Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Id	lentification Information		
For calendar plan year 2024 or fisc	al plan year beginning 01/01/2024	and ending 12/31/2024	
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this be employer information in accordance with the fo	
	x a single-employer plan	a DFE (specify)	,
B This return/report is:	the first return/report	the final return/report	
	an amended return/report	a short plan year return/report (less than 12 mg	onths)
C If the plan is a collectively-barga	ained plan, check here		
D Check box if filing under:	X Form 5558	automatic extension	the DFVC program
	special extension (enter description	n)	
E If this is a retroactively adopted	plan permitted by SECURE Act section 2	201, check here	
Part II Basic Plan Inforr	nation—enter all requested information	n	
1a Name of plan SETON HALL UNIVERSITY WEL	FARE BENEFIT PROGRAM		1b Three-digit plan number (PN) ▶ 505
			1c Effective date of plan 09/16/1966
2a Plan sponsor's name (employed Mailing address (include room City or town, state or province,	2b Employer Identification Number (EIN) 22-1500645		
SETON HALL UNIVERSITY			2c Plan Sponsor's telephone number 973-761-9181
400 SOUTH ORANGE AVENUE SOUTH ORANGE, NJ 070792646	2d Business code (see instructions) 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.

Otatoino	tationistic and attachment, as well as the discitoring relicion of this feature, and to the best of my knowledge and belief, it is that, something and belief, it is that, something the best of my knowledge and belief, it is that, something the best of my knowledge and belief, it is that, something the best of my knowledge and belief, it is that, something the best of my knowledge and belief.							
SIGN	Perri Demarest	10/1/2025	Terri Demarest					
HERE	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					

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

	Form 5500 (2024)	P	age 2		
3a	Plan administrator's name and address 🗵 Same as Plan Sponsor			3b Administra	tor's E IN
				3c Administration	tor's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from			4b EIN	
a c	Sponsor's name Plan Name			4d PN	
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 6a(2), 6b, 6c, and 6d).	(welfare pla	ans complete only lines 6a(1),		
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				1375
b	Retired or separated participants receiving benefits			6b	27
С	Other retired or separated participants entitled to future benefits			6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	1402
е	Deceased participants whose beneficiaries are receiving or are entitled to	receive ben	efits	6e	
f	Total. Add lines 6d and 6e			6f	
g(complete this terry			. 6g(1)	
g(complete this item/			. 6g(2)	
h	Number of participants who terminated employment during the plan year v less than 100% vested			. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only n			. 7	
	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code. 4A 4B 4D 4E 4H 4L 4Q				
9a	Plan funding arrangement (check all that apply) (1)	1	penefit arrangement (check all the	nat app l y)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1)	X Insurance Code section 412(e)(3) insurance contra	acts
	(3) Trust	(3)	Trust	,	
	(4) X General assets of the sponsor	(4)	X General assets of the	sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at		,	nber attached. (So	ee instructions)
а	Pension Schedules		eral Schedules	`	
	(1) R (Retirement Plan Information)	(1)	H (Financial Information	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	[I (Financial Informatio	•	0
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)		•	ached ⁹
		(4)	C (Service Provider Int	formation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)	D (DFE/Participating P	•	
	(4) DCG (Individual Plan Information) – Number Attached	(6)	☐ G (Financial Transaction	on Schedules)	
	(5) MEP (Multiple-Employer Retirement Plan Information)				

Receipt Confirmation Code

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	This Form is Open to Public Inspection			
For calendar plan year 202	24 or fiscal plai	n year beginning 01/01/2024		and en	ding 12/3	31/2024	_
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM			e-digit number (P i	N) •	505
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY				•	yer Identific 1500645	ation Number (EIN)
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:		<u> </u>				<u> </u>	
(a) Name of insurance car CIGNA HEALTH AND LIFE		COMPANY AND AFFILIATES					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu				ontract year I
(6) 2114	code	identification number	policy or contrac		(f)	From	(g) To
59-1031071	1031071 67369 3334085 1049 01/01/2024		4	12/31/2024			
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in l ine 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees			of fees paid				
							227254
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
		and address of the agent, broker	<u>, or other person to who</u> PAYSPHERE CIRCLE	m commiss	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		AGO, IL 60674				
(b) Amount of sales an	nd hase	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
		227254 E	BENEFIT ADVISOR PAY	MENTS			3
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ions or fees	were naid	
	(a) Italiic a	and address of the agent, broker	, or other person to who	111 00111111100	10113 01 1003	were paid	
(b) Amount of sales an	b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
							1

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5	
6	Con	ntracts With Allocated Funds:			
	а	State the basis of premium rates •			
			ı		
	b	Premiums paid to carrier	İ	6b	
	C.	Premiums due but unpaid at the end of the year	i i	6c	
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d	
		Specify nature of costs			
		Specify materials of cools			
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity		
		(3) \(\text{ other (specify) } \)			
		(5) Untilet (specify)			
	£	If anyther the complete of the			
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>		
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint			
	а		participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
			ī		
	b	Balance at the end of the previous year		7b	
	С		7c(1)		
		` '	7c(2) 7c(3)		
		- ` <i>` '</i>	7c(4)		
		` '	7c(5)		
		(o) Saler (speedly select)	(0)		
		(6)Total additions		7c(6)	
	Ы	(6)Total additions	Ī	70(0) 7d	
		Deductions:		7 G	
	•		7e(1)		
		· · · · · · · · · · · · · · · · · · ·	7e(2)		
			7e(3)		
			7e(4)		
		→			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second se	7f	

