your claim if the claim is denied. If you do not receive notification of the denial of a claim within the 30 day period, then if the claim is not otherwise paid, it will be deemed denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will

have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. See Part C, subsection (3), below for more information regarding your rights to appeal any adverse claim determination.

I-12. Does my coverage under this Plan end when my employment terminates?

Generally yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of the earlier of: (1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 90-day period following the close of the Plan Year in which the expense arose. In addition, you and your family will also have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer I-16, below. Under all circumstances, coverage ends upon the earlier of your death or the date the Plan terminates.

I-13. Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave as long as you opt to continue your coverage under the Plan and continue to make any applicable premium contributions that would otherwise be paid by your employer. Upon your return you will be permitted to re-enter the Plan on the same basis that you were participating in prior to taking FMLA leave. However, you will lose coverage when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

I-14. Does my coverage continue while I am absent on duty in the uniformed services?

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth in Answer I-16. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

I-15 Which Plan pays first if I am already enrolled in a Flexible Spending Account?

Please refer to Part A, "General Information About Our Plan" subsection (13) of this document to determine the Order of Benefit Payments option, if we provide the capability for you to participate in a Section 125 "Cafeteria" Flexible Spending Arrangement, in addition to this Plan.

I-16. What is "Continuation Coverage," and how does it work?

"Continuation Coverage" means your right, or your spouse and dependents' right, to continue to be covered under this Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below what is required for participation under this Plan.
- your death.
- divorce or legal separation from your spouse.
- your becoming eligible to receive Medicare benefits.
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notice of these rights that you will receive will explain all the rest of the terms and conditions of the continued coverage.

If you or any of your Eligible Dependents elect to continue coverage under the Plan, you or they will be required to pay premiums for the coverage. The Plan Administrator will inform you of the cost of continued coverage and the schedule for premium payments in the notice that will be sent to you and your Dependents after a Qualifying Event has occurred.

I-17. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

This Plan may be amended or terminated by a written resolution adopted by a majority of the Company's Board of Directors. The Plan will also automatically terminate if the Company (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates

with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

PART C
ADDITIONAL PLAN INFORMATION

1. Plan Accounting

The Plan Administrator shall periodically furnish you with a statement of your medical and dental expense reimbursement account for you to use in determining how much additional benefits remain in your account prior to the end of the Plan Year, which will also assist in budgeting for expense reimbursement needs in future Plan Years. You may also make a written request to receive a copy of your medical and dental expense reimbursement account from the Plan Administrator at any time.

2. Your Rights under ERISA

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

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 Pension and Welfare Benefit Administration.

b) 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 administrator may make a reasonable charge for the copies.

c) 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.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have an affirmative 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 under the Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan 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 Plan Administrator. If you have a claim for benefits that 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 domestic relations order or 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.

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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration, (800) 998-7542.

3. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. For a terminated employee or any Participant who is no longer eligible under the terms of this Plan, claims will still be reimbursed but only if such reimbursement requests are made by the earlier of 1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 90-day period following the close of the Plan Year in which the expense arose. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) The reasons for the denial;
b) Reference to the specific provisions of the Plan on which the denial was based;
c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
d) A description of the Plan's review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary shall have 180 days following the receipt of any notification of Claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the Claim, without deference to the initial denial and after taking into account all comments, information, documents, records and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 30 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

4. Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense Plan under Reg. § 1.105-11, it must comply with the non-discrimination requirements as set forth under § 105(h).

5. Highly Compensated Employees

Under the Internal Revenue Code, if you are deemed to be a "highly compensated employee", the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on "highly compensated employees" will apply. You will be notified of these limitations if you are affected.

6. No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

PART D
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our goal with the Plan is to allow you to have a greater portion of your allowable medical expense costs reimbursed to you without increasing the amount of taxes you pay; thereby increasing the amount of money you keep at the end of each pay period. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Attachment A

* VERY IMPORTANT NOTICE *
(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

INTRODUCTION

A federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

If your employer is subject to COBRA, you, as an employee of that employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

Qualifying Events

1. Termination of employment (for reasons other than gross misconduct.)

2. Involuntary termination of employee.

3. Reduction in hours of employment.

CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE

As a spouse of a covered employee, you have the right to continue coverage under your current health plan(s) if your coverage is lost due to any of the following qualifying events:

Qualifying Events

1. A termination of your spouse's employment (for reasons other than gross misconduct).

2. Reduction in your spouse's hours of employment.

3. The death of your spouse.

4. Divorce or legal separation from your spouse.

5. Your spouse becomes entitled to Medicare.

CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE

As a dependent child of a covered employee, you have the right to continue your current coverage if your coverage is lost due to any of the following qualifying events:

Qualifying Events

1. The termination of an employee parent's employment (for reasons other than gross misconduct).

2. Reduction in an employee parent's hours of employment with his/her current employer.

3. The death of your employee parent.

4. Parent's divorce or legal separation.

5. Employee parent becoming entitled to Medicare.

You cease to be a "dependent child" under the current health plan(s).

NOTIFICATION AND PREMIUMS

Under this law, it is <u>your</u> responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current health plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally appointed guardian is designated. This extension of the time period is referred to as “tolling”.

TERMINATION OF RIGHTS

If you do choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your employer terminates all group health coverage provided to its employees.

2. The premium for your continuation coverage is not paid in full the time prescribed under the Notifications and Premiums section of this notice.

3. You are or become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.

4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

ADDITIONAL INFORMATION

If you have questions about your right to continue coverage under your current health plan(s), please contact your Plan Administrator.

If you change your address, marital status, or become entitled to Medicare or another group health plan while you are covered under the plan, please notify your Plan Administrator.

Qualified Beneficiaries

The term Qualified Beneficiary (Q.B.) refers to individuals who are covered under the employee’s group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee **OR** any child born to, or placed for adoption with the covered employee during the period of continuation coverage.