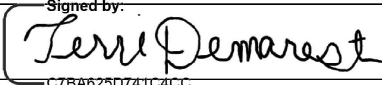


|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <div>Form 5500</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security<br/>Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Annual Return/Report of Employee Benefit Plan</div> <div>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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div> | <div>OMB Nos, 1210-0110<br/>1210-0089</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I                                                                                     | Annual Report Identification Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| A                                                                                          | This return/report is for: <div><div><input type="checkbox"/> a multiemployer plan</div><div><input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)</div><div><input checked="" type="checkbox"/> a single-employer plan</div><div><input type="checkbox"/> a DFE (specify) _____</div><div><input type="checkbox"/> the first return/report</div><div><input type="checkbox"/> the final return/report</div><div><input type="checkbox"/> an amended return/report</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months)</div></div> |
| C                                                                                          | If the plan is a collectively-bargained plan, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| D                                                                                          | Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558</div><div><input type="checkbox"/> automatic extension</div><div><input type="checkbox"/> the DFVC program</div><div><input type="checkbox"/> special extension (enter description)</div></div>                                                                                                                                                                                                                                                                                                                                                                                                       |
| E                                                                                          | If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|         |                                                                                                                                                                                                                                                                                                                                           |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information—enter all requested information                                                                                                                                                                                                                                                                                    |
| 1a      | Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                                                                                                                                                                                                                                                                             |
| 1b      | Three-digit plan number (PN) ▶ 505                                                                                                                                                                                                                                                                                                        |
| 1c      | Effective date of plan<br>09/16/1966                                                                                                                                                                                                                                                                                                      |
| 2a      | Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>SETON HALL UNIVERSITY<br><br>400 SOUTH ORANGE AVENUE<br>SOUTH ORANGE, NJ 070792646 |
| 2b      | Employer Identification Number (EIN)<br>22-1500645                                                                                                                                                                                                                                                                                        |
| 2c      | Plan Sponsor's telephone number<br>973-761-9181                                                                                                                                                                                                                                                                                           |
| 2d      | Business code (see instructions)<br>611000                                                                                                                                                                                                                                                                                                |

|                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         |           |                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------|
| 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                                                                                                                                                                                                                                                                                                                              | <div>Signed by: </div> <div>C7BA625D741C4CC...</div> | 10/1/2025 | Terri Demarest                                               |
|                                                                                                                                                                                                                                                                                                                                        | Signature of plan administrator                                                                                                         | Date      | Enter name of individual signing as plan administrator       |
| SIGN HERE                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |           |                                                              |
|                                                                                                                                                                                                                                                                                                                                        | Signature of employer/plan sponsor                                                                                                      | Date      | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |           |                                                              |
|                                                                                                                                                                                                                                                                                                                                        | Signature of DFE                                                                                                                        | Date      | Enter name of individual signing as DFE                      |

|                                                                                                                                                                                                                                |  |                                                                                       |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|------|
| Form 5500 (2024)                                                                                                                                                                                                               |  | Page 2                                                                                |      |
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> 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: |  | 4b EIN                                                                                |      |
| a Sponsor's name                                                                                                                                                                                                               |  | 4d PN                                                                                 |      |
| c Plan Name                                                                                                                                                                                                                    |  |                                                                                       |      |
| 5 Total number of participants at the beginning of the plan year                                                                                                                                                               |  | 5                                                                                     | 1345 |
| 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)                                                                                 | 1315 |
| a(2) Total number of active participants at the end of the plan year .....                                                                                                                                                     |  | 6a(2)                                                                                 | 1375 |
| b Retired or separated participants receiving benefits.....                                                                                                                                                                    |  | 6b                                                                                    | 27   |
| c Other retired or separated participants entitled to future benefits .....                                                                                                                                                    |  | 6c                                                                                    | 0    |
| d Subtotal. Add lines 6a(2), 6b, and 6c.....                                                                                                                                                                                   |  | 6d                                                                                    | 1402 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....                                                                                                                            |  | 6e                                                                                    |      |
| f Total. Add lines 6d and 6e.....                                                                                                                                                                                              |  | 6f                                                                                    |      |
| g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....                                                                              |  | 6g(1)                                                                                 |      |
| g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....                                                                                    |  | 6g(2)                                                                                 |      |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....                                                                                             |  | 6h                                                                                    |      |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                                                                                                  |  | 7                                                                                     |      |
| 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:                                                                          |  |                                                                                       |      |
| b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:                                                                           |  |                                                                                       |      |
| 4A 4B 4D 4E 4H 4L 4Q                                                                                                                                                                                                           |  |                                                                                       |      |
| 9a Plan funding arrangement (check all that apply)                                                                                                                                                                             |  | 9b Plan benefit arrangement (check all that apply)                                    |      |
| (1) <input checked="" type="checkbox"/> Insurance                                                                                                                                                                              |  | (1) <input checked="" type="checkbox"/> Insurance                                     |      |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts                                                                                                                                                        |  | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts               |      |
| (3) <input type="checkbox"/> Trust                                                                                                                                                                                             |  | (3) <input type="checkbox"/> Trust                                                    |      |
| (4) <input checked="" type="checkbox"/> General assets of the sponsor                                                                                                                                                          |  | (4) <input checked="" type="checkbox"/> General assets of the sponsor                 |      |
| 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)                                                                     |  |                                                                                       |      |
| a Pension Schedules                                                                                                                                                                                                            |  | b General Schedules                                                                   |      |
| (1) <input type="checkbox"/> R (Retirement Plan Information)                                                                                                                                                                   |  | (1) <input type="checkbox"/> H (Financial Information)                                |      |
| (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary                                                                        |  | (2) <input type="checkbox"/> I (Financial Information – Small Plan)                   |      |
| (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary                                                                                                      |  | (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached 9 |      |
| (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____                                                                                                                                         |  | (4) <input type="checkbox"/> C (Service Provider Information)                         |      |
| (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)                                                                                                                                               |  | (5) <input type="checkbox"/> D (DFE/Participating Plan Information)                   |      |
|                                                                                                                                                                                                                                |  | (6) <input type="checkbox"/> 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

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

|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier

CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 59-1031071 | 67369         | 3334085                               | 1049                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|                                      | 227254                        |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

|                                                                                                  |
|--------------------------------------------------------------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid |
| MERCER HEALTH AND BENEFITS, LLC. 4565 PAYSPHERE CIRCLE CHICAGO, IL 60674                         |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                          | (e) Organization code |
|-----------------------------------------------|---------------------------------|--------------------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose              |                       |
|                                               | 227254                          | BENEFIT ADVISOR PAYMENTS | 3                     |

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

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



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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                |  |                                                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Part II                                                                                                                                                        |  | Investment and Annuity Contract Information                                                                                                                         |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |  |                                                                                                                                                                     |  |
| 4                                                                                                                                                              |  | Current value of plan's interest under this contract in the general account at year end                                                                             |  |
| 5                                                                                                                                                              |  | Current value of plan's interest under this contract in separate accounts at year end                                                                               |  |
| 6 Contracts With Allocated Funds:                                                                                                                              |  |                                                                                                                                                                     |  |
| a State the basis of premium rates                                                                                                                             |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Premiums paid to carrier                                                                                                                                            |  |
| c                                                                                                                                                              |  | Premiums due but unpaid at the end of the year                                                                                                                      |  |
| d                                                                                                                                                              |  | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. |  |
|                                                                                                                                                                |  | Specify nature of costs                                                                                                                                             |  |
| e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify)                                                                     |  |                                                                                                                                                                     |  |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here                                                       |  |                                                                                                                                                                     |  |
| 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                |  |                                                                                                                                                                     |  |
| a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other                                       |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Balance at the end of the previous year                                                                                                                             |  |
| c                                                                                                                                                              |  | Additions:                                                                                                                                                          |  |
|                                                                                                                                                                |  | (1) Contributions deposited during the year                                                                                                                         |  |
|                                                                                                                                                                |  | (2) Dividends and credits                                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Interest credited during the year                                                                                                                               |  |
|                                                                                                                                                                |  | (4) Transferred from separate account                                                                                                                               |  |
|                                                                                                                                                                |  | (5) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (6) Total additions                                                                                                                                                 |  |
| d                                                                                                                                                              |  | Total of balance and additions (add lines 7b and 7c(6))                                                                                                             |  |
| e                                                                                                                                                              |  | Deductions:                                                                                                                                                         |  |
|                                                                                                                                                                |  | (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                           |  |
|                                                                                                                                                                |  | (2) Administration charge made by carrier                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Transferred to separate account                                                                                                                                 |  |
|                                                                                                                                                                |  | (4) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (5) Total deductions                                                                                                                                                |  |
| f                                                                                                                                                              |  | Balance at the end of the current year (subtract line 7e(5) from line 7d)                                                                                           |  |

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a☒ Health (other than dental or vision)

b☐ Dental

c☐ Vision

d☐ Life insurance

e☐ Temporary disability (accident and sickness)

f☐ Long-term disability

g☐ Supplemental unemployment

h☐ Prescription drug

i☐ Stop loss (large deductible)

j☐ HMO contract

k☐ PPO contract

l☒ Indemnity contract

m☐ Other (specify) ▶

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b

Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c

Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

22724650

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

11

Did the insurance company fail to provide any information necessary to complete Schedule A?

