

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025

- A This return/report is for: [X] 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. [X]
D Check box if filing under: [X] 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

1a Name of plan: RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.
1b Three-digit plan number (PN): 503
1c Effective date of plan: 01/01/2014
2a Plan sponsor's name (employer, if for a single-employer plan): BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.
2b Employer Identification Number (EIN): 36-4026252
2c Plan Sponsor's telephone number: 312-757-4689
2d Business code (see instructions): 238220

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include: Filed with authorized/valid electronic signature, Signature of plan administrator, Signature of employer/plan sponsor, and Signature of 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 checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<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>	2581
<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>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <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>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>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	
	<b>6a(2)</b>	
	<b>6b</b>	2655
	<b>6c</b>	
	<b>6d</b>	2655
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<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>	347

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

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
4A 4D 4E 4L 4U

<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 type="checkbox"/> <b>R</b> (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)
(2) <input 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 checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>2</u>
(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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**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

For calendar plan year 2024 or fiscal plan year beginning **06/01/2024** and ending **05/31/2025**

<b>A</b> Name of plan RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.		<b>B</b> Three-digit plan number (PN) ▶	503
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.		<b>D</b> Employer Identification Number (EIN) 36-4026252	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
HUMANA INSURANCE COMPANY

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
39-1263473	73288	327645	2136	06/01/2024	05/31/2025

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a)</b> Total amount of commissions paid 169280	<b>(b)</b> Total amount of fees paid 0
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
LABOR-FIRST LLC  
1000 MIDLANTIC DRIVE, SUITE 100  
MOUNT LAUREL, NJ 08054

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	
169280			0

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	<b>7e(1)</b>			
	<b>7e(2)</b>			
	<b>7e(3)</b>			
	<b>7e(4)</b>			
	(5) Total deductions .....			
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

**Part III Welfare Benefit Contract Information**  
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)
- b**  Dental
- c**  Vision
- d**  Life insurance
- e**  Temporary disability (accident and sickness)
- f**  Long-term disability
- g**  Supplemental unemployment
- h**  Prescription drug
- i**  Stop loss (large deductible)
- j**  HMO contract
- k**  PPO contract
- l**  Indemnity contract
- m**  Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>	
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>
	(4) Claims charged .....		<b>9b(4)</b>
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions .....	<b>9c(1)(A)</b>	
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	
	(D) Other expenses .....	<b>9c(1)(D)</b>	
	(E) Taxes .....	<b>9c(1)(E)</b>	
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	
	(G) Other retention charges .....	<b>9c(1)(G)</b>	
	(H) Total retention .....		<b>9c(1)(H)</b>
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>
	(2) Claim reserves .....		<b>9d(2)</b>
	(3) Other reserves .....		<b>9d(3)</b>
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	981076
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **06/01/2024** and ending **05/31/2025**

<p><b>A</b> Name of plan <b>RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>503</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>36-4026252</b></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**HUMANA INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
39-1263473	73288	327647	17	06/01/2024	05/31/2025

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;"><b>1344</b></p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;"><b>0</b></p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

**LABOR-FIRST LLC** **1000 MIDLANTIC DRIVE, SUITE 100**  
**MOUNT LAUREL, NJ 08054**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1344			0

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	<b>7e(1)</b>			
	<b>7e(2)</b>			
	<b>7e(3)</b>			
	<b>7e(4)</b>			
(5) Total deductions .....			<b>7e(5)</b>	0
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

**Part III Welfare Benefit Contract Information**  
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)
- b**  Dental
- c**  Vision
- d**  Life insurance
- e**  Temporary disability (accident and sickness)
- f**  Long-term disability
- g**  Supplemental unemployment
- h**  Prescription drug
- i**  Stop loss (large deductible)
- j**  HMO contract
- k**  PPO contract
- l**  Indemnity contract
- m**  Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>	
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>
	(4) Claims charged .....		<b>9b(4)</b>
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions .....	<b>9c(1)(A)</b>	
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	
	(D) Other expenses .....	<b>9c(1)(D)</b>	
	(E) Taxes .....	<b>9c(1)(E)</b>	
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	
	(G) Other retention charges .....	<b>9c(1)(G)</b>	
	(H) Total retention .....		<b>9c(1)(H)</b>
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>
	(2) Claim reserves .....		<b>9d(2)</b>
	(3) Other reserves .....		<b>9d(3)</b>
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	7417
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

<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 **06/01/2024** and ending **05/31/2025**

<b>A</b> Name of plan <b>RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>503</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.</b>	<b>D</b> Employer Identification Number (EIN) <b>36-4026252</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

**CAPITAL RESEARCH AND MGMT CO**

**95-1411037**

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

**ROBERT W. BAIRD & CO.**

**615 E. MICHIGAN ST., THIRD FLOOR  
MILWAUKEE, WI 53202**

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

**THE VANGUARD GROUP, INC.**

**23-1945930**

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

**WILLIAM BLAIR INV MGMT LLC**

**150 NORTH RIVERSIDE PLAZA  
CHICAGO, IL 60606**

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

FIDELITY MGMT AND RESEARCH CO

245 SUMMER STREET  
BOSTON, MA 02210

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

HARDING LOEVNER

P.O. BOX 4766  
CHICAGO, IL 60680-4766

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

JANUS HENDERSON INVESTORS US LLC

71 S. WACKER DRIVE, SUITE 3410  
CHICAGO, IL 60606

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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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**(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)

MARATHON HEALTH, LLC

26-0103977

(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?
13	NONE	480192	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)

EXPRESS SCRIPTS, INC.

43-1420563

(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?
12 13	NONE	341282	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)

BLUE CROSS BLUE SHIELD OF IL

36-1236610

(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?
12 13 73	NONE	280832	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	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)

UNION EYES, LLC

83-3067276

(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?
13	NONE	251033	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)

JOSEPH OHM

36-4026252

(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?
14 30	EMPLOYEE	77676	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)

BRIDGEWAY BENEFIT TECHNOLOGIES LLC

52-1796473

(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?
15 16 49 64	NONE	70411	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	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)

LISA BOWE

36-4026252

(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?
30 99	EMPLOYEE	48702	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	6223	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

GRACIELA DELGADO

36-4026252

(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?
30	EMPLOYEE	61228	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)

SEGAL

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?
11 16	NONE	56829	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)

LISA SURDYK

36-4026252

(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?
30	EMPLOYEE	50075	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)

MAIRE O'BRIEN

36-4026252

(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?
30	EMPLOYEE	48986	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)

MARIDZA TORRES-RAMOS

36-4026252

(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?
30	EMPLOYEE	47619	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)

DELTA DENTAL OF ILLINOIS

36-2612058

(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?
12 13	NONE	40861	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)

NATL INVSTMT SERVICES OF AMERICA

84-3937993

(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?
28 51	NONE	40189	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)

LEGACY PROFESSIONALS LLP

32-0043599

(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?
10 15	NONE	39913	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)

WASHINGTON CAPITAL MANAGEMENT, INC.

