Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148

IMPORTANT NOTICE

December 2011

To All Plan Participants:

Please read this notice carefully and keep it with your June 1, 2009 Summary Plan Description (SPD) booklet for future reference. If you would like to view or receive future notices electronically, please visit www.lineco.org.

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Benefits for Mental Health and Substance Abuse

Effective January 1, 2012, benefits for mental health and substance abuse services will be paid at the same benefit levels as the Comprehensive Major Medical Program. The new benefit schedule for these types of services starts on page 2 of this notice.

The changes can be summarized as follows:

- Benefits for mental health and substance abuse will be the same as the benefits for medical/surgical treatment.
- Pre-certification by ValueOptions is no longer required for regular outpatient and office visits for mental health/substance abuse treatment. However:
  - ~ You can and should continue to use the ValueOptions Member Assistance Program (MAP) for **FREE** visits and referrals. Remember, you must contact ValueOptions at 1-800-332-2191 before you see a counselor or psychiatrist in order to use your MAP benefits.
  - ~ If you have ValueOptions provide referrals for your outpatient/office treatment, you can be sure you receive the higher in-network benefits.
  - ~ Once you are in treatment, ValueOptions will work with your provider to assure that the plan of care is appropriate and medically necessary.

  Precertification by ValueOptions *will still be required* for inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy. Call 1-(800)-332-2191 to precertify.
- The PPO network for mental health and substance abuse—the ValueOptions network—is not changing. Although ValueOptions providers may also be in the Blue Cross Blue Shield network, the PPO level of benefits will only be paid for mental health and substance abuse treatment in the ValueOptions network.

Note: ValueOptions is the professional organization that provides Lineco's mental health provider network, serves as Lineco's mental health case manager and review organization, and manages Lineco's Member Assistance Program.

SCHEDULE OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Mental Health (Mental/Nervous Disorders)		
	Current Benefits	**Benefits as of January 1, 2012**
PPO Network	ValueOptions provider network	ValueOptions provider network
Calendar Year Deductibles	• $250/person • $500/family Applies to non-PPO providers only.	*All treatment subject to regular major medical deductibles—$300/person, $600/family.*
Emergency Room Deductible	n/a	*$50*
Inpatient	• 45 days per year • 80%	• *No day limits* • *80% PPO/70% non-PPO*
Partial Inpatient (Day Care)	• 75 days per year • 80%	• *No day limits* • *80% PPO/70% non-PPO*
Outpatient		
First 8 Visits	• 90% PPO • 80% non-PPO	• *80% PPO* • *70% non-PPO*
Subsequent Visits	• 90% PPO • 50% non-PPO	• *80% PPO* • *70% non-PPO*
Out-of-Pocket Limit	Coinsurance does NOT apply to out-of-pocket limit.	*Coinsurance applies to out-of-pocket limit.*
Precertification Requirement	• inpatient • residential • partial inpatient/intensive outpatient • outpatient • psychological testing • electroconvulsive therapy	• inpatient • residential • partial inpatient/intensive outpatient • psychological testing • electroconvulsive therapy
Precertification Non-Compliance Penalty	No payment unless precertified by ValueOptions. Plan may deny benefits for ANY treatment that is not determined to be medically necessary.	*Same as medical—$250 additional deductible for failure to precertify inpatient hospital treatment.* Plan may deny benefits for ANY treatment that is not determined to be medically necessary.
Provider Credentials	• PPO—credentialed and participating with ValueOptions • Non-PPO—licensed MD, DO or clinical psychologist (All ValueOptions PPO providers are covered, including Masters-level mental health providers such as social workers and counselors. Masters-level non-PPO providers are not covered.)	• PPO—credentialed and participating with ValueOptions • Non-PPO—licensed MD, DO or clinical psychologist (All ValueOptions PPO providers are covered, including Masters-level mental health providers such as social workers and counselors. Masters-level non-PPO providers are not covered.)