☐ Yes

☒ No

12

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ▶ 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
FIDELITY SECURITY LIFE INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 43-0949844 | 71870         | 1008322,1054008                       | 2271                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|                                      |                               |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                |  |                                                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Part II                                                                                                                                                        |  | Investment and Annuity Contract Information                                                                                                                         |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |  |                                                                                                                                                                     |  |
| 4                                                                                                                                                              |  | Current value of plan's interest under this contract in the general account at year end                                                                             |  |
| 5                                                                                                                                                              |  | Current value of plan's interest under this contract in separate accounts at year end                                                                               |  |
| 6 Contracts With Allocated Funds:                                                                                                                              |  |                                                                                                                                                                     |  |
| a State the basis of premium rates                                                                                                                             |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Premiums paid to carrier                                                                                                                                            |  |
| c                                                                                                                                                              |  | Premiums due but unpaid at the end of the year                                                                                                                      |  |
| d                                                                                                                                                              |  | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. |  |
|                                                                                                                                                                |  | Specify nature of costs                                                                                                                                             |  |
| e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify)                                                                     |  |                                                                                                                                                                     |  |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here                                                       |  |                                                                                                                                                                     |  |
| 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                |  |                                                                                                                                                                     |  |
| a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other                                       |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Balance at the end of the previous year                                                                                                                             |  |
| c                                                                                                                                                              |  | Additions:                                                                                                                                                          |  |
|                                                                                                                                                                |  | (1) Contributions deposited during the year                                                                                                                         |  |
|                                                                                                                                                                |  | (2) Dividends and credits                                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Interest credited during the year                                                                                                                               |  |
|                                                                                                                                                                |  | (4) Transferred from separate account                                                                                                                               |  |
|                                                                                                                                                                |  | (5) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (6) Total additions                                                                                                                                                 |  |
| d                                                                                                                                                              |  | Total of balance and additions (add lines 7b and 7c(6))                                                                                                             |  |
| e                                                                                                                                                              |  | Deductions:                                                                                                                                                         |  |
|                                                                                                                                                                |  | (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                           |  |
|                                                                                                                                                                |  | (2) Administration charge made by carrier                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Transferred to separate account                                                                                                                                 |  |
|                                                                                                                                                                |  | (4) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (5) Total deductions                                                                                                                                                |  |
| f                                                                                                                                                              |  | Balance at the end of the current year (subtract line 7e(5) from line 7d)                                                                                           |  |

Part III

Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☐ Dental

c ☒ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

10a

19833

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
DELTA DENTAL OF NEW JERSEY, INC.

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 22-1896118 | 55085         | 07742                                 | 2038                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 10762                                |                               |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC. 4565 PAYSPHERE CIRCLE  
CHICAGO, IL 60674

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 10762                                         |                                 |             | 3                     |

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

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



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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                |  |                                                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Part II                                                                                                                                                        |  | Investment and Annuity Contract Information                                                                                                                         |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |  |                                                                                                                                                                     |  |
| 4                                                                                                                                                              |  | Current value of plan's interest under this contract in the general account at year end                                                                             |  |
| 5                                                                                                                                                              |  | Current value of plan's interest under this contract in separate accounts at year end                                                                               |  |
| 6 Contracts With Allocated Funds:                                                                                                                              |  |                                                                                                                                                                     |  |
| a State the basis of premium rates                                                                                                                             |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Premiums paid to carrier                                                                                                                                            |  |
| c                                                                                                                                                              |  | Premiums due but unpaid at the end of the year                                                                                                                      |  |
| d                                                                                                                                                              |  | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. |  |
|                                                                                                                                                                |  | Specify nature of costs                                                                                                                                             |  |
| e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify)                                                                     |  |                                                                                                                                                                     |  |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here                                                       |  |                                                                                                                                                                     |  |
| 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                |  |                                                                                                                                                                     |  |
| a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other                                       |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Balance at the end of the previous year                                                                                                                             |  |
| c                                                                                                                                                              |  | Additions:                                                                                                                                                          |  |
|                                                                                                                                                                |  | (1) Contributions deposited during the year                                                                                                                         |  |
|                                                                                                                                                                |  | (2) Dividends and credits                                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Interest credited during the year                                                                                                                               |  |
|                                                                                                                                                                |  | (4) Transferred from separate account                                                                                                                               |  |
|                                                                                                                                                                |  | (5) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (6) Total additions                                                                                                                                                 |  |
| d                                                                                                                                                              |  | Total of balance and additions (add lines 7b and 7c(6))                                                                                                             |  |
| e                                                                                                                                                              |  | Deductions:                                                                                                                                                         |  |
|                                                                                                                                                                |  | (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                           |  |
|                                                                                                                                                                |  | (2) Administration charge made by carrier                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Transferred to separate account                                                                                                                                 |  |
|                                                                                                                                                                |  | (4) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (5) Total deductions                                                                                                                                                |  |
| f                                                                                                                                                              |  | Balance at the end of the current year (subtract line 7e(5) from line 7d)                                                                                           |  |

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☒ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☐ Other (specify) ▶

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

1076216

(2) Increase (decrease) in amount due but unpaid

9a(2)

0

(3) Increase (decrease) in unearned premium reserve

9a(3)

0

(4) Earned ((1) + (2) - (3))

9a(4)

1076216

b

Benefit charges (1) Claims paid

9b(1)

978902

(2) Increase (decrease) in claim reserves

9b(2)

9628

(3) Incurred claims (add (1) and (2))

9b(3)

988530

(4) Claims charged

9b(4)

988530

c

Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

10762

(B) Administrative service or other fees

9c(1)(B)

134918

(C) Other specific acquisition costs

9c(1)(C)

0

(D) Other expenses

9c(1)(D)

0

(E) Taxes

9c(1)(E)

0

(F) Charges for risks or other contingencies

9c(1)(F)

13991

(G) Other retention charges

9c(1)(G)

0

(H) Total retention

9c(1)(H)

159671

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

0

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

0

(2) Claim reserves

9d(2)

77496

(3) Other reserves

9d(3)

0

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

0

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

11

Did the insurance company fail to provide any information necessary to complete Schedule A?

☐ Yes

☒ No

12

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
ALPHA DENTAL PROGRAMS, INC.

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 74-2447512 | 95163         | 78998                                 | 229                                                                         | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 327                                  |                               |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC. 4565 PAYSPHERE CIRCLE  
CHICAGO, IL 60674

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 327                                           |                                 |             | 3                     |

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

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

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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                                                                                          |  |                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                           |  | <b>Investment and Annuity Contract Information</b> |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.                                                                           |  |                                                    |  |
| <b>4</b> Current value of plan's interest under this contract in the general account at year end .....                                                                                                                                   |  | <b>4</b>                                           |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....                                                                                                                                      |  | <b>5</b>                                           |  |
| <b>6</b> Contracts With Allocated Funds:                                                                                                                                                                                                 |  |                                                    |  |
| <b>a</b> State the basis of premium rates ▶                                                                                                                                                                                              |  |                                                    |  |
| <b>b</b> Premiums paid to carrier .....                                                                                                                                                                                                  |  | <b>6b</b>                                          |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                                                                            |  | <b>6c</b>                                          |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶                           |  | <b>6d</b>                                          |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶                                                        |  |                                                    |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                                                                               |  |                                                    |  |
| <b>7</b> Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                                                                                   |  |                                                    |  |
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ |  |                                                    |  |
| <b>b</b> Balance at the end of the previous year .....                                                                                                                                                                                   |  | <b>7b</b>                                          |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....                                                                                                                                                                    |  | <b>7c(1)</b>                                       |  |
| (2) Dividends and credits.....                                                                                                                                                                                                           |  | <b>7c(2)</b>                                       |  |
| (3) Interest credited during the year.....                                                                                                                                                                                               |  | <b>7c(3)</b>                                       |  |
| (4) Transferred from separate account.....                                                                                                                                                                                               |  | <b>7c(4)</b>                                       |  |
| (5) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7c(5)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (6)Total additions .....                                                                                                                                                                                                                 |  | <b>7c(6)</b>                                       |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                                                                                    |  | <b>7d</b>                                          |  |
| <b>e</b> Deductions:                                                                                                                                                                                                                     |  |                                                    |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                                                                                                |  | <b>7e(1)</b>                                       |  |
| (2) Administration charge made by carrier.....                                                                                                                                                                                           |  | <b>7e(2)</b>                                       |  |
| (3) Transferred to separate account .....                                                                                                                                                                                                |  | <b>7e(3)</b>                                       |  |
| (4) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7e(4)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (5) Total deductions .....                                                                                                                                                                                                               |  | <b>7e(5)</b>                                       |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                                                                                   |  | <b>7f</b>                                          |  |

Part III

Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☒ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

10a

32732

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
STANDARD INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 93-0242990 | 69019         | 170601                                | 1410                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                              |                                       |
|----------------------------------------------|---------------------------------------|
| (a) Total amount of commissions paid<br>6132 | (b) Total amount of fees paid<br>7133 |
|----------------------------------------------|---------------------------------------|

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC. 4565 PAYSPHERE CIRCLE  
CHICAGO, IL 60674

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
|                                               | 7133                            | BONUS       | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC. 1166 AVENUE OF THE AMERICAS  
22ND FLOOR  
NEW YORK, NY 10036

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 6132                                          |                                 |             | 3                     |



