Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148

IMPORTANT NOTICE

December 2010

To All Plan Participants:

The Trustees of the Line Construction Benefit Fund have adopted the following Plan changes, most of which are **effective January 1, 2011.** Many of these changes represent significant Plan enhancements. Please read this notice carefully and keep it with your June 1, 2009 Summary Plan Description (SPD) booklet for future reference.

AGE LIMIT FOR CHILDREN INCREASED
CHANGE TO DEFINITION OF DEPENDENT

The Plan's definition of an eligible dependent child is changing as follows effective January 1, 2011:

- The Plan will now cover your children through age 25 (coverage terminates on the child's 26th birthday).
- Children are not required to be students.
- If your child meets the definition of "child" below, the child's residence, financial dependence and marital status do not affect eligibility.

You do NOT have to re-enroll a child who was previously covered but who lost eligibility due to the prior age limit. If however, you want to add a child who was not previously covered, you can download a Family Enrollment Form at www.lineco.org and submit it to the Fund Office along with a copy of the child's birth certificate. Or call the Fund Office and they will mail you a Family Enrollment Form. If the child was not born of your current marriage, you will need to submit copies of the divorce decree and/or any pertinent court document.

NEW DEFINITION OF 'DEPENDENT' - Because of the changes described above, the Plan's definition of "dependent" has been restated effective January 1, 2011 to read as follows:

Dependent

1. A person who is your (employee's or retiree's) spouse, provided she is not legally separated from you. A certified copy of your marriage certificate must be on file at the Fund Office before claims for your spouse can be processed. If your spouse is a full-time active member of the military or armed forces of any country, she won't be considered a dependent under this Plan.

2. A person who is your (employee's or retiree's) child (see "Definition of Child" below):
   a. Who is less than 26 years old; or
   b. Who is 26 or older and who is disabled because of mental retardation, mental incapacity or physical handicap. The child must have become disabled before becoming age 26; must remain disabled and be incapable of self-sustaining employment; and must be dependent on you

for the major portion of his support. When the first claim is filed for the child, you must furnish proof that he became disabled before he became 26. You must furnish the proof at your own expense except that, if the Trustees require a physical examination, the Plan will pay for it. If the Trustees request proof of the child's disability in the future, you must furnish the proof or the child's coverage will terminate.

Definition of Child - For purposes of this definition, a child means any of the following:

1. A natural child of yours.
2. Any child legally adopted by you or placed in your home for adoption.
3. A stepchild of yours, meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to your spouse.
4. A child who is determined to be an alternate recipient under the terms of a court order which the Trustees determine to be a Qualified Medical Child Support Order. A copy of the court order will be required by the Fund Office before claims for the child will be considered for payment. You can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Fund Office.
5. A foster child who was placed in your home by a state or private social service agency.

The Plan will also cover your or your spouse's grandchild, sibling, nephew or niece under age 19, provided you have an order of guardianship or custody, and the child lives in a parent-child relationship with you, and is dependent on you for the major portion of his support. Coverage can be continued after age 19 if he is and remains a registered full-time student in an accredited secondary school, college, university, vocational or technical school, and remains dependent upon you for the major portion of his financial support. Proof of full-time student status for each school term must be submitted to the Fund Office before the child will be covered. Coverage will terminate when your grandchild, sibling, nephew or niece reaches age 25 or ceases to be a full-time student, whichever occurs first.

If a child is a full-time active member of the military or armed forces of any country, the child is not considered a dependent under this Plan.

Any child born of a covered person acting as a surrogate mother, that is, a female who became pregnant with the intent or understanding of relinquishing the child following the child's birth, will not be considered a dependent of the surrogate mother or her spouse.

CERTAIN DOLLAR LIMITS REMOVED

The Plan's $2,000,000 lifetime maximum under the Comprehensive Major Medical Expense Benefit is being removed effective January 1, 2011. The $1,000,000 annual maximum will remain in effect during 2011.

The annual dollar limit for outpatient substance abuse treatment is also being removed.

NEW PREVENTIVE CARE BENEFIT

Increased Coverage for Preventive Care

A new comprehensive preventive care benefit is being added to the Plan effective January 1, 2011. **Benefits for covered preventive services will be paid at 100% when you use a Blue Cross Blue Shield (BCBS) PPO provider and at 70% if you use an out-of-network (non-PPO) provider.** No

deductible will apply to PPO expenses, but the calendar year deductible will apply to non-PPO expenses. (To find a BCBS PPO provider, go to www.bcbsil.com, or call 1-800-810 Blue (2583)).

