

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A** This return/report is for:
  - a multiemployer plan
  - a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
  - a single-employer plan
  - a DFE (specify) \_\_\_\_\_
- B** This return/report is:
  - the first return/report
  - the final return/report
  - an amended return/report
  - a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. . . . . ▶
- D** Check box if filing under:
  - Form 5558
  - automatic extension
  - the DFVC program
  - special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan <u>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</u>	<b>1b</b> Three-digit plan number (PN) ▶ <u>001</u>
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</u>  <u>700 TOWER DRIVE</u> <u>SUITE 300</u> <u>TROY, MI 48098</u>	<b>1c</b> Effective date of plan <u>01/01/1993</u>  <b>2b</b> Employer Identification Number (EIN) <u>38-3031916</u>  <b>2c</b> Plan Sponsor's telephone number <u>248-813-9800</u>  <b>2d</b> Business code (see instructions) <u>238220</u>

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/13/2025	CHRISTOPHER M. SCOTT, CPAPFS, MST
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/13/2025	CHRISTOPHER M. SCOTT, CPAPFS, MST
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor  BENESYS INC DARRIS GAROUFALIS 700 TOWER DRIVE SUITE 300 TROY, MI 48098-2808		<b>3b</b> Administrator's EIN 38-2383171
		<b>3c</b> Administrator's telephone number 248-813-9800
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name		<b>4b</b> EIN  <b>4d</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	2515
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).		
<b>6a(1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	814
<b>6a(2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	772
<b>b</b> Retired or separated participants receiving benefits.....	<b>6b</b>	923
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	355
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....	<b>6d</b>	2050
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....	<b>6e</b>	412
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....	<b>6f</b>	2462
<b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>	
<b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	86

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  
1A 1C

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<b>a Pension Schedules</b>		<b>b General Schedules</b>	
(1) <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)	
(2) <input checked="" type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)	
(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached _____	
(4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____		(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)	
(5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)		(5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)	
		(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)	

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**Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)**

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**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) .....  Yes  No

If "Yes" is checked, complete lines 11b and 11c.

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**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) .....  Yes  No

**11c** Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

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<b>SCHEDULE MB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500 or 5500-SF.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

▶ **Round off amounts to nearest dollar.**  
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</u>	<b>B</b> Three-digit plan number (PN) ▶ <u>001</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</u>	<b>D</b> Employer Identification Number (EIN) <u>38-3031916</u>

**E** Type of plan: (1)  Multiemployer Defined Benefit (2)  Money Purchase (see instructions)

**1a** Enter the valuation date: Month 01 Day 01 Year 2024

<b>b</b> Assets	
(1) Current value of assets .....	<b>1b(1)</b> <u>257388418</u>
(2) Actuarial value of assets for funding standard account .....	<b>1b(2)</b> <u>271768738</u>
<b>c</b> (1) Accrued liability for plan using immediate gain methods .....	<b>1c(1)</b> <u>289679221</u>
(2) Information for plans using spread gain methods:	
(a) Unfunded liability for methods with bases .....	<b>1c(2)(a)</b>
(b) Accrued liability under entry age normal method .....	<b>1c(2)(b)</b>
(c) Normal cost under entry age normal method .....	<b>1c(2)(c)</b>
(3) Accrued liability under unit credit cost method .....	<b>1c(3)</b> <u>289679221</u>
<b>d</b> Information on current liabilities of the plan:	
(1) Amount excluded from current liability attributable to pre-participation service (see instructions) .....	<b>1d(1)</b>
(2) "RPA '94" information:	
(a) Current liability .....	<b>1d(2)(a)</b> <u>453217726</u>
(b) Expected increase in current liability due to benefits accruing during the plan year .....	<b>1d(2)(b)</b> <u>9085735</u>
(c) Expected release from "RPA '94" current liability for the plan year .....	<b>1d(2)(c)</b> <u>22733803</u>
(3) Expected plan disbursements for the plan year .....	<b>1d(3)</b> <u>23383803</u>

