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

2016

This Form is Open to Public Inspection

						inspection	
Part I		dentification Information					
For cale	ndar plan year 2016 or fis	cal plan year beginning 01/01/2016		and ending 12/31/2016	<u> </u>		
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)						ns.)	
		a single-employer plan	a DFE (specif	y)			
B This	return/report is:	the first return/report	the final return	n/report			
		an amended return/report	a short plan ye	ear return/report (less than 12 m	nonths)	onths)	
C If the	plan is a collectively-barg	ained plan, check here				× X	
D Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the	e DFVC program	
		special extension (enter descriptio	n)				
Part II	Basic Plan Infor	mation—enter all requested informat	ion				
1a Nam	ne of plan ALL UNIVERSITY WELFARE BEI				1b	Three-digit plan number (PN) ▶	505
					1c	Effective date of pl	an
Mail	ing address (include roon	rer, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box e, country, and ZIP or foreign postal coo	:) de (if foreign, see instr	ructions)	2b	Employer Identifica Number (EIN) 22-1500645	ation
	HALL UNIVERSITY	•			2c	2c Plan Sponsor's telephone number 973-761-9181	
400 S ORANGE AVENUE SOUTH ORANGE, NJ 07079-2646				2d Business code (see instructions) 611000			
Caution	: A penalty for the late o	r incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is e	stablis	shed.	
		er penalties set forth in the instructions rell as the electronic version of this retu					
SIGN	Filed with authorized/vali	d electronic signature.	09/21/2017	TERRI L. DEMAREST			
HERE	Signature of plan adm	inistrator	Date	Enter name of individual sign	ing as	plan administrator	
SIGN							
HERE	Signature of employer	/nlan snonsor	Date	Enter name of individual sign	ing as	employer or plan sr	oneor
	orginature or employer	plan sponsor	Date	Enter name of individual sign	ing as	ciripioyer or plan sp	011301
SIGN							
HERE			+				
Proparor	Signature of DFE	ame, if applicable) and address (include	Date	Enter name of individual sign		DFE telephone number	
ricparci	S name (meloding illim ne	and, ii applicable) and address (include	, room or suite name	,	a. o. o		

Form 5500 (2016) Page **2**

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, and he plan number from the last return/report. Ab EIN	3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN		
Sponsor's name					•
Sponsor's name					
Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), a(1) Total number of active participants at the beginning of the plan year 6a(1) 11119 a(2) Total number of active participants at the edin of the plan year 6a(2) 1121 b Retired or separated participants receiving benefits. 6b 122 c Other retired or separated participants entitled to future benefits. 6c 0 d Subtotal. Add lines 6a(2), 6b, and 6c. 6d 1133 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 6 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). 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 In the plan provides welfare benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4L 9a Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (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) 10 Purchase Plan Actuarial Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan Actuarial (3) A (Insurance Information) (4) C (Service Provider Information) (5) C (Service Provider Information) (6) C (Service Provider Information) (7) C (Service Provider Information)	4		report filed for this plan, enter the name,	4b EIN	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year. 6a(1) 1119 a(2) Total number of active participants at the beginning of the plan year. 6a(2) 1121 b Retired or separated participants receiving benefits. 6b 12 c Other retired or separated participants receiving benefits. 6c 0 d Subtotal. Add lines 6a(2), 6b, and 6c. 6d 1133 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 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). 6g h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4L 9a Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) Q 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) 10 Poneck all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) 10 Poneck all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) 10 Poneck all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) 10 Poneck all applicable boxes in 10a and 10b to indicate whi	а	Sponsor's name		4c PN	
Section Continue of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(1), 6b, 6c, and 6d).	5	Total number of participants at the beginning of the plan year		5	1125
Retired or separated participants at the end of the plan year Sa(2) 1121	6		(welfare plans complete only lines 6a(1),		
b Retired or separated participants receiving benefits	a(1) Total number of active participants at the beginning of the plan year		6a(1)	1119
C Other retired or separated participants entitled to future benefits 6. C 0 d Subtotal. Add lines 6a(2), 6b, and 6c. 6. 6d 1133 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 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) 6g h Number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested 6h 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this Item) 7 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4L 9a Plan funding arrangement (check all that apply) (1)	a(2	Total number of active participants at the end of the plan year		6a(2)	1121
d Subtotal. Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits		6b	12
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	С	Other retired or separated participants entitled to future benefits		6c	0
f Total. Add lines 6d and 6e	d	d Subtotal. Add lines 6a(2), 6b, and 6c.			1133
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	е	Deceased participants whose beneficiaries are receiving or are entitled to rec	eive benefits	6e	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	f	Total. Add lines 6d and 6e.		6f	_
less than 100% vested Sh	g			6g	
Ba If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4L 9a Plan funding arrangement (check all that apply) (1)	h			6h	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4L 9a Plan funding arrangement (check all that apply) (1)	7	Enter the total number of employers obligated to contribute to the plan (only n	7		
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4L	es from the List of Plan Characteristics Codes	s in the inst	
Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Trust (4) X General assets of the sponsor (4) X General assets of the sponsor (5) General Schedules (1) H (Financial Information) (2) H (Financial Information) (3) X 3 A (Insurance Information) C (Service Provider Information) (3) D (DFE/Participating Plan Information)	эа			at apply)	
(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 attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) NB (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) C (Service Provider Information) D (DFE/Participating Plan Information)		`` 🗎	I H	insurance o	contracts
(4)					
a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (4) Financial Information - Small Plan) (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)		H	(4) X General assets of the sp	oonsor	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, where indicated, enter the numb	er attached	d. (See instructions)
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	а	Pension Schedules	b General Schedules		
Purchase Plan Actuarial Information) - signed by the plan actuary (3)				nation)	
(*)		Purchase Plan Actuarial Information) - signed by the plan	(3) A (Insurance Infor	mation)	,
				-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Yes"	If "Yes" is checked, complete lines 11b and 11c.					
11b Is the p	11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
Receipt	ne Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the t Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid t Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)					