Immunizations for children under age 19 will be paid at 100% with no deductible whether or not a PPO provider is billing for the service. The $1,000 limit will no longer apply.

- ➡ If you obtain a covered immunization at a participating Express Scripts (ESI) pharmacy, there will be no cost to you and no claims to file if you first show the pharmacist your ESI card. Most major pharmacy chains are in the ESI network. If you need additional information about participating ESI pharmacies, call 1-877-327-0568 or go to www.express-scripts.com.

The pharmacy products that are included in the list of covered preventive care expenses (folic acid supplements, oral fluoride, aspirin, and iron supplements) will be paid at 100%. (Also see the (*) note on page 5.)

This new preventive care benefit replaces the current Routine Physical Exam Benefit, and the current benefit for colorectal cancer screenings. Benefits for physical exams and colonoscopies will be covered when they meet the criteria in the list below. Benefits will be paid at 100% if you use a BCBS PPO provider, and at 70% after the deductible if you use an out-of-network provider.

Lab and x-ray charges related to covered preventive care (which are currently covered under the Diagnostic X-Ray and Lab (DXL) Benefit will also be covered under the new benefit. (Preventive/routine lab and x-ray will no longer be covered under the DXL Benefit.)

In addition, since the new benefit provides comprehensive coverage for well-child care, the $500 well-child care benefit for Prenatal Care Program participants is being discontinued.

The list of included services is shown below and is subject to change.

PREVENTIVE CARE BENEFIT

<table>
<tr><th colspan="2">A. IMMUNIZATIONS
PPO (or Express Scripts Participating Pharmacy)= 100% no deductible
Non-PPO = 70% after deductible
100% for children 0-18 (PPO and non-PPO)</th></tr>
<tr><th>Covered Immunization</th><th>Frequency</th></tr>
<tr><td>1. Hepatitis B (HepB)</td><td rowspan="13">as recommended by the Advisory Committee on Immunization Practices (ACIP) and that have been adopted by the Director of the Centers for Disease Control and Prevention, including:
• Recommended Immunization Schedule for Persons Aged 0 Through 6 Years
• Recommended Immunization Schedule for Persons Aged 7 Through 18 Years
• Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind
• Recommended Adult Immunization Schedule</td></tr>
<tr><td>2. Rotavirus (RV)</td></tr>
<tr><td>3. Diphtheria, tetanus and pertussis (DTaP)</td></tr>
<tr><td>4. Influenza type B (Hib)</td></tr>
<tr><td>5. Pneumococcal (PCV/PPSV)</td></tr>
<tr><td>6. Polio (IPV)</td></tr>
<tr><td>7. Influenza (seasonal)</td></tr>
<tr><td>8. Measles, mumps & rubella (MMR)</td></tr>
<tr><td>9. Varicella</td></tr>
<tr><td>10. Hepatitis A (HepA)</td></tr>
<tr><td>11. Meningococcal (MCV)</td></tr>
<tr><td>12. Human papillomavirus (HPV)</td></tr>
<tr><td>13. Zoster (shingles)</td></tr>
</table>