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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                                                                                          |  |                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                           |  | <b>Investment and Annuity Contract Information</b> |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.                                                                           |  |                                                    |  |
| <b>4</b> Current value of plan's interest under this contract in the general account at year end .....                                                                                                                                   |  | <b>4</b>                                           |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....                                                                                                                                      |  | <b>5</b>                                           |  |
| <b>6</b> Contracts With Allocated Funds:                                                                                                                                                                                                 |  |                                                    |  |
| <b>a</b> State the basis of premium rates ▶                                                                                                                                                                                              |  |                                                    |  |
| <b>b</b> Premiums paid to carrier .....                                                                                                                                                                                                  |  | <b>6b</b>                                          |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                                                                            |  | <b>6c</b>                                          |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶                           |  | <b>6d</b>                                          |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶                                                        |  |                                                    |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                                                                               |  |                                                    |  |
| <b>7</b> Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                                                                                   |  |                                                    |  |
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ |  |                                                    |  |
| <b>b</b> Balance at the end of the previous year .....                                                                                                                                                                                   |  | <b>7b</b>                                          |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....                                                                                                                                                                    |  | <b>7c(1)</b>                                       |  |
| (2) Dividends and credits.....                                                                                                                                                                                                           |  | <b>7c(2)</b>                                       |  |
| (3) Interest credited during the year.....                                                                                                                                                                                               |  | <b>7c(3)</b>                                       |  |
| (4) Transferred from separate account.....                                                                                                                                                                                               |  | <b>7c(4)</b>                                       |  |
| (5) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7c(5)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (6)Total additions .....                                                                                                                                                                                                                 |  | <b>7c(6)</b>                                       |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                                                                                    |  | <b>7d</b>                                          |  |
| <b>e</b> Deductions:                                                                                                                                                                                                                     |  |                                                    |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                                                                                                |  | <b>7e(1)</b>                                       |  |
| (2) Administration charge made by carrier.....                                                                                                                                                                                           |  | <b>7e(2)</b>                                       |  |
| (3) Transferred to separate account .....                                                                                                                                                                                                |  | <b>7e(3)</b>                                       |  |
| (4) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7e(4)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (5) Total deductions .....                                                                                                                                                                                                               |  | <b>7e(5)</b>                                       |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                                                                                   |  | <b>7f</b>                                          |  |

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a

☐ Health (other than dental or vision)

b

☐ Dental

c

☐ Vision

d

☒ Life insurance

e

☐ Temporary disability (accident and sickness)

f

☐ Long-term disability

g

☐ Supplemental unemployment

h

☐ Prescription drug

i

☐ Stop loss (large deductible)

j

☐ HMO contract

k

☐ PPO contract

l

☐ Indemnity contract

m

☒ Other (specify) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

349380

(2) Increase (decrease) in amount due but unpaid

9a(2)

-26496

(3) Increase (decrease) in unearned premium reserve

9a(3)

0

(4) Earned ((1) + (2) - (3))

9a(4)

322884

b

Benefit charges (1) Claims paid

9b(1)

550100

(2) Increase (decrease) in claim reserves

9b(2)

468859

(3) Incurred claims (add (1) and (2))

9b(3)

1018959

(4) Claims charged

9b(4)

1018959

c

Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

21072

(B) Administrative service or other fees

9c(1)(B)

0

(C) Other specific acquisition costs

9c(1)(C)

0

(D) Other expenses

9c(1)(D)

41869

(E) Taxes

9c(1)(E)

6463

(F) Charges for risks or other contingencies

9c(1)(F)

25830

(G) Other retention charges

9c(1)(G)

0

(H) Total retention

9c(1)(H)

95234

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

0

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

0

(2) Claim reserves

9d(2)

0

(3) Other reserves

9d(3)

0

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

0

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

11

Did the insurance company fail to provide any information necessary to complete Schedule A?

☐ Yes

☒ No

12

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
STANDARD INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 93-0242990 | 69019         | 170601                                | 1384                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 11322                                |                               |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
RSC INSURANCE BROKERAGE, INC. 3525 NORTH CAUSEWAY BOULEVARD  
SUITE 815  
METARIE, LA 70002

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 5984                                          |                                 |             | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
EMERSON ROGERS, LLC. 669 RIVER DRIVE  
SUITE 305  
ELMWOOD PARK, NJ 07407

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 5338                                          |                                 |             | 3                     |

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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                                                                                          |  |                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                           |  | <b>Investment and Annuity Contract Information</b> |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.                                                                           |  |                                                    |  |
| <b>4</b> Current value of plan's interest under this contract in the general account at year end .....                                                                                                                                   |  | <b>4</b>                                           |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....                                                                                                                                      |  | <b>5</b>                                           |  |
| <b>6</b> Contracts With Allocated Funds:                                                                                                                                                                                                 |  |                                                    |  |
| <b>a</b> State the basis of premium rates ▶                                                                                                                                                                                              |  |                                                    |  |
| <b>b</b> Premiums paid to carrier .....                                                                                                                                                                                                  |  | <b>6b</b>                                          |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                                                                            |  | <b>6c</b>                                          |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶                           |  | <b>6d</b>                                          |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶                                                        |  |                                                    |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                                                                               |  |                                                    |  |
| <b>7</b> Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                                                                                   |  |                                                    |  |
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ |  |                                                    |  |
| <b>b</b> Balance at the end of the previous year .....                                                                                                                                                                                   |  | <b>7b</b>                                          |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....                                                                                                                                                                    |  | <b>7c(1)</b>                                       |  |
| (2) Dividends and credits.....                                                                                                                                                                                                           |  | <b>7c(2)</b>                                       |  |
| (3) Interest credited during the year.....                                                                                                                                                                                               |  | <b>7c(3)</b>                                       |  |
| (4) Transferred from separate account.....                                                                                                                                                                                               |  | <b>7c(4)</b>                                       |  |
| (5) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7c(5)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (6)Total additions .....                                                                                                                                                                                                                 |  | <b>7c(6)</b>                                       |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                                                                                    |  | <b>7d</b>                                          |  |
| <b>e</b> Deductions:                                                                                                                                                                                                                     |  |                                                    |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                                                                                                |  | <b>7e(1)</b>                                       |  |
| (2) Administration charge made by carrier.....                                                                                                                                                                                           |  | <b>7e(2)</b>                                       |  |
| (3) Transferred to separate account .....                                                                                                                                                                                                |  | <b>7e(3)</b>                                       |  |
| (4) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7e(4)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (5) Total deductions .....                                                                                                                                                                                                               |  | <b>7e(5)</b>                                       |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                                                                                   |  | <b>7f</b>                                          |  |

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☐ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☒ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☐ Other (specify) ▶

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

198378

(2) Increase (decrease) in amount due but unpaid

9a(2)

-13514

(3) Increase (decrease) in unearned premium reserve

9a(3)

0

(4) Earned ((1) + (2) - (3))

9a(4)

184864

b

Benefit charges (1) Claims paid

9b(1)

185768

(2) Increase (decrease) in claim reserves

9b(2)

329342

(3) Incurred claims (add (1) and (2))

9b(3)

515110

(4) Claims charged

9b(4)

515110

c

Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

15225

(B) Administrative service or other fees

9c(1)(B)

0

(C) Other specific acquisition costs

9c(1)(C)

0

(D) Other expenses

9c(1)(D)

45264

(E) Taxes

9c(1)(E)

1941

(F) Charges for risks or other contingencies

9c(1)(F)

22183

(G) Other retention charges

9c(1)(G)

0

(H) Total retention

9c(1)(H)

84613

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

0

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

0

(2) Claim reserves

9d(2)

0

(3) Other reserves

9d(3)

0

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

0

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

11

Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ▶ 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
EVERNORTH CARE SOLUTIONS, INC.

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 86-1465626 | 00000         | 3013                                  | 3778                                                                        | 01/01/2024              | 12/31/2024 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|                                      |                               |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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



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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                |  |                                                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Part II                                                                                                                                                        |  | Investment and Annuity Contract Information                                                                                                                         |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |  |                                                                                                                                                                     |  |
| 4                                                                                                                                                              |  | Current value of plan's interest under this contract in the general account at year end                                                                             |  |
| 5                                                                                                                                                              |  | Current value of plan's interest under this contract in separate accounts at year end                                                                               |  |
| 6 Contracts With Allocated Funds:                                                                                                                              |  |                                                                                                                                                                     |  |
| a State the basis of premium rates                                                                                                                             |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Premiums paid to carrier                                                                                                                                            |  |
| c                                                                                                                                                              |  | Premiums due but unpaid at the end of the year                                                                                                                      |  |
| d                                                                                                                                                              |  | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. |  |
|                                                                                                                                                                |  | Specify nature of costs                                                                                                                                             |  |
| e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify)                                                                     |  |                                                                                                                                                                     |  |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here                                                       |  |                                                                                                                                                                     |  |
| 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                |  |                                                                                                                                                                     |  |
| a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other                                       |  |                                                                                                                                                                     |  |
| b                                                                                                                                                              |  | Balance at the end of the previous year                                                                                                                             |  |
| c                                                                                                                                                              |  | Additions:                                                                                                                                                          |  |
|                                                                                                                                                                |  | (1) Contributions deposited during the year                                                                                                                         |  |
|                                                                                                                                                                |  | (2) Dividends and credits                                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Interest credited during the year                                                                                                                               |  |
|                                                                                                                                                                |  | (4) Transferred from separate account                                                                                                                               |  |
|                                                                                                                                                                |  | (5) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (6) Total additions                                                                                                                                                 |  |
| d                                                                                                                                                              |  | Total of balance and additions (add lines 7b and 7c(6))                                                                                                             |  |
| e                                                                                                                                                              |  | Deductions:                                                                                                                                                         |  |
|                                                                                                                                                                |  | (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                           |  |
|                                                                                                                                                                |  | (2) Administration charge made by carrier                                                                                                                           |  |
|                                                                                                                                                                |  | (3) Transferred to separate account                                                                                                                                 |  |
|                                                                                                                                                                |  | (4) Other (specify below)                                                                                                                                           |  |
|                                                                                                                                                                |  | (5) Total deductions                                                                                                                                                |  |
| f                                                                                                                                                              |  | Balance at the end of the current year (subtract line 7e(5) from line 7d)                                                                                           |  |

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☐ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☒ Other (specify) ▶ EMPLOYEE ASSISTANCE PROGRAM

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b

Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c

Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

34813

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ► 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
CIGNA HEALTH AND LIFE INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 59-1031071 | 67369         | CI110069                              | 37                                                                          | 01/01/2024              | 12/31/2024 |

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

|                                              |                                      |
|----------------------------------------------|--------------------------------------|
| (a) Total amount of commissions paid<br>3858 | (b) Total amount of fees paid<br>172 |
|----------------------------------------------|--------------------------------------|

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS ADMIN  
PO BOX 850502  
MINNEAPOLIS, MN 55485

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 3858                                          |                                 |             | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC.  
4565 PAYSPHERE CIRCLE  
CHICAGO, IL 60674

