Nationwide Life Insurance Company

Home Office: Columbus, Ohio

STOP LOSS INSURANCE CONTRACT

Nationwide Life Insurance Company ("Company") agrees to reimburse the Policyholder as outlined under the provisions of this Stop Loss Insurance Contract ("Contract").

Policyholder: **Brick Board of Education**

Contract Number: **NWL0071NJ-01**

Effective Date: **08/01/2016**

Anniversary Date: **06/30/2017**
And the same day each year thereafter.

This Contract is legally binding between the Policyholder and the Company. The consideration for this Contract includes, but is not limited to, the Application and the payment of premiums as provided hereinafter.

The Policyholder is entitled to the reimbursement determined in this Contract if the Policyholder is eligible for insurance under the provisions of this Contract. Reimbursement is subject to the terms and conditions of this Contract.

The first premium is due on the first day of the Contract Period. Subsequent premiums are due on the first day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01a.m. Standard Time at the principal office of the Policyholder.

This Contract is governed by the laws of the state of **New Jersey**

The sections set forth on the following pages are a part of this Contract.

IN WITNESS WHEREOF, the Company has caused this Contract to be executed at Columbus, Ohio.

Nationwide Life Insurance Company

Secretary

President

COUNTERSIGNED: ______________________________

(Licensed Resident Agent - Where required by Law)

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SCHEDULE OF STOP LOSS

Coverage specified herein is applicable only during the Contract Period from 08/01/2016 to 06/30/2017, and is further subject to all terms and conditions of this Contract, unless annotated below.

AGGREGATE STOP LOSS ☒ Yes ☐ No

Benefit Period: Covered Persons Employee Benefit Plan Losses Incurred from 08/01/2016 through 06/30/2017, and Paid from 08/01/2016 through 06/30/2017.

Coverages applying to Aggregate Stop Loss include:

☒ Medical

Aggregate Percentage Reimbursable (Excess of Attachment Point) 100%

Monthly Aggregate Factors:	Employee	Employee & Child	Employee & Spouse	Employee & Family
Medical	$570.21	$969.36	$1,254.47	$1,739.15

All coverages are combined for determination of Aggregate Stop Loss liability under the terms of this Contract.

Maximum Aggregate Benefit per Benefit Period $5,000,000
(Excess of Annual Aggregate Attachment Point)

Maximum Employee Benefit Plan Losses per Covered Person per Benefit Period $300,000
Minimum Annual Aggregate Attachment Point $17,877,936

Aggregate Premium per Employee per month $3.27 and $0.40 for Terminal Liability Run-Out

SPECIFIC STOP LOSS ☒ Yes ☐ No

Benefit Period: Covered Persons Employee Benefit Plan Losses Incurred from 08/01/2016 through 06/30/2017 and Paid from 08/01/2016 through 06/30/2017.

Losses Incurred prior to this Contract Effective Date will be limited to n/a

Coverage applying to Specific Stop Loss include:

☒ Medical

Specific Deductible (Per Person) $300,000
Specific Percentage Reimbursable (Excess of Deductible) 100%

Lifetime Maximum Specific Benefit Unlimited
(per Covered Person in excess of the Specific Deductible)

Specific Premium per month:		
	Employee Only	$23.45
	Employee and Child:	$39.88
	Employee and Spouse	$51.62
	Employee & Family	$71.55

SPECIAL LIMITATIONS:

See Disclosure Statement dated June 30, 2016, and Stop Loss Insurance Proposal (both of which form a part of the Application) for conditions and limitations in addition to those listed in the Application and Contract.