B. ADULT PREVENTIVE CARE/SCREENINGS PPO = 100% no deductible Non-PPO = 70% after deductible	
Covered Service or Supply	**Frequency**
1. Ultrasound screening for abdominal aortic aneurysm (men age 65-75 who smoke(d))	one per lifetime
2. Counseling for alcohol misuse (adults)	one session per lifetime
3. Aspirin to prevent cardiovascular disease (men age 45-79; women age 55-79), when prescribed by physician	covered based on physician's recommendations*
4. Counseling for BRCA screening (women with a family history of BRCA 1 or BRCA 2 risk factors)	one session per lifetime
5. Counseling about chemoprevention of breast cancer (women at high risk)	one session per lifetime
6. Screening for high blood pressure (adults age 18+)	one per calendar year
7. Mammograms (women age 40+)	one per calendar year
8. Screening for cervical cancer	one per calendar year
9. Folic acid supplements (women capable of pregnancy)	0.4 to 0.8 mg (400-800 µg) per day* (employees and spouses only)
10. Screening for cholesterol abnormalities (men age 35+, or age 20+ if increased risk; women age 45+, or age 20+ if increased risk)	one per calendar year
11. Screening for depression (adults)	one per lifetime
12. Screening for diabetes (adults with blood pressure greater than 135/80)	one per calendar year
13. Counseling for diet (adults at increased risk for diet-related chronic disease)	one session per lifetime
14. Screening for gonorrhea (women at increased risk)	one per calendar year
15. Screening for syphilis (persons at increased risk)	one per calendar year
16. Screening for HIV (adults)	one per lifetime unless patient is at increased risk for HIV infection
17. Screening for chlamydial infection (women age ≤24 or at increased risk)	one per calendar year
18. Counseling for sexually transmitted infections (adults at increased risk)	one session per lifetime
19. Screening and counseling for obesity (adults)	one session per lifetime
20. Screening for osteoporosis (women age 65; age 60 if increased risk of osteoporotic fractures)	one per lifetime
21. Counseling for tobacco use (adults)	one session per lifetime
22. Screening for colorectal cancer (adults age 50-75) - tests and procedures within the age and frequency guidelines established by the American Cancer Society (which recommends that persons at average risk should have an initial colonoscopy at age 50), including colorectal exams, flexible sigmoidoscopies, barium enemas, and colonoscopies.	
23. Routine physical examination (professional fee)	one per calendar year

C. PEDIATRIC PREVENTIVE CARE/SCREENINGS (NEWBORN - AGE 21 YEARS) PPO = 100% no deductible Non-PPO = 70% after deductible	
Covered Service or Supply	**Frequency**
1. Newborn screenings for hemoglobinopathies, hearing loss, hypothyroidism, phenylketonuria(PKU), and heritable disorders (as recommended by the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children that went into effect May 21, 2010)	one per lifetime
2. Prophylactic medication for gonorrhea	one per lifetime

3. Health history	as recommended by the American Academy of Pediatrics and Bright Futures
4. Measurements, including height, weight, BMI, blood pressure, etc.	
5. Sensory (vision and hearing) screening	
6. Developmental screening	
7. Autism screening	
8. Behavioral assessment	
9. Alcohol/drug assessment	
10. Physician examination	
11. Metabolic screening	
12. Hemoglobin screening	
13. Lead screening	
14. Dyslipidemia screening	
15. STI screening	
16. Cervical dysplasia screening	
17. Oral health risk assessment	
18. Anticipatory guidance	
19. Iron supplements (children age 6-12 months at increased risk for anemia)	as prescribed by child's physician*
20. Screening for visual acuity (children <5 years)	one per calendar year
21. Screening and counseling for obesity (children age 6+)	one per lifetime
22. Oral fluoride (children 6 months+ if water source deficient in fluoride)	as prescribed through age 15*
23. Screening for depression (children age 12-18)	one per lifetime
24. Counseling for sexually transmitted infections (children at increased risk)	one session per lifetime
25. Screening for HIV (children age 11-21 at increased risk)	one per lifetime

* *A written doctor's prescription is required. A dentist's prescription is acceptable for oral fluoride. Only generic products will be covered unless a generic substitute is not available. You can obtain these products for a $0 co-pay at an Express Scripts (ESI) participating pharmacy using your ESI drug card. There are no claims to file if you obtain these products at an ESI pharmacy. You may also file a paper claim to Lineco. Your claim must include a copy of the doctor's prescription and an itemized pharmacy bill. Cash register receipts alone will not be accepted.*

The services covered under this new benefit are based on the following recommendations and are subject to change:

- Items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

EMERGENCY TREATMENT

Effective January 1, 2011, hospital emergency room services provided by a non-PPO hospital (a hospital that is not in the Blue Cross Blue Shield PPO network) will be paid at the PPO payment percentage if the treatment was sought due to an emergency. An "emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably

expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

NO PREEXISTING CONDITION LIMITATION FOR CHILDREN

The Plan's preexisting condition limitation for foster children is being eliminated effective January 1, 2011.

SPECIALTY DRUG STEP THERAPY PROGRAM

The Express Scripts' Specialty Step Management Program has been added to your prescription drug plan effective October 4, 2010.

