Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB No. 1210-0110
1210-0089

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A This return/report is for: [X] a multiemployer plan [ ] a multiple employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instr.)

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 ▶ [X]

D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program
[ ] special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 04/11/1958

2a 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)
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

1 WALL STREET

BURLINGTON MA 01803-4768

2b Employer Identification Number (EIN) **-***2430

2c Plan Sponsor's telephone number 781-345-4400

2d Business code (see instructions) 484120

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.

SIGN HERE	Signature of plan administrator	7/7/22 Date	SEAN OBRIEN (UNION TRUSTEE) Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	7/10/22 Date	CHRISTOPHER LANGAN (EMP TRUSTEE) Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2020)
v. 200204

3a Plan administrator's name and address [X] Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number

4 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: a Sponsor's name c Plan Name	4b EIN 4d PN

5 Total number of participants at the beginning of the plan year	5	71887
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a (1) Total number of active participants at the beginning of the plan year	6a(1)	21293
a (2) Total number of active participants at the end of the plan year	6a(2)	21608
b Retired or separated participants receiving benefits	6b	25107
c Other retired or separated participants entitled to future benefits	6c	18131
d Subtotal. Add lines **6a(2), 6b,** and **6c**	6d	64846
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	7295
f Total. Add lines **6d** and **6e**	6f	72141
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	388

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

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

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) [ ] Insurance	(1) [ ] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	(3) [X] Trust
(4) [ ] General assets of the sponsor	(4) [ ] 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)

a Pension Schedules

(1) [X] **R** (Retirement Plan Information)

(2) [X] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1) [X] **H** (Financial Information)

(2) [ ] **I** (Financial Information - Small Plan)

(3) [ ] **A** (Insurance Information)

(4) [X] **C** (Service Provider Information)

(5) [X] **D** (DFE/Participating Plan Information)

(6) [ ] **G** (Financial Transaction Schedules)

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

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.

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 2020 Form M-1 annual report. If the plan was not required to file the 2020 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 _____

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.	2020 This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A Name of plan	B Three-digit plan number (PN) ▶
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND	001

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F	04-6372430

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

ABS ALPHA GLOBAL EQUITIES 98-0544028
55 RAILROAD AVE
GREENWICH CT 06830

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

INTERCONTINENTAL US REAL ESTATE FUN 11-3786306
1270 SOLDER FIELD ROAD
BOSTON MA 02135

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

ALINDA INFRASTRUCTURE FUND II 26-2932089
100 WEST PUTNAM AVENUE, 3RD FLOOR
GREENWICH CT 06830

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

ABS INVESTMENT MANAGEMENT, LLC 13-4205457
537 STEAMBOAT RD
GREENWICH CT 06830

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

BBH CAPITAL PARTNERS V 47-3774837
140 BROADWAY
NEW YORK NY 10005

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

CRESCENT MEZZANINE PARTNERS 80-0790681
11100 SANTA MONICA BLVD, SUITE 2000
LOS ANGELES CA 90025

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

ENTRUST GLOBAL PARTNERS OFFSHORE LP 90-0644478
375 PARK AVENUE, 24TH FLOOR
NEW YORK NY 10152

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

LEVINE LEICHTMAN PTR II 26-1936690
335 NORTH MAPLE DRIVE, SUITE 130
BEVERLY HILLS CA 90210

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

CRESCENT HIGH INCOME FUND 45-5287411
11100 SANTA MONICA BLVD, SUITE 2000
LOS ANGELES CA 90025

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

RREEF AMERICAN REIT II 36-4215573
222 S. RIVERSIDE PLAZA
CHICAGO IL 60606

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

OAKTREE MEZZANINE FUND IV 26-0174894
333 SOUTH GRAND AVE, 28TH FLOOR
LOS ANGELES CA 90007

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

ALINDA INFRASTRUCTURE FD III 98-1210428
100 WEST PUTNAM AVENUE, 3RD FLOOR
GREENWICH CT 06830

SCHEDULE C (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider 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.**