Substance Abuse		
	Current Benefits	**Benefits as of January 1, 2012**
PPO Network	ValueOptions provider network	ValueOptions provider network
Calendar Year Deductibles	$250/person for non-PPO providers only.	*All treatment subject to regular major medical deductibles—$300/person, $600/family.*

(continued on next page)

	Current Benefits	Benefits as of January 1, 2012
Emergency Room Deductible	n/a	*$50*
Inpatient	• Two 21-day confinements lifetime. • Treatment program must be completed or no benefits are payable. • 80% • No disability benefits will be paid for non-completed program.	• *No limit on days or confinements.* • *Plan may cover incomplete treatment program but only if it is medically necessary and appropriate.* • *80% PPO • 70% non-PPO* • No disability benefits will be paid for non-completed program.
Intensive Outpatient	• 45 days per year • 90% PPO • 80% non-PPO	• *No days limit* • *80% PPO • 70% non-PPO*
Outpatient	• 90% PPO • 80% non-PPO	• *80% PPO • 70% non-PPO*
Out-of-Pocket Limit	Coinsurance does NOT apply to out-of-pocket limit.	*Coinsurance applies to out-of-pocket limit.*
Precertification Requirement	• inpatient • residential • partial inpatient/intensive outpatient • outpatient treatment • electroconvulsive therapy	• inpatient • residential • partial inpatient/intensive outpatient • psychological testing • electroconvulsive therapy
Precertification Non-Compliance Penalty	No payment unless precertified by ValueOptions. Plan may deny benefits for ANY treatment that is not determined to be medically necessary.	*Same as medical—$250 additional deductible for failure to precertify inpatient hospital treatment.* Plan may deny benefits for ANY treatment that is not determined to be medically necessary.
Provider Credentials	See Mental Health section above.	See Mental Health section above.
Acute Drug/Alcohol Usage	Excluded	*Covered if medically necessary.*

What Isn't Changing - All benefits remain subject to the following limitations and Plan provisions:

- medical necessity,
- reasonable and customary fee limits,
- the annual dollar limit that applies to all medical expenses,
- the provider network, which is the ValueOptions network, not the Blue Cross Blue Shield network,
- covered provider requirements, and
- general Plan exclusions and provisions—see the Summary Plan Description booklet for details.

Important Reminder

Inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy REQUIRE pre-certification by ValueOptions.

In addition, ValueOptions will continue to provide Lineco's Member Assistance Program (MAP). You can access the MAP 24 hours per day, 365 days per year. Up to six face-to-face visits with a professional MAP counselor are provided at no cost to you. Call 1-(800)-332-2191 to access the MAP.

Autism Assistance Benefit

Effective January 1, 2012 Lineco will provide benefits for early detection and treatment of autism. The new benefits are designed to help reduce some of the costs incurred by parents of pre-school children with autism spectrum disorders.

Benefits will now be payable for the following services provided to **children from birth thru 5 years of age** who are diagnosed with an autism spectrum disorder:

- Diagnosis and screening by a medical doctor (M.D. or D.O.) or psychologist. The Plan will also cover these services when provided by a Masters-level licensed behavioral health specialist participating in the ValueOptions network;
- Physical therapy by a licensed physical therapist, when ordered by an M.D., D.O. or psychologist;
- Occupational therapy by a licensed occupational therapist, when ordered by an M.D., D.O. or psychologist;
- Speech therapy by a licensed speech or language therapist, when ordered by an M.D., D.O. or psychologist; and
- Office visits, therapy and counseling provided by when ordered by an M.D., D.O. or psychologist. The Plan will also cover these services when provided by a Masters-level licensed behavioral health specialist participating in the ValueOptions network.

Covered expenses will be paid under the regular Comprehensive Benefit (major medical) provisions, subject to deductibles and coinsurance. Covered speech therapy for autism will not be subject to the regular $90-per-visit and 50-visits-per-year limits. However, all out-of-network services will be subject to usual and customary fee limits, and all services must be medically necessary.