"Step therapy" is used to guide a patient with a chronic condition to a less costly medication (called a "step one" drug), if appropriate, before he tries a more expensive drug (called a "step two" drug). The goal is to ensure that the patient receives an appropriate medication for his condition. Since an appropriate drug is not always the most costly, step therapy can also help reduce costs.

This program affects four categories of specialty drugs:

Erythroid stimulants	Epogen, Arenesp
Growth hormones	Genotropin, Humatrope, Nutropin/AQ, Tev-Tropin, Norditropin/Norfles, Omnitrope, Saizen
Multiple sclerosis	Extavia, Avonex
Inflammatory conditions	Simponi, Cimzia, Kineret, Amevive, Stelara, Rituxan, Remicade, Orencia, Actemra

Only patients who are newly prescribed medications in these categories will be affected.

Express Scripts will mail affected participants more information about the Specialty Step Management Program.

Please note that Lineco requires many specialty drugs to be ordered through Curascript, the Express Scripts specialty pharmacy.

NEW APPEALS PROCEDURES

The following changes will apply to Lineco's claim appeal procedures effective January 1, 2011:

1. If you appeal the denial of a claim to the Claim Review Committee, the Plan will provide you with all new evidence relied upon or considered by the Plan in connection with the appeal. (This will generally apply to appeals involving medical judgments. For those types of appeals, the "new evidence" would be the written medical judgment provided by the independent health care professional who reviews your appeal.)

2. **External Review -** If you appeal to the Claim Review Committee but the review process still results in an adverse benefit determination, you may, in certain cases, request an additional review by an independent review organization (IRO). An independent external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity. It does not apply to claim denials related to a person's eligibility for coverage.

   You must apply for the external review within four months after the date of receipt of the written appeal decision you received from the Fund. To request an external review, call or write the Fund

Office. Fund Office staff will provide you with the information you need to file your formal request for an external review and provide you with the information you need to complete the process.

You may apply for an expedited external review if the claim involves a medical condition for which the regular timeframe for completion of an appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility. To request an external review, call or write the Fund Office. Fund Office staff will provide you with the information you need to complete the process.

OTHER PLAN CHANGES

1. Divorced or legally separated spouses of retirees can make COBRA self-payments for the lesser of 36 months or until the spouse attains age 65. This Plan change was effective July 1, 2010.

2. Effective May 1, 2010 for Weekly Income Benefits, the rule requiring that the employee see a doctor within 15 days after the last day the employee worked for a contributing employer is eliminated.

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• Summary of Material Modifications • EIN: 36-6066988 PN: 501 • c106/smm2010-1

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NOTICES REQUIRED BY FEDERAL LAW

Notice Regarding Removal of Lifetime Limit

The lifetime limit on the dollar value of medical benefits under the Line Construction Benefit Fund no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Fund Office. Contact information is shown at the top of page 1 of this notice.

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 their 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.

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 regula-

tions require all employers in the states listed in the table starting below to issue the notice. Lineco is merely 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 September 1, 2010. 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: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	
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: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml Telephone: 1-800-694-3084

IDAHO – Medicaid and CHIP	**NEBRASKA** – 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://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479 **IOWA** – Medicaid 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	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/ MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 **LOUISIANA** – Medicaid 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	**NEW MEXICO** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557 **MASSACHUSETTS** – 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	**NEW YORK** – 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	Website: http://www.nyhealth.gov/health_care/ medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
site: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	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

PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, 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
http:///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, 2009. 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 total and permanent 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 total and permanent disability claims incurred under the terms of the plan. The total premiums paid for the policy year ending December 31, 2009 were $1,963,778.

Basic Financial Statements

The value of plan assets, after subtracting liabilities of the plan was $435,916,957 as of December 31, 2009, compared to $366,504,346 as of January 1, 2009. During the plan year the plan experienced an increase in its net assets of $69,412,611. During the plan year, the plan had total income of $292,830,707, including (but not limited to) employer contributions of $223,958,495, participant contributions of $11,802,714, realized gains of $3,459,505 from the sale of assets and earnings from investments of $49,454,692. Plan expenses were $223,418,096. These expenses included $8,099,208 in administrative expenses and $215,318,888 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, and 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 $38.25 for the full annual report or $.25 per page for any part thereof. 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. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

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.