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
|                                               | 172                             | BONUS       | 3                     |

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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                                   |  |                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                    |  | <b>Investment and Annuity Contract Information</b> |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.                    |  |                                                    |  |
| <b>4</b> Current value of plan's interest under this contract in the general account at year end .....                                                                            |  | <b>4</b>                                           |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....                                                                               |  | <b>5</b>                                           |  |
| <b>6</b> Contracts With Allocated Funds:                                                                                                                                          |  |                                                    |  |
| <b>a</b> State the basis of premium rates ▶                                                                                                                                       |  |                                                    |  |
| <b>b</b> Premiums paid to carrier .....                                                                                                                                           |  | <b>6b</b>                                          |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                     |  | <b>6c</b>                                          |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... |  | <b>6d</b>                                          |  |
| Specify nature of costs ▶                                                                                                                                                         |  |                                                    |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity                                                   |  |                                                    |  |
| (3) <input type="checkbox"/> other (specify) ▶                                                                                                                                    |  |                                                    |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                        |  |                                                    |  |
| <b>7</b> Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                            |  |                                                    |  |
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee                                     |  |                                                    |  |
| (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶                                                                                           |  |                                                    |  |
| <b>b</b> Balance at the end of the previous year .....                                                                                                                            |  | <b>7b</b>                                          |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....                                                                                                             |  | <b>7c(1)</b>                                       |  |
| (2) Dividends and credits.....                                                                                                                                                    |  | <b>7c(2)</b>                                       |  |
| (3) Interest credited during the year.....                                                                                                                                        |  | <b>7c(3)</b>                                       |  |
| (4) Transferred from separate account.....                                                                                                                                        |  | <b>7c(4)</b>                                       |  |
| (5) Other (specify below) .....                                                                                                                                                   |  | <b>7c(5)</b>                                       |  |
| ▶                                                                                                                                                                                 |  |                                                    |  |
| (6)Total additions .....                                                                                                                                                          |  | <b>7c(6)</b>                                       |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                             |  | <b>7d</b>                                          |  |
| <b>e</b> Deductions:                                                                                                                                                              |  |                                                    |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                                         |  | <b>7e(1)</b>                                       |  |
| (2) Administration charge made by carrier.....                                                                                                                                    |  | <b>7e(2)</b>                                       |  |
| (3) Transferred to separate account .....                                                                                                                                         |  | <b>7e(3)</b>                                       |  |
| (4) Other (specify below) .....                                                                                                                                                   |  | <b>7e(4)</b>                                       |  |
| ▶                                                                                                                                                                                 |  |                                                    |  |
| (5) Total deductions .....                                                                                                                                                        |  | <b>7e(5)</b>                                       |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                            |  | <b>7f</b>                                          |  |

Part III

Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☐ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☒ Other (specify) ▶ CRITICAL ILLNESS

9 Experience-rated contracts:

a Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

10a

13548

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2024</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 |                                                      |
| A Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                            | B Three-digit plan number (PN) ▶ 505                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SETON HALL UNIVERSITY            | D Employer Identification Number (EIN)<br>22-1500645 |

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

1 Coverage Information:

(a) Name of insurance carrier  
CIGNA HEALTH AND LIFE INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 59-1031071 | 67369         | AI110075                              | 39                                                                          | 01/01/2024              | 12/31/2024 |

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

|                                              |                                     |
|----------------------------------------------|-------------------------------------|
| (a) Total amount of commissions paid<br>1277 | (b) Total amount of fees paid<br>61 |
|----------------------------------------------|-------------------------------------|

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS ADMIN  
PO BOX 850502  
MINNEAPOLIS, MN 55485

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 1277                                          |                                 |             | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MERCER HEALTH AND BENEFITS, LLC.  
4565 PAYSPHERE CIRCLE  
CHICAGO, IL 60674

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
|                                               | 61                              | BONUS       | 3                     |



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

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

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

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

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

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

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

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

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

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

|                                                                                                                                                                                                                                          |  |                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                           |  | <b>Investment and Annuity Contract Information</b> |  |
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.                                                                           |  |                                                    |  |
| <b>4</b> Current value of plan's interest under this contract in the general account at year end .....                                                                                                                                   |  | <b>4</b>                                           |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....                                                                                                                                      |  | <b>5</b>                                           |  |
| <b>6</b> Contracts With Allocated Funds:                                                                                                                                                                                                 |  |                                                    |  |
| <b>a</b> State the basis of premium rates ▶                                                                                                                                                                                              |  |                                                    |  |
| <b>b</b> Premiums paid to carrier .....                                                                                                                                                                                                  |  | <b>6b</b>                                          |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                                                                            |  | <b>6c</b>                                          |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶                           |  | <b>6d</b>                                          |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶                                                        |  |                                                    |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                                                                               |  |                                                    |  |
| <b>7</b> Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                                                                                   |  |                                                    |  |
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ |  |                                                    |  |
| <b>b</b> Balance at the end of the previous year .....                                                                                                                                                                                   |  | <b>7b</b>                                          |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....                                                                                                                                                                    |  | <b>7c(1)</b>                                       |  |
| (2) Dividends and credits.....                                                                                                                                                                                                           |  | <b>7c(2)</b>                                       |  |
| (3) Interest credited during the year.....                                                                                                                                                                                               |  | <b>7c(3)</b>                                       |  |
| (4) Transferred from separate account.....                                                                                                                                                                                               |  | <b>7c(4)</b>                                       |  |
| (5) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7c(5)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (6)Total additions .....                                                                                                                                                                                                                 |  | <b>7c(6)</b>                                       |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                                                                                    |  | <b>7d</b>                                          |  |
| <b>e</b> Deductions:                                                                                                                                                                                                                     |  |                                                    |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year                                                                                                                                                                |  | <b>7e(1)</b>                                       |  |
| (2) Administration charge made by carrier.....                                                                                                                                                                                           |  | <b>7e(2)</b>                                       |  |
| (3) Transferred to separate account .....                                                                                                                                                                                                |  | <b>7e(3)</b>                                       |  |
| (4) Other (specify below) .....                                                                                                                                                                                                          |  | <b>7e(4)</b>                                       |  |
| ▶                                                                                                                                                                                                                                        |  |                                                    |  |
| (5) Total deductions .....                                                                                                                                                                                                               |  | <b>7e(5)</b>                                       |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                                                                                   |  | <b>7f</b>                                          |  |

Part III

Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)

b ☐ Dental

c ☐ Vision

d ☐ Life insurance

e ☐ Temporary disability (accident and sickness)

f ☐ Long-term disability

g ☐ Supplemental unemployment

h ☐ Prescription drug

i ☐ Stop loss (large deductible)

j ☐ HMO contract

k ☐ PPO contract

l ☐ Indemnity contract

m ☒ Other (specify) ▶ ACCIDENT

9 Experience-rated contracts:

a Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

10a

4642

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

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

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

## Carriers' Schedules

Initial  
TD

I have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

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**Cigna Health and Life Insurance Company**

A Cigna company  
Hartford, CT 06152


**Schedule A Insurance Information**
**Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator**

|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------|-------------------|------------------------------------------------------------|--|
| A. Plan Name                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                     | SETON HALL UNIVERSITY                                                    |                                                                    | B. Three-Digit Plan #(PN)                                           |                                                    | Plan will Provide |                                                            |  |
| C. Plan Sponsor's Name:                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                     | Plan will Provide                                                        |                                                                    | D. Company Identification Number:                                   |                                                    | Plan will Provide |                                                            |  |
| <b>Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)</b>                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| 1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| (b) EIN                                                                                                                                                                                                                                                                                                                                                                                                          | (c) NAIC Code                                                                                                                                                                                                       | (d) Contract or Identification Number                                    | (e) Approx.no.of persons covered at end of policy or contract year | Policy/Contract Year                                                |                                                    |                   |                                                            |  |
| 59-1031071                                                                                                                                                                                                                                                                                                                                                                                                       | 67369                                                                                                                                                                                                               | 3334085                                                                  | 1,049 Employees                                                    | (f) From                                                            | (g) To                                             |                   |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                     |                                                                          |                                                                    | 01/01/2024                                                          | —                                                  | 12/31/2024        |                                                            |  |
| 2. Insurance fees and commissions information. Enter total fees and commissions paid                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| (a) Total Amount of commissions paid                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                     |                                                                          |                                                                    | (b) Total Amount of fees paid                                       |                                                    |                   |                                                            |  |
| \$0                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                     |                                                                          |                                                                    | \$228,118                                                           |                                                    |                   |                                                            |  |
| 3. Persons receiving commissions and fees.                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                     | Fees and commissions paid                                                |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| (a) Name and address of the agent, broker or other person to who commissions and fees were paid                                                                                                                                                                                                                                                                                                                  | (b) Amount of sales and base commissions paid                                                                                                                                                                       | (c) Amount*                                                              | (d) Purpose*                                                       | (e) Organization code                                               |                                                    |                   |                                                            |  |
| Non Experience - Rated                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                     | *Refer to footnotes for incentive \$\$ amounts and purpose as applicable |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| MERCER HEALTH & BENEFITS,4565 PAYSPPHERE CIR,CHICAGO,IL,60674                                                                                                                                                                                                                                                                                                                                                    | \$0                                                                                                                                                                                                                 | \$227,254                                                                | Benefit Advisor Payments                                           | 3- Insurance Agent or Broker                                        |                                                    |                   |                                                            |  |
| <b>Part II Investment and Annuity Contract Information</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                     |                                                                          |                                                                    | This section not applicable to this Plan                            |                                                    |                   |                                                            |  |
| <b>Outstanding Monies Due &gt;</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                     |                                                                          |                                                                    | \$0 contract number of identification > same as 1d                  |                                                    |                   |                                                            |  |
| <b>Part III Welfare Benefit Contract Information</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| 8. Benefit and Contract information                                                                                                                                                                                                                                                                                                                                                                              | (a) <input checked="" type="checkbox"/> Health (Other than dental or vision)                                                                                                                                        |                                                                          | (b) <input type="checkbox"/> Dental                                |                                                                     | (c) <input type="checkbox"/> Vision                |                   | (d) <input type="checkbox"/> Life Insurance                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | (e) <input type="checkbox"/> Temporary Disability (accident and sickness)                                                                                                                                           |                                                                          | (f) <input type="checkbox"/> Long- Term disability                 |                                                                     | (g) <input type="checkbox"/> Supplemental Unemploy |                   | (h) <input type="checkbox"/> Prescription drug             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | (i) <input type="checkbox"/> Stop Loss (Large deductible)                                                                                                                                                           |                                                                          | (j) <input type="checkbox"/> HMO contract                          |                                                                     | (k) <input type="checkbox"/> PPO Contract          |                   | (l) <input checked="" type="checkbox"/> Indemnity contract |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | (m) <input type="checkbox"/> Other (Prepaid Dental)                                                                                                                                                                 |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| 9. Experience-Rated Contracts                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                     |                                                                          |                                                                    | This section not applicable for this Plan                           |                                                    |                   |                                                            |  |
| 10. Nonexperience-rated contracts                                                                                                                                                                                                                                                                                                                                                                                | (a) Total premiums or subscriptions charges paid to carrier                                                                                                                                                         |                                                                          |                                                                    | \$22,724,650                                                        |                                                    |                   |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | Premium Due as of                                                                                                                                                                                                   |                                                                          |                                                                    | 02/12/2025                                                          |                                                    | \$0               |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | (b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | Specify nature of costs                                                                                                                                                                                             |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| <b>PART IV Provision of Information</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                     |                                                                          |                                                                    |                                                                     |                                                    |                   |                                                            |  |
| 11. Did the insurance company fail to provide any information necessary to complete Schedule A?                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                     |                                                                          |                                                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                    |                   |                                                            |  |
| 12. If the answer to line 11 is "Yes", specify the information not provided. >                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                     |                                                                          |                                                                    | Answer "Not Applicable"                                             |                                                    |                   |                                                            |  |