Р	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 individu							viduai
8	Bene	fit and contract type (check all applicable boxes)				·	•	·	
	a X	• • • • • • • • • • • • • • • • • • • •	b Dental	(c∏∨	ision		d ☐ Life insura	nce
	e 🗀	Temporary disability (accident and sickness)	f ☐ Long-term disabili		=	upplemental unem		h ☐ Prescriptio	
	: =						pioyment	- 🗏	-
	'	Stop loss (large deductible)	j HMO contract		k ∐ P	PO contract		I X Indemnity	contract
	m _	Other (specify)							
	_								
9	•	rience-rated contracts:		0 (4)				_	
		Premiums: (1) Amount received		9a(1)				_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)	-			_	
		(3) Increase (decrease) in unearned premium res		9a(3)			90(4)		
	-	(4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid					9a(4)		
		(2) Increase (decrease) in claim reserves		9b(1) 9b(2)				-	
		(3) Incurred claims (add (1) and (2))			_		9b(3)		
		(4) Claims charged					9b(4)		
	,	Remainder of premium: (1) Retention charges (o					00(4)		
	_	(A) Commissions		9c(1)(A	<u>, </u>				
		(B) Administrative service or other fees		9c(1)(E					
		(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	3)				
		(H) Total retention	_		_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	cred	dited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits a	fter ret	irement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 90	:(2).)		9e		
10		nexperience-rated contracts:					- 10		00704050
	_	Total premiums or subscription charges paid to c					10a		22724650
		If the carrier, service, or other organization incurrent					106		
		retention of the contract or policy, other than repo cify nature of costs.	orted in Part I, line ∠ abov	e, report a	amouni	L	10b		
	Opoc	, mataro or occion							
Р	art I	V Provision of Information							
11	Did	the insurance company fail to provide any inform	ation necessary to comp	ete Sched	dule A?	·	Yes	X No	
12	If th	e answer to line 11 is "Yes," specify the information	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection			
For calendar plan year 202	24 or fiscal pl	an year beginning 01/01/2024		and en	ding 12/3	31/2024	
A Name of plan SETON HALL UNIVERSI	TY WELFARI	E BENEFIT PROGRAM			e-digit number (P i	V) •	505
C Plan sponsor's name a SETON HALL UNIVERSI		ne 2a of Form 5500		-	yer Identific 1500645	ation Number	(EIN)
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:	ate concaule	7. marriada contracto grouped	as a anicimi area il ana il	i can be re	oortou on u	omgle concut	no 7 t.
(a) Name of insurance ca		E COMPANY					
		1	(e) Approximate no	umber of		Policy or o	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
43-0949844	71870	1008322,1054008	2271		01/01/202	4	12/31/2024
2 Insurance fee and composition descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Damana vasaivina aan		face (Complete as many entri		noroono)			_
J Persons receiving com		fees. (Complete as many entried and address of the agent, broke			·		
			ees and other commissio				
(b) Amount of sales ar commissions pai			ees and other commissio	•	•		(e) Organization code
commissions par	id.	d (c) Amount (d) Purpose				(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(-)		,				
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5	
6	Con	ntracts With Allocated Funds:			
	а	State the basis of premium rates •			
			ı		
	b	Premiums paid to carrier	İ	6b	
	C.	Premiums due but unpaid at the end of the year	i i	6c	
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d	
		Specify nature of costs			
		Specify materials of cools			
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity		
		(3) \(\text{ other (specify) } \)			
		(5) Untilet (specify)			
	£	If anyther the complete of the			
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>		
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint			
	а		participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
			ī		
	b	Balance at the end of the previous year		7b	
	С		7c(1)		
		` '	7c(2) 7c(3)		
		- ` <i>` '</i>	7c(4)		
		` '	7c(5)		
		(o) Saler (speedly select)	(0)		
		(6)Total additions		7c(6)	
	Ы	(6)Total additions	Ī	70(0) 7d	
		Deductions:		7 G	
	•		7e(1)		
		· · · · · · · · · · · · · · · · · · ·	7e(2)		
			7e(3)		
			7e(4)		
		→			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f	

Part II	I Welfare Benefit Contract Information if more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of th ing purposes if such con	tracts are	experi	ience-rated as a unit	t. Where cor	ntracts cover individ	
8 Bene	fit and contract type (check all applicable boxes)							
а ∏	Health (other than dental or vision)	b Dental		c 🛛 '	Vision		d Life insurance	3
e	Temporary disability (accident and sickness)	f Long-term disabil		=	Supplemental unem	plovment	h ☐ Prescription o	Irua
. □	Stop loss (large deductible)	j HMO contract	-	- =	PPO contract	p.10 y	Indemnity cor	-
• <u>⊔</u>	, , ,	j 🗌 Tilvio contract		" П .	i i O contract			iliaci
m _	Other (specify)							
0 =								
•	ience-rated contracts:		0-(4)					
	remiums: (1) Amount received		9a(1)				_	
,	2) Increase (decrease) in amount due but unpaid		9a(2)				_	
•	3) Increase (decrease) in unearned premium res 4) Earned ((1) + (2) - (3))		9a(3)			90(4)		
_	3enefit charges (1) Claims paid				•••••	. 9a(4)		
	• , ,		9b(1) 9b(2)				_	
•	Increase (decrease) in claim reserves Incurred claims (add (1) and (2))					9b(3)		
•	4) Claims charged					9b(4)		
,	Remainder of premium: (1) Retention charges (c					35(4)		
	(A) Commissions	,	9c(1)(Δ1			_	
	(B) Administrative service or other fees		9c(1)(l				_	
	(C) Other specific acquisition costs		9c(1)(0				_	
	(D) Other expenses		9c(1)(I				_	
	(E) Taxes		9c(1)(I				_	
	(F) Charges for risks or other contingencies .		9c(1)(l					
	(G) Other retention charges		0 (4) (4					
	(H) Total retention		-			9c(1)(H)		
(2) Dividends or retroactive rate refunds. (These	amounts were 🗌 paid i	n cash, or	☐ cre	edited.)	9c(2)		
	Status of policyholder reserves at end of year: (1	ш .		_		9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
	Dividends or retroactive rate refunds due. (Do n					9e		
10 Non	experience-rated contracts:			. , ,		,		
a ·	· Γotal premiums or subscription charges paid to α	arrier				10a		19833
b	f the carrier, service, or other organization incur	red any specific costs in o	connection	n with 1	the acquisition or			
	retention of the contract or policy, other than rep					10b		
Spec	ify nature of costs.							
Part I\	/ Provision of Information							
		nation necessary to comm	Note Saha	dula ^	<u></u>	Yes	X No	
	the insurance company fail to provide any inform		nete Sche	uule A	\f	100	<u> </u>	
12 If the	e answer to l ine 11 is "Yes," specify the informat	ion not provided. •						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

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OMB No. 1210-0110

Pension Benefit Guaranty Co	Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				n is Open to Public Inspection		
For calendar plan year 20	24 or fiscal pla	n year beginning 01/01/2024		and en	ding 12/3	31/2024	
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C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY				·	yer Identific 1500645	cation Number (EIN)
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 ca		(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
22-1896118	55085	07742	2038			4	12/31/2024
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid			(b) To	otal amount	of fees paid		
		10762					
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke		m commiss	ions or fees	were paid	
MERCER HEALTH AND E	BENEFITS, LL		5 PAYSPHERE CIRCLE CAGO, IL 60674				
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	10762						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ione or fees	were naid	
	(a) Name	and address of the agent, broke	er, or other person to who	III COMINISS	10113 01 1003	were paid	
(b) Amount of sales a			ees and other commissio				
commissions pa	id	(c) Amount		(d) Purpose	е		(e) Organization code

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4	
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6	Con	ntracts With Allocated Funds:			
	а	State the basis of premium rates •			
			ı		
	b	Premiums paid to carrier	İ	6b	
	C.	Premiums due but unpaid at the end of the year	i i	6c	
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d	
		Specify nature of costs			
		Specify materials of cools			
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity		
		(3) \(\text{ other (specify) } \right\)			
		(5) Untilet (specify)			
	£	If anyther the complete of the			
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>		
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint			
	а		participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
			ī		
	b	Balance at the end of the previous year		7b	
	С		7c(1)		
		` '	7c(2) 7c(3)		
		- ` <i>` '</i>	7c(4)		
		` '	7c(5)		
		(o) Saler (speedly select)	(0)		
		(6)Total additions		7c(6)	
	Ы	(6)Total additions	Ī	70(0) 7d	
		Deductions:		7 G	
	•		7e(1)		
		· · · · · · · · · · · · · · · · · · ·	7e(2)		
			7e(3)		
			7e(4)		
		→			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f	