Form 5500 (2016)

Receipt Confirmation Code_

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SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).			11110 1 011	Inspection			
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016		and er	nding 12/3	1/2016	
A Name of plan SETON HALL UNIVERSI	TY WELFARE I	BENEFIT PROGRAM		B Thre	e-digit number (PN	N) •	505
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY				-	oyer Identifica 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:							
(a) Name of insurance ca AETNA LIFE INSURANCE							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
06-6033492	60054	0473649	1339		01/01/2016	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		17392					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	• • • • • • • • • • • • • • • • • • • •	nd address of the agent, broker,	•	m commiss	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales a	nd hase	Fee	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
						3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		y , ,				·	
(b) Amount of sales and base		Fee	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	A (N) ()						

Schedule A (Form 5500) 2	2016	Page 2 - 1	
(a) No.	no and address of the agent broke	ar at other person to whom commissions or fees were paid	
(a) Nai	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 commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me 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) Na	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	(c) Amount	(d) Purpose	Organization
commissions paid	(c) since.	(4) - 5	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
			1
(b) Amount of sales and base	(a) A == a == t	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me 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

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F	art					
		Where individual contracts are provided, the entire group of such indivithis report.	idual contra	cts with each carrier mag	y be treated	as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
					01:	
	b	Premiums paid to carrier			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participat	tion guarantee		
		(3) guaranteed investment (4) other				
		(4) 🖺 344 4 444 4 4 4 4 4 4 4 4 4 4 4 4 4 4				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(2)7			70(0)	
	ч	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:	Γ		, ru	
	•	(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	

P	an	۵	Δ

Pa	rt II	I Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employees of th ting purposes if such con	tracts are expe	erience-rated as a uni	t. Where co	ntracts cover individual
8 E	Bene	fit and contract type (check all applicable boxes)					
á	а 🗌	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
•	e 🗆	Temporary disability (accident and sickness)	f Long-term disabil	itv a	Supplemental unem	plovment	h Prescription drug
i		Stop loss (large deductible)	j HMO contract		PPO contract	, , ,	I Indemnity contract
i	m X		• 🗆	~ _	11 0 contract		I Indemnity contract
9 ⊨	xper	ience-rated contracts:					
á	a P	remiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid	t	9a(2)			
	(3) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	
		Benefit charges (1) Claims paid					
		2) Increase (decrease) in claim reserves				_	
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(-	4) Claims charged				9b(4)	
	C I	Remainder of premium: (1) Retention charges (c	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)			4
		(F) Charges for risks or other contingencies .		0-(4)(0)			_
		(G) Other retention charges				0-(4)(11)	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				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 n	ot include amount entere	d in line 9c(2)	<u>.)</u>	9e	
		experience-rated contracts:				40-	050446
	_	Total premiums or subscription charges paid to o				10a	352142
		If the carrier, service, or other organization incur				10b	
ç		etention of the contract or policy, other than repify nature of costs.	orted in Part I, line 2 abov	ve, report arric	Junt	100	<u> </u>
Pa	rt I\	/ Provision of Information					
11	Did	the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	A?	Yes	X No
		e answer to line 11 is "Yes," specify the informat					