OMB No. 1210-0110

2020

This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)
04-6372430

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

AFL-CIO BIT 52-6328901
ONE EAST PRATT STREET 5TH FLOOR EAS
BALTIMORE MD 21202

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

BLACKSTONE REAL ESTATE PARTNER 26-0288589
345 PARK AVENUE
NEW YORK NY 10154

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

PRINCIPAL ENHANCED 20-0928198
711 HIGH STREET
DES MOINES IA 50392

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

STRATEGIC PARTNERS REAL ESTATE VII 82-5302597
345 PARK AVENUE
NEW YORK NY 10154

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

TERRACAP PARTNERS IV 81-4021164
23421 WALDEN CENTER DR., SUITE 300
ESTERO FL 34134

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

ULLICO 90-0622302
8403 COLESVILLE RD
SILVER SPRING MD 20910

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

SIGULER GUFF SM BUY OPP IV 83-2907311
200 PARK AVENUE, 23RD FLOOR
NEW YORK NY 10166

(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 on page 1, 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) SEE STATEMENT 1

MARQUETTE ASSOCIATES 36-3485298
180 N LASALLE
CHICAGO IL 60601

(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?
27 50	NONE	1326667.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STATE STREET GLOBAL ADVISORS 13-1868136
BOX 5488
BOSTON MA 02284

(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 18	NONE	864188.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☐

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

DRIEHAUS CAPITAL MANAGEMENT 20-3634295
PO BOX 10127
CHICAGO IL 60610

(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 68	NONE	603300.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

UNION INSURANCE GROUP 36-4226088
303 W ERIE ST STE310
CHICAGO IL 60654

(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?
23 50	NONE	552307.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FEINBERG, CAMPBELL & ZACK 04-2738936
177 MILK STREET
BOSTON MA 02109

(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 50	NONE	444561.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BOSTON PARTNERS 98-0202744
60 EAST 42ND STREET, SUITE 1550
NEW YORK NY 10065

(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 68	NONE	353275.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

CBIZ 31-1582098
1845 WALNUT STREET, 14TH FLOOR
PHILADELPHIA PA 19103

(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 50	NONE	256856.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STATE STREET BANK & TRUST 04-1867445
200 NEW PORT AVE
QUINCY MA 02171

(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?
25 28 99	NONE	256250.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☒ No ☐

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

GAMCO 13-4044521
ONE CORPORATE CENTER
RYE NY 10580

(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 50	NONE	235044.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

DARCANGELO & CO.,LLP 13-2550103
120 LOMOND CT
UTICA NY 13502

(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 50	NONE	210140.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SIERRA INVESTMENT 68-0370668
PO BOX 5727
VACAVILLE CA 95696

(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 99	NONE	188053.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MELLON INVESTMENTS CORP 25-6078093
ONE WALL STREET
NEW YORK NY 10005

(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 50	NONE	148972.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

ZIEGLER CAPITAL MGMT, LLC 43-1273600
70 WEST MADISON, SUITE 2400
CHICAGO IL 60602

(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 50	NONE	128226.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MORGAN, LEWIS & BOCKIUS 23-0891050
PO BOX 8500
PHILADELPHIA PA 19178

(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 50	NONE	119475.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SB FERNANDES & COMPANY 03-8445474
201 BIRCH KNOLL RD
RUTLAND VT 05701

(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 50	NONE	113222.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

BRIAN RAINVILLE 32-8608348
208 WEST SAINT PAUL AVE
CHICAGO IL 60614

(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?
16 50	NONE	42000.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PJ GREEN, INC. 16-1438577
100 WHITESBORO ST
UTICA NY 13504

(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 50	NONE	32500.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VINTAGE 04-3551065
16 MASON AVE, UNIT 4
NORTH ATTLEBORO MA 02760

(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 50	NONE	26581.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

IBM CORPORATION 36-4826312
1 NORTH CASTLE DRIVE C/O IBM TAX DE
ARMONK NY 10504

(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 50	NONE	22067.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BOSTONIAN ENTERPRISES, INC. 47-2148884
4 ALEXANDER AVE
MEDFORD MA 02155

