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

2022

This Form is Open to Public Inspection

	Part I Annual Report Identification Information						
For cale	ndar plan year 2022 or fis	cal plan year beginning 01/01/2022		and ending 12/31/2022			
A This	return/report is for:	a multiemployer plan		oloyer plan (Filers checking this b mployer information in accordan		ıs.)	
		·)					
B This	return/report is:	the first return/report	the final return	/report			
		an amended return/report	a short plan ye	ear return/report (less than 12 mo	onths)		
C If the	plan is a collectively-barg	ained plan, check here					
D Chec	k box if filing under:	X Form 5558	automatic exte	ension	the DFVC program		
		special extension (enter descriptio	n)				
E If this	is a retroactively adopted	I plan permitted by SECURE Act section	201, check here				
Part II	Basic Plan Infor	mation—enter all requested information	on				
	ne of plan HALL UNIVERSITY WEL	FARE BENEFIT PROGRAM			1b Three-digit plan number (PN) ▶	505	
					1c Effective date of plan 09/16/1966	n	
Mai City	ing address (include room or town, state or province	rer, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) e, country, and ZIP or foreign postal code	e (if foreign, see instr	uctions)	2b Employer Identification Number (EIN) 22-1500645		
SETON	HALL UNIVERSITY				2c Plan Sponsor's telephone number 973-761-9181		
	RANGE AVENUE ORANGE, NJ 07079-264	6			2d Business code (see instructions) 611000		
Caution	· A nonalty for the late o	r incomplete filing of this return/repor	rt will be assessed	unloss roasonable cause is es	tablished		
		er penalties set forth in the instructions,				Huloc	
stateme	nts and attachments, as w	ell as the electronic version of this return	/report, and to the b	est of my knowledge and belief,	it is true, correct, and comp	plete.	
SIGN HERE	Filed with authorized/valid	d electronic signature.	09/12/2023	TERRI DEMAREST			
Signature of plan administrator Date Enter name of individual signing					ng as plan administrator		
SIGN							
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual signir	ng as employer or plan spo	nsor	
SIGN							

Enter name of individual signing as DFE

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 4b EIN If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 5 1295 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 1281 a(1) Total number of active participants at the beginning of the plan year 6a(1) 1276 a(2) Total number of active participants at the end of the plan year 6a(2)9 Retired or separated participants receiving benefits 6b 0 Other retired or separated participants entitled to future benefits..... 1285 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4H 4L 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules (1) R (Retirement Plan Information) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)

X

A (Insurance Information)

C (Service Provider Information)D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

(3)

(4)

(5)

(6)

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

actuary

(3)

Page 3

Form 5500 (2022)

Receipt Confirmation Code

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2022

			ERISA section 103(a)(2)		lion		Inspection
For calendar plan year 20	22 or fiscal pla	an year beginning 01/01/2022		and en	nding 12/31/	/2022	
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM		B Thre	e-digit number (PN)) •	505
C Plan sponsor's name a SETON HALL UNIVERSIT		ne 2a of Form 5500		•	oyer Identifica 1500645	tion Number	(EIN)
		rning Insurance Contract A. Individual contracts grouped					
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
06-0838648	70815	681147G	1524		01/01/2022		12/31/2022
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	st in line 3	the agents, b	rokers, and o	ther persons in
(a) Total	amount of com	nmissions paid		(b) To	otal amount o	f fees paid	
		35313					15871
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke			ions or fees v	vere paid	
JAMES R NELLIGAN & AS	SSOCIATES L		STATE ROUTE 35 STE 3 , NJ 07719	368			
(h) American of color of		F	ees and other commissio	ns paid			
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	12754	6377 F	EES				3
	(a) Nama	and address of the agent, broke	r or other person to who	n commiss	ione or food v	vere naid	
MERCER HEALTH AND B		4565	PAYSPHERE CIRCLE AGO, IL 60674	II COMMISS	ions or rees v	vere paid	
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	18379						3