Lineco will NOT cover Applied Behavior Analysis or similar programs, or any inpatient, partial inpatient, residential, in-home or intensive therapies. Lineco also excludes experimental and/or investigative strategies, such as dietary therapy, pet therapy, family counseling, and non-medically necessary services. ***Having the proposed treatment plan reviewed in advance by ValueOptions is strongly recommended so that you do not incur expenses for treatment that is not covered.***

The treatment can be for the autism spectrum disorder itself or for a related physical, mental health or behavioral health condition. For the purpose of this Plan, "autism spectrum disorder" means autistic disorder, Asperger's syndrome and pervasive developmental disorders not otherwise specified. It excludes childhood disintegrative disorder and Rett's syndrome.

Expanded Speech Therapy Benefits for Children

Lineco's speech therapy benefits are being expanded effective January 1, 2012. Lineco will now cover speech therapy for children for congenital medical defects and acute diseases, including hearing deficits caused by specifically diagnosed illnesses, cerebral palsy, and neurological disorders.

Before this Plan change, speech therapy benefits were only payable if the patient had normal speech and lost it as a result of sickness or accidental injury, or as required for a child after repair of a cleft palate. Speech therapy for a child for any other diagnosis was not covered.

Covered speech therapy expenses include up to 50 visits per calendar year, with a maximum allowable amount of $90 per visit. Allowable expenses are subject to the deductible and coinsurance. The services must be prescribed by a medical doctor and rendered by a qualified speech therapist.

Note: Speech therapy for autism is covered under the Autism Assistance Benefit described above.

The Plan will continue to exclude speech therapy for other developmental delays, attention disorders, behavioral problems, psychosocial delays, verbal apraxia, or stuttering or stammering unless due to a specific disease or injury.

Bariatric Surgery by Non-PPO Surgeon is Excluded

Effective January 1, 2012, bariatric (obesity) surgery will only be covered when performed by a PPO surgeon. The Plan already requires that the procedure be performed at a PPO hospital.

Lineco's other coverage requirements remain the same. In addition to the requirement that the procedure be performed by a PPO surgeon at a PPO hospital, bariatric surgery will only be covered if:

1. The patient is at least 100 pounds over his medically desirable weight and has a Body Mass Index of at least 40;
2. The obesity is a threat to the individual's life due to the existence of complicating health factors; and
3. During the twelve-month period prior to the proposed surgery, the patient must have a documented history of at least 6 continuous months of physician-assisted attempts to reduce weight by more conservative measures (there must be at least 7 office visits: the initial visit plus one monthly visit for 6 months during the 12-month period prior to the proposed surgery); and
4. The patient has obtained prior authorization from the Fund Office.

If Your Doctor Opts Out of Medicare

A physician who opts out of Medicare is only permitted to see Medicare patients if the patient signs an agreement saying he will be responsible for paying the provider's bills.

When Lineco is secondary to Medicare, and the physician providing the service has opted out of the Medicare system, this Plan will coordinate its benefits the same *as if* the provider had *not* opted out. This means you will be responsible for the 80% that Medicare would have paid. You will also be responsible for any amounts over and above the Medicare allowable amount. Your total out-of-pocket costs could be substantial. This rule will not apply to pathologists, anesthesiologists, radiologists or, emergency medicine physicians. This provision is effective January 1, 2012. Medicare-eligible participants should always verify that their physicians accept Medicare assignment.

Other Plan Changes and Clarifications

- **The Routine Exam and Diagnostic X-Ray and Lab (DXL) Benefits** were reinstated effective January 1, 2011. These benefits are described in your Summary Plan Description (SPD) booklet.
- **The following changes and clarifications apply to the Preventive Care Benefit:**

  Oral fluoride treatment is covered for children age 6 months through age 5 (not 15) whose water supply is fluoride-deficient. As before, a doctor's or dentist's prescription is required.

  If a pharmacy product is covered under the Preventive Care Benefit (aspirin, iron supplements, folic acid and oral fluoride are covered in certain circumstances), only the generic, non-compounded versions of the product will be covered.

  These clarifications were effective January 1, 2011.

- **Annual Dollar Limits** - The maximum benefit payable under the Comprehensive Major Medical Expense Benefit will be $1,250,000 for expenses incurred during 2012.