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

		pursuant to E	RISA section 103(a)(2).			Inspection
For calendar plan year	2016 or fiscal plar	year beginning 01/01/2016	and	ending 12/31/2	2016	
A Name of plan SETON HALL UNIVER	SITY WELFARE I	BENEFIT PROGRAM		nree-digit an number (PN)	<u> </u>	505
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY				ployer Identificati 2-1500645	ion Number (EIN)
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each 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 Informatio	n:					
(a) Name of insurance CIGNA HEALTH AND LI		COMPANY AND AFFILIATES				
4.5 = 0.1	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) F	rom	(g) To
59-1031071	67369	3334085	1083	01/01/2016		12/31/2016
2 Insurance fee and co descending order of t		ation. Enter the total fees and total	ll commissions paid. List in line	3 the agents, br	okers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		9702				170092
3 Persons receiving co	ommissions and fe	ees. (Complete as many entries	as needed to report all persons)).		
		nd address of the agent, broker,		issions or fees w	ere paid	
MERCER HEALTH AND	BENEFITS, LLC		YSPHERE CIRCLE GO, IL 60674			
(b) Amount of sales	and base	Fee	s and other commissions paid			
commissions		(c) Amount	\	(d) Purpose		
9702			NERAL AGENT PAYMENTS			3
	(a) Name a	nd address of the agent, broker,	or other person to whom commi	issions or fees w	ere paid	
MERCER HEALTH AND		4565 PA	YSPHERE CIRCLE GO, IL 60674			
(b) Amount of sales and base		Fee	s and other commissions paid			
commissions		(c) Amount	(d) Purp	ose		(e) Organization code
		3471 BE	NEFIT ADVISOR PAYMENTS			3
For Donomuork Boduo	tion Act Notice	and the Instructions for Form F	E00		Cabas	lula A (Farm FFOO) 2046

Schedule A (Form 5500) 2	2016	Page 2 - 1	
(a) No.	no and address of the agent broke	ar at other person to whom commissions or fees were paid	
(a) Nai	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 commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me 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) Na	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	(c) Amount	(d) Purpose	Organization
commissions paid	(c) since.	(4) - 5	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
			1
(b) Amount of sales and base	(a) A == a == t	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me 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

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Pa	art					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ts with each carrier ma	y be treated	as a unit for purposes of
4 (Curr	rent value of plan's interest under this contract in the general account at year		4		
5 (Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Cont	tracts With Allocated Funds:				
í	a	State the basis of premium rates				
					OI:	
	b	Premiums paid to carrier			6b	
	Y C	Premiums due but unpaid at the end of the year			6c	
,	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
(е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7 (Conf	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
í	а	Type of contract: (1) deposit administration (2) immedia	ite participati	ion guarantee		
		(3) guaranteed investment (4) other				
		(4) 🗆 344 4 444 4 4 4 4 4 4 4 4 4 4 4 4 4 4				
	b	Balance at the end of the previous year			7b	
(С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
					7-(0)	
	4	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:	Γ		/ u	
	-	(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)	

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Pa	rt I	If more than one con the information may	be combined for report	ation group of employees of the ing purposes if such cont ual contracts with each ca	racts are expe	erience-rated as a un	it. Where co	ntracts cover	nizations(s), individual
8	3ene	efit and contract type (chec	k all applicable boxes)			·		-	
	a 🔀	7		b X Dental	c×	Vision		d Life ins	urance
	-	<u>-</u>		=	_		1	느	
	e [Temporary disability (acc		f Long-term disabili		Supplemental unen	npioyment	h Prescri	_
	i L	Stop loss (large deductib	le)	j HMO contract	k _	PPO contract		I X Indemn	ity contract
	m [Other (specify)							
9 E	Ехре	rience-rated contracts:							
-	a F	Premiums: (1) Amount rece	ived		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)		
	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)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions			9c(1)(A)				
		(B) Administrative serv	ice or other fees		9c(1)(B)				
		(C) Other specific acqu	uisition costs		9c(1)(C)				
		(D) Other expenses			9c(1)(D)				
		(E) Taxes			9c(1)(E)				
		(F) Charges for risks o	r other contingencies .		9c(1)(F)				
		(G) Other retention cha	arges		9c(1)(G)				
		(H) Total retention					9c(1)(H)		
		(2) Dividends or retroactive	e rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
		Status of policyholder rese		_			· · · ·		-
		(2) Claim reserves	• ,	•					
		(3) Other reserves							
	е	Dividends or retroactive ra	te refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)			
10		nexperience-rated contract	,			,	· ·		
	а	Total premiums or subscri	ption charges paid to c	arrier			10a		17782282
	_	If the carrier, service, or ot	• .						
		retention of the contract or					10b		
,		cify nature of costs.			•				
Da	p4 F	V Dravision of In-	formation						
	rt I						1		
11	Did	the insurance company fa	il to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
12	If th	ne answer to line 11 is "Yes	s," specify the informati	on not provided.					