0 1 1 1 4	/ -		
Schedule A	(Form	5500) 2022

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

MERSON REID LLC			
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
4180	2090	FEES PAID	3
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MERCER HUMAN RESOURCE CON	ISULTING 4565 F	PAYSPHERE CIRCLE AGO, IL 60674	
(b) Amount of colon and boso		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	4814	ADDITIONAL COMPENSATION	3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
AMES R NELLIGAN & ASSOC LLC		STATE ROUTE 35 STE 368 , NJ 07719	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	2590	BONUS PAID	3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(h) Amount of calca and base		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information			
	۵. ۱	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier r	may be treated as a ເ	ınit for purposes of
4	Curi	this report. Tent value of plan's interest under this contract in the general account at year of	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:		•	
•	а	State the basis of premium rates			
		·			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6с	
	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			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	=	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(+) [] 9			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	75	
	Ū	(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)	0
	Ч	(6)Total additions			0
		Deductions:		74	
	·	(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)		
		• Other (Specify Below)	13(4)		
	_	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

Pa	art I	Welfare Benefit Contract Informatic If more than one contract covers the same grout the information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such conti	racts are exp	erience-rated as a unit	t. Where co	ntracts cover individual
8	Pone		oonii dolo wilii ddoii dd	arrier may be	troated as a arm for pr	ui pooco oi ti	по горога
		efit and contract type (check all applicable boxes) Health (other than dental or vision) b	Dental	٦	Vision		d X Life insurance
	a _	<u></u>		c	<u></u>		
	e	Temporary disability (accident and sickness) f	Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH AND DIS	SMEMBERMENT				
	L	-					
9 1	Ехре	erience-rated contracts:					
	a P	Premiums: (1) Amount received		9a(1)			
	((2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserve		9a(3)			
		(4) Earned ((1) + (2) - (3))	·			9a(4)	0
	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)	0
	((4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a	n accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	· · · · · · · · · · · · · · · · · · ·			9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These am	ounts were paid in	cash, or	credited.)	9c(2)	
		Status of policyholder reserves at end of year: (1) Ar	_			9d(1)	
		(2) Claim reserves	·			9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do not in				9e	
10		nexperience-rated contracts:			,		
		Total premiums or subscription charges paid to carri	er			10a	536928
		If the carrier, service, or other organization incurred					000020
		retention of the contract or policy, other than reporter				10b	
		cify nature of costs.	,	, ,			•
Pá	art I'	V Provision of Information					
			an nococcary to compl	oto Schodula	Λ2 Π	Yes	X No
		I the insurance company fail to provide any information		ete ocheaule	: A!	103	79 110
12	If th	he 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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	1/2022	
A Name of plan SETON HALL UNIVERSI	TY WELFARI	E BENEFIT PROGRAM			e-digit number (PI	N) •	505
C Plan sponsor's name a SETON HALL UNIVERSIT		ine 2a of Form 5500			oyer Identific 1500645	ation Number (EIN)
		erning Insurance Contrac A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		E COMPANY AND AFFILIATES					
(b) [IN]	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
59-1031071	67369	3334085	1019	9 01/01/2022		2	12/31/2022
2 Insurance fee and com descending order of the		mation. Enter the total fees and to d.	otal commissions paid. L	st in line 3	the agents,	brokers, and of	ther persons in
(a) Total	amount of co	mmissions paid		(b) To	otal amount	of fees paid	
		0					200208
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	e and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LL	C 4565 F CHICA	PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales a	ad book	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
		200208 B	BENEFIT ADVISOR PAYI	MENTS			3
	(a) Name	e and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd hase	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A	(Form	5500	2022
Scriedule A	(FOIIII	5500) 2022

(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions palu	(2)	(7)	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	3 ,		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			33.03
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of color		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information			
	۵. ۱	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier r	may be treated as a ເ	ınit for purposes of
4	Curi	this report. Tent value of plan's interest under this contract in the general account at year of	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:		•	
•	а	State the basis of premium rates			
		·			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6с	
	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			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	=	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(+) [] 9			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	75	
	Ū	(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)	0
	Ч	(6)Total additions			0
		Deductions:		74	
	·	(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)		
		• Other (Specify Below)	13(4)		
	_	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