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 employees, the entire group of such individual contracts with each						
8 Benefit and contract type (check all applicable boxes)	on carrier may be tre	ated as a unit for purposes of the	по торот.			
	c □ v	/ision	d ☐ Life insurance			
	브		블			
$f e \; \bigsqcup \;$ Temporary disability (accident and sickness) $\; \; \; f \; \bigsqcup \;$ Long-term dis	- =		h Prescription drug			
i 📗 Stop loss (large deductible) j 📗 HMO contract	: k ∐ P	PPO contract	I Indemnity contract			
m ☐ Other (specify) ▶						
9 Experience-rated contracts:						
a Premiums: (1) Amount received		1076216				
(2) Increase (decrease) in amount due but unpaid		0				
(3) Increase (decrease) in unearned premium reserve		0				
(4) Earned ((1) + (2) - (3))			1076216			
b Benefit charges (1) Claims paid		978902	_			
(2) Increase (decrease) in claim reserves		9628	000500			
(3) Incurred claims (add (1) and (2))			988530			
(4) Claims charged		<u>9b(4)</u>	988530			
C Remainder of premium: (1) Retention charges (on an accrual basis) –		40700	_			
(A) Commissions	- ` ` ` - - - - - - - - 	10762	_			
(B) Administrative service or other fees	0 (4)(0)	134918				
(C) Other specific acquisition costs(D) Other expenses	2 (4)(5)	0	_			
(E) Taxes	0 (4)(5)	0	_			
(F) Charges for risks or other contingencies	A (4)(=)	13991	_			
(G) Other retention charges	2 (4)(2)	0				
(H) Total retention		1	159671			
(2) Dividends or retroactive rate refunds. (These amounts were \square pa	_		0			
d Status of policyholder reserves at end of year: (1) Amount held to prov	_		0			
(2) Claim reserves			77496			
(3) Other reserves		2.1(2)	0			
Dividends or retroactive rate refunds due. (Do not include amount ent			0			
10 Nonexperience-rated contracts:		1				
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	he acquisition or				
retention of the contract or policy, other than reported in Part I, line 2						
Specify nature of costs.						
Part IV Provision of Information						
11 Did the insurance company fail to provide any information necessary to co	omplete Schedule A?	? Yes	X No			
12 If the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					n is Open to Public Inspection		
For calendar plan year	2024 or fiscal pl	an year beginning 01/01/2024		and en	ding 12/3	31/2024	
A Name of plan SETON HALL UNIVE	RSITY WELFARI	E BENEFIT PROGRAM			e-digit number (Pl		505
C Plan sponsor's nam SETON HALL UNIVER		ne 2a of Form 5500		D Employer Identification Number (EIN) 22-1500645			
		erning Insurance Contra A. Individual contracts grouped					
1 Coverage Information		<u> </u>					
(a) Name of insurance	e carrier GRAMS, INC.		(e) Approximate no	imher of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
7.0.1.75.10	05400	7000		policy or contract year			
74-2447512 95163 78		78998	229		01/01/202	4	12/31/2024
2 Insurance fee and of descending order of		nation. Enter the total fees and t	total commissions paid. L	ist in l ine 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		327					
3 Persons receiving of	commissions and	fees. (Complete as many entri	es as needed to report all	persons).			
		and address of the agent, broke	er, or other person to who 5 PAYSPHERE CIRCLE	m commiss	ions or fees	were paid	
MERCER HEALTH AN	D BENEFITS, LL		CAGO, IL 60674				
(b) Amount of sale	s and hase	F	ees and other commissio	ns paid			
commissions		(c) Amount		(d) Purpos	е		(e) Organization code
	327						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were naid	
	(a) Name	and address of the agent, broke	er, or other person to who	III COMINISS	10113 01 1003	were paid	
(b) Amount of sale		Se Fees and other commissions paid					
commissions	paid	(c) Amount		(d) Purpose	е		(e) Organization code

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of				
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of				
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4					
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5					
6	Con	ntracts With Allocated Funds:							
	а	State the basis of premium rates							
			ı						
	b	Premiums paid to carrier	İ	6b					
	C.	Premiums due but unpaid at the end of the year	i i	6c					
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d					
		Specify nature of costs							
		Specify materials of cools							
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity						
		(3) \(\text{ other (specify) } \right\)							
		(5) Untilet (specify)							
	£	If anyther the complete of the							
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>						
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint							
	а		participation guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶							
			ī						
	b	Balance at the end of the previous year		7b					
	С		7c(1)						
		` '	7c(2) 7c(3)						
		- ` <i>` '</i>	7c(4)						
		` '	7c(5)						
		(o) Saler (speedly select)	(0)						
		(6)Total additions		7c(6)					
	Ы	(6)Total additions	Ī	70(0) 7d					
		Deductions:		7 G					
	•		7e(1)						
		· · · · · · · · · · · · · · · · · · ·	7e(2)						
			7e(3)						
			7e(4)						
		→							
		(5) Total deductions		7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f					

Part III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporting	roup of employees of the s				
employees, the entire group of such individu					
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 unem	ployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k┌	PPO contract		Indemnity contract
m Other (specify)	- <u>L</u>	_	_		
Care (eposity)					
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 rese	erve	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 (or	· —	0~(4)(4)	I		_
(A) Commissions		9c(1)(A) 9c(1)(B)			-
(B) Administrative service or other fees (C) Other specific acquisition costs	——————————————————————————————————————	9c(1)(B) 9c(1)(C)			-
(D) Other expenses		9c(1)(D)			-
(E) Taxes	<u> </u>	9c(1)(E)			_
(F) Charges for risks or other contingencies	 	9c(1)(F)			7
(G) Other retention charges	 	9c(1)(G)			
(H) Total retention				9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These	amounts were naid in c	ash, or	credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1)	Amount held to provide be	enefits afte	r retirement	9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do no	t include amount entered i	n line 9c(2	<u>).</u>)	9e	
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to ca	arrier			10a	32732
b If the carrier, service, or other organization incurre	, ,			405	
retention of the contract or policy, other than repo Specify nature of costs.	rted in Part I, line 2 above,	report am	ount	10b	
opeony nature or costs.					
Part IV Provision of Information				,	
11 Did the insurance company fail to provide any information	ation necessary to complet	e Schedule	e A?	Yes	X No
12 If the answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	rporation		nies are required to provide the information at to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 202	24 or fiscal pla	an year beginning 01/01/2024		and en	ding 12/3	31/2024		
A Name of plan				B Three	e-digit			
SETON HALL UNIVERSI	TY WELFARE	E BENEFIT PROGRAM		plan	number (Pl	N) •	505	
C Plan sponsor's name a		ne 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)	
SETON HALL UNIVERSI	ΓY			22-	1500645			
		rning Insurance Contract A. Individual contracts grouped a						
1 Coverage Information:		-				-		
(a) Name of insurance ca								
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year	
(b) EIN	code	t '' l persons covered at end of			(f)	From	(g) To	
93-0242990	69019	170601	1410	0 01/01/2024		4	12/31/2024	
2 Insurance fee and communication descending order of the		nation. Enter the total fees and tot	al commissions paid. L	ist in l ine 3	the agents,	brokers, and of	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
6132 7133					7133			
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all	persons).				
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH AND B	ENEFITS, LL	(,	PAYSPHERE CIRCLE GO, IL 60674					
(b) Amount of sales ar	nd hase	Fee	es and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code	
		7133 B	ONUS				3	
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH AND B	ENEFITS, LL	C. 22ND	AVENUE OF THE AMER FLOOR /ORK, NY 10036	RICAS				
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
	6132						3	
For Paperwork Reductio	n Act Notice,	, see the Instructions for Form !	5500.			Sched	dule A (Form 5500) 2024	