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

							•
For calendar plan year 201	16 or fiscal plan	year beginning 01/01/2016		and en	ding 12/31/2016	3	
A Name of plan SETON HALL UNIVERSIT	Y WELFARE E	BENEFIT PROGRAM			e-digit number (PN)	•	505
C Plan sponsor's name a	s shown on line	2a of Form 5500		D Emplo	yer Identification N	Number (EIN)
SETON HALL UNIVERSIT	Υ			22-	1500645		
		ning Insurance Contraction Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car HARTFORD LIFE AND ACC							
4 > ===	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From		(g) To
06-0838648	70815	ADD-S02063	0		01/01/2016		12/31/2016
2 Insurance fee and comr descending order of the		tion. Enter the total fees and tot	tal commissions paid. Lis	st in line 3	the agents, broker	rs, and ot	her persons in
(a) Total a	mount of comn			(b) To	otal amount of fees	s paid	
		130					0
3 Persons receiving comm	missions and fe	es. (Complete as many entries	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker,	, or other person to whom	n commiss	ions or fees were	paid	
MERCER HEALTH AND BE	ENEFITS, LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales an	d base	Fee	es and other commission	er commissions paid			
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
	130						3
	(a) Name a	nd address of the agent, broker,	, or other person to whom	n commiss	ions or fees were	paid	
(b) Amount of sales an	d base	Fee	es and other commission	s paid			
commissions pai		(c) Amount	(d) Purpose	е		(e) Organization code
For Paperwork Reduction	n Act Notice, s	ee the Instructions for Form	5500.			Sched	lule A (Form 5500) 2016 v. 160205

Schedule A (Form 5500) 2	2016	Page 2 - 1					
(a) No.	me and address of the agent broke	ar at other person to whom commissions or fees were paid					
(a) Nai	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Na	me 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) Na	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	(c) Amount	(d) Purpose	Organization				
commissions paid	(c) since it	(4) - 5	code				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
			1				
(b) Amount of sales and base	(a) Amazunt	Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me 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				

_		•
חבי	Δ	-5
ay	•	•

Pa	art					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ts with each carrier ma	y be treated	as a unit for purposes of
4 (Curr	rent value of plan's interest under this contract in the general account at year		4		
5 (Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Cont	tracts With Allocated Funds:				
í	a	State the basis of premium rates				
					OI:	
	b	Premiums paid to carrier			6b	
	Y C	Premiums due but unpaid at the end of the year			6c	
,	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
(е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7 (Conf	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
í	а	Type of contract: (1) deposit administration (2) immedia	ite participati	ion guarantee		
		(3) guaranteed investment (4) other				
		(4) 🗆 344 4 444 4 4 4 4 4 4 4 4 4 4 4 4 4 4				
	b	Balance at the end of the previous year			7b	
(С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
					7-(0)	
	4	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:	Γ		/ u	
	-	(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)	

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Pa	art I	II Welfare Benefit Contract Informa	ation					
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such con	tracts are expe	erience-rated as a un	it. Where co	ontracts cov	
8	Bene	efit and contract type (check all applicable boxes)						-
	а	Health (other than dental or vision)	b Dental	с	Vision		d ☐ Life i	nsurance
	e [f Long-term disabil	<u></u>	Supplemental unem	nlovmont		cription drug
	. L				1	іріоўпіспі	=	_
	י ו	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Inde	mnity contract
	m)	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
_								
	•	rience-rated contracts:					4	
		Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			4	
		(3) Increase (decrease) in unearned premium res				0-(4)		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid		(-)			-	
		(2) Increase (decrease) in claim reserves				9b(3)		
		(4) Claims charged(4)				9b(4)		
		Remainder of premium: (1) Retention charges (c				05(4)		
	•	(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B)			7	
		(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 .						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_			9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid i	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)		
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:				40-		000
	_	Total premiums or subscription charges paid to c				10a		863
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than representations of the contract or policy, other than representations of the contract or policy.	, .		•	10b		
	Spe	cify nature of costs.	orted in Fart I, line 2 abov	ve, report arrio	Juin	100		
	Оро	,						
Pa	art l	V Provision of Information						
		the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	Α?	Yes	X No	
		ne answer to line 11 is "Yes," specify the informat						
. 4	n u	io anomon to into 11 to 100, openity the initilitat	on not provided.					