91-1042342

(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?
28 51	NONE	36186	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)

OPTUM FINANCIAL, INC.

47-0858530

(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?
13	NONE	33254	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)

NANCY JONES

36-4026252

(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?
30	EMPLOYEE	30586	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)

GREGORIO, STEC, KLEIN & HOSE

99-0408958

(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?
29	NONE	26605	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)

DATAMATION IMAGING SERVICES CORP.

36-4303011

(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?
49	NONE	21250	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)

LANER MUCHIN, LTD.

36-3088463

(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?
29	NONE	16683	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)

EYEMED VISION CARE LLC

31-1656473

(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?
12 13	NONE	13904	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)

HINES & ASSOCIATES, INC.

36-3545085

(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?
49	NONE	11055	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)

ZELIS PAYMENTS HOLDING LLC

84-3069529

(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?
49	NONE	10108	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)

AMALGAMATED BANK OF CHICAGO

36-0721895

(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?
19 52 62	NONE	7916	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STADTLER TECHNOLOGIES LLC

10952 TANGLEWOOD DR  
YORKVILLE, IL 60560

(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?
49	NONE	7375	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(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?
			Yes <input type="checkbox"/> No <input 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
STADTLER TECHNOLOGIES LLC 10952 TANGLEWOOD DR YORKVILLE, IL 60560	49	DID NOT RESPOND TO THE PLAN'S MULTIPLE REQUESTS FOR INFORMATION REGARDING INDIRECT COMPENSATION RECEIVED.

<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
BRIDGEWAY BENEFIT TECHNOLOGIES LLC  52-1796473	15 16 49 64	DID NOT RESPOND TO THE PLAN'S MULTIPLE REQUESTS FOR INFORMATION REGARDING INDIRECT COMPENSATION RECEIVED.

<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>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>	<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>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025

<b>A</b> Name of plan <u>RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.</u>	<b>B</b> Three-digit plan number (PN)	<u>503</u>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.</u>	<b>D</b> Employer Identification Number (EIN) <u>36-4026252</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)
---------------	--

<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 OF AMERICA, LLC</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>392449</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 OF AMERICA, LLC</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>951953</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 OF AMERICA, LLC</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>9092536</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>REAL ASSET INCOME FUND, LLC</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>WASHINGTON CAPITAL MANAGEMENT, INC</u>		
<b>c</b> EIN-PN <u>86-3454983-001</u>	<b>d</b> Entity code <u>E</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>7664416</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)
<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)
<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)





<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>06/01/2024</b> and ending <b>05/31/2025</b>			
<b>A</b> Name of plan <b>RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>B</b> Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;"><b>503</b></td> </tr> </table>	<b>B</b> Three-digit plan number (PN) ▶	<b>503</b>
<b>B</b> Three-digit plan number (PN) ▶	<b>503</b>		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>D</b> Employer Identification Number (EIN) <b>36-4026252</b></td> </tr> </table>	<b>D</b> Employer Identification Number (EIN) <b>36-4026252</b>	
<b>D</b> Employer Identification Number (EIN) <b>36-4026252</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>	-34188	-42632
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	762759	838811
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	3352905	4294720
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	1246062	1777555
<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>		
<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>	10797086	10436938
<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>	7156796	7664416
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	42874928	36798255
<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>		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	111462	91509
f Total assets (add all amounts in lines 1a through 1e).....	1f	66267810	61859572
<b>Liabilities</b>			
g Benefit claims payable.....	1g	1794824	2170237
h Operating payables.....	1h	54989	45186
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	1711528	378649
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	3561341	2594072
<b>Net Assets</b>			
l Net assets (subtract line 1k from line 1f).....	1l	62706469	59265500

**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: (A) Employers.....	2a(1)(A)	8731834	
(B) Participants.....	2a(1)(B)	3479586	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		12211420
<b>b Earnings on investments:</b>			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	74069	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	851539	
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	2b(6)		689852
(7) Net investment gain (loss) from pooled separate accounts .....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts .....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities .....	2b(9)		507620
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	2b(10)		3521788
<b>c</b> Other income .....	2c		18265
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	2d		17874553

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	20408398	
(2) To insurance carriers for the provision of benefits .....	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3) .....	2e(4)		20408398
<b>f</b> Corrective distributions (see instructions) .....	2f		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	2g		
<b>h</b> Interest expense.....	2h		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	2i(1)	394689	
(2) Contract administrator fees .....	2i(2)		
(3) Recordkeeping fees .....	2i(3)	13706	
(4) IQPA audit fees .....	2i(4)	20264	
(5) Investment advisory and investment management fees .....	2i(5)	83908	
(6) Bank or trust company trustee/custodial fees .....	2i(6)	9423	
(7) Actuarial fees .....	2i(7)	56829	
(8) Legal fees .....	2i(8)	41207	
(9) Valuation/appraisal fees .....	2i(9)		
(10) Other trustee fees and expenses .....	2i(10)	20025	
(11) Other expenses.....	2i(11)	267073	
(12) Total administrative expenses. Add lines 2i(1) through (11) .....	2i(12)		907124
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	2j		21315522

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line 2j from line 2d.....	2k		-3440969
<b>l</b> Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan .....	2l(2)		

**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: LEGACY PROFESSIONALS LLP

(2) EIN: 32-0043599

**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		500000
<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 \_\_\_\_\_.

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

Financial Statements

May 31, 2025

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund  
Local 130, U.A.**

Financial Statements with Supplementary Information

May 31, 2025 and 2024

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## **Report of Independent Auditors**

To the Participants and Trustees of  
Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund  
Local 130, U.A.

### ***Opinion***

We have audited the financial statements of Plumbers' Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of May 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of Plumbers' Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. as of May 31, 2025 and 2024, and the changes in its net assets available for benefits and benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

### ***Basis for Opinion***

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the *Auditors' Responsibilities for the Audit of the Financial Statements* section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### ***Responsibilities of Management for the Financial Statements***

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### ***Responsibilities of Management for the Financial Statements (continued)***

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Management is also responsible for maintaining a current Plan instrument, including all Plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

### ***Auditors' Responsibilities for the Audit of the Financial Statements***

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit;
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements;
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed;
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements; and
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