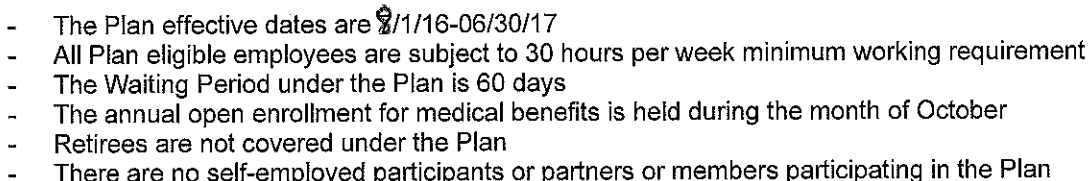
Issuance of the Contract does not indicate or suggest approval of any stop loss claim(s) submitted under the Contract and not yet adjudicated, and shall not constitute a waiver of any of its terms or conditions.

Specific Advance Funding option is included.

Terminal Liability Run Out option is included under Aggregate and Specific coverage.

Eligible participants of the Policyholder's subsidiaries, affiliates and/or locations listed on the Policyholder's Signed Application will be covered under the Contract only if such participants were listed on the census and properly disclosed to the Company during underwriting of the Contract, and such participants' benefits are administered pursuant to the terms of the approved Plan.

Based on the representations of the Policyholder to the Company during underwriting of the Contract, the Contract assumes the following:



- The Plan effective dates are 8/1/16-06/30/17
- All Plan eligible employees are subject to 30 hours per week minimum working requirement
- The Waiting Period under the Plan is 60 days
- The annual open enrollment for medical benefits is held during the month of October
- Retirees are not covered under the Plan
- There are no self-employed participants or partners or members participating in the Plan

The Company shall have no responsibility for the expenses of any employee (or his/her dependents) not subject to any of the above assumptions. In addition, should the Company learn at anytime that any of the above assumptions are incorrect, the Company will have the right to revise the terms, conditions and provisions of the Contract or deny a claim affected by any of the above assumptions

Any continuation coverage including disability, total disability, leave of absence (including but not limited to workers' compensation or severance leave) or layoff provisions of the Plan that begins on or after the effective date of this contract, will be limited to the lesser of:

-The time period from the date when the participant is no longer on the regular payroll of the group and/or performing the duties of his/her job with the employer on a full time basis and until the end of the Contract Period; or

- Until the date the continuation coverage ends under the Plan;

Claims for any person who began a continuance prior to the effective date of this contract will not be covered under this contract unless such participant's leaves were identified and specifically approved in writing by the Company. This requirement is in addition to those imposed by the Disclosure Statement.

If the renewal contract is offered, the Company will continue coverage for the participants who were subject to the above provision for the duration of the renewal Contract Period, provided that the Policyholder identifies the type of continuance for each participant and the participant is specifically approved in writing by the Company at the time of renewal.

Routine care in connection with cancer clinical trials will be covered to the extent required by PPACA. Any complications from non-covered treatment administered in a clinical trial will not be covered, unless the Plan demonstrates that it was required to provide such coverage by PPACA.

In the event that a claim incurred during the Benefit Period is denied by the Plan during the Benefit Period and subsequently submitted for an external review by an Independent Review Organization (IRO) in accordance with the provisions of the Patient Protection and Affordable Care Act, and the Plan is required to pay such claim as a result of an IRO decision that occurs after the Benefit Period, the Company will treat this claim as having been paid during the Benefit Period provided that : 1) the Plan is a non-grandfathered plan and the Company was advised of the non-grandfathered status during underwriting; 2) the Company is advised that the claim has been submitted to the IRO within 10 days of the claim being submitted to the IRO; 3) the Plan pays the claim within 10 days of the Plan's receipt of the decision; 4) the Company is advised of the IRO decision prior to payment of the claim; and 5) all information necessary to determine the eligibility of the claim under the Contract is submitted to the Company within 30 days of payment of the claim. This waives no provisions of the Contract except as noted above and all other provisions of the Contract apply.

THIRD PARTY ADMINISTRATOR: Horizon BCBS of New Jersey
3 Penn Plaza East
Newark, NJ 07105

Dated at ______________________________ this __________ day of ____________________, 2017

Policyholder ____

Title ____

Witness ____

DEFINITIONS

AGGREGATE STOP LOSS means the amount that the Company agrees to reimburse the Policyholder after the end of the Contract Period for Losses Paid by the Policyholder over and above the Policyholder's Annual Aggregate Attachment Point as set forth in the Schedule of Stop Loss, and subject to the terms and conditions of the Contract.