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Securily 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

2016

This Form is Open to Public Inspection

Part I	Annual Report Ide	ntification Information						
For calen	dar plan year 2016 or fiscal	plan year beginning	01/01/2016	and ending	12/31/2016			
A This re	eturn/report is for:	a multiemployer plan	participating er	nployer information in a	ng this box must attach a list o ccordance with the form instru	of ctions.)		
		🛛 a single-employer plan	a DFE (specify)				
B This re	eturn/report is:	the first return/report	the final return	report/				
	•	an amended return/report	a short plan ye	ar return/report (less tha	an 12 months)			
C If the	olan is a collectively-bargain	ned plan, check here	3.0000000					
D Check	box if filing under:	Form 5558 special extension (enter desc	automatic exter	nsion	the DFVC program	l		
D 411	D. J. Dl. J. Same	· · · · · · · · · · · · · · · · · · ·						
Part II 1a Nam	e of plan	ation—enter all requested info			1b Three-digit pla			
Set	on Hall Universi	ty wellare benefit	riogiam		1c Effective date 0 0 9 / 16 / 19 6	of plan		
Maili	ng address (include room, a	, if for a single-employer plan) apt., suite no. and street, or P.C country, and ZIP or foreign post	D. Box) al code (if foreign, see instr	uctions)	2b Employer Iden Number (EIN) 22-150064			
	on Hall Universi				2c Plan Sponsor's number (973) 761-			
	S Orange Avenue th Orange		ŊJ	07079-2646	2d Business code instructions) 611000			
504	en orange							
Undern	nalties of perjury and other	Incomplete filing of this retur penalties set forth in the instru Il as the electronic version of thi	ctions. I declare that I have	examined this return/rea	port, including accompanying	schedules,		
SIGN	ts and attachments, as we	Demarts	01-1-	Terri L	Demarest			
HERE	Signature of plan admin		Date	Enter name of individ	lual signing as plan administra	tor		
SIGN HERE	Olginates of passes							
Signature of employer/plan sponsor			Date	Enter name of individ	Enter name of individual signing as employer or plan sp			
SIGN			B./	Cut as use of in divid	dual signing on DEE			
	Signature of DFE	ne, if applicable) and address (i	Date	Enter name of individ	Preparer's telephone numi	per		
Ргераге	rs name (including inm hai	те, п арупсаме) апи аситозе (г	madad foom of date name					

Form 5500 (2016) Page **2**

3a	Plan administrator's name and address 🔀 Same as Plan Sponsor			3b Admi	nistrator's EIN
				3c Admi numl	nistrator's telephone ber
4	If the name and/or EIN of the plan sponsor has changed since the last return/r EIN and the plan number from the last return/report:	report filed for thi	s plan, enter the name,	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			5	1,125
6	Number of participants as of the end of the plan year unless otherwise stated (6a(2), 6b, 6c, and 6d).	(welfare plans co	emplete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	1,119
a(2	7) Total number of active participants at the end of the plan year			6a(2)	1,121
b	Retired or separated participants receiving benefits			6b	12
С	Other retired or separated participants entitled to future benefits			6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	1,133
е	Deceased participants whose beneficiaries are receiving or are entitled to rece	eive benefits		6e	
f	Total. Add lines 6d and 6e.			6f	
g	Number of participants with account balances as of the end of the plan year (o complete this item)			6g	
h	Number of participants that terminated employment during the plan year with a less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only m	. , .	· , , , , , , , , , , , , , , , , , , ,	7	
b	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature codes. 4A 4B 4D 4E 4L	s from the List of	FPlan Characteristics Codes	s in the ins	
9a	(1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor	(1) X (2) (3) (4) X	Code section 412(e)(3) in Trust General assets of the sp	insurance oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta	ached, and, whe	re indicated, enter the numb	er attache	d. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	b General S (1) (2) (3) (4)	H (Financial Inform I (Financial Inform A (Insurance Inform C (Service Provide	nation – Sn mation) er Informat	ion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	D (DFE/Participati G (Financial Trans	-	