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of				
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of				
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4					
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5					
6	Con	ntracts With Allocated Funds:							
	а	State the basis of premium rates							
			ı						
	b	Premiums paid to carrier	İ	6b					
	C.	Premiums due but unpaid at the end of the year	i i	6c					
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d					
		Specify nature of costs							
		Specify materials of cools							
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity						
		(3) \(\text{ other (specify) } \right\)							
		(5) Untilet (specify)							
	£	If anyther the complete of the							
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>						
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint							
	а		participation guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶							
			ī						
	b	Balance at the end of the previous year		7b					
	С		7c(1)						
		` '	7c(2) 7c(3)						
		- ` <i>` '</i>	7c(4)						
		` '	7c(5)						
		(o) Saler (speedly select)	(0)						
		(6)Total additions		7c(6)					
	Ы	(6)Total additions	Ī	70(0) 7d					
		Deductions:		7 G					
	•		7e(1)						
		· · · · · · · · · · · · · · · · · · ·	7e(2)						
			7e(3)						
			7e(4)						
		→							
		(5) Total deductions		7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f					

Part III	Welfare Benefit Contract Inform If more than one contract covers the same	group of employees of the				
	the information may be combined for repor employees, the entire group of such individ					
8 Benefit a	and contract type (check all applicable boxes)					
а∏н	lea l th (other than dental or vision)	b Dental	с□	Vision		d X Life insurance
е ⊟т	emporary disability (accident and sickness)	f Long-term disability	α∏	Supplemental une	mployment	h Prescription drug
	top loss (large deductible)		y ∐ k ∏			
		j HMO contract	^ _	PPO contract		Indemnity contract
m 🛛 o	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT				
0 = :						
•	nce-rated contracts:	Г	0-(4)		0.40000	_
	niums: (1) Amount received	-	9a(1)		349380	_
	Increase (decrease) in amount due but unpai	T-	9a(2) 9a(3)		-26496	_
, ,	Increase (decrease) in unearned premium res	<u>-</u>			92(4)	322884
_	Earned ((1) + (2) - (3)) nefit charges (1) Claims paid		9b(1)		9a(4) 550100	322004
	Increase (decrease) in claim reserves	-	9b(2)		468859	_
` ,	Incurred claims (add (1) and (2))	-				1018959
` '	Claims charged					1018959
. ,	mainder of premium: (1) Retention charges (05(4)	1010000
•	(A) Commissions	· -	9c(1)(A)		21072	
	(B) Administrative service or other fees		9c(1)(B)		0	
	(C) Other specific acquisition costs	T	9c(1)(C)		0	
	(D) Other expenses	-	9c(1)(D)		41869	
	(E) Taxes	-	9c(1)(E)		6463	
	(F) Charges for risks or other contingencies	T	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	e amounts were paid in o	cash, or 🗌 c	redited.)	9c(2)	0
	atus of policyholder reserves at end of year: (´					0
	Claim reserves					0
` '	Other reserves					0
` '	ridends or retroactive rate refunds due. (Do n				1	0
10 Nonex	perience-rated contracts:				•	
a Tot	tal premiums or subscription charges paid to	carrier			10a	
b If th	ne carrier, service, or other organization incur	red any specific costs in co	nnection with	the acquisition or		
	ention of the contract or policy, other than rep				10b	
Specify	nature of costs.					
Part IV	Provision of Information					
	e insurance company fail to provide any inform	nation necessary to comple	te Schedule	A? 「	Yes	X No
	Inswer to line 11 is "Yes," specify the informat					
i nuica	morror to fine 11 to 100, specify the illiothial	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).				This For	This Form is Open to Public Inspection		
For calendar plan year 202	24 or fiscal plar	year beginning 01/01/2024		and en	ding 12/3	31/2024	_
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM			e-digit number (P i	N) •	505
C Plan sponsor's name a SETON HALL UNIVERSIT		e 2a of Form 5500		D Employer Identification Number (EIN) 22-1500645			
		ning Insurance Contract					
1 Coverage Information:						•	
(a) Name of insurance ca STANDARD INSURANCE							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
93-0242990 69019		170601	1384 01/01/202		4	12/31/2024	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in l ine 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		11322					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,				were paid	
RSC INSURANCE BROKE	RAGE, INC.	SUITE	NORTH CAUSEWAY BC 815 RIE, LA 70002	DULEVARD			
(b) Amount of sales ar	nd haso	Fee	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	5984						3
	(a) Name a	nd address of the agent, broker.	or other person to who	m commiss	ions or fees	were paid	
EMERSON ROGERS, LLC	;.	SUITE	VER DRIVE 305 OOD PARK, NJ 07407				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	5338						3

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of				
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of				
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4					
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5					
6	Con	ntracts With Allocated Funds:							
	а	State the basis of premium rates							
			ı						
	b	Premiums paid to carrier	İ	6b					
	C.	Premiums due but unpaid at the end of the year	i i	6c					
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d					
		Specify nature of costs							
		Specify materials of cools							
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity						
		(3) \(\text{ other (specify) } \right\)							
		(5) Untilet (specify)							
	£	If anyther the complete of the							
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>						
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint							
	а		participation guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶							
			ī						
	b	Balance at the end of the previous year		7b					
	С		7c(1)						
		` '	7c(2) 7c(3)						
		- ` <i>` '</i>	7c(4)						
		` '	7c(5)						
		(o) Saler (speedly select)	(0)						
		(6)Total additions		7c(6)					
	Ы	(6)Total additions	Ī	70(0) 7d					
		Deductions:		7 G					
	•		7e(1)						
		· · · · · · · · · · · · · · · · · · ·	7e(2)						
			7e(3)						
			7e(4)						
		→							
		(5) Total deductions		7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f					