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>  <u>BENJAMIN HOLLE, MAAA</u> Type or print name of actuary  <u>SEGAL</u> Firm name  <u>7701 FRANCE AVE S</u> <u>SUITE 225</u> <u>EDINA, MN 55435-5296</u> Address of the firm	<u>09/16/2025</u> Date  <u>23-07400</u> Most recent enrollment number  <u>952-259-2600</u> Telephone number (including area code)
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

**2** Operational information as of beginning of this plan year:

<b>a</b> Current value of assets (see instructions) .....	<b>2a</b>	257388419
<b>b</b> "RPA '94" current liability/participant count breakdown:	<b>(1) Number of participants</b>	<b>(2) Current liability</b>
<b>(1)</b> For retired participants and beneficiaries receiving payment .....	1365	247091501
<b>(2)</b> For terminated vested participants .....	365	55261890
<b>(3)</b> For active participants:		
<b>(a)</b> Non-vested benefits .....		22482335
<b>(b)</b> Vested benefits .....		128382000
<b>(c)</b> Total active .....	756	150864335
<b>(4)</b> Total .....	2486	453217726
<b>c</b> If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage .....	<b>2c</b>	56.79 %

**3** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	
07/01/2024	26772986					
			<b>Totals ▶</b>	<b>3(b)</b>	26772986	
<b>(d)</b> Total withdrawal liability amounts included in line 3(b) total .....					<b>3(c)</b>	
					<b>3(d)</b>	0

**4** Information on plan status:

<b>a</b> Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)).....	<b>4a</b>	93.8 %
<b>b</b> Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5 .....	<b>4b</b>	N
<b>c</b> Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>d</b> If the plan is in critical status or critical and declining status, does line 1(c) reflect any benefit reductions for the first time (see instructions)? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>e</b> If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date .....	<b>4e</b>	
<b>f</b> If the plan is in critical status or critical and declining status, and is: • Projected to emerge from critical status within 30 years, enter the plan year in which it is projected to emerge; • Projected to become insolvent within 30 years, enter the plan year in which insolvency is expected and check here ..... <input type="checkbox"/> • Neither projected to emerge from critical status nor become insolvent within 30 years, enter "9999."	<b>4f</b>	

**5** Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

<b>a</b> <input type="checkbox"/> Attained age normal	<b>b</b> <input type="checkbox"/> Entry age normal	<b>c</b> <input checked="" type="checkbox"/> Accrued benefit (unit credit)	<b>d</b> <input type="checkbox"/> Aggregate
<b>e</b> <input type="checkbox"/> Frozen initial liability	<b>f</b> <input type="checkbox"/> Individual level premium	<b>g</b> <input type="checkbox"/> Individual aggregate	<b>h</b> <input type="checkbox"/> Shortfall
<b>i</b> <input type="checkbox"/> Other (specify):			
<b>j</b> If box h is checked, enter period of use of shortfall method .....	<b>5j</b>		
<b>k</b> Has a change been made in funding method for this plan year? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>l</b> If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>m</b> If line k is "Yes," and line l is "No," enter the date (MM/DD/YYYY) of the ruling letter (individual or class) approving the change in funding method .....	<b>5m</b>		

**6 Checklist of certain actuarial assumptions:**

<b>a</b> Interest rate for "RPA '94" current liability.....	<b>6a</b>	3.29 %
<b>b</b> Rates specified in insurance or annuity contracts.....	Pre-retirement	Post-retirement
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
<b>c</b> Mortality table code for valuation purposes:		
<b>(1)</b> Males .....	<b>6c(1)</b>	A A
<b>(2)</b> Females .....	<b>6c(2)</b>	AF AF
<b>d</b> Valuation liability interest rate .....	<b>6d</b>	7.00 % 7.00 %
<b>e</b> Salary scale .....	<b>6e</b>	% <input checked="" type="checkbox"/> N/A
<b>f</b> Withdrawal liability interest rate:		
<b>(1)</b> Type of interest rate .....	<b>6f(1)</b>	<input type="checkbox"/> Single rate <input type="checkbox"/> ERISA 4044 <input checked="" type="checkbox"/> Other <input type="checkbox"/> N/A
<b>(2)</b> If "Single rate" is checked in (1), enter applicable single rate .....	<b>6f(2)</b>	%
<b>g</b> Estimated investment return on actuarial value of assets for year ending on the valuation date .....	<b>6g</b>	6.4 %
<b>h</b> Estimated investment return on current value of assets for year ending on the valuation date .....	<b>6h</b>	12.2 %
<b>i</b> Expense load included in normal cost reported in line 9b .....	<b>6i</b>	<input checked="" type="checkbox"/> N/A
<b>(1)</b> If expense load is described as a percentage of normal cost, enter the assumed percentage.....	<b>6i(1)</b>	%
<b>(2)</b> If expense load is a dollar amount that varies from year to year, enter the dollar amount included in line 9b.....	<b>6i(2)</b>	
<b>(3)</b> If neither (1) nor (2) describes the expense load, check the box .....	<b>6i(3)</b>	<input type="checkbox"/>