***Auditors' Responsibilities for the Audit of the Financial Statements (continued)***

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

*Legacy Professionals LLP*

Westchester, Illinois

February 13, 2026

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

**Statements of Net Assets Available for Benefits**

May 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
<b>Assets</b>		
Investments - at fair value		
Mutual funds	\$ 36,798,255	\$ 42,874,928
Common and collective trusts	10,436,938	10,797,086
Real estate investment fund	7,664,416	7,156,796
Money market funds and invested cash	<u>1,777,555</u>	<u>1,246,062</u>
Total investments	<u>56,677,164</u>	<u>62,074,872</u>
Receivables		
Contractor contributions - net of esimated credit losses of \$322,094 (2025) and \$207,270 for (2024)	838,811	762,759
Accrued investment income	162	595
Prescription drug rebates	4,081,929	3,152,185
Contract administrator operating deposits	<u>200,000</u>	<u>200,000</u>
Total receivables	<u>5,120,902</u>	<u>4,115,539</u>
Property and equipment		
Furniture and Equipment	203,373	203,373
Less accumulated depreciation	<u>(111,864)</u>	<u>(91,911)</u>
Net property and equipment	<u>91,509</u>	<u>111,462</u>
Prepaid expenses	<u>12,629</u>	<u>125</u>
Total assets	<u>61,902,204</u>	<u>66,301,998</u>
<b>Liabilities and Net Assets</b>		
Liabilities		
Fees mandated by ACA	16,647	15,300
Cash overdrafts	42,632	34,188
Accounts payable and accrued expenses	28,539	39,689
Deferred participant contributions	285,205	363,448
Due to related organizations - net	<u>93,444</u>	<u>1,348,080</u>
Total liabilities	<u>466,467</u>	<u>1,800,705</u>
Net assets available for benefits	<u>\$ 61,435,737</u>	<u>\$ 64,501,293</u>

See accompanying notes to financial statements.

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

**Statements of Changes in Net Assets Available for Benefits**

Years Ended May 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
<b>Additions</b>		
Investment income		
Net appreciation in fair value of investments	\$ 4,719,260	\$ 7,495,734
Interest and dividends	<u>925,608</u>	<u>909,360</u>
	5,644,868	8,405,094
Less investment expenses	<u>(85,448)</u>	<u>(82,962)</u>
Investment income - net	5,559,420	8,322,132
Contractor contributions	8,731,834	9,087,706
Participant contributions	3,479,586	3,155,429
Transitional reinsurance fee refund	<u>18,265</u>	<u>-</u>
Total additions	<u>17,789,105</u>	<u>20,565,267</u>
<b>Deductions</b>		
Cost of benefits		
Claims		
Health - net	9,739,463	9,100,365
Medicare advantage premiums	1,006,150	907,740
Prescription drug - net	7,013,576	6,244,669
Death benefits	<u>593,333</u>	<u>566,667</u>
Total claims	<u>18,352,522</u>	<u>16,819,441</u>
Claims administration fees		
PPO and administrative fees	676,879	680,092
Hospital utilization review	11,055	10,619
Health reimbursement account fees	3,354	5,205
Wellness centers	946,058	1,276,799
Other	<u>43,117</u>	<u>39,478</u>
Total claims administration fees	<u>1,680,463</u>	<u>2,012,193</u>
Total cost of benefits	20,032,985	18,831,634
Fees mandated by ACA	16,647	15,300
Administrative expenses	<u>805,029</u>	<u>782,960</u>
Total deductions	<u>20,854,661</u>	<u>19,629,894</u>
<b>Net increase (decrease)</b>	(3,065,556)	935,373
<b>Net assets available for benefits</b>		
Beginning of year	<u>64,501,293</u>	<u>63,565,920</u>
End of year	<u>\$ 61,435,737</u>	<u>\$ 64,501,293</u>

See accompanying notes to financial statements.

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

**Statements of Benefit Obligations**

May 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
<b>Amounts currently payable</b>		
Claims payable and claims incurred but not reported	\$ <u>2,170,237</u>	\$ <u>1,794,824</u>
 <b>Postretirement benefit obligations</b>		
Current retirees, beneficiaries and dependents	279,258,138	184,968,256
Other participants fully eligible for benefits	22,285,549	22,715,315
Other participants not yet fully eligible for benefits	<u>315,363,442</u>	<u>237,379,593</u>
Total postretirement benefit obligations	<u>616,907,129</u>	<u>445,063,164</u>
Total benefit obligations	<u>\$ 619,077,366</u>	<u>\$ 446,857,988</u>

See accompanying notes to financial statements.

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

**Statements of Changes in Benefit Obligations**

Years Ended May 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
<b>Amounts currently payable</b>		
Balance at beginning of year	\$ 1,794,824	\$ 1,400,039
Increase attributable to changes in Claims payable and claims incurred but not reported	<u>375,413</u>	<u>394,785</u>
Balance at end of year	<u>2,170,237</u>	<u>1,794,824</u>
<b>Postretirement benefit obligations</b>		
Balance at beginning of year	445,063,164	320,503,030
Increase (decrease) attributable to		
Service cost	19,488,611	15,569,515
Interest cost	25,114,174	16,468,313
Expected benefits paid net of retiree contributions	(16,076,032)	(13,578,340)
Actuarial experience loss	10,210,728	-
Changes in actuarial assumptions	<u>133,106,484</u>	<u>106,100,646</u>
Balance at end of year	<u>616,907,129</u>	<u>445,063,164</u>
Total benefit obligations	<u>\$ 619,077,366</u>	<u>\$ 446,857,988</u>

See accompanying notes to financial statements.

**Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund,  
Local 130, U.A.**

**Notes to Financial Statements**

May 31, 2025 and 2024

**Note 1. Summary of Significant Accounting Policies**

**Method of Accounting** - The accompanying financial statements of Plumbers' Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. (the Plan) have been prepared using the accrual basis of accounting.

**Investments** - The investments of the Plan are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price). Net appreciation or depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Purchases and sales of the investments are reflected on a trade-date basis.

Dividend income is recorded on the ex dividend date. Interest income is recorded on the accrual basis.

**Contributions Receivable** - Contractor contributions due and not paid prior to the year end are recorded as contributions receivable. Contractor contributions due as determined by payroll compliance audits are reserved for uncertain collections. The receivable is shown net of an allowance for uncollectible accounts (estimated credit losses) of \$322,094 and \$207,270 at May 31, 2025 and 2024, respectively.

**Property and Equipment** - Property and equipment consist of office furniture and equipment and are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed by the straight-line method over estimated useful lives ranging from five to ten years.

Depreciation expense for the years ended May 31, 2025 and 2024 was \$22,075 and \$22,434 respectively.

**Prescription Drug Rebates** - The Plan utilizes a pharmacy benefit manager (PBM) who periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned and can be estimated. Refunds due as of the financial statement date have been reported as a receivable. Prescription drug benefits are net of refunds earned of \$10,812,470 and \$8,361,667 for the years ended May 31, 2025 and 2024, respectively.

## **Note 1. Summary of Significant Accounting Policies**

**Revenue Recognition** - Revenue derived from employer contributions is recognized in the period in which covered work is performed, based on the number of hours worked in covered employment and contribution rates set forth in the collective bargaining agreements.

Employers are required to remit contributions monthly. The Plan carries out its purpose described in Note 2 within a jurisdiction located primarily in the following counties of Illinois: Bureau, Cook, DeKalb, DuPage, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, McHenry, Putnam, Will, and parts of Livingston, Marshall, and Woodford Counties.

**Deferred Participant Contributions** - Certain participants make contributions to receive benefits under the Plan. Contributions received in advance of the corresponding eligibility period are recognized as deferred income.