Welfare Benefit Contract Information

Part III

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 report employees, the entire group of such individ	.								
8	Ber	nefit aı	nd contract type (check all applicable boxes)						<u> </u>			
	а	_	ealth (other than dental or vision)	b∏	Dental			с□	Vision		d∏	Life insurance
	е	片	emporary disability (accident and sickness)	- =	Long-term	disahili	tv		Supplemental unem	nlovment	ьĦ	Prescription drug
	:	느		느	-		·y		-	picyment	- =	-
	•	=	op loss (large deductible)	ı 🗆	HMO contra	act		n ∐	PPO contract		•⊔	Indemnity contract
	m	∐ Ot	her (specify)									
_	_											
9			ce-rated contracts:				0-/4	<u>. </u>		400070	-	
	а		iums: (1) Amount received				9a(1			198378	\dashv	
		٠,,	ncrease (decrease) in amount due but unpaid				9a(2 9a(3			-13514	-	
			ncrease (decrease) in unearned premium res Earned ((1) + (2) - (3))							. 9a(4)		184864
	b		efit charges (1) Claims paid				9b(1			185768		104004
	~		ncrease (decrease) in claim reserves							329342	+	
			ncurred claims (add (1) and (2))							9b(3)		515110
		. ,	Claims charged							9b(4)		515110
	С	٠,	nainder of premium: (1) Retention charges (c									
			(A) Commissions				9c(1)(A)		15225		
		((B) Administrative service or other fees				9c(1)(0		
		((C) Other specific acquisition costs				9c(1)(C)		0		
		((D) Other expenses				9c(1)(_		45264		
		((E) Taxes				9c(1)(1941		
			(F) Charges for risks or other contingencies .				9c(1)(_		22183	4	
		((G) Other retention charges				9c(1)(G)		0		
			(H) Total retention							9c(1)(H)		84613
	_		Dividends or retroactive rate refunds. (These					_		9c(2)	_	0
	d	Stat	us of policyholder reserves at end of year: (1) Amou	ınt he l d to p	orovide	benefits	after	retirement	9d(1)		0
		` '	Claim reserves							9d(2)	+	0
	_	` '	Other reserves							9d(3)	+	0
_	<u>е</u>		dends or retroactive rate refunds due. (Do n	ot inclu	de amount	entered	d in line s)c(2).	<u>.)</u>	9e		0
1		•	erience-rated contracts:							100		
	a		al premiums or subscription charges paid to c							10a	+	
	b Spe	rete	e carrier, service, or other organization incurintion of the contract or policy, other than repotature of costs.							10b		
	Part	IV	Provision of Information									
1	1 Di	d the	insurance company fail to provide any inform	ation r	ecessary to	o comp	ete Sche	dule	A?	Yes	ΧN	0
1	12 If the answer to line 11 is "Yes," specify the information not provided.											

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection				
For calendar plan ye	ar 2024 or fiscal p	lan year beginning 01/01/2024		and endi	ng 12/3	1/2024		
A Name of plan SETON HALL UNIV	ERSITY WELFAF	RE BENEFIT PROGRAM		B Three-plan n	digit umber (PI	1)	505	
C Plan sponsor's na SETON HALL UNIV		line 2a of Form 5500		D Employer Identification Number (EIN) 22-1500645				
		erning Insurance Contra A. Individual contracts grouped						
1 Coverage Informa	ation:							
(a) Name of insuran EVERNORTH CARE (b) EIN			(e) Approximate no persons covered a policy or contract	t end of	(f)	Policy or o	contract year (g) To	
86-1465626	00000	3013	3778		01/01/202	4	12/31/2024	
descending order (a)	of the amount paid of the amount of control	mmissions paid d fees. (Complete as many entri e and address of the agent, broke	es as needed to report all er, or other person to who	(b) Tota persons). m commission	al amount	of fees paid	(e) Organization code	
	(a) Name	e and address of the agent, broke	er, or other person to who	m commissio	ns or fees	were paid		
	(4)		.,					
(b) Amount of sa	les and base	F	ees and other commissio	ns paid				
commissio		(c) Amount		(d) Purpose			(e) Organization code	

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of				
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of				
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4					
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5					
6	Con	ntracts With Allocated Funds:							
	а	State the basis of premium rates							
			ı						
	b	Premiums paid to carrier	İ	6b					
	C.	Premiums due but unpaid at the end of the year	i i	6c					
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d					
		Specify nature of costs							
		Specify materials of cools							
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity						
		(3) \(\text{ other (specify) } \right\)							
		(5) Untilet (specify)							
	£	If anyther the complete of the							
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>						
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint							
	а		participation guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶							
			ī						
	b	Balance at the end of the previous year		7b					
	С		7c(1)						
		` '	7c(2) 7c(3)						
		- ` <i>` '</i>	7c(4)						
		` '	7c(5)						
		(o) Saler (speedly select)	(0)						
		(6)Total additions		7c(6)					
	Ы	(6)Total additions	Ī	70(0) 7d					
		Deductions:		7 G					
	•		7e(1)						
		· · · · · · · · · · · · · · · · · · ·	7e(2)						
			7e(3)						
			7e(4)						
		→							
		(5) Total deductions		7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f					

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the	e same emplover(s)	or members of the same er	mplovee organizations(s).
the information may be combined for reporting purposes if such con			
employees, the entire group of such individual contracts with each c	arrier may be treated	d as a unit for purposes of th	nis report.
8 Benefit and contract type (check all applicable boxes)			
a ☐ Health (other than dental or vision) b ☐ Dental	c Visio	n	d Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g ∏ Supp	olemental unemployment	h Prescription drug
i ☐ Stop loss (large deductible) i ☐ HMO contract	k	contract	I Indemnity contract
m X Other (specify) ▶ EMPLOYEE ASSISTANCE PROGRAM	ш -		
Other (specify)			
9 Experience-rated contracts:			
·	00(1)		
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)	00(4)	
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid	9b(1)		_
(2) Increase (decrease) in claim reserves		01-(0)	
(3) Incurred claims (add (1) and (2))			
(4) Claims charged		<u>9b(4)</u>	
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			
(H) Total retention	_	 	
(2) Dividends or retroactive rate refunds. (These amounts were paid i	n cash, or	ed.) 9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after retiren	ment 9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entere	d 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 o	connection with the a	acquisition or	
retention of the contract or policy, other than reported in Part I, line 2 above			
Specify nature of costs.			
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to comp	llete Schedulo A2	☐ Yes	X No
	victe Schedule A (<u> </u>
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation			Insurance companies are required to provide the pursuant to ERISA section 103(a)(2).			ion	This Form is Open to Public Inspection	
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024					and ending 12/31/2024			
A Name of plan SETON HALL UNIVERSITY WELFAR			E BENEFIT PROGRAM			e-digit number (Pi		505
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY					D Emplo	EIN)		
	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 Info	ormation:							
(a) Name of inst		INSURANC		(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN		(c) NAIC code	(d) Contract or identification number		persons covered at end of		From	(g) To
59-1031071		67369	CI110069	37	с усаг	01/01/202	4	12/31/2024
2 Insurance fee descending or			nation. Enter the total fees and	total commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
			nmissions paid	(b) Total amount of fees paid				
			3858				172	
3 Persons rece	eiving comr	missions and	fees. (Complete as many entri	es as needed to report all	persons).			
		(a) Name	and address of the agent, brok		m commiss	ions or fees	were paid	
MERCER HEALTH AND BENEFITS ADMIN PO BOX 850502 MINNEAPOLIS, MN 55485								
(b) Amount of sales and base			F	ees and other commission	ns paid			
commissions paid			(c) Amount		(d) Purpose			(e) Organization code
3858							3	
		(a) Name	and address of the agent, brok	er or other person to who	m commiss	ions or fees	were naid	
MERCER HEALT	TH AND BI		.C. 4565	5 PAYSPHERE CIRCLE CAGO, IL 60674			, more pana	
(b) Amount of sales and base			F	ees and other commission	ns paid			
	issions pai		(c) Amount	(d) Purpose				(e) Organization code
		172	BONUS				3	