**7 New amortization bases established in the current plan year:**

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	4770721	489532
4	2530435	259652

**8 Miscellaneous information:**

<b>a</b> If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM/DD/YYYY) of the ruling letter granting the approval .....	<b>8a</b>	
<b>b</b> Demographic, benefit, and contribution information		
<b>(1)</b> Is the plan required to provide a projection of expected benefit payments? (See instructions) If "Yes," see instructions for required attachment. ....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>(2)</b> Is the plan required to provide a Schedule of Active Participant Data? (See instructions). ....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>(3)</b> Is the plan required to provide a projection of employer contributions and withdrawal liability payments? (See instructions) If "Yes," attach a schedule. ....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>c</b> Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>d</b> If line c is "Yes," provide the following additional information:		
<b>(1)</b> Was an extension granted automatic approval under section 431(d)(1) of the Code? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(2)</b> If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended ..	<b>8d(2)</b>	
<b>(3)</b> Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(4)</b> If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2)) .....	<b>8d(4)</b>	
<b>(5)</b> If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension .....	<b>8d(5)</b>	
<b>(6)</b> If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>e</b> If box 5h is checked or the plan received an amortization extension for this plan year under Code section 431(d), enter the difference between the amount necessary to satisfy the plan's minimum funding standard for this plan year and the amount that would have been necessary without using the shortfall method or extending the amortization period(s). ....	<b>8e</b>	

**9 Funding standard account statement for this plan year:**

**Charges to funding standard account:**

<b>a</b> Prior year funding deficiency, if any .....	<b>9a</b>	
<b>b</b> Employer's normal cost for plan year as of valuation date.....	<b>9b</b>	5563753

<b>c</b> Amortization charges as of valuation date:		Outstanding balance	
(1) All bases except funding waivers and certain bases for which the amortization period has been extended .....	<b>9c(1)</b>	90015786	19950206
(2) Funding waivers .....	<b>9c(2)</b>		
(3) Certain bases for which the amortization period has been extended.....	<b>9c(3)</b>		
<b>d</b> Interest as applicable on lines 9a, 9b, and 9c.....	<b>9d</b>		1785977
<b>e</b> Total charges. Add lines 9a through 9d.....	<b>9e</b>		27299936
<b>Credits to funding standard account:</b>			
<b>f</b> Prior year credit balance, if any.....	<b>9f</b>		53646517
<b>g</b> Employer contributions. Total from column (b) of line 3.....	<b>9g</b>		26772986
		Outstanding balance	
<b>h</b> Amortization credits as of valuation date.....	<b>9h</b>	18458786	2881759
<b>i</b> Interest as applicable to end of plan year on lines 9f, 9g, and 9h .....	<b>9i</b>		4894034
<b>j</b> Full funding limitation (FFL) and credits:			
(1) ERISA FFL (accrued liability FFL).....	<b>9j(1)</b>	97906148	
(2) "RPA '94" override (90% current liability FFL) .....	<b>9j(2)</b>	142410718	
(3) FFL credit .....	<b>9j(3)</b>		
<b>k</b> (1) Waived funding deficiency .....	<b>9k(1)</b>		
(2) Other credits .....	<b>9k(2)</b>		
<b>l</b> Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2) .....	<b>9l</b>		88195296
<b>m</b> Credit balance: If line 9l is greater than line 9e, enter the difference .....	<b>9m</b>		60895360
<b>n</b> Funding deficiency: If line 9e is greater than line 9l, enter the difference .....	<b>9n</b>		
<b>o</b> Current year's accumulated reconciliation account:			
(1) Due to waived funding deficiency accumulated prior to the current plan year.....	<b>9o(1)</b>		
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:			
(a) Reconciliation outstanding balance as of valuation date .....	<b>9o(2)(a)</b>		
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)).....	<b>9o(2)(b)</b>		
(3) Total as of valuation date.....	<b>9o(3)</b>		
<b>10</b> Contribution necessary to avoid an accumulated funding deficiency. (see instructions.).....	<b>10</b>		0
<b>11</b> Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions .....			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<b>A</b> Name of plan <b>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>38-3031916</b>	