ANNUAL AGGREGATE ATTACHMENT POINT for any one Contract Period means the greater of:
- the sum of the Monthly Aggregate Attachment Point; or
- the Minimum Annual Aggregate Attachment Point.

BENEFIT PERIOD means the period of time in which a claim must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under the Policyholder's Stop Loss Contract. This period does not alter the Effective Date, Contract Period, or waive the Contract's eligibility requirements.

CONTRACT PERIOD means the specified period in the Schedule of Stop Loss, beginning no earlier than the Effective Date of the Contract and continuing until coverage terminates in accordance with the Contract Termination provision.

COVERED PERSON means any one individual entitled to benefits under the specific terms and provisions of the Employee Benefit Plan. Only eligible classes and individual(s) whose initial and continued eligibility is fully described in the copy of the Plan on file with the Company shall be considered a Covered Person.

COVERED UNIT means the following person or persons who are covered under the Plan:

- an Employee;
- an Employee with dependents; or
- such other defined unit as agreed upon between the Company and the Policyholder.

EMPLOYEE BENEFIT PLAN (also known as the Plan) means the self-funded Plan of benefits provided by the Policyholder for Covered Persons. A copy of the Plan or plans in effect on the Contract Effective Date is on file with the Company and made a part of this Contract.

INCURRED means the date on which the Services Are Rendered or supplies are received by the Covered Person. Inpatient facility charges with continuous facility stay, that fall over two or more Contract years will be considered on a pro rata/per diem basis by dividing the total amount of eligible charges by the total number of days of confinement and multiplying by the number of days of confinement in each Contract year.

LATE ENTRANT is an eligible Covered Person who requests coverage in the Employee Benefit Plan more than 30 days after the date the person was first eligible to enroll. A person shall not be considered a Late Entrant if he:
- was covered under another Policyholder's group health plan at the time of initial enrollment; and
- stated at the time of initial enrollment that coverage under another Policyholder's group health plan was the reason for declining coverage; and
- has lost coverage under another Policyholder's group health plan due to termination of employment, termination of the plan, death of a spouse or divorce; and
- requests coverage within 30 days after termination of such coverage; or
- applies for coverage on a spouse or minor child within 30 days of a court order requiring coverage be provided under the Plan.

LOSS, LOSSES means Reasonable and Customary Charges actually Paid by the Policyholder for eligible benefits under the Plan.

MAXIMUM AGGREGATE BENEFIT means the maximum amount reimbursable by the Company to the Policyholder for the Contract Period.

MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT means the lowest amount of the Policyholder's responsibility for the Contract Period, as set forth in the Schedule of Stop Loss, for Losses under the Plan.

MONTHLY AGGREGATE ATTACHMENT POINT means the total number of Covered Units for that given Contract month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Stop Loss. However, in the event of a reduction in the number of Covered Units under the Plan, the Monthly Aggregate Attachment Point will not be reduced more than five percent from the preceding Monthly Aggregate Attachment Point.

PAY, PAID, PAYMENT means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment may be deemed made on the date that both: 1. the payor directly tenders payment by mailing (or by other form of delivery) a draft or check; and 2. The account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

POLICYHOLDER is the legal entity to whom the Company has issued the Contract.

PROOF OF LOSS is documentation evidencing a Loss as required in the claim submission forms furnished by the Company.

REASONABLE AND CUSTOMARY CHARGE(S) means the usual charge made by the provider of care for a service, not to exceed the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. If the Plan has a contracted fee arrangement with certain health care providers, "Reasonable and Customary Charges" shall mean the lessor of the applicable fee as defined in that fee arrangement contract or the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed.