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

Part II Investment and Annuity Contract Information		unal constructo with cook corrier was	. h a tua ata d	and a sumit for manage of				
	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	Curr	rent value of plan's interest under this contract in the general account at year e	4					
5	Curr	rent value of plan's interest under this contract in separate accounts at year en	5					
6	Con	ntracts With Allocated Funds:						
	а	State the basis of premium rates •						
				01				
	b	Premiums paid to carrier	6b					
	ч С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.	·	6d				
		Specify nature of costs		ll				
		•						
	е	Type of contract: (1) individual policies (2) group deferred	annuity					
		(3) other (specify)	·					
		(a) Li callel (appeality)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ting plan, check here					
7		ntracts With Unallocated Funds (Do not include portions of these contracts main	<u> </u>					
•	a		e participation guarantee					
	а		s participation guarantee					
		(3) guaranteed investment (4) other						
	h	Deleges at the end of the averticus		7b				
	b C	Additions: (1) Contributions deposited during the year	7c(1)	7.0				
	·	(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year.	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
)						
		(6)Total additions		7c(6)				
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d				
	е	Deductions:						
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2)					
		(3) Transferred to separate account	7e(3)					
		(4) Other (specify below)	7e(4)					
)						
		(5) Total deductions		7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f					

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							
	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 contra							
	act R FFO contract						
m X Other (specify) ▶ CRITICAL ILLNESS							
O Comparison on marked annother star.							
9 Experience-rated contracts: a Premiums: (1) Amount received	90(1)						
()							
(2) Increase (decrease) in amount due but unpaid							
(3) Increase (decrease) in unearned premium reserve							
b Benefit charges (1) Claims paid	, , , ,						
(2) Increase (decrease) in claim reserves							
(3) Incurred claims (add (1) and (2))							
(4) Claims charged	20.00						
C Remainder of premium: (1) Retention charges (on an accrual basis							
(A) Commissions	2 (4)(4)						
(B) Administrative service or other fees							
(C) Other specific acquisition costs	0 (4)(0)						
(D) Other expenses	2 (4)(5)						
(E) Taxes	0-(4)(5)						
(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.)						
d Status of policyholder reserves at end of year: (1) Amount held to p							
(2) Claim reserves							
(3) Other reserves							
e Dividends or retroactive rate refunds due. (Do not include amount	entered in line 9c(2).)						
10 Nonexperience-rated contracts:							
a Total premiums or subscription charges paid to carrier							
b If the carrier, service, or other organization incurred any specific co	sts in connection with the acquisition or						
retention of the contract or policy, other than reported in Part I, line	2 above, report amount						
Specify nature of costs.							
Part IV Provision of Information							
11 Did the insurance company fail to provide any information necessary to complete Schedule A?							
12 If the answer to line 11 is "Yes," specify the information not provided.	•						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation			 Insurance companies are required to provide the interpretation pursuant to ERISA section 103(a)(2). 			tion		s Form is Open to Public Inspection		
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024					and ending 12/31/2024					
A Name of plan SETON HALL UNIVERSITY WELFARI			E BENEFIT PROGRAM			e-digit n number (Pl	N) •	505		
C Plan spon SETON HALI			ine 2a of Form 5500		-	D Employer Identification Number (EIN)				
					22-1500645					
Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each control 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 CIGNA HEAL			E COMPANY							
		(a) NAIC	(d) Contract or	(e) Approximate n	umber of	Policy or contract year		ontract year		
(b) E	EIN	(c) NAIC code	(d) Contract or identification number	'	persons covered at end of policy or contract year		From	(g) To		
59-1031071		67369	AI110075	39	39		4	12/31/2024		
	fee and comr		mation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in		
			nmissions paid	(b) Total amount of fees			of fees paid	paid		
			1277	61						
3 Persons re	eceiving comr	missions and	fees. (Complete as many entri	es as needed to report all	persons).					
		(a) Name	and address of the agent, broke		m commiss	sions or fees	were paid			
MERCER HEA	ALTH AND B	ENEFITS AD	JIVIIIN	3OX 850502 NEAPOLIS, MN 55485						
(b) Amou	nt of sales an	nd hase	F	ees and other commissio	ns paid					
(b) Amount of sales and base commissions paid			(c) Amount		(d) Purpos	e		(e) Organization code		
		1277						3		
			and address of the agent, broke		m commiss	sions or fees	were paid		_	
MERCER HEA	ALTH AND B	ENEFITS, LL	_C.	5 PAYSPHERE CIRCLE CAGO, IL 60674						
									_	
(b) Amou	nt of sa l es an	ıd base			s and other commissions paid					
com	missions pai	d	(c) Amount	BONUS	(d) Purpos	e		(e) Organization code	-	
			61	201100				3		

Fees and other commissions paid

(c) Amount

(d) Purpose

(b) Amount of sales and base

commissions paid

(e)

Organization

code

ı	Part	• • •	al contracto with each corrier may	ha traataa	l ac a unit for numero of
		Where individual contracts are provided, the entire group of such individu this report.	al contracts with each carrier may	be treated	i as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year en	d	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year end		5	
6	Con	ntracts With Allocated Funds:			
	а	State the basis of premium rates •			
			ı		
	b	Premiums paid to carrier	İ	6b	
	C.	Premiums due but unpaid at the end of the year	i i	6c	
	d	If the carrier, service, or other organization incurred any specific costs in connectention of the contract or policy, enter amount	·	6d	
		Specify nature of costs			
		Speany materials of costs			
	е	Type of contract: (1) individual policies (2) group deferred a	nnuity		
		(3) \(\text{ other (specify) } \right\)			
		(5) Untilet (specify)			
	£	If anyther the complete of the			
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminati	<u> </u>		
1		ntracts With Unallocated Funds (Do not include portions of these contracts maint			
	а		participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
			ī		
	b	Balance at the end of the previous year		7b	
	С		7c(1)		
		` '	7c(2) 7c(3)		
		- ` <i>` '</i>	7c(4)		
		` '	7c(5)		
		(o) Galler (openity selectiv)	(0)		
		(6)Total additions		7c(6)	
	Ы	(6)Total additions	Ī	70(0) 7d	
		Deductions:		7 G	
	•		7e(1)		
		· · · · · · · · · · · · · · · · · · ·	7e(2)		
			7e(3)		
			7e(4)		
		→			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	T and the second second second second second second second second second second second second second second se	7f	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such con employees, the entire group of such individual contracts with each of	tracts are experience-rated as a un	it. Where contracts cover individual
8 Benefit and contract type (check all applicable boxes)		
a ☐ Health (other than dental or vision) b ☐ Dental	c	d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g Supp l emental unen	nployment h Prescription drug
	k ☐ PPO contract	- =
i	k ∐ PPO contract	Indemnity contract
m ☑ Other (specify) ▶ ACCIDENT		
0 -		
9 Experience-rated contracts:	0 - (4)	
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)	90(4)
(4) Earned ((1) + (2) - (3))		9a(4)
	9b(1) 9b(2)	
(2) Increase (decrease) in claim reserves		9b(3)
		9b(4)
(4) Claims charged		35(4)
(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	0.(4)(5)	
(G) Other retention charges	0 (4)(0)	
(H) Total retention		9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were \(\) paid i	_	
d Status of policyholder reserves at end of year: (1) Amount held to provide		
(2) Claim reserves		9d(2)
(3) Other reserves		9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entere		9e
10 Nonexperience-rated contracts:	d iii iiie 30(2)./	
Total premiums or subscription charges paid to carrier		10a 4642
b If the carrier, service, or other organization incurred any specific costs in o		100
retention of the contract or policy, other than reported in Part I, line 2 above		10b
Specify nature of costs.	, · - -	
Part IV Provision of Information		
		l vaa
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule A?	Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.		