**Benefit Obligations** - Benefit obligations are determined by the Plan's actuary using accepted actuarial principles, based on paid and incurred claim cost studies, Plan benefits, and other data as considered necessary.

**Health Reimbursement Arrangement (HRA) Accounts** - HRA account balances held by certain participants at the time of retirement are transferred to the Plan at that time. Accordingly, included in net assets available for benefits as of May 31, 2025 and 2024 are amounts available to reimburse participants for qualifying medical expenses totaling approximately \$278,000 and \$270,000 respectively.

**Estimates** - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

**Transitional Reinsurance Fee Refund** - The Plan opted into the transitional reinsurance fee class action lawsuit which challenged the legality of requiring self-insured multiemployer welfare plans to pay the transitional reinsurance fees as mandated by the Affordable Care Act. As part of the judgment, the Plan was awarded a total recovery in the amount of \$18,265 which was received in January 2025.

**Subsequent Events** - Subsequent events have been evaluated through February 13, 2026, which is the date the financial statements were available to be issued.

## **Note 2. Description of the Plan**

The Plan was established effective January 1, 2014 as a separate plan and trust to offer benefits to retired participants previously covered under the retiree program of Plumbers' Welfare Fund, Local 130, U.A. The Plan was established pursuant to a collective bargaining agreement between the local union and various contractor associations. The purpose of the Plan is to provide medical, dental, vision and prescription drug benefits for eligible participants and their dependents. The Plan is a multiemployer welfare plan, subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

## **Note 2. Description of the Plan (continued)**

To be eligible for benefits, participants must qualify as a former participant or the spouse or surviving spouse of a former participant of the Plumbers' Welfare Fund, Local 130, U.A. A former participant is an individual who either became permanently disabled while eligible for benefits under the Plumbers' Welfare Fund, Local 130, U.A., or is receiving retirement benefits under the provisions of either the Plumbers' Pension Fund, Local 130, U.A.; the Plumbers and Steamfitters Local Union No. 422 Pension Fund; the Plumbers Local Union No. 93 Pension Plan; the Northern Illinois Pension Fund (Local 501); or the Plumbing Employees' Pension Trust for Employees of Affiliated Plans, if the individual was eligible for benefits under the Plumbers' Welfare Fund, Local 130, U.A. when pension benefits commenced. A former participant also includes a retiree who was covered as a retiree under the Plumbers' Local Union No. 93, Health and Welfare Fund or as a retired plumbing employee under Local 501 immediately prior to the effective date of the merger of those plans with the Plumbers' Welfare Fund, Local 130, U.A.

The Plan offers self-pay health coverage to eligible participants, their spouses, and surviving spouses to provide uninterrupted coverage between retirement and the time Medicare coverage begins. If a participant elects self-pay retiree coverage, coverage begins the month after eligibility under the Plumbers' Welfare Fund, Local 130, U.A. terminates. Self-payments are due by the 20th day of the month before the month of coverage. The maximum period of self-pay coverage is five years for a former participant and ten years for his or her spouse, and terminates when the participant attains age 65, becomes entitled to Medicare, or fails to pay the monthly premium by the end of any month of coverage. Additionally, in September 2019, the Plan was amended to allow for dependent coverage effective January 1, 2020 for medical, dental, and vision benefits.

The Health Reimbursement Arrangement (HRA), is a record keeping account that the Plan sets up and maintains on behalf of participants to keep track of contributions, reimbursements and a participant's available balance. The HRA accounts are available to reimburse out-of-pocket medical expenses such as deductibles, co-payments and other dollar limits imposed by the Plan. Former participants with accumulated HRA credits in their health and welfare plan may retain their credits for the payment of (1) prescription drug benefits not otherwise excluded under the Plan (2) approved Medicare expenses that are not paid by Medicare due to the Medicare deductible and co-insurance and (3) amounts that exceed the reasonable charges or cost for the services under Medicare that the former participant must pay. All participant HRA accounts are assets of the Plan. Participants are not vested in the balance of their HRA accounts. No earnings are credited to the HRA accounts. Requests for reimbursement may be made at the end of each calendar quarter. A participant may be reimbursed up to the lesser of the amount of covered expenses or the amount of credits accumulated. Additionally, reimbursement cannot be made for any amount that was paid from another source such as other health coverage. HRA reimbursements totaled \$19,632 and \$20,765 during the years ended May 31, 2025 and 2024, respectively. There were no amounts approved for payment from HRA accounts but not yet paid at either May 31, 2025 or 2024.

**Note 2. Description of the Plan (continued)**

The Plan offers a Medicare Advantage benefit. Retirees, spouses and surviving spouses who are at least 65 and enrolled in Medicare Parts A and B are eligible for the Medicare Advantage health benefits. This benefit covers the Retiree's Medicare-approved hospital and medical benefits so long as the services provided are Medicare-approved with no deductibles or copayments required. If a retiree fails to enroll in Part A and/or B of Medicare, no benefits will be provided. A monthly premium is charged for coverage under the Medicare Advantage benefit, which is deducted from the pension benefit payable to the retiree. Alternatively, payment may be made directly the Fund Office.

Participants should refer to the summary plan description for more complete information.

**Note 3. Priorities upon Termination**

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy, or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

**Note 4. Tax Status**

The Plan obtained its notice of exemption in on April 15, 2015, in which the Internal Revenue Service stated that the trust established under the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the notice of exemption. The Plan's administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. They therefore believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require the Plan to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by tax authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

## Note 5. Fair Value Measurements

The *Fair Value Measurements and Disclosures* Topic of the FASB Accounting Standards Codification established a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described following.

### Basis of Fair Value Measurement

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities
Level 2	Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly
Level 3	Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable

The following tables set forth, by level within the fair value hierarchy, the Plan's investment assets at fair value as of May 31, 2025 and 2024. As required, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. In accordance with generally accepted accounting principles, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in the following tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net asset available for benefits.

	Total	Fair Value Measurements at 5/31/25 Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	\$ 36,798,255	\$ 36,798,255	\$ -	\$ -
Money market funds and invested cash	1,777,555	-	1,777,555	-
	38,575,810	\$ 36,798,255	\$ 1,777,555	\$ -
Investments measured at net asset value:				
Common and collective trusts	10,436,938			
Real estate investment trust	7,664,416			
Total	\$ 56,677,164			

**Note 5. Fair Value Measurements (continued)**

	Total	Fair Value Measurements at 5/31/24 Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	\$ 42,874,928	\$ 42,874,928	\$ -	\$ -
Money market funds and invested cash	1,246,062	-	1,246,062	-
	44,120,990	\$ 42,874,928	\$ 1,246,062	\$ -
Investments measured at net asset value:				
Common and collective trusts	10,797,086			
Real estate investment trust	7,156,796			
Total	\$ 62,074,872			

Level 1 Measurements

The fair values of the mutual funds are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value as of the last business day of each period presented.