SPECIFIC DEDUCTIBLE means the amount of the Policyholder's responsibility for each Covered Person under the Plan during the Benefit Period as specified in the Schedule of Stop Loss. For each Covered Person, the Specific Deductible will apply separately to each Benefit Period. If this Contract terminates during any Contract Period, the Specific Deductible will be calculated as if this Contract had remained in effect for the full Contract Period.

SPECIFIC STOP LOSS means the amount the Company will reimburse the Policyholder for eligible Losses Paid by the Policyholder over and above the Specific Deductible for a Covered Person while this Contract is in force as set forth in the Schedule of Stop Loss, and subject to the terms, conditions and limitations of this Contract.

SERVICES ARE RENDERED means the date the services were provided.

THIRD PARTY ADMINISTRATOR means a firm or person which has been retained by the Policyholder to pay claims and/or provide administrative services on behalf of the Policyholder Plan. Administrator in this definition does not have the same meaning as the term "Plan Administrator" used in the Employee Retirement Income Security Act of 1974 (ERISA), unless the Policyholder has specifically appointed their Administrator to perform as such.

DUTIES OF THE POLICYHOLDER

DUTIES OF THE POLICYHOLDER in this Contract are conditions precedent to the Company's liability. No reimbursement shall be payable unless, the conditions precedent have been met.

THIRD PARTY ADMINISTRATOR: The Policyholder may retain a Third Party Administrator, who is approved by the Company, to act as the Policyholder's agent in performing administrative duties on behalf of the Policyholder. Without waiving any of its rights under this Contract, and without making the designated Third Party Administrator a party to this Contract, the Company and the Policyholder agree to recognize the Third Party Administrator as an agent for the Policyholder.

PAYMENT OF CLAIMS: The Policyholder must Pay all eligible claims under the Plan within forty-five days from the date adequate proof is provided to the Policyholder. If the Policyholder fails to pay claims within the forty-five day time limit, that claim will not count towards the satisfaction of either the Annual Aggregate Deductible or the Specific Deductible or be reimbursed under this Contract and the Company will have the option to terminate this Contract

COOPERATION WITH AUDITS: The Policyholder and its Third Party Administrator must cooperate with the Company in the event the Company exercises its right to audit as set forth in this Contract.

NOTICE OF CLAIM: Policyholder's written Proof of Loss must be submitted to the Company within 90 days of it being Paid by the Policyholder

LITIGATION: A copy of any document filed by or against the Policyholder in any court in connection with litigation under the Plan must be promptly furnished to the Company. The Policyholder shall pay all attorneys' fees and any punitive or exemplary damages incurred under this Contract by reason of any litigation in which the Company shall, without its fault, become involved through or on account of this Contract or the Plan.

TAXES: In the event any taxing authority which has jurisdiction over either of the parties finds that Additional Taxes must be paid in respect of this Contract, the Plan, or related matters, the Policyholder shall be responsible for such Additional Taxes. An amount equal to the total amount to be paid because of such Additional Taxes shall be promptly paid by the Policyholder to the Company upon written request. "Additional Taxes" means those which are in addition to the premium taxes paid by the Company with respect to this Contract.

REPORTING REQUIREMENTS: The Policyholder will submit by the 12th day of each month or as soon as reasonably possible but no longer than 30 days all Proof of Loss reports and supporting documents including, but not limited to, a monthly summary of all Losses Paid by the Policyholder and total number of Covered Units covered under the Plan during the prior month. The Policyholder will be responsible for the investigation, auditing, calculating and the Payment of all claims under the Plan.

RECORDS: The Policyholder will maintain records of all Covered Persons under the Plan during the Contract Period and for a period of seven years after the termination of this Contract. The Policyholder shall make such records available to the Company as needed to evaluate its liability under this Contract.

The Policyholder will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

TERMINATION: The Policyholder will immediately notify the Company if the Policyholder's Plan is terminated.

TIMELINESS: Time is of the essence. The Policyholder must comply with all deadlines stated in this Contract.