Carriers' Schedules

Thave 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



ı	Schedule A Insurance Information Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator							
A. Plan Name	SET	ON HALL UNIVERSITY	B. Three-	Digit Plan #(PN)		II Provide		
C. Plan Sponsor's Na		n will Provide		ny Identification Number		II Provide		
		Contract Coverage, Fees an				in Part III)		
Coverage Informati	` ' '	e of Insurance Carrier:Cigna				0 1 1 \/		
(b) EIN (c) NAIC Code 1 Contract or 1 Contra								
2. Insurance fees and	commissions informa	tion. Enter total fees and con	nmissions paid					
(a) Total Amount of commissions paid \$0 (b) Total Amount of fees paid \$228								
3. Persons receiving of	commissions and fees.			Fees and co	ommissions paid			
(a) Name and address or other person to and fees were paid		(b) Amount of sales and base commissions paid	(c) Amount*	(d) Pur	pose*	(e) Organization code		
Non Experience - Ra	ted		*Refer to footnote purpose as appli	es for incentive \$\$ amoui cable	nts and			
MERCER HEALTH & PAYSPHERE CIR,CI		\$0	\$227,254	Benefit Advisor F	Payments	3- Insurance Agent or Broker		
Part II Investment a	and Annuity Contract I	nformation	•	tion not app l icable to	this Plan			
Outstanding Monies	Due >		\$0 contract number of identification > same as 1d					
If more than one continuous	reporting purposes if	group of employees of the sa such contracts are experience treated as a unit for purpo	ce-rated as a unit.					
			o) □ Dental	(c) 🗖 Vision	(c	l) 🛘 Life Insurance		
8. Benefit and	(e) L Temporary D	Disabi l ity (accident and (f) 🗖 Long-Term d	isability (g) 🛮 Suppler	mental Unemply (h) Prescription drug		
Contract information	(i) ☐ Stop Loss (L (m) ☐ Other (Prepa	.arge deductible) (j) HMO contract	t (k) PPO Co	ontract (I)	☐ Indemnity contract		
9. Experience-Rated				This sect	tion not app l icable fo	r this P l an		
	(a) Total premiums	s or subscriptions charges pa	aid to carrier			\$22,724,650		
	Premium Due as	of			02/12/2025	\$0		
10. Nonexperience- rated contracts	acquisition or re amount	ervice or other organization in etention of the contract or po						
PART IV Provision	Specify nature of	COSTS						
		de any information necessar	v to complete Saha	odulo A2		☑No		
		the information not provided		edule A?	Answer "Not Appl			
12. If the answer to in	ne it is fes, specify	the information not provided	ı. <i>></i>		Answei Not Appi	icable		
		S REPORT IS ACCURATE A ED AND IS CERTIFIED AS E			TION AVAILABLE T	O CIGNA COMPANIES		

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

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 B. Three-Digit Plan #(PN) SETON HALL UNIVERSITY A. Plan Name Plan will Provide C. Plan Sponsor's Name: D. Company Identification Number: Plan will Provide Plan will Provide Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III) Name of Insurance Carrier:Cigna Health and Life Insurance Company and affiliates ("Cigna") 1. Coverage Information (a) Policy/Contract Year Contract or (e) Approx.no.of persons covered NAIC Code (b) EIN (f) From (g) To Identification Number at end of policy or contract year 59-1031071 67369 3334085 1,049 Employees 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 form 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 Continuants of \$0administered 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, 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

eport 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:	N E	NAIC	Am	Amount
SETON HALL UNIVERSITY	10083221001	SETON HALL UNIVERSITY	1,024	2,255	430949844 71870	71870	ès	\$19,725.35
SETON HALL UNIVERSITY	10083221002	SETON HALL UNIVERSITY COBRA	0	0	430949844 71870	71870		\$107.78
SETON HALL UNIVERSITY COBRA	10540081001	SETON HALL UNIVERSITY COBRA	ω	16	430949844 71870	71870		\$0.00
			1,032	2,271		To	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		otal:	_				
Name Contract or ID# Address Line 1 City State Zip Code							
	Amount		State Zip Code	City	Address Line 1	tract or ID	Payee Name

Form 5500 - Insurance Information

Plan sponsor's na	me:	SETON HALL UNIV	/ERSITY					
Part I	Information Cond	erning Insurance	Contract Coverage, Fees, and	Commission	าร			
1 Coverage inform	nation:							
(a) Name of insura	nce carrier:	DELTA DENTAL OF	NEW JERSEY, INC.					
				(e)	Approximate	number of persons	Policy or co	ntract year
(b) EIN	(c) NAIC code	(d) Cont	ract or identification number	cov	ered at end of	f policy or contract	(f) From	(g) To
					y.	ear	(1) 110111	(8) 10
22-1896118	55085		07742	Tot	al Subscribers 973	Total Members 2,038	1/1/24	12/31/24
2 Insurance fee a	nd commission info	rmation						
(a) Total amount o	f commission paid:		\$10,762					
3 Persons receiving	ng commissions and	fees						
(a) Name and addr	ess of the agent, br	oker, or other perso	on to whom commissions or fee	es were paid				
Name:	MERCER HEALTH &	BENEFITS,LLC		Nam	e:			
Address Line 1:	4565 PAYSPHERE C	IRCLE		Addı	ess Line 1:			
Address Line 2:				Addı	ess Line 2:			
Address Line 3:				Addı	ess Line 3:			
City, State Zip:	CHICAGO, IL 60674			City,	State Zip:			
Amount:	\$10,762			Amo	unt:			
Name:				Nam	e:			
Address Line 1:				Addı	ess Line 1:			
Address Line 2:				Addi	ess Line 2:			
Address Line 3:				Addı	ess Line 3:			
City, State Zip:				City,	State Zip:			
Amount:				Amo	unt:			
Part III	Welfare Benefit (Contract Informati	on					
8 Benefit and co	ntract type							
a 🗆 Health (other	than dental or vision)	b ☑ Dental	c 🗆 N	/ision		d 🗆 Life insurance	
e 🗆 Temporary di	sability (accident and	sickness)	f ☐ Long-term disability	g 🗆 🤄	Supplemental u	nemployment	h ☐ Prescription drug	
i ☐ Stop loss (lar	ge deductible)	•	j ☐ HMO contract	k□I	PPO contract		I ☐ Indemnity contra	ct
m 🗆 Other (specif	-							
9 Experience-rat								
a Premiums: (1)	Amount received					. 9a(1)	\$1,076,216	
						9a(2)	\$0	
1.1	-	-	e			. 9a(3)	\$0	
	-						9a(4)	\$1,076,216
						9b(1)	\$978,902	<i>\$1,07.0,210</i>
_						9b(2)	\$9,628	
							9b(3)	\$988,530
							9b(4)	\$988,530
	premium: (1) Reten							, ,
						. 9c(1)(A)	\$10,762	
` '						9c(1)(B)	\$134,918	
							\$0	
							\$0	
	•						\$0	
							\$13,991	
		-					\$13,331	
	-						9c(1)(H)	\$159,671
			ounts were □ paid in cash, or ▷					\$139,671
		•					1 1	, 50
	-		nount held to provide benefits a				9d(1)	677 400
							9d(2)	\$77,496
			clude amount entered in line 9c				9d(3)	
	etroactive rate refu ce-rated contracts:		cique amount entered in line 90	·(∠).)			9e	
			er				100	
•	•	• .	y specific costs in connection with			••••••	10a	
-	-		y specific costs in connection witr ed in Part I, line 2 above, report a	-			10b	
or recention of	and contract of polit	.,, Janer alan report	au i ait i, iiiic 2 above, iepoit a	vu::t			1	