**Comments**

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

**Cigna Health and Life Insurance Company**

A Cigna company  
Hartford, CT 06152



**Schedule A Insurance Information - Footnotes**  
**Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator**

|                                                                                                                                           |                        |                                                     |                                                                                          |                                                                    |  |                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|-------------------|--|
| A. Plan Name                                                                                                                              |                        | SETON HALL UNIVERSITY                               |                                                                                          | B. Three-Digit Plan #(PN)                                          |  | Plan will Provide |  |
| C. Plan Sponsor's Name:                                                                                                                   |                        | Plan will Provide                                   |                                                                                          | D. Company Identification Number:                                  |  | Plan will Provide |  |
| Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III) |                        |                                                     |                                                                                          |                                                                    |  |                   |  |
| 1. Coverage Information (a) Name of Insurance Carrier:Cigna Health and Life Insurance Company and affiliates ("Cigna")                    |                        |                                                     |                                                                                          |                                                                    |  |                   |  |
| (b) EIN<br>59-1031071                                                                                                                     | (c) NAIC Code<br>67369 | (d) Contract or<br>Identification Number<br>3334085 | (e) Approx.no.of persons covered<br>at end of policy or contract year<br>1,049 Employees | Policy/Contract Year<br>(f) From (g) To<br>01/01/2024 - 12/31/2024 |  |                   |  |

Part I, line 1a: "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna companies whose contracts fund the plan are grouped as a single unit by Cigna for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna companies are grouped as a unit for purposes of this report. To reference individual contracts please refer to the Schedule A Appendix pages contained within this reporting package, if applicable.

Part I, line 2a, 2b: The following amounts were paid to your broker(s) / consultant(s) during the contract year:

Commissions: \$0 General Agent Fees: \$0 Benefit Advisor Fees: \$227,254

Part I, line 3c: Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: \$864 (Broker and General Agents combined) attributable to your plan for the 2024 calendar year. These amounts are funded from Cigna companies general overhead.  
Contact your broker/consultant for further details.

In addition to the Commissions/Benefit Advisor Fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence produce and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation.

The contract holder is not entitled to a return of any premium or other payment made to Cigna company unless the Cigna company agrees otherwise in writing. The Cigna companies may use payments received for any purpose in its sole discretion.

If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.

Part 1, line 2a, 2b, 3b and/or 3c: Represents the amount of Commissions/Benefit Advisor Fees paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

Part 1, line 3b and/or c: May include prior year Commissions/Benefit Advisor Fees not previously reported.

Part 1, line 3b and/or c: There may be adjustments made to Commissions and/or Benefit Advisor Fee payments outside the policy period that are not reflected on this form.

Line 10a: May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

Line 10a: Includes payments by State Continuant of \$0 administered by Cigna and applicable to your account.

- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation is based on averaged premium, Commissions/Benefit Advisor Fees and available lives.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation for broker/general agent Commission/Benefit Advisor Fee amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents. Subscriber and membership information is available for your contract policy year on the employer portal at [www.cignaaccess.com](http://www.cignaaccess.com), report titled, Subscriber and Membership Reporting.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year.
- Premium also includes taxes, fees and assessments imposed under the Patient Protection and Affordable Care Act.

Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

| Report Start Date | Report End Date |
|-------------------|-----------------|
| 1/1/24            | 12/31/24        |

Report Generated: 2/5/25

Payments Received by carrier from plan or plan sponsor:

| Name of Plan                | Contract or ID # | Enrollment Group            | Approximate number of subscribers covered at end of policy or contract year: | Approximate number of subscribers and dependents covered at end of policy or contract year: | EIN       | NAIC  | Amount             |
|-----------------------------|------------------|-----------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------|-------|--------------------|
| SETON HALL UNIVERSITY       | 10083221001      | SETON HALL UNIVERSITY       | 1,024                                                                        | 2,255                                                                                       | 430949844 | 71870 | \$19,725.35        |
| SETON HALL UNIVERSITY       | 10083221002      | SETON HALL UNIVERSITY COBRA | 0                                                                            | 0                                                                                           | 430949844 | 71870 | \$107.78           |
| SETON HALL UNIVERSITY COBRA | 10540081001      | SETON HALL UNIVERSITY COBRA | 8                                                                            | 16                                                                                          | 430949844 | 71870 | \$0.00             |
|                             |                  |                             | 1,032                                                                        | 2,271                                                                                       |           |       | Total: \$19,833.13 |

Commissions or fees paid by carrier to agents, brokers or other persons:

| Payee Name | Contract or ID # | Address Line 1 | City | State | Zip Code | Amount |
|------------|------------------|----------------|------|-------|----------|--------|
|            |                  |                |      |       |          | Total: |

Note: Payments and applicable fees or commissions related to the plan or plan sponsor, which are not paid and posted within the date range provided above, are not included in this report. Instead, such payments will be included in prior or subsequent Schedule A reporting, as appropriate. Payments and applicable fees or commissions may vary from the carrier's billed amounts.