(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 50	NONE	20700.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PENSION BENEFIT INFO, LLC 82-2042737
333 SOUTH 7TH ST. SUITE 2400
MINNEAPOLIS MN 55402

(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 50	NONE	18276.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

WINDSTREAM 46-2847717
PO BOX 9001013
LOUISVILLE KY 40290-1013

(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 50	NONE	17035.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ITECH SOLUTIONS 06-1414922
27 MILL PLAIN ROAD STE 3
DANBURY CT 06811

(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 50	NONE	16917.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HANOVER INSURANCE CO. 04-3263626
PO BOX 580045
CHARLOTTE NC 28258

(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 50	NONE	12522.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

AM WINS BROKERAGE 22-3297313
PO BOX 60343
CHARLOTTE NC 28260

(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?
22 50	NONE	12495.	Yes [X] No [ ]	Yes [X] No [ ]	0.	Yes [X] No [ ]

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

PITNEY BOWES INC 06-0495050
PO BOX 371887
PITTSBURGH PA 15250-7887

(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 50	NONE	12353.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CONNECTIVITY SYSTEMS, INC. 23-2991794
1220 VALLEY FORGE RD STE 18
PHOENIXVILLE PA 19460

(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 50	NONE	12310.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

WB MASON 04-2455641
59 CENTRE ST
BROCKTON MA 02301

(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 50	NONE	8552.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NATIONAL COORDINATING 52-1041104
815 16TH STREET
N.W. WASHINGTON DC 20006

(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 50	NONE	8250.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VANGUARD SYSTEMS INC 23-2493967
2901 DUTTON MILL RD SUITE 220
ASTON PA 19014

(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 50	NONE	7560.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

CORPORATE RISK ADVISORS 04-2532724
PO BOX 290788
BOSTON MA 02129

(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?
23 50	NONE	7427.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RENA GYFTOPOULOUS AIA, LEED AP 86-2273679
185 I ST.
SOUTH BOSTON MA 02127

(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 50	NONE	7320.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

O'SULLIVAN & ASSOCIATES 02-5608070
18 LAUREL DRIVE
NORWELL MA 02061

(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 50	NONE	7000.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

PROXYVOTE PLUS 76-0702630
1200 SHERMER RD, SUITE 216
NORTHBROOKE IL 60062

(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 50	NONE	6600.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NEW ENGLAND INSURANCE GROUP 46-3082222
200 RESERVOIR ST
NEEDHAM MA 02494

(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?
22 50	NONE	6187.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LIBERTY MUTUAL 04-1543470
PO BOX 2839
NEW YORK NY 10116

(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?
22 50	NONE	6046.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a on page 1, 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) SEE STATEMENT 1

DE LAGE LANDEN FINANCIAL SVC 38-1904500
PO BOX 41602
PHILADELPHIA PA 19101

(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 50	NONE	5461.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

COMPU-CALL 51-0288326
PO BOX 3335
S ATTLEBORO MA 02703

(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 50	NONE	5443.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

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.

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

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

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

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

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

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

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.	2020 This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A Name of plan: NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FU

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500: NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN): 04-6372430

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SIERRA FRANKLIN EAFE PLUS EQUITY TR

b Name of sponsor of entity listed in (a): FIDUCIARY TRUST INTERNATIONAL OF THE SOUTH

c EIN-PN 90-6149946 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 24191737.

a Name of MTIA, CCT, PSA, or 103-12 IE: ARISTOTLE SMALL-CAP EQUITY FUND

b Name of sponsor of entity listed in (a): ARISTOTLE CAPITAL BOSTON, LLC

c EIN-PN 81-4315797 003 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 35370491.

a Name of MTIA, CCT, PSA, or 103-12 IE: EMERGING MARKETS SMALL-CAP FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 26-6149812 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 80941297.

a Name of MTIA, CCT, PSA, or 103-12 IE: RUSSELL 1000(R) VALUE INDX NL MUTUA

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 90-0337987 123 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 714105888.

a Name of MTIA, CCT, PSA, or 103-12 IE: AGGREGATE BOND INDEX NL FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-0025081 070 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 193738967.

a Name of MTIA, CCT, PSA, or 103-12 IE: MSCI ACWI EX USA NL FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 90-0337987 159 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 203592492.