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

The Standard

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	B) AMOUNT OF COMI	MISSION PAID	FEES PAID	E) ORG.	
BROKER TO WHOM COMMISSION OR FEES WERE PAID	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	CODE
MERCER HEALTH & BENEFITS 1166 AVE OF AMERICAS 22 FLR NEW YORK, NY 10036	\$6,132.43	\$0.00	\$0.00		3
MERCER HEALTH & BENEFITS 4565 PAYSPHERE CIRCLE CHICAGO, IL 60674	\$7,132.90	\$0.00	\$0.00		3

TOTAL COMMISSIONS PAID \$13,265.33
TOTAL CONTINGENT COMP PAID \$0.00

^{*&#}x27;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.

Docusign Envelope ID: F55A39D4-8970-4103-8B82-C9B5ECC3EF52 FOR THE PERIOD OF 1/1/2024 TO 12/31/2024

LONG FORM INFORMATION

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

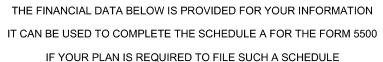
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT \$ 0.00

(2) CLAIM RESERVES: \$0.00

(3) OTHER RESERVES: \$0.00

di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE: \$0.00

LONG FORM INFORMATION



C) PLAN SPONSOR: SETON HALL UNIVERSITY

PART I

1) COVERAGE - LONG TERM DISABILITY

The Standard

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	B) AMOUNT OF COM	MISSION PAID	FEES PAI	D	E) ORG.
BROKER TO WHOM COMMISSION OR FEES WERE PAID	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	CODE
EMERSON ROGERS LLC 669 RIVER DRIVE SUITE 305 ELMWOOD PARK, NJ 07407	\$5,337.75	\$0.00	\$0.00		3
RSC INS BROKERAGE INC 3525 NORTH CAUSEWAY BOULEVARD SUITE 815 METARIE, LA 70002	\$5,983.79	\$0.00	\$0.00		3

TOTAL COMMISSIONS PAID \$11,321.54

TOTAL CONTINGENT COMP PAID \$0.00

^{*&#}x27;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.

Docusign Envelope ID: F55A39D4-8970-4103-8B82-C9B5ECC3EF52 FOR THE PERIOD OF 1/1/2024 TO 12/31/2024

LONG FORM INFORMATION

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

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Docusion Envelope	11)	E00A39D4-897U	410.5	-888/-	CARDEC	ルバー	·n/

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)

Part I. Service Provider Information	
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 (a) Evernorth Care Solutions, Inc Identification Number and NAIC Code	86-1465626 N/A
(b) Service Codes:	12 Claims Processing 13 Contract Administrator 38 Participant Communication 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" See Appendix included with this reporting
Line 3.	Not applicable to Evernorth Care Solutions, Inc.
Part II. Service Providers Who Fail or Refuse to Provide Information	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

Insurer:	Cigna Health and Life Insurance Company
EIN:	59-1031071
NAIC Code:	67369
Contract/Policy Number:	CI110069
Contract/Policy Year From:	01/01/2024
Contract/Policy Year To:	12/31/2024
Policy or Benefit Type:	Voluntary Critical Illness
Approximate Number of persons covered at the	Please refer to your census reports or billing
end of the policy year:	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.

Total premiums paid to Cigna during the policy year: \$13,548.45

See below for total commissions and fees paid by Cigna during the policy year.

Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
Mercer Health & Benefits Admin Llc Po Box 850502 Minneapolis, MN 55485-0502	\$3,857.50	\$0.00	Standard Commissions
Mercer Health & Benefits Llc 4565 Paysphere Circle 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.

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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

Surer: Cigna Health and Life Insurance Company		
EIN:	59-1031071	
NAIC Code:	67369	
Contract/Policy Number:	Al110075	
Contract/Policy Year From:	01/01/2024	
Contract/Policy Year To:	12/31/2024	
Policy or Benefit Type:	Accidental Injury	
Approximate Number of persons covered at the Please refer to your census reports or billing		
end of the policy year:	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.

Total premiums paid to Cigna during the policy year: \$4,641.77

See below for total commissions and fees paid by Cigna during the policy year.

Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
Mercer Health & Benefits Llc 4565 Paysphere Circle Chicago, IL 60674	\$0.00	\$60.76	Overrides
Mercer Health & Benefits Admin Llc Po Box 850502 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.

Accidental Injury, Critical Illness, and Hospital Care plans or insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group, are administered by Cigna Health and Life Insurance Company, and are insured by Cigna Health and Life Insurance Company. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc. Confidential, unpublished property of Cigna Healthcare. © 2025 Cigna Healthcare.

The Summary Annual Report...SAR The 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.

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 and reference the OMB Control Number 1210-0040.

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

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.

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For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Print Form

5558 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

Form **5558** (Rev. 1-2024)

Pa	art I Identification		
A	Name of filer, plan administrator, or plan sponsor (see instructions)	В	Employer identification number (EIN)
	SETON HALL UNIVERSITY		22-1500645
	Number, street, and room or suite no. (If a P.O. box, see instructions.)		
	400 SOUTH ORANGE AVENUE		
	City or town, state, and ZIP code		
	SOUTH ORANGE NJ 070792646		
C	Name of plan	D	Three-digit plan number (PN)
	SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM		505
E	Plan year end date		
	12/31/2024		
Pa	art II Extension of Time To File Form 5500 Series, and/or Form 895	55-9	SSA
1	1 Check this box if you are requesting an extension of time on line 2 to file the in Part I, item C, above.	e fire	st Form 5500 series return/report for the plan listed
2	2 I request an extension of time until 1 0 /1 5 /2 0 2 5 to file Form 5	500	series. See instructions.
3	3 I request an extension of time until/ to file Form 8	3955	-SSA. See instructions.
	The application is automatically approved to the date shown on line 2 and/or the normal due date of Form 5500 series, and/or Form 8955-SSA for which the		

Cat. No. 12005T

and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.