Form 5500 - Insurance Information

|                                                                                                                                                                                                                         |               |                                       |                                                                             |                        |                         |          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|------------------------|-------------------------|----------|
| Plan sponsor's name: SETON HALL UNIVERSITY                                                                                                                                                                              |               |                                       |                                                                             |                        |                         |          |
| Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions                                                                                                                                        |               |                                       |                                                                             |                        |                         |          |
| 1 Coverage information:                                                                                                                                                                                                 |               |                                       |                                                                             |                        |                         |          |
| (a) Name of insurance carrier: DELTA DENTAL OF NEW JERSEY, INC.                                                                                                                                                         |               |                                       |                                                                             |                        |                         |          |
| (b) EIN                                                                                                                                                                                                                 | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year |                        | Policy or contract year |          |
|                                                                                                                                                                                                                         |               |                                       |                                                                             |                        | (f) From                | (g) To   |
| 22-1896118                                                                                                                                                                                                              | 55085         | 07742                                 | Total Subscribers<br>973                                                    | Total Members<br>2,038 | 1/1/24                  | 12/31/24 |
| 2 Insurance fee and commission information                                                                                                                                                                              |               |                                       |                                                                             |                        |                         |          |
| (a) Total amount of commission paid: \$10,762                                                                                                                                                                           |               |                                       |                                                                             |                        |                         |          |
| 3 Persons receiving commissions and fees                                                                                                                                                                                |               |                                       |                                                                             |                        |                         |          |
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid                                                                                                                        |               |                                       |                                                                             |                        |                         |          |
| Name: MERCER HEALTH & BENEFITS,LLC                                                                                                                                                                                      |               |                                       | Name:                                                                       |                        |                         |          |
| Address Line 1: 4565 PAYSPIRE CIRCLE                                                                                                                                                                                    |               |                                       | Address Line 1:                                                             |                        |                         |          |
| Address Line 2:                                                                                                                                                                                                         |               |                                       | Address Line 2:                                                             |                        |                         |          |
| Address Line 3:                                                                                                                                                                                                         |               |                                       | Address Line 3:                                                             |                        |                         |          |
| City, State Zip: CHICAGO, IL 60674                                                                                                                                                                                      |               |                                       | City, State Zip:                                                            |                        |                         |          |
| Amount: \$10,762                                                                                                                                                                                                        |               |                                       | Amount:                                                                     |                        |                         |          |
| Name:                                                                                                                                                                                                                   |               |                                       | Name:                                                                       |                        |                         |          |
| Address Line 1:                                                                                                                                                                                                         |               |                                       | Address Line 1:                                                             |                        |                         |          |
| Address Line 2:                                                                                                                                                                                                         |               |                                       | Address Line 2:                                                             |                        |                         |          |
| Address Line 3:                                                                                                                                                                                                         |               |                                       | Address Line 3:                                                             |                        |                         |          |
| City, State Zip:                                                                                                                                                                                                        |               |                                       | City, State Zip:                                                            |                        |                         |          |
| Amount:                                                                                                                                                                                                                 |               |                                       | Amount:                                                                     |                        |                         |          |
| Part III Welfare Benefit Contract Information                                                                                                                                                                           |               |                                       |                                                                             |                        |                         |          |
| 8 Benefit and contract type                                                                                                                                                                                             |               |                                       |                                                                             |                        |                         |          |
| a <input type="checkbox"/> Health (other than dental or vision)                                                                                                                                                         |               |                                       |                                                                             |                        |                         |          |
| b <input checked="" type="checkbox"/> Dental                                                                                                                                                                            |               |                                       |                                                                             |                        |                         |          |
| c <input type="checkbox"/> Vision                                                                                                                                                                                       |               |                                       |                                                                             |                        |                         |          |
| d <input type="checkbox"/> Life insurance                                                                                                                                                                               |               |                                       |                                                                             |                        |                         |          |
| e <input type="checkbox"/> Temporary disability (accident and sickness)                                                                                                                                                 |               |                                       |                                                                             |                        |                         |          |
| f <input type="checkbox"/> Long-term disability                                                                                                                                                                         |               |                                       |                                                                             |                        |                         |          |
| g <input type="checkbox"/> Supplemental unemployment                                                                                                                                                                    |               |                                       |                                                                             |                        |                         |          |
| h <input type="checkbox"/> Prescription drug                                                                                                                                                                            |               |                                       |                                                                             |                        |                         |          |
| i <input type="checkbox"/> Stop loss (large deductible)                                                                                                                                                                 |               |                                       |                                                                             |                        |                         |          |
| j <input type="checkbox"/> HMO contract                                                                                                                                                                                 |               |                                       |                                                                             |                        |                         |          |
| k <input type="checkbox"/> PPO contract                                                                                                                                                                                 |               |                                       |                                                                             |                        |                         |          |
| l <input type="checkbox"/> Indemnity contract                                                                                                                                                                           |               |                                       |                                                                             |                        |                         |          |
| m <input type="checkbox"/> Other (specify) ▶                                                                                                                                                                            |               |                                       |                                                                             |                        |                         |          |
| 9 Experience-rated contracts:                                                                                                                                                                                           |               |                                       |                                                                             |                        |                         |          |
| a Premiums: (1) Amount received.....                                                                                                                                                                                    |               |                                       | 9a(1)                                                                       | \$1,076,216            |                         |          |
| (2) Increase (decrease) in amount due but unpaid.....                                                                                                                                                                   |               |                                       | 9a(2)                                                                       | \$0                    |                         |          |
| (3) Increase (decrease) in unearned premium reserve.....                                                                                                                                                                |               |                                       | 9a(3)                                                                       | \$0                    |                         |          |
| (4) Earned ((1) + (2) - (3)).....                                                                                                                                                                                       |               |                                       | 9a(4)                                                                       |                        | \$1,076,216             |          |
| b Benefit charges (1) Claims paid.....                                                                                                                                                                                  |               |                                       | 9b(1)                                                                       | \$978,902              |                         |          |
| (2) Increase (decrease) in claims reserves.....                                                                                                                                                                         |               |                                       | 9b(2)                                                                       | \$9,628                |                         |          |
| (3) Incurred claims (add (1) and (2)).....                                                                                                                                                                              |               |                                       | 9b(3)                                                                       |                        | \$988,530               |          |
| (4) Claims charged.....                                                                                                                                                                                                 |               |                                       | 9b(4)                                                                       |                        | \$988,530               |          |
| c Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                                                                                                  |               |                                       |                                                                             |                        |                         |          |
| (A) Commissions.....                                                                                                                                                                                                    |               |                                       | 9c(1)(A)                                                                    | \$10,762               |                         |          |
| (B) Administrative service or other fees.....                                                                                                                                                                           |               |                                       | 9c(1)(B)                                                                    | \$134,918              |                         |          |
| (C) Other specific acquisition costs.....                                                                                                                                                                               |               |                                       | 9c(1)(C)                                                                    | \$0                    |                         |          |
| (D) Other expenses.....                                                                                                                                                                                                 |               |                                       | 9c(1)(D)                                                                    | \$0                    |                         |          |
| (E) Taxes.....                                                                                                                                                                                                          |               |                                       | 9c(1)(E)                                                                    | \$0                    |                         |          |
| (F) Charges for risks or other contingencies.....                                                                                                                                                                       |               |                                       | 9c(1)(F)                                                                    | \$13,991               |                         |          |
| (G) Other Retention Charges.....                                                                                                                                                                                        |               |                                       | 9c(1)(G)                                                                    | \$0                    |                         |          |
| (H) Total Retention.....                                                                                                                                                                                                |               |                                       | 9c(1)(H)                                                                    |                        | \$159,671               |          |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input checked="" type="checkbox"/> credited.).....                                                            |               |                                       | 9c(2)                                                                       |                        | \$0                     |          |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits at retirement.....                                                                                                                |               |                                       | 9d(1)                                                                       |                        |                         |          |
| (2) Claims reserves.....                                                                                                                                                                                                |               |                                       | 9d(2)                                                                       |                        | \$77,496                |          |
| (3) Other reserves.....                                                                                                                                                                                                 |               |                                       | 9d(3)                                                                       |                        |                         |          |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....                                                                                                                        |               |                                       | 9e                                                                          |                        |                         |          |
| 10 Nonexperience-rated contracts:                                                                                                                                                                                       |               |                                       |                                                                             |                        |                         |          |
| a Total premiums or subscription charges paid to carrier.....                                                                                                                                                           |               |                                       | 10a                                                                         |                        |                         |          |
| b If the carrier, service, or other organization included any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... |               |                                       | 10b                                                                         |                        |                         |          |

This statement contains only the data necessary to complete your Form 5500. It does not represent the actual form. For further information about filing, please contact your attorney or tax consultant.





Form 5500 - Insurance Information

Group Name: SETON HALL UNIVERSITY

Group Number: 78998

Division Number:

Number of Subscribers: 117

Number of Members: 229

Commissions Paid: \$327.35

Plan Year: 01/01/2024 -12/31/2024

Premium Paid: \$32,731.86

Carrier: Alpha Dental Programs, Inc.

Delta EIN: 74-2447512

Delta NAIC: 95163

This statement contains only the data necessary to complete your Form 5500.  
It does not represent the actual form. For further information about filing,  
please contact your attorney or tax consultant.

APPENDIX  
BROKER COMMISSIONS

|                              |                     |
|------------------------------|---------------------|
| Broker Name:                 | \$Commissions Paid: |
| MERCER HEALTH & BENEFITS LLC | \$327.35            |



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SETON HALL UNIVERSITY

PART I

1) COVERAGE - LIFE INSURANCE

|                               |                            |
|-------------------------------|----------------------------|
| a) CARRIER:                   | STANDARD INSURANCE COMPANY |
| b) EIN:                       | 93-0242990                 |
| c) NAIC CODE:                 | 000-69019                  |
| d) CONTRACT NUMBER:           | 170601                     |
| e) NUMBER OF PERSONS COVERED: | 1,410                      |
| f) FROM:                      | 1/1/2024                   |
| g) TO:                        | 12/31/2024                 |

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

|                             |             |
|-----------------------------|-------------|
| AMOUNT OF COMMISSIONS PAID: | \$21,071.79 |
| FEED PAID / AMOUNT:         | \$0.00      |

| A) NAME & ADDRESS OF AGENT OR<br>BROKER TO WHOM COMMISSION OR<br>FEES WERE PAID | B) AMOUNT OF COMMISSION PAID |                     | FEES PAID   |            | E) ORG.<br>CODE |
|---------------------------------------------------------------------------------|------------------------------|---------------------|-------------|------------|-----------------|
|                                                                                 | COMMISSIONS                  | CONTINGENT<br>COMP* | C) AMOUNT   | D) PURPOSE |                 |
| MERCER HEALTH & BENEFITS<br>1166 AVE OF AMERICAS 22 FLR<br>NEW YORK, NY 10036   | \$6,132.43                   | \$0.00              | \$0.00      |            | 3               |
| MERCER HEALTH & BENEFITS<br>4565 PAYSPIRE CIRCLE<br>CHICAGO, IL 60674           | \$7,132.90                   | \$0.00              | \$0.00      |            | 3               |
| TOTAL COMMISSIONS PAID                                                          |                              |                     | \$13,265.33 |            |                 |
| TOTAL CONTINGENT COMP PAID                                                      |                              |                     | \$0.00      |            |                 |

\*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PART III -170601

7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRATS

|                                                      |               |                |
|------------------------------------------------------|---------------|----------------|
| a) PREMIUMS: (1) AMOUNT RECEIVED:                    | \$349,380.19  |                |
| (2) INCREASE (DECREASE) IN DUE BUT UNPAID:           | (\$26,496.00) |                |
| (3) INCREASE (DECREASE) IN UNEARED PREMIUM RESERVE:  | \$0.00        |                |
| (4) EARNED PREMIUM ((1)+(2) - (3)):                  |               | \$322,884.19   |
| b) BENEFIT CHARGES: (1) CLAIMS PAID:                 | \$550,100.00  |                |
| (2) INCREASE (DECREASE) CLAIM RESERVES:              | \$468,859.00  |                |
| (3) INCURRED CLAIMS ((1)+(2)):                       |               | \$1,018,959.00 |
| (4) CLAIMS CHARGED:                                  |               | \$1,018,959.00 |
| c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:      |               |                |
| (A) COMMISSIONS:                                     | \$21,071.79   |                |
| (B) ADMINISTRATIVE SERVICE OR OTHER FEES:            | \$0.00        |                |
| (C) OTHER SPECIFIC ACQUISITION COSTS:                | \$0.00        |                |
| (D) OTHER EXPENSES:                                  | \$41,869.37   |                |
| (E) TAXES:                                           | \$6,463.26    |                |
| (F) CHARGES FOR RISK OR OTHER CONTINGENCIES:         | \$25,830.00   |                |
| (G) OTHER RETENTION CHARGES:                         | \$0.00        |                |
| (H) TOTAL RETENTION:                                 |               | \$95,234.43    |
| ci) DIVIDEND OR RETROACTIVE RATE REFUND:             |               |                |
| d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR   |               |                |
| (1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT |               | \$ 0.00        |
| (2) CLAIM RESERVES:                                  |               | \$0.00         |
| (3) OTHER RESERVES:                                  |               | \$0.00         |
| di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE:        |               | \$0.00         |