Level 2 Measurements

Money market funds and investment cash are valued at cost, which approximates fair value.

Measurements Using Net Asset Value as a Practical Expedient

Certain investments are valued at the net asset value per share, used as a practical expedient to estimate fair value. The net asset value is based on the fair values of the underlying assets held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported net asset value.

Certain investments are considered direct filing entities (DFEs) and file a Form 5500 annual report with the U.S Department of Labor. The Plan is not required to disclose the significant investment strategies of DFE investments. Withdrawals are generally available on a monthly basis with notice periods ranging from zero to thirty days.

## **Note 6. Funding Policy**

The Plan is funded by both contractor and participant contributions.

### Contractor Contributions

Participating contractors contribute such amounts as specified in their collective bargaining agreement. The hourly contribution rate was \$2.00 for each of the years ended May 31, 2025 and 2024.

### Self-Pay

Participants can elect self-pay coverage to remain covered from the time of retirement to the time Medicare coverage begins. Participant contribution rates are determined annually. Participant self-pay contributions were paid at a monthly rates ranging from \$212 to \$1,450 for each of the years ended May 31, 2025 and 2024, depending on the participant's pension credits earned.

The Plan offers a Medicare Advantage benefit to eligible participants with premiums ranging from \$58 to \$250.

## **Note 7. Related Organizations**

### Identification of Related Organizations

The Plan has a number of related organizations including a local union, a multiemployer pension plan, a health and welfare plan, a defined contribution retirement plan, two education funds, and three industry funds, all of which are tax-exempt.

### Shared Expenses

The Plan shares certain employees, the operation of the wellness centers, office space, and other expenses with the related welfare and pension plans. During the normal course of business, the related welfare and pension plan initially pay certain costs which are then allocated to the Plan annually. At May 31, 2025 and 2024, the Plan owed \$124,245 and \$921,157, respectively, to the related welfare plan. At May 31, 2025, the Plan was owed \$474 from the related pension plan for amounts reimbursed in excess of allocated costs. At May 31, 2024, the Plan owed \$13,119 to the related pension plan for such costs. At May 31, 2024, the Plan also owed \$412,168 to the related pension plan for an inadvertent investment transfer received. This amount was reimbursed shortly after year end.

As described above, the Plan shares office space with the related pension and welfare plans. The Plan is allocated a portion of the rent based on estimates of space utilized. The Plan's portion of rent expenses for the years ended May 31, 2025 and 2024 was \$35,692 and \$36,493, respectively.

## **Note 7. Related Organizations (continued)**

### Benefit Plan Participation

The Plan shares full-time employees with the related welfare plan, who are covered under the related multiemployer defined benefit pension plan. The Plan's allocated portion of the contributions to this plan was \$70,500 and \$68,249 for the years ended May 31, 2025 and 2024, respectively.

Additionally, full-time office staff shared with the related welfare plan are eligible to participate in the related defined contribution retirement plan. The Plan's allocated portion of the contributions to this plan was \$25,410 and \$22,244 for the years ended May 31, 2025 and 2024, respectively.

The Plan's shared full-time office staff are also covered by the Plan and related active welfare plan. The Plan's allocated portion of the contributions to the Plan and related welfare plan was \$77,853 and \$72,226 for the years ended May 31, 2025 and 2024, respectively.

### Contributions and Collections

Processing of employer contributions and administration of the audit and collections program on behalf of the Plan is the responsibility of the related welfare plan. Allocations of audit and collection expenses, which are primarily comprised of employee related, occupancy, office expense and professional fees, totaled \$55,427 and \$47,045 for the years ended May 31, 2025 and 2024, respectively. At May 31, 2025 and 2024, the Plan owed \$13,428 and \$4,546, respectively, to the related welfare plan for allocated collection expenses.

### Lockbox Accounts

Contributions for the Plan and other related organizations are received and deposited into three shared lockbox accounts held by the related welfare plan. On a regular basis, contributions due to the related organizations are transferred from the lockbox accounts to the respective organizations' accounts. Amounts received by the related welfare plan and not yet remitted to the Plan at May 31, 2025 and 2024 totaled \$43,755 and \$2,910 respectively.

## **Note 8. Postretirement Benefit Obligations**

The postretirement benefit obligation represents the total actuarial present value of those estimated future benefits that are attributed to employee service rendered to May 31, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

## Note 8. Postretirement Benefit Obligations (continued)

The present value of the expected postretirement benefit obligations is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

Some of the significant assumptions used in the valuations as of May 31, 2025 and 2024 were as follows:

- Mortality:

2025 - Healthy - 95% of Pri-2012 Healthy Retiree Blue Collar Headcount-weighted Mortality Tables, projected generationally from 2012 using Scale MP-2021

2025 - Disabled - 95% of Pri-2012 Disabled Retiree Headcount-weighted Mortality Tables, projected generationally from 2012 using Scale MP-2021

2025 - Surviving spouse - 95% of Pri-2012 Contingent Blue Collar Headcount-weighted Mortality Tables, projected generationally from 2012 using Scale MP-2021

2024 - Healthy and surviving spouse - RP-2006 Headcount-Weighted Blue Collar Annuitant Mortality Tables, projected generationally from 2006 using Scale MP-2017

2024 - Disabled - RP-2006 Headcount-Weighted Disabled Retiree Mortality Tables, projected generationally from 2006 using Scale MP-2017

- Rates of retirement (percentage of actives who retire at stated age):

<u>Age</u>	<u>Rate</u>
55-59	5%
60	15%
61	10%
62	35%
63-64	25%
65+	100%

- Health care trend rates:

Non-Medicare medical, prescription drug, vision, and administrative fees:

2025 - 8.25% graded to 4.50% over 15 years

2024 - 7.50% graded to 4.50% over 12 years

Medicare medical:

2025 - 115.00% for one year, then 6.50% graded to 4.50% over eight years

2024 - 0.00% for one year, then 5.00% graded to 4.50% over two years

**Note 8. Postretirement Benefit Obligations (continued)**

Medicare prescription drug:

2025 - 13.00% graded to 4.50% over 17 years

2024 - 38.00% for one year, then 10.50% graded to 4.50% over 12 years

- Discount rates:

2025 - 5.75%

2024 - 5.50%

- Coverage elections:

Future Medicare-eligible retirees and spouses:

Medical and prescription drug 100%

Future Medicare-eligible spouses:

Medical and prescription drug 100%

The trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point, the estimated obligation would increase as of May 31, 2025 and 2024 by \$102,236,326 and \$79,579,365, respectively.

During the year ended May 31, 2025, valuation assumption changes increased obligations by \$133,106,484. This was primarily due to modifying the future trend on per capita health costs, including the increase in the 2026 Medicare Advantage premium. Other changes include updating valuation-year per capita health costs, retiree contribution rates remaining consistent rather than increasing as expected, and updating assumed future mortality rates. This increase was partially offset by a decrease in obligations due to increasing the discount rate from 5.50% to 5.75%.