**Part I Service Provider Information (see instructions)**

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

**a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).....  Yes  No

**b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

BENESYS, INC.

700 TOWER DRIVE STE 300  
TROY, MI 48098

38-2383171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 10 12 13 14 15 16 36	NONE	267482	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

NATIONAL INVESTMENT SERVICES

200 W MADISON ST STE 2900  
CHICAGO, IL 60606

80-0169636

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 18 27 28 33 51	NONE	142563	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

STRATEGIC CAPITAL INVESTMENT ADVR.

700 EAST BUTTERFIELD RD  
LOMBARD, IL 60148

36-4268891

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 17 27 28 72	NONE	94170	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

THE SEGAL COMPANY INC.

333 WEST 34TH STREET  
NEW YORK, NY 10001

13-1975125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 11 19 27 28 31 33 51	NONE	61701	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

NICKLE & SAPH, INC

44 MACOMB PLACE  
MOUNT CLEMENS, MI 48043

38-1799688

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 22 23	NONE	6300	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

ASHER KELLY LAW

25800 NORTHWESTERN HWY  
SOUTHFIELD, MI 48075

84-3379113

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 29	NONE	53769	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

AMERICAN GRAPHICS PRINTING CO

34895 GROESBECK HIGHWAY  
CLINTON TOWNSHIP, MI 48035

38-2090031

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 36	NONE	28899	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

BULTYNCK & CO., PLLC

15985 CANAL ROAD  
CLINTON TOWNSHIP, MI 48038

20-3920878

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 10	NONE	21500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

COMERICA BANK

411 WEST LAFAYETTE  
DETROIT, MI 48226

42-1741646

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 18 19 27 28 33 37 38 51 59	NONE	30072	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

DIGITAL DATA, INC.

PO BOX 1389  
SUMMERFIELD, FL 34492

04-3668352

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 36	NONE	8232	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

STEFANSKY, HOLLOWAY, & NICHOLS

22260 HAGGERTY RD STE 350  
NORTHVILLE, MI 48167

38-2388845

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 10	NONE	6550	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

UNITED ACTUARIAL SERVICES, INC.

11590 N MERIDIAN ST 610  
CARMEL, IN 46032

35-2156428

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 17 11	NONE	11792	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**Part I Service Provider Information (continued)**

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

**Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)**  
(complete as many entries as needed)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE D</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration	<b>DFE/Participating Plan Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <hr/> <b>2024</b>  <hr/> <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<b>A</b> Name of plan <u>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</u>	<b>B</b> Three-digit plan number (PN)	<u>001</u>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</u>	<b>D</b> Employer Identification Number (EIN) <u>38-3031916</u>	

<b>Part I</b>	<b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b> (Complete as many entries as needed to report all interests in DFEs)
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<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>PRINCIPAL U.S. PROPERTY SEPARATE AC</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>PRINCIPAL LIFE INSURANCE COMPANY</u>		
<b>c</b> EIN-PN <u>42-0127290-027</u>	<b>d</b> Entity code <u>P</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>892973</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS TOTAL ABSOLUTE RETURN FUND, LLC</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES, INC</u>		
<b>c</b> EIN-PN <u>45-4783986-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>4355244</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS CORE FIXED INCOME FUND, LLC</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES, INC</u>		
<b>c</b> EIN-PN <u>20-0005644-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>40930603</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS HIGH YIELD FUND, LLC</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES, INC</u>		
<b>c</b> EIN-PN <u>39-2021943-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1767264</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>AFL-CIO BUILDING INVESTMENT TRUST</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>PNC BANK, NATIONAL ASSOCIATION AS TRUSTEE</u>		
<b>c</b> EIN-PN <u>52-6328901-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1730015</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>U.S. CORE PARTNERS COLLECTIVE INVES</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>BENEFIT TRUST COMPANY</u>		
<b>c</b> EIN-PN <u>87-6914227-341</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>6525617</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