Pa	art II	I Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual
8	Bene	fit and contract type (check all applicable boxes)		•	<u> </u>		•
	a X	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
			H	<u> </u>	4		븜
	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescription drug
	i 📗	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I X Indemnity contract
	m	Other (specify)					
9 1	Exper	rience-rated contracts:					
	a P	remiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
	(3) Increase (decrease) in unearned premium res	erve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	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)	0
	(4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	0
	((2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)	
	d :	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
	((2) Claim reserves				9d(2)	
	((3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e	
10	Non	experience-rated contracts:					
	a ·	Total premiums or subscription charges paid to c	arrier			10a	20022307
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or		
		retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b	
	э рес	ify nature of costs.					
Pa	art I\	/ Provision of Information					
11	Did	the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No
12	If th	e answer to line 11 is "Yes." specify the informati	on not provided.	<u> </u>			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 202	22 or fiscal pla	n year beginning 01/01/2022		and er	nding 12/31/2022		
A Name of plan SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM					ee-digit n number (PN)	<u> </u>	505
0.71				D = .	oyer Identification Nui		=
	C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY					mber (EIN)
Part I Informat on a separa	ion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmissions Provide ported on a single Sc	e infor	mation for each contract e A.
1 Coverage Information:							
(a) Name of insurance car FIDELITY SECURITY LIFE		COMPANY					
(1.) FINI	(c) NAIC	(d) Contract or	(e) Approximate no		Polic	cy or contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From		(g) To
43-0949844	71870	1008322	2247		01/01/2022		12/31/2022
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers,	and ot	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees pa	aid	
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name o	and address of the agent, broke	i, or other person to who	TH COMMISS	sions of fees were par	<u>u</u>	
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were pai	id	
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A	(Form	5500	2022
Scriedule A	(FOIIII	5500) 2022

(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions palu	(2)	(7)	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	3 ,		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			33.03
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of color		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information			
	۵. ۱	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier r	may be treated as a ເ	ınit for purposes of
4	Curi	this report. Tent value of plan's interest under this contract in the general account at year of	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:		•	
•	а	State the basis of premium rates			
		·			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6с	
	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			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	=	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(+) [] 9			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	75	
	Ū	(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)	0
	Ч	(6)Total additions			0
		Deductions:		74	
	·	(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)		
		• Other (Specify Below)	13(4)		
	_	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

Pa	rt III	Welfare Benefit Contract Informatif 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 the ing purposes if such cont	racts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
8 E	Benef	it and contract type (check all applicable boxes)			·	· ·	<u> </u>
		Health (other than dental or vision)	b Dental	cX	Vision		d Life insurance
	一片		H	<u> </u>	4		범
'	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	pioyment	h Prescription drug
	' ∐	Stop loss (large deductible)	j 📗 HMO contract	k _	PPO contract		I Indemnity contract
-	m 📙	Other (specify)					
9 E	xperi	ence-rated contracts:					
	a Pr	emiums: (1) Amount received		9a(1)			
	(2	2) Increase (decrease) in amount due but unpaid	I	9a(2)			
	(3	3) Increase (decrease) in unearned premium res	erve	9a(3)			
	(4	4) Earned ((1) + (2) - (3))				. 9a(4)	0
	b E	Benefit charges (1) Claims paid		9b(1)			
	(2	2) Increase (decrease) in claim reserves		9b(2)			
	(3	3) Incurred claims (add (1) and (2))				9b(3)	0
	(4	1) Claims charged				9b(4)	
	C F	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	0
	(:	2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d 8	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		2) Claim reserves	•			9d(2)	
	•	3) Other reserves				9d(3)	
	e È) Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	9e	
10	None	experience-rated contracts:					
	a T	otal premiums or subscription charges paid to c	arrier			10a	81194
	b II	f the carrier, service, or other organization incuri	ed any specific costs in c	onnection wit	h the acquisition or		
		etention of the contract or policy, other than repo				10b	
,	Speci	fy nature of costs.					
Pa	rt IV	Provision of Information					
		he insurance company fail to provide any inform	ation necessary to compl	ete Schedule	. А?	Yes	X No
		e answer to line 11 is "Yes." specify the informat		2.0 201104410			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to FRISA section 103(a)(2)

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

	pursuant to ERISA section 103(a)(2).					Inspection	
For calendar plan year 20	22 or fiscal pl	an year beginning 01/01/2022		and en	nding 12/3	1/2022	
A Name of plan SETON HALL UNIVERSIT	TY WELFARE	BENEFIT PROGRAM			e-digit number (PN	1)	505
C Plan sponsor's name a SETON HALL UNIVERSIT		ine 2a of Form 5500			oyer Identific 1500645	ation Number (EIN)
		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca DELTA DENTAL OF NEW		D.					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
22-1896118	55085	07742	1925		01/01/2022	!	12/31/2022
2 Insurance fee and com descending order of the		mation. Enter the total fees and to	otal commissions paid. L	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of cor	mmissions paid		(b) To	otal amount	of fees paid	
20267 0							0
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BENI	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd hoos	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
20267							3
	(a) Nama	and address of the agent, broke	r or other person to when	m commiss	ions or foos	wore paid	
	(a) Name	and address of the agent, bloke	i, or other person to who	II COMMISS	ions or rees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A	(Form	5500	2022
Scriedule A	(FOIIII	5500) 2022