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

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

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
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c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

a Plan name
b Name of plan sponsor
c EIN-PN

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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). ▶ File as an attachment to Form 5500.	2020 This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A Name of plan

NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FU

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500

NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)

04-6372430

Part I Asset and Liability Statement

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.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	61443367	64708504
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1780111424	1671067290
(2) Participant contributions	1b(2)		
(3) Other SEE STATEMENT 2	1b(3)	5657191	4964837
c General investments:			
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)	30357035	11234588
(2) U.S. Government securities	1c(2)	38586276	60118373
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	17223739	18761848
(B) All other	1c(3)(B)	26745918	31968855
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	521087	335440
(B) Common	1c(4)(B)	127187642	138412433
(5) Partnership/joint venture interests	1c(5)	722581382	809671624
(6) Real estate (other than employer real property)	1c(6)	142790000	143790000
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	1188548273	1251940873
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance co. general account (unallocated contracts)	1c(14)		
(15) Other SEE STATEMENT 3	1c(15)	1842412	1681564

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	197612	157561
f Total assets (add all amounts in lines 1a through 1e)	1f	4143793358	4208813790
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	2060944	2602943
i Acquisition indebtedness	1i	79857000	80561078
j Other liabilities SEE STATEMENT 4	1j	7578314	8871582
k Total liabilities (add all amounts in lines 1g through 1j)	1k	89496258	92035603
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	4054297100	4116778187

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.

Income		(a) Amount	(b) Total
a **Contributions:**			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	275579393	
(B) Participants	2a(1)(B)		
(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)		275579393
b **Earnings on investments:**			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	7934	
(B) U.S. Government securities	2b(1)(B)	834920	
(C) Corporate debt instruments	2b(1)(C)	1414805	
(D) Loans (other than to participants)	2b(1)(D)	-20595	
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	26068289	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		28305353
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	2818257	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		2818257
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	258534154	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	233910445	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		24623709
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	1000000	
(B) Other	2b(5)(B)	128647224	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		129647224

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		282278562
(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)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income SEE STATEMENT 5	2c		94273
d Total income. Add all **income** amounts in column (b) and enter total	2d		743346771
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	661655016	
(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)		661655016
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	1098098	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)	11566047	
(4) Other SEE STATEMENT 6	2i(4)	6546523	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		19210668
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		680865684
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		62481087
l 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) [X] 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) [X] 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: DARCANGELO & CO., LLP (2) EIN: 13-2550103

d The opinion of an independent qualified public accountant is **not attached** because:
(1) [ ] This form is filed for a CCT, PSA, 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.
During the plan year:

		Yes	No	Amount
a 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.)	4a		X	

		Yes	No	Amount
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.)	4b		X	
c 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.)	4c		X	
d 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.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		10000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g 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?	4g		X	
h 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?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j 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.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n 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	4n		X	

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.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** 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 421433 .

SCHEDULE MB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND

D Employer Identification Number (EIN)
04-6372430

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

1a Enter the valuation date: Month 10 Day 01 Year 2020

b	Assets		
	(1) Current value of assets	1b(1)	2,298,267,263
	(2) Actuarial value of assets for funding standard account	1b(2)	2,478,766,808
c	(1) Accrued liability for plan using immediate gain methods	1c(1)	8,927,543,224
	(2) Information for plans using spread gain methods:		
	(a) Unfunded liability for methods with bases	1c(2)(a)	
	(b) Accrued liability under entry age normal method	1c(2)(b)	
	(c) Normal cost under entry age normal method	1c(2)(c)	
	(3) Accrued liability under unit credit cost method	1c(3)	8,927,543,224
d	Information on current liabilities of the plan:		
	(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1)	
	(2) "RPA '94" information:		
	(a) Current liability	1d(2)(a)	19,735,382,028
	(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	455,021,483
	(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	672,268,290
	(3) Expected plan disbursements for the plan year	1d(3)	672,268,290