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SETON HALL UNIVERSITY

PART I

1) COVERAGE - LONG TERM DISABILITY

|                               |                            |
|-------------------------------|----------------------------|
| a) CARRIER:                   | STANDARD INSURANCE COMPANY |
| b) EIN:                       | 93-0242990                 |
| c) NAIC CODE:                 | 000-69019                  |
| d) CONTRACT NUMBER:           | 170601                     |
| e) NUMBER OF PERSONS COVERED: | 1,384                      |
| f) FROM:                      | 1/1/2024                   |
| g) TO:                        | 12/31/2024                 |

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

|                             |             |
|-----------------------------|-------------|
| AMOUNT OF COMMISSIONS PAID: | \$15,224.77 |
| FEED PAID / AMOUNT:         | \$0.00      |

| A) NAME & ADDRESS OF AGENT OR<br>BROKER TO WHOM COMMISSION OR<br>FEES WERE PAID          | B) AMOUNT OF COMMISSION PAID |                     | FEES PAID   |            | E) ORG.<br>CODE |
|------------------------------------------------------------------------------------------|------------------------------|---------------------|-------------|------------|-----------------|
|                                                                                          | COMMISSIONS                  | CONTINGENT<br>COMP* | C) AMOUNT   | D) PURPOSE |                 |
| EMERSON ROGERS LLC<br>669 RIVER DRIVE<br>SUITE 305<br>ELMWOOD PARK, NJ 07407             | \$5,337.75                   | \$0.00              | \$0.00      |            | 3               |
| RSC INS BROKERAGE INC<br>3525 NORTH CAUSEWAY BOULEVARD<br>SUITE 815<br>METARIE, LA 70002 | \$5,983.79                   | \$0.00              | \$0.00      |            | 3               |
| TOTAL COMMISSIONS PAID                                                                   |                              |                     | \$11,321.54 |            |                 |
| TOTAL CONTINGENT COMP PAID                                                               |                              |                     | \$0.00      |            |                 |

\*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PART III -170601

7) BENEFIT TYPE:LONG TERM DISABILITY

EXPERIENCE RATED CONTRATS

|                                                      |               |              |
|------------------------------------------------------|---------------|--------------|
| a) PREMIUMS: (1) AMOUNT RECEIVED:                    | \$198,377.90  |              |
| (2) INCREASE (DECREASE) IN DUE BUT UNPAID:           | (\$13,514.00) |              |
| (3) INCREASE (DECREASE) IN UNEARED PREMIUM RESERVE:  | \$0.00        |              |
| (4) EARNED PREMIUM ((1)+(2) - (3)):                  |               | \$184,863.90 |
| b) BENEFIT CHARGES: (1) CLAIMS PAID:                 | \$185,767.87  |              |
| (2) INCREASE (DECREASE) CLAIM RESERVES:              | \$329,341.99  |              |
| (3) INCURRED CLAIMS ((1)+(2)):                       |               | \$515,109.86 |
| (4) CLAIMS CHARGED:                                  |               | \$515,109.86 |
| c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:      |               |              |
| (A) COMMISSIONS:                                     | \$15,224.77   |              |
| (B) ADMINISTRATIVE SERVICE OR OTHER FEES:            | \$0.00        |              |
| (C) OTHER SPECIFIC ACQUISITION COSTS:                | \$0.00        |              |
| (D) OTHER EXPENSES:                                  | \$45,263.59   |              |
| (E) TAXES:                                           | \$1,941.09    |              |
| (F) CHARGES FOR RISK OR OTHER CONTINGENCIES:         | \$22,183.00   |              |
| (G) OTHER RETENTION CHARGES:                         | \$0.00        |              |
| (H) TOTAL RETENTION:                                 |               | \$84,612.45  |
| ci) DIVIDEND OR RETROACTIVE RATE REFUND:             |               |              |
| d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR   |               |              |
| (1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT |               | \$ 0.00      |
| (2) CLAIM RESERVES:                                  |               | \$0.00       |
| (3) OTHER RESERVES:                                  |               | \$0.00       |
| di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE:        |               | \$0.00       |

## Self-Insured Benefits

Schedule As will not be included in the 5500 for the benefits that were self-insured. Schedule As are only to report fully insured benefits.

We did include the appropriate benefit code(s) for the benefit(s) and checked general assets for funding.

**Disclaimer:** Wrangle, an Ascensus® company, as well as its employees and affiliates do not offer legal or accounting consultation or services and does not assist with plan design or implementation. Information provided by Wrangle is for informational purposes only and is not intended to constitute legal or other advice or opinions on any specific matters. The client should always seek the advice of an independent qualified attorney, accountant, or other professional advisor. Wrangle applies its best effort to provide accurate and complete information and provides its service in accordance with ERISA and based on the information provided by the client-. This document contains information that is confidential and any use, disclosure, distribution, or duplication by anyone other than an intended recipient is prohibited. Ascensus is not a broker, consultant, or fiduciary, as defined by ERISA. Ascensus® and the Ascensus logo are registered trademarks of Ascensus, LLC. Copyright© 2024 Wrangle, an Ascensus® company. All rights reserved.

BABETTE BROOKS  
SETON HALL UNIVERSITY  
400 SOUTH ORANGE AVE  
SOUTH ORANGE, NJ 07079

Account Number: 3013

**EVERNORTH CARE SOLUTIONS, INC.**  
**Information for Completion of Schedule C for Plan Year beginning: January 1, 2024–December 31, 2024**  
**(Employee Assistance Program)**

|                                                                                                                                  |                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I. Service Provider Information</b>                                                                                      |                                                                                                                                                                        |
| Line 1. Information on Persons Receiving Only Eligible Indirect Compensation                                                     | Check “No” with respect to Evernorth Care Solutions, Inc.                                                                                                              |
| Line 2. Information on Other Service Providers Receiving Direct or Indirect Compensation                                         | 86-1465626                                                                                                                                                             |
| (a) Evernorth Care Solutions, Inc Identification Number and NAIC Code                                                            | N/A                                                                                                                                                                    |
| (b) Service Codes:                                                                                                               | 12 Claims Processing<br>13 Contract Administrator<br>38 Participant Communication<br>50 Direct Compensation                                                            |
| (c) Relationship to Employer or Employee Organization:                                                                           | EVERNORTH Behavioral Health, Inc. has contracted with Employer to administer its Employee Assistance Plan                                                              |
| (d) Direct compensation paid to Evernorth Care Solutions, Inc.:                                                                  | \$34,813.44                                                                                                                                                            |
| (e) Did Service Provider receive indirect compensation?                                                                          | Check “No”                                                                                                                                                             |
| (f) Did indirect compensation include eligible indirect compensation?                                                            | Check “No”                                                                                                                                                             |
| (g) Total indirect compensation received by Evernorth Care Solutions, Inc.:                                                      | \$0 See Appendix for indirect compensation                                                                                                                             |
| (h) Was a formula provided by Evernorth Care Solutions, Inc. instead of an amount or estimated amount for indirect compensation? | Check “Yes”<br>See Appendix included with this reporting                                                                                                               |
| Line 3.                                                                                                                          | Not applicable to Evernorth Care Solutions, Inc.                                                                                                                       |
| <b>Part II. Service Providers Who Fail or Refuse to Provide Information</b>                                                      | Do not identify Evernorth Care Solutions, Inc. in this section as information required for completion of Schedule C has been provided by Evernorth Care Solutions, Inc |

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE BY:

Registrar & Date

NOTE TO POLICYHOLDERS: If you have elected not to receive identifiable health information, this report complies with your election. Nevertheless, please note that you may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

BABETTE BROOKS  
SETON HALL UNIVERSITY  
400 SOUTH ORANGE AVE  
SOUTH ORANGE, NJ 07079

Account Number: 3013

**Footnotes:**

The following amounts were paid to your broker(s) /consultant(s) during the plan year:

Commissions: \$ .00

Contact your broker/consultant for further details.

In addition, CIGNA HealthCare enters into compensation programs under which certain brokers/consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, is funded from our general overhead, and is not required to be reported on Schedule C. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent/ broker for specific information about their participation.

Number of persons covered detail (i.e. membership) noted is based upon preassumed CIGNA factors by product based upon eligibility (i.e. plan participants) received. These CIGNA factors are utilized as CIGNA does not solicit membership detail for all ECS/CHS products. This information is being provided for convenience in calculating your indirect compensation. If you maintain your own membership reporting information, you may utilize that information for the purposes of your indirect calculation instead.

Membership: 3778

**APPENDIX FOR SERVICE PROVIDER INFORMATION REGARDING SOURCES OF INDIRECT COMPENSATION  
EXCLUDING ELIGIBLE INDIRECT COMPENSATION TO BE REPORTED ON  
SCHEDULE C PART I, LINE 3**

(a) Service provider name: Evernorth Care Solutions, Inc.