(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions palu	(2)	(7)	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	3 ,		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			33.03
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of color		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information			
	۵. ۱	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier r	may be treated as a ເ	ınit for purposes of
4	Curi	this report. Tent value of plan's interest under this contract in the general account at year of	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:			
•	а	State the basis of premium rates			
		·			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6с	
	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			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	=	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(+) [] 9			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	75	
	Ū	(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)	0
	Ч	(6)Total additions			0
		Deductions:		74	
	·	(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)		
		• Other (Specify Below)	13(4)		
	_	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

Pa	art I	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are expe	érience-rated as a unit	. Where co	ontract	s cover individual
8	Bono	efit and contract type (check all applicable boxes)						
•	a 「	_	b X Dental	сГ	Vision		d□	Life insurance
	늗		H	<u> </u>] 		범	
	e _	Temporary disability (accident and sickness)	f ∐ Long-term disabili	=	Supplemental unemp	oloyment		Prescription drug
	i L	Stop loss (large deductible)	j HMO contract	k	PPO contract		IЦ	Indemnity contract
	m	Other (specify)						
		_						
9	Ехре	erience-rated contracts:						
	a F	Premiums: (1) Amount received		9a(1)		1037290)	
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		1037290
	b	Benefit charges (1) Claims paid		9b(1)		795357	7	
		(2) Increase (decrease) in claim reserves		9b(2)		1942	2	
		(3) Incurred claims (add (1) and (2))				9b(3)		797299
		(4) Claims charged				9b(4)		797299
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions		9c(1)(A)		20267	7	
		(B) Administrative service or other fees		9c(1)(B)		120060)	
		(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)		13485	5_	
		(G) Other retention charges		9c(1)(G)		Τ		450040
		(H) Total retention	_	_		9c(1)(H))	153812
		(2) Dividends or retroactive rate refunds. (These a	amounts were 📗 paid ir	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		62966
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2)	.)	9e		
10	Noi	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		
		If the carrier, service, or other organization incurre retention of the contract or policy, other than report cify nature of costs.				10b		_
Pź	art I	IV Provision of Information						
							V	
		the insurance company fail to provide any informa		ete Schedule	A?	Yes	X No	1
12	If th	he answer to line 11 is "Yes." specify the information	n not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 202	22 or fiscal pla	n year beginning 01/01/2022		and er	nding 12/31/2022		
A Name of plan SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM					ee-digit n number (PN)	>	505
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY					oyer Identification Nu 1500645	mber (EIN)
Part I Informat on a separa	tion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and I	and Cor	nmissions Provideported on a single Sc	e infori chedule	mation for each contract e A.
1 Coverage Information:							
(a) Name of insurance ca ALPHA DENTAL PROGRA							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Polic	y or co	ontract year
(5) EIN	code	identification number	policy or contract		(f) From		(g) To
74-2447512	95163	78998	277	•	01/01/2022		12/31/2022
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers,	and ot	her persons in
(a) Total a	amount of com	missions paid		(b) T	otal amount of fees p	aid	
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were pa	id	
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were pa	id	
(h) Amount of colors	ad bass	Fe	ees and other commissio	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A	(Form	5500	2022
Scriedule A	(FOIIII	5500) 2022

(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions palu	(2)	(7)	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	3 ,		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			33.03
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of color		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information			
	۵. ۱	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a u	nit for purposes of
4	Curi	this report. ent value of plan's interest under this contract in the general account at year e	4		
		ent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:		•	
•	a	State the basis of premium rates			
		·			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	=	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(+) [] 3			
	b	Balance at the end of the previous year		7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)	10	
	Ū	(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)	0
	Ь	Total of balance and additions (add lines 7b and 7c(6)).			0
		Deductions:		14	
		(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)		
)			
		(F) Takal daduskinga		70(F)	0
	f	(5) Total deductions		7e(5) 7f	0
	1	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	0