Statement by Enrolled Actuary

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

SIGN HERE

BRYAN M. MCCORMICK BMM
Signature of actuary

05/24/2022
Date

BRYAN M. MCCORMICK
Type or print name of actuary

2007345
Most recent enrollment number

CBIZ Retirement & Invest Solutions
Firm name

215-587-0700
Telephone number (including area code)

1845 WALNUT STREET SUITE 1000
PHILADELPHIA PA 19103-4755
Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

2 Operational information as of beginning of this plan year:

			(1) Number of participants	(2) Current liability
a	Current value of assets (see instructions)	2a		2298267263
b	"RPA '94" current liability/participant count breakdown:			
	(1) For retired participants and beneficiaries receiving payment		32399	8368946761
	(2) For terminated vested participants		18403	3642340203
	(3) For active participants:			
	(a) Non-vested benefits			320446228
	(b) Vested benefits			7403648836
	(c) Total active		21293	7724095064
	(4) Total		72095	19735382028
c	If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c		11.6500 %

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

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04-01-2021	119065796				
04-01-2021	241476144				
10-01-2021	25839258				
			Totals ▶ 3(b)	386381198	3(c)

4 Information on plan status:

a	Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	4a	27.80 %
b	Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	4b	D
c	Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?		[X] Yes [ ] No
d	If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)?		[ ] Yes [X] No
e	If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	4e	
f	If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here [X]	4f	2030

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

a [ ] Attained age normal **b** [ ] Entry age normal **c** [X] Accrued benefit (unit credit) **d** [ ] Aggregate
e [ ] Frozen initial liability **f** [ ] Individual level premium **g** [ ] Individual aggregate **h** [ ] Shortfall
i [ ] Other (specify):

j	If box h is checked, enter period of use of shortfall method	5j		
k	Has a change been made in funding method for this plan year?		[ ] Yes	[X] No
l	If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?		[ ] Yes	[ ] No
m	If line k is "Yes," and line l is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method	5m		

6 Checklist of certain actuarial assumptions:

			Pre-retirement	Post-retirement
a	Interest rate for "RPA '94" current liability	6a	2.55 %	
b	Rates specified in insurance or annuity contracts		☐ Yes ☒ No ☐ N/A	☐ Yes ☒ No ☐ N/A
c	Mortality table code for valuation purposes:			
	(1) Males	6c(1)	A	A
	(2) Females	6c(2)	A	A
d	Valuation liability interest rate	6d	8.50 %	8.50 %
e	Expense loading	6e	6.6 % ☐ N/A	% ☒ N/A
f	Salary scale	6f	% ☒ N/A	
g	Estimated investment return on actuarial value of assets for year ending on the valuation date	6g		4.9 %
h	Estimated investment return on current value of assets for year ending on the valuation date	6h		5.6 %

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	158821701	17627081

8 Miscellaneous information:

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

9 Funding standard account statement for this plan year:

			Outstanding balance	
Charges to funding standard account:				
a	Prior year funding deficiency, if any	9a		4342984966
b	Employer's normal cost for plan year as of valuation date	9b		138063934
c	Amortization charges as of valuation date:			
	(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	2210083106	406600793
	(2) Funding waivers	9c(2)		
	(3) Certain bases for which the amortization period has been extended	9c(3)		
d	Interest as applicable on lines 9a, 9b, and 9c	9d		415450224
e	Total charges. Add lines 9a through 9d	9e		5303099917

Credits to funding standard account:

f	Prior year credit balance, if any		9f	
g	Employer contributions. Total from column (b) of line 3		9g	386381198
		Outstanding balance		
h	Amortization credits as of valuation date	9h 104291656		29139493
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h		9i	17529392
j	Full funding limitation (FFL) and credits:			
	(1) ERISA FFL (accrued liability FFL)	9j(1) 2630425098		
	(2) "RPA '94" override (90% current liability FFL)	9j(2) 16042577387		
	(3) FFL credit		9j(3)	
k	(1) Waived funding deficiency		9k(1)	
	(2) Other credits		9k(2)	
l	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)		9l	433050083
m	Credit balance: If line 9l is greater than line 9e, enter the difference		9m	
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference		9n	4870049834
9o	Current year's accumulated reconciliation account:			
	(1) Due to waived funding deficiency accumulated prior to the 2020 plan year		9o(1)	
	(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:			
	(a) Reconciliation outstanding balance as of valuation date		9o(2)(a)	
	(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))		9o(2)(b)	
	(3) Total as of valuation date		9o(3)	
10	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)		10	4870049834
11	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions			[X] Yes [ ] No