**c** EIN-PN

**d** Entity code

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)



<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>38-3031916</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**1** Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	6486441	4978739
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	2185375	2035244
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	1707553	2087699
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	9242692	1788082
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	15691552	25279373
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>	47507184	57443372
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	174739351	201995672
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts).....	<b>1c(14)</b>		
<b>(15)</b> Other.....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	257560148	295608181
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>		
<b>h</b> Operating payables.....	<b>1h</b>	171729	154066
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>		
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	171729	154066
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	257388419	295454115

**Part II Income and Expense Statement**

**2** Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	26772986	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>		
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		26772986
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	162996	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>	1088177	
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		1251173
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>	3673445	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		3673445
<b>(3)</b> Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	9644832	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	9567106	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		77726
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>	-556690	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		-556690

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		1189410
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		28368092
<b>c</b> Other income .....	<b>2c</b>		5418
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		60781560

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	21575733	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>		
(3) Other .....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		21575733
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>		
(2) Contract administrator fees .....	<b>2i(2)</b>	245175	
(3) Recordkeeping fees .....	<b>2i(3)</b>		
(4) IQPA audit fees .....	<b>2i(4)</b>	23460	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	488651	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	13341	
(7) Actuarial fees .....	<b>2i(7)</b>	76953	
(8) Legal fees .....	<b>2i(8)</b>	48021	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	244530	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		1140131
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		22715864

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		38065696
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1)  Unmodified (2)  Qualified (3)  Disclaimer (4)  Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1)  DOL Regulation 2520.103-8 (2)  DOL Regulation 2520.103-12(d) (3)  neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **BULTYNCK & CO., P.L.L.C.**

(2) EIN: **20-3920878**

**d** The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1)  This form is filed for a CCT, PSA, DCG or MTIA. (2)  It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

**Part IV Compliance Questions**

**4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		2500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

**5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?.....  Yes  No  
If "Yes," enter the amount of any plan assets that reverted to the employer this year \_\_\_\_\_.

**5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> PN(s)

**5c** Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) .....  Yes    No    Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 1069410.

<b>SCHEDULE R</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Retirement Plan Information</b>  This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<b>A</b> Name of plan <u>PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>001</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <u>PLUMBERS LOCAL 98 DEFINED BENEFIT PENSION FUND</u>	<b>D</b> Employer Identification Number (EIN) <u>38-3031916</u>	

<b>Part I</b>	<b>Distributions</b>
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**All references to distributions relate only to payments of benefits during the plan year.**

**1** Total value of distributions paid in property other than in cash or the forms of property specified in the instructions..... 

1	
---	--

**2** Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):  
 EIN(s): \_\_\_\_\_

**Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.**

**3** Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year..... 

3	23
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<b>Part II</b>	<b>Funding Information</b> (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)
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**4** Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....  Yes  No  N/A  
**If the plan is a defined benefit plan, go to line 8.**

**5** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
**If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.**

<b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....	<b>6a</b>	
<b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>6b</b>	
<b>c</b> Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	<b>6c</b>	

**If you completed line 6c, skip lines 8 and 9.**

**7** Will the minimum funding amount reported on line 6c be met by the funding deadline?.....  Yes  No  N/A

**8** If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? .....  Yes  No  N/A

<b>Part III</b>	<b>Amendments</b>
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**9** If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box.....  Increase  Decrease  Both  No

<b>Part IV</b>	<b>ESOPs</b> (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
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**10** Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....  Yes  No

**11 a** Does the ESOP hold any preferred stock? .....  Yes  No

**b** If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) .....  Yes  No

**12** Does the ESOP hold any stock that is not readily tradable on an established securities market? .....  Yes  No

**Part V Additional Information for Multiemployer Defined Benefit Pension Plans**

**13** Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

**a** Name of contributing employer JOHN E GREEN P&H INC

**b** EIN 38-0607500

**c** Dollar amount contributed by employer 3167989

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**a** Name of contributing employer GUIDELINE PLBG & HTG

**b** EIN 38-2475531

**c** Dollar amount contributed by employer 2008546

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**a** Name of contributing employer CONTI MECHANICAL

**b** EIN 38-1884765

**c** Dollar amount contributed by employer 1685045

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**a** Name of contributing employer PROGRESSIVE MECHANICAL INC.