During the year ended May 31, 2024, valuation assumption changes increased obligations by \$106,100,646. This was primarily due to updating the valuation-year per capita health costs and modifying the future trend on per capita health costs and retiree contribution rates, including the estimated impact of the Inflation Reduction Act on the Plan's Medicare costs. This increase was partially offset by a decrease in obligations due to increasing the discount rate from 5.00% to 5.50%.

The cost of the postretirement benefit obligations is shared by the participating employers and retirees. For the years ended May 31, 2025 and 2024, retirees were projected to contribute approximately 14% and 18%, respectively, of the estimated cost of providing their postretirement benefits.

**Note 8. Postretirement Benefit Obligations (continued)**

The Plan's excess of benefit obligations over net assets relates primarily to the postretirement benefit obligations. The Plan empowers the Board of Trustees to increase or decrease annually the amount of self-payments by eligible retired participants, to adjust the employer contribution rate, to transfer additional assets from the related welfare fund as deemed appropriate by the Board and the Plan's actuary, and to modify the terms and conditions under which retiree eligibility may be maintained; therefore, the annual cost of the Plan can be reduced or eliminated prospectively by action of the Board of Trustees.

The foregoing assumptions are based on the presumption that the Plan will continue. If the Plan was to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

**Note 9. Risks and Uncertainties**

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and those changes could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

The Plan has a significant portion of its assets invested in the mutual fund Vanguard Total Stock Market Fund. This investment represented approximately 40% and 44% of the Plan's net assets available for benefits as of May 31, 2025 and 2024, respectively.

**Note 10. Concentration of Cash**

Cash consists of monies held in accounts without significant withdrawal restrictions. The Plan places its cash with financial institutions deemed to be creditworthy. Balances are insured by the FDIC up to \$250,000 per financial institution. Although balances may at times exceed insured limits, the Plan believes its credit risk to be minimal.

### Note 11. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500:

	<u>2025</u>	<u>2024</u>
Net assets available for benefits per the financial statements	\$ 61,435,737	\$ 64,501,293
Less - benefit obligations currently payable	<u>(2,170,237)</u>	<u>(1,794,824)</u>
Net assets available for benefits per the Form 5500	<u>\$ 59,265,500</u>	<u>\$ 62,706,469</u>

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500 for the year ended May 31, 2025:

Benefits paid to or for participants per the financial statements	\$ 20,032,985
Add - amounts currently payable at end of year	2,170,237
Less - amounts currently payable at beginning of year	<u>(1,794,824)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 20,408,398</u>

**Report of Independent Auditors on Supplemental Schedules**

To the Participants and Trustees of  
Plumbers' Retiree Medical Plan  
of the Plumbers' Welfare Fund  
Local 130, U.A.

We have audited the financial statements of Plumbers' Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. (the Plan) as of and for the years ended May 31, 2025 and 2024, and our report thereon dated February 13, 2026, which expressed an unmodified opinion on those financial statements, appears on pages 1 through 3. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. Supplemental Schedules 1 and 2 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

*Legacy Professionals LLP*

Westchester, Illinois

February 13, 2026

PLUMBERS' RETIREE MEDICAL PLAN OF THE  
 PLUMBERS' WELFARE FUND, LOCAL 130, U.A.  
 EIN 36-4026252  
 PLAN NO. 503  
 Y/E: 05/31/25

	<u>COST</u>	<u>FMV</u>
INTEREST BEARING CASH		
MIDWEST INSTITUTIONAL TRUST COMPANY		
GOVERNMENT MONEY MARKET PREMIER	44,906	44,906
AMALGAMATED BANK OF CHICAGO		
GOVERNMENT MONEY MARKET PREMIER	<u>1,732,649</u>	<u>1,732,649</u>
TOTAL INTEREST-BEARING CASH	<u>1,777,555</u>	<u>1,777,555</u>
REGISTERED INVESTMENT COMPANIES		
MUTUAL FUNDS		
MIDWEST INSTITUTIONAL TRUST COMPANY		
AMERICAN EUROPACIFIC GROWTH FUND	See attached	684,778
BAIRD CORE PLUS BOND FUND	See attached	9,044,466
FIDELITY ADVISOR INTERNATIONAL	See attached	715,063
HARDING LOEVNER INTERNATIONAL	See attached	477,195
JANUS HENDERSON OVERSEAS FUND	See attached	684,927
WILLIAM BLAIR INTRNATIONAL LEADERS FUND CLASS I	See attached	747,914
VANGUARD TOTAL STOCK MARKET INDEX FUND	See attached	<u>24,443,912</u>
TOTAL REGISTERED INVESTMENT COMPANIES		<u>36,798,255</u>
COMMON AND COLLECTIVE TRUSTS		
COMERICA		
NIS HIGH YIELD FUND, LLC	302,350	392,449
NIS CORE FIXED INCOME FUND	8,155,161	9,092,536
NIS ABSOLUTE RETURN FUND, LLC	<u>756,030</u>	<u>951,953</u>
TOTAL COMMON AND COLLECTIVE TRUSTS	<u>9,213,541</u>	<u>10,436,938</u>
103-12		
WASHINGTON CAPITAL REAL ASSET INCOME FUND LLC	<u>6,800,000</u>	<u>7,664,416</u>
TOTAL INVESTMENTS HELD		<u>56,677,164</u>