Pa	art II	I Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	fit and contract type (check all applicable boxes)		•	<u> </u>		·	-
	а ∏	Health (other than dental or vision)	b X Dental	с	Vision		d Life insurance	
	片		<u> </u>	<u> </u>	<u></u>			
	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	pioyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Exper	rience-rated contracts:						
	a P	remiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid		9a(2)				
	(3) Increase (decrease) in unearned premium res	erve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	b i	Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
		3) Incurred claims (add (1) and (2))				9b(3)		0
	(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		0
	((2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1				9d(1)		_
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
), Dividends or retroactive rate refunds due.(Do no				9e		
10		experience-rated contracts:		•	,	•		Ī
		Total premiums or subscription charges paid to c	arrier			10a	4182	1
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	th the acquisition or		119	
		retention of the contract or policy, other than repo				10b		
	ърес	ify nature of costs.						
	art IV					Voc	⊠ No	_
		the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No	_
12	If the	e answer to line 11 is "Yes." specify the informati	on not provided.					

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

2022

This Form is Open to Public Inspection

Part I	Annual Report Id	lentification Information						
For calenda	For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022							
A This return/report is for:			a multiple-employer plan (Filers checking t participating employer information in accor	•				
B This return/report is:		X a single-employer plan☐ the first return/report☐ an amended return/report	a DFE (specify) the final return/report a short plan year return/report (less than 1:	,				
C If the pla	an is a collectively-barga	ained plan, check here		▶ 🗌				
D Check box if filing under:		X Form 5558 special extension (enter description	automatic extension the DFVC program					
E If this is	a retroactively adopted	plan permitted by SECURE Act section	n 201, check here	.▶ □				
Part II	Basic Plan Inform	nation—enter all requested informati	ion					
1a Name of plan SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM			1b Three-digit plan number (PN) ▶ 505					
2a Plan sp Mailing City or	2b Employer Identification Number (EIN) 22–1500645							
SETO	N HALL UNIVERS	2c Plan Sponsor's telephone number 973-761-9181						
	400 S ORANGE AVENUE SOUTH ORANGE NJ 07079-2646			2d Business code (see instructions) 611000				
5001	SOUTH ORANGE NJ 07079-2646							

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

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

SIGN HERE	Levi Demarest	09/12/2023	Terri Demarest
SIGN HERE	Signature of plan administrator		Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor Signature of DFE	Date	Enter name of individual signing as employer or plan sponsor Enter name of individual signing as DFE

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

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3a	Plan administrator's name and address $\overline{\mathbb{X}}$ Same as Plan Sponsor	X Same as Plan Sponsor			3b Administrator's EIN		
				3c Admini	istrator's telephone er		
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:			4b EIN			
a C	Sponsor's name Plan Name				4d PN		
5	Total number of participants at the beginning of the plan year			5	1,295		
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2) , 6b , 6c , and 6d).	ed (welfare plans co	omplete only lines 6a(1),				
a(1) Total number of active participants at the beginning of the plan year			6a(1)	1,281		
a(2) Total number of active participants at the end of the plan year			6a(2)	1,276		
b	Retired or separated participants receiving benefits			6b	9		
С	Other retired or separated participants entitled to future benefits			6c	C		
d	Subtotal. Add lines 6a(2), 6b, and 6c.				1,285		
е	Deceased participants whose beneficiaries are receiving or are entitled to re	6e					
f	Total. Add lines 6d and 6e .	6f					
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)						
h	Number of participants who terminated employment during the plan year witl less than 100% vested			6h			
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plar	ns complete this item)	7			
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits, enter the applicable welfare feature could be determined by the plan provides welfare benefits.	des from the List of	FPlan Characteristics Codes	s in the instru			
9a	Plan funding arrangement (check all that apply) (1) X Insurance	9b Plan benefi (1)	t arrangement (check all that Insurance	at apply)			
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance co	ontracts		
	(3) Trust	(3)	Trust				
	(4) X General assets of the sponsor	(4)	General assets of the sp				
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, whe	re indicated, enter the numb	ber attached.	. (See instructions)		
а	Pension Schedules	b General S	chedules				
	(1) R (Retirement Plan Information)	(1)	H (Financial Inforr	mation)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	nation – Sma	all Plan)		
	Purchase Plan Actuarial Information) - signed by the plan	(3)	5 A (Insurance Infor	rmation)			
	actuary	(4)	C (Service Provide	er Informatio	on)		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participati	ing Plan Info	rmation)		
	Information) - signed by the plan actuary	(6)	G (Financial Trans	saction Sche	edules)		
		` ' _	, , , , , , , , , , , , , , , , , , , ,		,		