(b) Service codes:

12 Claims Processing

38 Participant Communications

50 Direct payments from the Plan

13 Contract Administrator

(c) Amount of indirect compensation: \$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:

CitiBank NA, One Penns Way, New Castle, DE 19720

(e) Description of indirect compensation, including any formula used to determine eligibility or amount: *Earnings credits associated with bank account utilized by Connecticut General in the administration of claim overpayment recoveries. Applicable to all self-funded plans administered by Connecticut General.*

"Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:

- eviCore
- Evernorth Care Solutions
- Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)"

Eligible Indirect Compensation Formula/Estimate: For calendar year 2024, \$0.01 per participant/member with the average annual rate of the earnings credit at 3.66%.



Cigna Supplemental Health Solutions  
900 Cottage Grove Road  
Bloomfield, CT 06002



Seton Hall University  
400 S. Orange Avenue  
South Orange, NJ 07079-0000

## Annual Policy Information Report ("APIR")

Date Prepared: January 1, 2025

| <b>Insurer:</b>                                                                                                                                                                                                                                                                                                                               | Cigna Health and Life Insurance Company                                        |                            |                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------|-------------------------------|
| <b>EIN:</b>                                                                                                                                                                                                                                                                                                                                   | 59-1031071                                                                     |                            |                               |
| <b>NAIC Code:</b>                                                                                                                                                                                                                                                                                                                             | 67369                                                                          |                            |                               |
| <b>Contract/Policy Number:</b>                                                                                                                                                                                                                                                                                                                | CI110069                                                                       |                            |                               |
| <b>Contract/Policy Year From:</b>                                                                                                                                                                                                                                                                                                             | 01/01/2024                                                                     |                            |                               |
| <b>Contract/Policy Year To:</b>                                                                                                                                                                                                                                                                                                               | 12/31/2024                                                                     |                            |                               |
| <b>Policy or Benefit Type:</b>                                                                                                                                                                                                                                                                                                                | Voluntary Critical Illness                                                     |                            |                               |
| <b>Approximate Number of persons covered at the end of the policy year:</b>                                                                                                                                                                                                                                                                   | Please refer to your census reports or billing statement for this information. |                            |                               |
| Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year. |                                                                                |                            |                               |
| <b>Total premiums paid to Cigna during the policy year:</b> \$13,548.45                                                                                                                                                                                                                                                                       |                                                                                |                            |                               |
| See below for total commissions and fees paid by Cigna during the policy year.                                                                                                                                                                                                                                                                |                                                                                |                            |                               |
| <b>Name and Address of Each Recipient of Fees and/or Commissions</b>                                                                                                                                                                                                                                                                          | <b>Amount of Commissions Paid</b>                                              | <b>Amount of Fees Paid</b> | <b>Purpose for Which Paid</b> |
| Mercer Health & Benefits Admin Llc<br>Po Box 850502<br>Minneapolis, MN 55485-0502                                                                                                                                                                                                                                                             | \$3,857.50                                                                     | \$0.00                     | Standard Commissions          |
| Mercer Health & Benefits Llc<br>4565 Paysphere Circle<br>Chicago, IL 60674                                                                                                                                                                                                                                                                    | \$0.00                                                                         | \$172.36                   | Overrides                     |

Notes:

01/03/2025 02:59

- In addition to the commissions and other fees reported, Cigna enters into compensation programs under which certain brokers/consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, and is funded from our general overhead. Contact your agent/broker for specific information about their participation.
- Your agent or broker may have also participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation.
- This is not an official form. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.

Cigna Supplemental Health Solutions  
900 Cottage Grove Road  
Bloomfield, CT 06002



Seton Hall University  
400 S. Orange Avenue  
South Orange, NJ 07079-0000

## Annual Policy Information Report ("APIR")

Date Prepared: January 1, 2025

| <b>Insurer:</b>                                                                                                                                                                                                                                                                                                                               | Cigna Health and Life Insurance Company                                        |                            |                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------|-------------------------------|
| <b>EIN:</b>                                                                                                                                                                                                                                                                                                                                   | 59-1031071                                                                     |                            |                               |
| <b>NAIC Code:</b>                                                                                                                                                                                                                                                                                                                             | 67369                                                                          |                            |                               |
| <b>Contract/Policy Number:</b>                                                                                                                                                                                                                                                                                                                | AI110075                                                                       |                            |                               |
| <b>Contract/Policy Year From:</b>                                                                                                                                                                                                                                                                                                             | 01/01/2024                                                                     |                            |                               |
| <b>Contract/Policy Year To:</b>                                                                                                                                                                                                                                                                                                               | 12/31/2024                                                                     |                            |                               |
| <b>Policy or Benefit Type:</b>                                                                                                                                                                                                                                                                                                                | Accidental Injury                                                              |                            |                               |
| <b>Approximate Number of persons covered at the end of the policy year:</b>                                                                                                                                                                                                                                                                   | Please refer to your census reports or billing statement for this information. |                            |                               |
| Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year. |                                                                                |                            |                               |
| <b>Total premiums paid to Cigna during the policy year:</b> \$4,641.77                                                                                                                                                                                                                                                                        |                                                                                |                            |                               |
| See below for total commissions and fees paid by Cigna during the policy year.                                                                                                                                                                                                                                                                |                                                                                |                            |                               |
| <b>Name and Address of Each Recipient of Fees and/or Commissions</b>                                                                                                                                                                                                                                                                          | <b>Amount of Commissions Paid</b>                                              | <b>Amount of Fees Paid</b> | <b>Purpose for Which Paid</b> |
| Mercer Health & Benefits Llc<br>4565 Paysphere Circle<br>Chicago, IL 60674                                                                                                                                                                                                                                                                    | \$0.00                                                                         | \$60.76                    | Overrides                     |
| Mercer Health & Benefits Admin Llc<br>Po Box 850502<br>Minneapolis, MN 55485-0502                                                                                                                                                                                                                                                             | \$1,277.49                                                                     | \$0.00                     | Standard Commissions          |

Notes:

01/03/2025 01:02

- In addition to the commissions and other fees reported, Cigna enters into compensation programs under which certain brokers/consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, and is funded from our general overhead. Contact your agent/broker for specific information about their participation.
- Your agent or broker may have also participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation.
- This is not an official form. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.

## The Summary Annual Report...SAR

<sup>Initial</sup>  


I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

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## **SUMMARY ANNUAL REPORT**

### **For Seton Hall University Welfare Benefit Program**

This is a summary of the annual report of the Seton Hall University Welfare Benefit Program, EIN 22-1500645, Plan No. 505, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Seton Hall University has committed itself to pay certain self-insured Prescription Drug and Health Flexible Spending Account claims incurred under the terms of the plan.

### **Insurance Information**

The plan has contracts with Cigna Health and Life Insurance Company and Affiliates, Fidelity Security Life Insurance Company, Delta Dental of New Jersey, Inc., Alpha Dental Programs, Inc., Standard Insurance Company, Evernorth Care Solutions, Inc., and Cigna Health and Life Insurance Company to pay Medical, Dental, Vision, Life Insurance, Long-term Disability, Accidental Death and Dismemberment, Employee Assistance Program, Critical Illness, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$24,454,193.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2024, the premiums paid under such "experience-rated" contracts were \$1,623,974 and the total of all benefit claims paid under these contracts during the plan year was \$2,522,599.

### **Your Rights To Additional Information**

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

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Seton Hall University at 400 South Orange Avenue, South Orange, NJ, 070792646 or by telephone at 973-761-9181.

You also have the legally protected right to examine the annual report at the main office of the plan (Seton Hall University, 400 South Orange Avenue, South Orange, NJ, 070792646) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S.

Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## Form 5558

Initial  
TD

I have reviewed the Form 5558.

The following is a copy of the Form 5558. Wrangle has submitted the original to the IRS on the Plan Sponsor's behalf (unless the Plan Sponsor indicated that they had already done so).

The IRS's Form 5558's purpose is to request for an automatic extension for the Form 5500 filing deadline by 2 ½ months.

This form does not require a signature.

Currently Form 5558 cannot be e-filed; a hard copy is to be mailed. To be accepted and receive the extension, the IRS does require without leniency for the mailing to be postmarked by or on the due date of the Form 5500 filing deadline.

**Disclaimer:** Wrangle, LLC as well as its employees and affiliates do not offer legal and accounting consultation and services. Information relayed through Wrangle-produced materials serves to provide general information only; whether expressed or implied it is not intended to constitute legal or other advice or opinions on any specific matters and is not intended to replace the advice of a qualified attorney, accountant, or other professional advisor. Wrangle applies its best effort to provide accurate and complete results and provides its service in accordance with the ERISA rules that govern Form 5500 completion. This email may contain information that is confidential. Any use, disclosure, distribution, or duplication by anyone other than an intended recipient is prohibited. This email may include the use of links to a third-party's website, and the use of these links is done at your own discretion and risk.

Form **5558**  
(Rev. January 2024)  
  
Department of the Treasury  
Internal Revenue Service

Application for Extension of Time  
To File Certain Employee Plan Returns  
  
Go to *www.irs.gov/Form5558* for the latest information.

OMB No. 1545-1610  
  
File With IRS Only

Part I Identification

|                                                                                                                                                                                                                                                                                  |                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A</b> Name of filer, plan administrator, or plan sponsor (see instructions)<br>SETON HALL UNIVERSITY<br>Number, street, and room or suite no. (If a P.O. box, see instructions.)<br>400 SOUTH ORANGE AVENUE<br>City or town, state, and ZIP code<br>SOUTH ORANGE NJ 070792646 | <b>B</b> Employer identification number (EIN)<br>22-1500645 |
| <b>C</b> Name of plan<br>SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM                                                                                                                                                                                                           | <b>D</b> Three-digit plan number (PN)<br>505                |
| <b>E</b> Plan year end date<br>12/31/2024                                                                                                                                                                                                                                        |                                                             |

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

- 1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, item C, above.
- 2 I request an extension of time until 1 0 / 1 5 / 2 0 2 5 to file Form 5500 series. See instructions.
- 3 I request an extension of time until / / to file Form 8955-SSA. See instructions.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.