- **When an Adult Child Has Other Coverage** - The Plan has a set of rules that regulate how its benefits will be paid when a claim is submitted for an eligible individual who is also covered under another health plan. The following provision is being added to those rules effective January 1, 2011:

  > If an eligible child is employed and/or married, the plan covering the child as an employee will pay first, the plan covering the child as a spouse will pay second, and the plan covering the child as a dependent child will pay third.

  When a plan pays first, it pays its full benefits. When a plan pays second, it reduces its benefits so that the total paid by both plans does not exceed 100% of the allowable expenses on the claim. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.

- **Disabled Children Over Age 26 Must Be Unmarried.** The Plan has a rule extending eligibility beyond the limiting age of 26 for an adult child who is disabled because of mental retardation, mental incapacity or physical handicap. Please note that coverage will only be extended for an *unmarried* adult child. This is not a Plan change—the requirement that the child be unmarried was inadvertently omitted from a prior notice.

NOTICE ABOUT WALGREENS AND EXPRESS SCRIPTS

At the time this notice was prepared, Walgreens and Express Scripts, Lineco's prescription benefit manager, were engaged in a contract dispute. If their dispute is not resolved before the end of the year, Walgreens will not be in the Express Script's network as of January 1, 2012. Participants who utilize Walgreens for prescriptions should consider an alternative pharmacy so they do not incur higher out of pocket prescription costs. Visit www.express-scripts.com for more information on locating a participating pharmacy.

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NOTICES REQUIRED BY FEDERAL LAW

Reminder About Coverage for Breast Reconstruction

Lineco will consider charges for the following services and supplies to be covered medical expenses when the charges are incurred by a covered person who is receiving Plan benefits for a mastectomy, and when the person elects (in consultation with her physician) breast reconstruction in connection with the mastectomy: 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications relating to all stages of the mastectomy, including lymphedemas. Plan benefits payable for these services and supplies are subject to the deductibles, co-payment percentages and maximum benefit limitations applicable to covered services for other covered medical conditions.

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family mem-

bers of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

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The following notice applies to individuals who are required to pay premiums in order to be covered by an employer-sponsored health plan. The information in this notice will NOT be relevant to most Lineco participants because Lineco participants do not pay premiums directly to Lineco for coverage. Nevertheless, federal regulations require all employers in the states listed in the table starting below to issue the notice. Lineco is simply sending this notice on behalf of its participating employers.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	**MISSOURI** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	

NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

SUMMARY ANNUAL REPORT FOR
LINE CONSTRUCTION BENEFIT FUND

This is a summary annual report of the Line Construction Benefit Fund, EIN 36-6066988, Plan No. 501 for the year ended December 31, 2010. The annual report has been filed with the Employee Benefit Security Administration as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Line Construction Benefit Fund has committed themselves to pay all benefits other than life insurance and temporary disability claims incurred under the terms of the plan.

Insurance Information

The plan has a group contract with the Trustmark Life Insurance Company to pay certain life insurance and temporary disability claims incurred under the terms of the plan. The total premiums paid for the policy year ending December 31, 2010 were $1,380,288.

Basic Financial Statements

The value of plan assets, after subtracting liabilities of the plan was $495,441,402 as of December 31, 2010, compared to $435,916,957 as of January 1, 2010. During the plan year the plan experienced an increase in its net assets of $59,524,445. During the plan year, the plan had total income of $281,477,547, including (but not limited to) employer contributions of $223,957,881, participant contributions of $14,453,662, realized gains of $1,576,309 from the sale of assets and earnings from investments of $36,840,138. Plan expenses were $221,953,102. These expenses included $7,437,004 in administrative expenses and $214,516,098 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, upon request. The items listed below are included in that report:

an accountant's report;
financial information and information on payments to service providers;
assets held for investment;
insurance information including sales commissions paid by insurance carriers;
transactions in excess of 5 percent of plan assets; and
information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Line Construction Benefit Fund who is plan sponsor, at 2000 Springer Drive, Lombard, IL 60148, (800) 323-7268. The charge to cover copying costs will be $.25 per page. You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes or a statement of income and expenses of the plan and accompanying notes or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan at 2000 Springer Drive, Lombard, IL 60148 and the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department of Labor should be addressed to: Public Disclosure Room, N1513, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.