-

**RET Med PI of PI Welf LOC 130 Rollup**

Statement Period: 06/01/24 through 05/31/25

**Asset and Liability Positions  
05/31/25**

Account ID	Asset Description <i>Asset ID (CUSIP) / Ticker</i>	Shares / Par	% of Asset Category at Mrkt	Total Cost / Unit Price	Total Market / Unit Price	Market Appr/Depr	% of Acct at Mrkt	Accrued Income	Estimated Annual Income Rate	Market Yield
<b>Equity Funds</b>										
<b>Large Cap</b>										
AC	- Vanguard Total Stock Market Index Fd Class I #855 <i>922908801 / VITSX</i>	172,993.011	88.07	10,384,036.64 <i>60.026</i>	24,443,912.45 <i>141.300</i>	14,059,875.81	44.49		315,712.00 <i>1.82500</i>	1.29%
<b>Total Large Cap</b>			<b>88.07</b>	<b>10,384,036.64</b>	<b>24,443,912.45</b>	<b>14,059,875.81</b>	<b>44.49</b>	<b>0.00</b>	<b>315,712.00</b>	<b>1.29%</b>
<b>International</b>										
AC	- American Eupac Fund Class R6 #2616 <i>298706821 / RERGX</i>	11,403.466	2.47	589,991.26 <i>51.738</i>	684,778.13 <i>60.050</i>	94,786.87	1.25		6,921.00 <i>0.60700</i>	1.01%
AC	- Fidelity Advisor International Capital Appreciation Fund Class Z #2886 <i>315920157 / FIDZX</i>	19,553.260	2.58	567,013.71 <i>28.998</i>	715,062.72 <i>36.570</i>	148,049.01	1.30		5,279.00 <i>0.27000</i>	.74%
AC	- Harding Loevner International Small Companies Portfolio - Inst #206 <i>412295875 / HLMRX</i>	25,168.508	1.72	489,314.77 <i>19.442</i>	477,194.91 <i>18.960</i>	- 12,119.86	.87		5,537.00 <i>0.22000</i>	1.16%
AC	- Janus Henderson Overseas Fund Class N <i>47103D835 / JDINX</i>	13,490.783	2.47	621,273.46 <i>46.052</i>	684,927.05 <i>50.770</i>	63,653.59	1.25		10,981.00 <i>0.81400</i>	1.60%
AC	- William Blair International Leaders CI R6 #2272 <i>969251685 / WILJX</i>	34,434.337	2.69	517,200.02 <i>15.020</i>	747,913.80 <i>21.720</i>	230,713.78	1.36		4,166.00 <i>0.12100</i>	.56%
<b>Total International</b>			<b>11.93</b>	<b>2,784,793.22</b>	<b>3,309,876.61</b>	<b>525,083.39</b>	<b>6.02</b>	<b>0.00</b>	<b>32,884.00</b>	<b>.99%</b>
<b>Total Equity Funds</b>			<b>100.00</b>	<b>13,168,829.86</b>	<b>27,753,789.06</b>	<b>14,584,959.20</b>	<b>50.51</b>	<b>0.00</b>	<b>348,596.00</b>	<b>1.26%</b>

**RET Med PI of PI Welf LOC 130 Rollup**

Statement Period: 06/01/24 through 05/31/25

<b>Asset and Liability Positions 05/31/25</b>										
Account ID	Asset Description <i>Asset ID (CUSIP) / Ticker</i>	Shares / Par	% of Asset Category at Mrkt	Total Cost / Unit Price	Total Market / Unit Price	Market Appr/Depr	% of Acct at Mrkt	Accrued Income	Estimated Annual Income Rate	Market Yield
<b>Total Equity</b>			<u>100.00</u>	<u>13,168,829.86</u>	<u>27,753,789.06</u>	<u>14,584,959.20</u>	<u>50.51</u>	<u>0.00</u>	<u>348,596.00</u>	<u>1.26%</u>
<b>Fixed Income</b>										
<b>Fixed Income Funds Taxable</b>										
AC	- Baird Core Plus Bond Fund Inst #71 <i>057071870 / BCOIX</i>	896,379.168	33.32	9,098,916.29 <i>10.151</i>	9,044,465.81 <i>10.090</i>	- 54,450.48	16.46		379,168.00 <i>0.42300</i>	4.19%

FOOTNOTES

STATEMENT 1

SCHEDULE C- BOX (D) FOR ADMINISTRATOR AND EMPLOYEES: THE AMOUNT OF DIRECT COMPENSATION ATTRIBUTABLE TO PLAN EMPLOYEES AND REPORTED ON SCHEDULE C HAS BEEN DETERMINED IN ACCORDANCE WITH DEPARTMENT OF LABOR RULES AND REGULATIONS FOR COMPLETING FORM 5500. THESE AMOUNTS MAY CONSIST OF ELEMENTS CONSIDERED TO BE TAXABLE AS WELL AS NON-TAXABLE DETERMINED UNDER THE CURRENT INTERNAL REVENUE CODE.

SCHEDULE C - THE ADMINISTRATOR AND CERTAIN EMPLOYEES OF THE PLAN ARE SHARED EMPLOYEES WITH THE RELATED WELFARE PLAN. THE RELATED WELFARE PLAN INITIALLY PAYS THE SALARIES AND BENEFITS AND AMOUNTS ARE PERIODICALLY REIMBURSED ON A ALLOCATION APPROVED BY THE TRUSTEES. THE ALLOCATED AMOUNTS ARE REPORTED IN THIS FORM 5500 FILING.

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 2

Table with 2 columns: NAME, SERVICE CODES. Rows include BRIDGEWAY BENEFIT TECHNOLOGIES LLC with codes 15, 16, 49, 64.

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 3

Table with 2 columns: NAME, SERVICE CODES. Rows include BRIDGEWAY BENEFIT TECHNOLOGIES LLC with codes 15, 16, 49, 64.

CODES TO SCHEDULE C, LINE 4(B)

SCHEDULE H	OTHER RECEIVABLES	STATEMENT 4
DESCRIPTION	BEGINNING	ENDING
ACCRUED INVESTMENT INCOME	595.	162.
PREPAID EXPENSES	125.	12,629.
PRESCRIPTION DRUG REBATES	3,152,185.	4,081,929.
CONTRACT ADMINISTRATOR OPERATING DEP	200,000.	200,000.
TOTAL TO SCHEDULE H, LINE 1B(3)	3,352,905.	4,294,720.

SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT 5
DESCRIPTION	BEGINNING	ENDING
DEFERRED PARTICIPANT CONTRIBUTIONS	363,448.	285,205.
DUE TO RELATED ORGANIZATIONS	1,348,080.	93,444.
TOTAL TO SCHEDULE H, LINE 1J	1,711,528.	378,649.

SCHEDULE H	OTHER INCOME	STATEMENT 6
DESCRIPTION	AMOUNT	
TRANSITIONAL REINSURANCE REFUND	18,265.	
TOTAL TO SCHEDULE H, LINE 2C	18,265.	

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT 7
DESCRIPTION	AMOUNT	
COMPUTER	85,203.	
DEPRECIATION	22,480.	
INSURANCE	15,009.	
MEETING AND CONFERENCE	7,180.	
OFFICE EXPENSES	59,845.	
PAYROLL TAXES	17,720.	
PRINTING AND POSTAGE	6,158.	
RENT	36,831.	
FEES MANDATED BY THE ACA	16,647.	
TOTAL TO SCHEDULE H, LINE 2I(11)	267,073.	

**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 4085 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. 1510-0110  
1510-0099

**2024**

This Form is Open to  
Public Inspection

**Part I Annual Report Identification Information**

For calendar plan year 2024 or fiscal plan year beginning **06/01/2024** and ending **05/31/2025**

- 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.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 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 RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND LOCAL 130, U.A.	<b>1b</b> Three-digit plan number (PN) ▶ 503
	<b>1c</b> Effective date of plan 01/01/2014
<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) BOARD OF TRUSTEES OF THE PLUMBERS' WELFARE FUND, LO  1340 WEST WASHINGTON BOULEVARD  CHICAGO IL 60607	<b>2b</b> Employer Identification Number (EIN) 36-4026252
	<b>2c</b> Plan Sponsor's telephone number 312-757-4689
	<b>2d</b> Business code (see instructions) 238220

**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>	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	<i>[Signature]</i>	<i>[Date]</i>	JAMES O'SULLIVAN
<b>SIGN HERE</b>	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>	<i>[Signature]</i>	<i>[Date]</i>	JAMES F. COYNE
<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 checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number