**b** EIN 20-5056157

**c** Dollar amount contributed by employer 1591470

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**a** Name of contributing employer UNIVERSAL PIPING INDUSTRIAL

**b** EIN 38-3630755

**c** Dollar amount contributed by employer 1560299

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**a** Name of contributing employer DE-CAL

**b** EIN 38-3023202

**c** Dollar amount contributed by employer 1532040

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 05 Day 01 Year 2025

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) 22.90

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify): \_\_\_\_\_

**14** Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

<b>a</b> The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment).....	<b>14a</b>	0
<b>b</b> The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	<b>14b</b>	0
<b>c</b> The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	<b>14c</b>	0

**15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

<b>a</b> The corresponding number for the plan year immediately preceding the current plan year .....	<b>15a</b>	
<b>b</b> The corresponding number for the second preceding plan year .....	<b>15b</b>	

**16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

<b>a</b> Enter the number of employers who withdrew during the preceding plan year .....	<b>16a</b>	
<b>b</b> If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers .....	<b>16b</b>	

**17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment .....

**Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans**

**18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment .....

**19** If the total number of participants is 1,000 or more, complete lines (a) and (b):

**a** Enter the percentage of plan assets held as:  
 Public Equity: 87.6 % Private Equity: \_\_\_\_\_ % Investment-Grade Debt and Interest Rate Hedging Assets: \_\_\_\_\_ %  
 High-Yield Debt: \_\_\_\_\_ % Real Assets: \_\_\_\_\_ % Cash or Cash Equivalents: 3.7 % Other: 8.7 %

**b** Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:  
 0-5 years  5-10 years  10-15 years  15 years or more

**20 PBGC missed contribution reporting requirements.** If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

**a** Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero?  Yes  No

**b** If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation: \_\_\_\_\_

**Part VII IRS Compliance Questions**

**21a** Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?  Yes  No

**21b** If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

Design-based safe harbor method

"Prior year" ADP test

"Current year" ADP test

N/A

**22** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter \_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) and the Opinion Letter serial number \_\_\_\_\_.

<b>Structured Attachment</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Schedule MB, line 8b(2)</b> <b>Schedule of Active Participant Data</b>	<b>2024</b>  This Form is Open to Public Inspection
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<b>Name of Plan</b>	PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND						
<b>Plan Year Begin Date</b>	01/01/2024	<b>Plan Year End Date</b>	12/31/2024	<b>EIN</b>	38-3031916	<b>PN</b>	001

Attained Age	YEARS OF CREDITED SERVICE					
	Under 1			1 to 4		
	No.	Average		No.	Average	
		Compensation	Accrued Monthly Benefit		Compensation	Accrued Monthly Benefit
Under 25	1			31		
25 to 29	1			52		
30 to 34				25		
35 to 39				21		
40 to 44	1			13		
45 to 49				8		
50 to 54				2		
55 to 59				5		
60 to 64						
65 to 69						
70 & Up						

Attained Age	YEARS OF CREDITED SERVICE					
	5 to 9			10 to 14		
	No.	Average		No.	Average	
		Compensation	Accrued Monthly Benefit		Compensation	Accrued Monthly Benefit
Under 25	4					
25 to 29	25			2		
30 to 34	29			21		
35 to 39	20			17		
40 to 44	22			10		
45 to 49	3			5		
50 to 54	6			9		
55 to 59	5			2		
60 to 64	1					
65 to 69						
70 & Up						

<b>Name of Plan</b>	PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND						
<b>Plan Year Begin Date</b>	01/01/2024	<b>Plan Year End Date</b>	12/31/2024	<b>EIN</b>	38-3031916	<b>PN</b>	001