MISCELLANEOUS PROVISIONS

AMENDMENT TO THE PLAN: No Plan change will affect this Contract without the Company's written consent. Written notice of the Plan change must be given to the Company prior to the effective date of the change. If such advance written notice is not received and accepted, the Company's reimbursement may be made as if the Plan had not been amended, at the Company's discretion. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

AUDITS: The Company will have the right:

- to inspect, copy and audit all records and procedures of the Policyholder and Third Party Administrator developed and maintained for the Plan that are applicable to the administration of the Stop Loss Insurance Contract, and
- to require, upon request, proof of records satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

CHANGES: This Contract can be altered only with the consent of the Company and then only in writing. No such alteration of this Contract shall be valid unless endorsed on or attached to this Contract. No Agent, Broker, or Third Party Administrator has the authority to alter this Contract or to waive any of its provisions, including premiums shown in the Schedule of Stop Loss.

CHANGES TO MANAGED CARE: If the Plan or its third party administrator has a contracted fee arrangement with certain health care providers and/or hospitals and the contract is terminated or cancelled or the charges or fee schedule allowed under the contract is increased, the Policyholder or Third Party Administrator shall notify the Company within 10 days of the Policyholder's or Third Party Administrator's notice of such an occurrence. The Company shall have the right to adjust the premium rates and/or the Specific Deductible amount and/or the Annual Aggregate Attachment Point. If such notice is not given, the Company's liability for contract changes shall be deemed the lesser of the new contract or the contract charges prior to the cancellation, termination or change.

CLERICAL ERROR: Clerical error, inadvertent delay or omission in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error, inadvertent delay or omission is not prejudicial to the Company and is rectified promptly upon discovery.

CONCEALMENT, FRAUD: This entire Contract will be void if, the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Contract, including any claim or any case of fraud by the Policyholder or its Third Party Administrator or other Agent relating to this Contract.

ENTIRE CONTRACT: The entire Contract between the Company and the Policyholder will consist of this Contract, the Application (including the Disclosure Statement), approved amendments and riders, and the Policyholder's Plan Document which is on file with the Company.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Third Party Administrator will not impose upon the Company any liability other than the liability defined in this Contract. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

LEGAL ACTION: No legal action may be brought against the Company until there has been full compliance with all the terms of this Contract. All Contract terms will be interpreted under the laws of the state shown on page 1 of this Contract. No legal action may be brought to recover on this Contract within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished. Venue for any legal action filed by either party under this Contract, shall be located in Columbus, Ohio.

LIABILITY: The Company will have neither the right nor the obligation under this Contract to directly pay any Covered Person or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Contract. Nothing in this Contract shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Employee Benefit Plan or to any supplement or amendment to it. The Policyholder may not assign reimbursement under this Contract, and the Company will not recognize any such assignment.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of this Contract. Should subsequent information become known which, if known prior to final underwriting of this Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

NONCONFLICTING LANGUAGE WITH PLAN AND STOP LOSS CONTRACT: Any provision in the Plan which purports to alter or conflict with the terms, conditions or provision of this Contract shall be null and void insofar as it might affect the Company's liability under this Contract.

NOTICE: For the purpose of any notice required from the Company under the provisions of this Contract, notice to the Policyholder's Third Party Administrator shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Policyholder's Third Party Administrator. Notice from the Policyholder to the Company's designee and notice from the Third Party Administrator to the Company's designee shall be considered notice to the Company. Notice from the Policyholder to the Policyholder's Third Party Administrator and notice from the Third Party Administrator to the Policyholder shall not be considered notice to the Company.

OFFSET: Any payment or overpayment of a claim made to the Policyholder due to error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any refund owed to the Company for such payment or overpayment or any premium owed to the Company against any reimbursement due the Policyholder.

OTHER COVERAGE: The reimbursement provided by this Contract is in excess of other coverages such as group insurance, excess insurance, reinsurance, plan benefits including insurance or benefits established by any federal, state or local law.