<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
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<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	2,581
<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>a(1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	
<b>a(2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	2,655
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b>	<b>6d</b>	2,655
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b>	<b>6f</b>	
<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>(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>	347

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

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
**4A 4D 4E 4L 4U**

<b>9a</b> Plan funding arrangement (check all that apply) <b>(1)</b> <input type="checkbox"/> Insurance <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts <b>(3)</b> <input checked="" type="checkbox"/> Trust <b>(4)</b> <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) <b>(1)</b> <input type="checkbox"/> Insurance <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts <b>(3)</b> <input checked="" type="checkbox"/> Trust <b>(4)</b> <input type="checkbox"/> General assets of the sponsor
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**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<p><b>a Pension Schedules</b></p> <p><b>(1)</b> <input type="checkbox"/> <b>R</b> (Retirement Plan Information)</p> <p><b>(2)</b> <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p><b>(3)</b> <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p> <p><b>(4)</b> <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) - Number Attached _____</p> <p><b>(5)</b> <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)</p>	<p><b>b General Schedules</b></p> <p><b>(1)</b> <input checked="" type="checkbox"/> <b>H</b> (Financial Information)</p> <p><b>(2)</b> <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan)</p> <p><b>(3)</b> <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) - Number Attached <u>  2  </u></p> <p><b>(4)</b> <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)</p> <p><b>(5)</b> <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)</p> <p><b>(6)</b> <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)</p>
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**RET Med PI of PI Welf LOC 130 Rollup**

Account Number:  
Statement Period: 06/01/24 through 05/31/25

**5% Transactions**

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
- Baird Intermediate Bond Fd Instl #70							
Recd 3523.332 Shs As A Reinvested Div of \$ 10.250 Per Sh		.00	.00	10.250	36,114.15	36,114.15	.00
Recd 3465.349 Shs As A Reinvested Div of \$ 10.290 Per Sh		.00	.00	10.290	35,658.44	35,658.44	.00
Recd 3375.398 Shs As A Reinvested Div of \$ 10.480 Per Sh		.00	.00	10.480	35,374.17	35,374.17	.00
Recd 3489.369 Shs As A Reinvested Div of \$ 10.570 Per Sh		.00	.00	10.570	36,882.63	36,882.63	.00
Sold 42694.498 Shs 09/30/24		.00	.00	10.540	450,000.00	457,258.07	- 7,258.07
Recd 3465.968 Shs As A Reinvested Div of \$ 10.370 Per Sh		.00	.00	10.370	35,942.09	35,942.09	.00
Recd 3644.249 Shs As A Reinvested Div of \$ 10.350 Per Sh		.00	.00	10.350	37,717.98	37,717.98	.00
Recd 4055.437 Shs As A Reinvested Div of \$ 10.250 Per Sh		.00	.00	10.250	41,568.23	41,568.23	.00
Sold 72815.535 Shs 01/21/25		.00	.00	10.300	750,000.00	779,854.38	- 29,854.38
Recd 2901.590 Shs As A Reinvested Div of \$ 10.300 Per Sh		.00	.00	10.300	29,886.38	29,886.38	.00
Recd 3082.585 Shs As A Reinvested Div of \$ 10.390 Per Sh		.00	.00	10.390	32,028.06	32,028.06	.00
Sold 57636.888 Shs 03/13/25		.00	.00	10.410	600,000.00	617,291.07	- 17,291.07
Recd 3061.228 Shs As A Reinvested Div of \$ 10.370 Per Sh		.00	.00	10.370	31,744.93	31,744.93	.00
Sold 916531.557 Shs 03/28/25		.00	.00	10.410	9,541,093.51	9,783,319.11	- 242,225.60
Purchases	10	.00	.00	10.360	352,917.06	352,917.06	.00
Sales	4	.00	.00	10.408	11,341,093.51	11,637,722.63	- 296,629.12

**RET Med PI of PI Welf LOC 130 Rollup**

Account Number:  
Statement Period: 06/01/24 through 05/31/25

**5% Transactions**

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
- Baird Core Plus Bond Fund Inst #71							
Purchased 886699.507 Shs 03/28/25	*	.00	.00	10.150	9,000,000.00	9,000,000.00	.00
Purchased 53204.869 Shs 03/31/25		.00	.00	10.170	541,093.51	541,093.51	.00
Recd 3090.882 Shs As A Reinvested Div of \$ 10.120 Per Sh		.00	.00	10.120	31,279.73	31,279.73	.00
Sold 49652.433 Shs 05/15/25		.00	.00	10.070	500,000.00	503,972.20	- 3,972.20
Recd 3036.343 Shs As A Reinvested Div of \$ 10.050 Per Sh		.00	.00	10.050	30,515.25	30,515.25	.00
Purchases	4	.00	.00	10.151	9,602,888.49	9,602,888.49	.00
Sales	1	.00	.00	10.070	500,000.00	503,972.20	- 3,972.20
- GS Fin Sq Gov #465							
Purchases	40	.00	.00	1.000	5,728,313.45	5,728,313.45	.00
Sales	19	.00	.00	1.000	5,817,202.47	5,817,202.47	.00
- Vanguard Total Stock Market Index Fd Class I #855							
Sold 11459.129 Shs 06/26/24		.00	.00	130.900	1,500,000.00	627,775.72	872,224.28
Recd 753.922 Shs As A Reinvested Div of \$ 130.270 Per Sh		.00	.00	130.270	98,213.42	98,213.42	.00
Sold 9695.704 Shs 08/28/24		.00	.00	134.080	1,300,000.00	531,168.43	768,831.57
Recd 626.416 Shs As A Reinvested Div of \$ 137.340 Per Sh		.00	.00	137.340	86,031.95	86,031.95	.00
Sold 6527.415 Shs 09/30/24		.00	.00	137.880	900,000.00	357,597.22	542,402.78
Sold 10254.307 Shs 12/09/24		.00	.00	146.280	1,500,000.00	561,770.88	938,229.12
Recd 598.125 Shs As A Reinvested Div of \$ 143.130 Per Sh		.00	.00	143.130	85,609.57	85,609.57	.00
Sold 5150.037 Shs 01/21/25		.00	.00	145.630	750,000.00	282,139.09	467,860.91

**RET Med PI of PI Welf LOC 130 Rollup**

Account Number:  
Statement Period: 06/01/24 through 05/31/25

**5% Transactions**

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
Recd 643.616 Shs As A Reinvested Div of \$ 135.860 Per Sh		.00	.00	135.860	87,441.72	87,441.72	.00
Sold 9896.793 Shs 05/15/25		.00	.00	141.460	1,400,000.00	542,184.87	857,815.13
Purchases	4	.00	.00	136.265	357,296.66	357,296.66	.00
Sales	6	.00	.00	138.723	7,350,000.00	2,902,636.21	4,447,363.79

\* Transactions noted by an asterisk are in themselves greater than 5% of beginning Plan Year market values.