SCHEDULE R (Form 5500)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	2020 This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)
04-6372430

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions 1 0

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

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

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3 0

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month ___ Day ___ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) 6a

b Enter the amount contributed by the employer to the plan for this plan year 6b

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) 6c

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

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

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

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box ..... ☐ Increase ☐ Decrease ☐ Both ☒ No

Part IV ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ Yes ☐ No

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

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

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

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

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer UNITED PARCEL SERVICES
b EIN 36-2407381 **c** Dollar amount contributed by employer 186724882.
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 07 Day 31 Year 2023
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) 6.20
(2) Base unit measure: ☒ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents)
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents)
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents)
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents)
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents)
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

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

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: [X] last contributing employer [ ] alternative [ ] reasonable approximation (see instructions for required attachment)	**14a**	23090
b The plan year immediately preceding the current plan year. [ ] Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14b**	24042
c The second preceding plan year [ ] Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14c**	25592

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

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	96.04
b The corresponding number for the second preceding plan year	**15b**	93.94

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

a Enter the number of employers who withdrew during the preceding plan year	**16a**	8
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	39925275

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

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

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

19 If the total number of participants is 1,000 or more, complete lines (a) through (c)

a Enter the percentage of plan assets held as:
Stock: 5.6 % Investment-Grade Debt: 3.6 % High-Yield Debt: .0 % Real Estate: 5.8 % Other: 85.0 %

b Provide the average duration of the combined investment-grade and high-yield debt:
[ ] 0-3 years [X] 3-6 years [ ] 6-9 years [ ] 9-12 years [ ] 12-15 years [ ] 15-18 years [ ] 18-21 years [ ] 21 years or more

c What duration measure was used to calculate line 19(b)?
[X] Effective duration [ ] Macaulay duration [ ] Modified duration [ ] Other (specify):

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

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

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

[ ] Yes.

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

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

[ ] No. Other. Provide explanation _____

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 1

NAME	SERVICE CODES
STATE STREET GLOBAL ADVISORS	28
STATE STREET GLOBAL ADVISORS	51
STATE STREET GLOBAL ADVISORS	18
STATE STREET GLOBAL ADVISORS	19

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 2

DESCRIPTION	BEGINNING	ENDING
ACCRUED INCOME RECEIVABLE	899794.	930669.
RECEIVABLE FOR SECURITY SOLD	3555656.	1516097.
FOREIGN EXCHANGE RECEIVABLE	1201741.	2518071.
TOTAL TO SCHEDULE H, LINE 1B(3)	5657191.	4964837.

SCHEDULE H OTHER GENERAL INVESTMENTS STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
RESTON HEIGHTS CURRENT ASSETS	1842412.	1681564.
TOTAL TO SCHEDULE H, LINE 1C(15)	1842412.	1681564.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 4

DESCRIPTION	BEGINNING	ENDING
PAYABLE FOR SECURITY PURCHASED	6375863.	6353233.
FOREIGN EXCHANGE PAYABLE	1202451.	2518349.
TOTAL TO SCHEDULE H, LINE 1J	7578314.	8871582.

SCHEDULE H — OTHER INCOME — STATEMENT 5

DESCRIPTION	AMOUNT
OTHER INCOME	94273.
TOTAL TO SCHEDULE H, LINE 2C	94273.

SCHEDULE H — OTHER ADMINISTRATIVE EXPENSES — STATEMENT 6

DESCRIPTION	AMOUNT
ADMINISTRATIVE EXPENSES	6546523.
TOTAL TO SCHEDULE H, LINE 2I(4)	6546523.