Attained Age	YEARS OF CREDITED SERVICE					
	15 to 19			20 to 24		
	No.	Average		No.	Average	
		Compensation	Accrued Monthly Benefit		Compensation	Accrued Monthly Benefit
Under 25						
25 to 29						
30 to 34						
35 to 39	14			3		
40 to 44	29			24		
45 to 49	16			36		
50 to 54	18			33		
55 to 59	10			28		
60 to 64	11			9		
65 to 69						
70 & Up						

Attained Age	YEARS OF CREDITED SERVICE					
	25 to 29			30 to 34		
	No.	Average		No.	Average	
		Compensation	Accrued Monthly Benefit		Compensation	Accrued Monthly Benefit
Under 25						
25 to 29						
30 to 34						
35 to 39						
40 to 44	2					
45 to 49	14					
50 to 54	21			14		
55 to 59	21			22		
60 to 64	7			4		
65 to 69				1		
70 & Up						

<b>Name of Plan</b>	PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND						
<b>Plan Year Begin Date</b>	01/01/2024	<b>Plan Year End Date</b>	12/31/2024	<b>EIN</b>	38-3031916	<b>PN</b>	001

Attained Age	YEARS OF CREDITED SERVICE					
	35 to 39			40 & Up		
	No.	Average		No.	Average	
		Compensation	Accrued Monthly Benefit		Compensation	Accrued Monthly Benefit
Under 25						
25 to 29						
30 to 34						
35 to 39						
40 to 44						
45 to 49						
50 to 54						
55 to 59	11					
60 to 64	3			2		
65 to 69						
70 & Up	1					

<b>Structured Attachment</b> Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	<b>Schedule MB, line 8b(3)</b> <b>Schedule of Projection of Employer Contributions and Withdrawal Liability Payments</b>	<b>2024</b> <hr/> This Form is Open to Public Inspection
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<b>Name of Plan</b>	PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND						
<b>Plan Year Begin Date</b>	01/01/2024	<b>Plan Year End Date</b>	12/31/2024	<b>EIN</b>	38-3031916	<b>PN</b>	001

Plan Year	Employer Contributions	Withdrawal Liability Payments	Total
2024	22302000		22302000
2025	22585500		22585500
2026	20929230		20929230
2027	20929230		20929230
2028	20929230		20929230
2029	20929230		20929230
2030	20929230		20929230
2031	20929230		20929230
2032	20929230		20929230
2033	20929230		20929230

<p><b>Structured Attachment</b></p> <p style="text-align: center;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center;">Pension Benefit Guaranty Corporation</p>	<p><b>Schedule MB, line 8b(1)</b></p> <p><b>Schedule of Projection of Expected Benefit Payments</b></p>	<p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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<b>Name of Plan</b>	PLUMBERS LOCAL NO 98 DEFINED BENEFIT PENSION FUND						
<b>Plan Year Begin Date</b>	01/01/2024	<b>Plan Year End Date</b>	12/31/2024	<b>EIN</b>	38-3031916	<b>PN</b>	001

Plan Year	Active Participants	Terminated Vested Participants	Retired Participants and Beneficiaries Receiving Payments	Total
2024	2074289	244358	20415343	22733990
2025	2442328	373779	19664420	22480527
2026	2983288	499650	19102697	22585635
2027	3623181	862652	18515077	23000910
2028	4392633	928291	17931672	23252596
2029	4883184	1239842	17272325	23395351
2030	5338558	1476907	16615736	23431201
2031	5818873	1562491	15947010	23328374
2032	6090502	1718859	15240870	23050231
2033	6361977	2011058	14518969	22892004
2034	6680411	2224478	13794416	22699305
2035	6908223	2295483	13044485	22248191
2036	7211015	2528921	12282502	22022438
2037	7494038	2869309	11526668	21890015
2038	7805416	2958659	10766286	21530361
2039	8023564	3237215	10012517	21273296
2040	8278473	3481443	9267729	21027645
2041	8458101	3491387	8538839	20488327



### **Attachments Unavailable**

Attachments for the selected filing cannot be publicly disclosed over the website as the Department of Labor determined that one or more attachments may contain sensitive personally identifiable information. Please contact the Department of Labor EBSA Public Disclosure Office as noted below in order to request a redacted copy of the document you need.

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Employee Benefits Security Administration  
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