OVER-REIMBURSEMENT, THIRD PARTY RECOVERY, OTHER CARRIER LIABILITIES: Amounts Paid which are reimbursed by, or payable by other insurance companies, reinsurers or third parties will not be included in Aggregate Stop Loss or Specific Stop Loss.

- Should there be a recovery of Paid claims due to a subrogation, reimbursement, or third party liability provision in the Plan, the amount of recovered Plan payments will not apply to Specific Stop Loss or Aggregate Stop Loss. The Company will not reimburse amounts recovered. If the Company reimburses the Policyholder for amounts that are later recovered from a third party payer, the amount recovered must be refunded by the Policyholder to the Company to the extent of any reimbursement, whether or not this Contract is still in force on the date the recovery is received.
- Should there be an over-reimbursement made to the Policyholder due to clerical or other error, the over-reimbursement must be refunded.
- If benefits for a Covered Unit are payable under an extension of benefits provision of a previous insurance carrier, the Company will not accept responsibility for the expenses payable under the prior coverage for such individuals.

PARTIES TO THE CONTRACT: The parties to this Contract are the Policyholder and the Company. The Company's sole liability under this Contract is to the Policyholder. This Contract does not create any right or legal relation between the Company and a Covered Person under the Employee Benefit Plan. This Contract will not be deemed to make the Company a party to any agreement between the Policyholder and any Third Party Administrator.

RENEWAL: At the end of the Contract Period, but only by mutual agreement of the Policyholder and the Company, this Contract may be renewed for another Contract Period. The renewal may be subject to new premium rates, new underwriting terms, a new Benefit Period and new Contract terms. Company approval of a continuance request by the Policyholder for Stop Loss Insurance resulting in a new Contract Period, Benefit Period and new Contract terms and conditions will effect a new Schedule of Stop Loss.

SEVERABILITY CLAUSE: Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public contract, will not render any of the remaining provisions of this Contract invalid.

SUBROGATION: The Policyholder has the sole obligation to pursue, to the full extent of the legal remedies available to it, all claims that it may have against third parties when they arise out of an occurrence which results in a Loss. Should the Policyholder fail to pursue a claim that it may have against a third party, and should it not otherwise pursue all legal remedies available to it and should the Company then become liable to make payments under the terms and conditions of this Contract, then the Company shall determine its payment under this Contract as if the Policyholder had in fact pursued its legal remedies and had been successful.

WAIVER: Failure of the Company to insist upon the Policyholder's strict compliance with any requirement or condition of this Contract at any time or under any circumstance shall not constitute a waiver of such requirements or condition by the Company at any time under the same or different circumstances.

EXCLUSIONS

Losses under the Plan shall not include, and the Company shall not be liable for, any of the following.

1. Court costs, interest upon judgments, cost of investigations or other claims administration costs, legal expenses and punitive or other damages assessed against, or incurred by, the Policyholder, Third Party Administrator or other party associated with the Plan.
2. Amounts Paid for
   - any individual who is not eligible for benefits under the Plan;
   - any services or supplies, rendered to a Covered Person, when such service or supply is not a covered service under the Plan.
3. Amounts Paid for Covered Persons which are in excess of Reasonable and Customary charges.
4. Claims arising out of or caused by or contributed to or in consequence of war or act of war, declared or not, hostilities, invasion or civil war.
5. Claims arising out of or in the course of any occupation or employment for wage or profit for which the Covered Unit is entitled to benefits under any Workers' Compensation or Occupational Disease Act or Law.
6. Claims arising out of nuclear accident.
7. Any managed care discount, negotiated discount, audit savings or other discount or savings forfeited or waived by the Policyholder for any reason, including but not limited to untimely payment.
8. Experimental or Investigative services, treatments, procedures, technology, supplies or drugs which:
   - have not been approved by the Federal Food and Drug Administration;
   - are not widely recognized and accepted as effective, safe and appropriate for the sickness or injury by the medical profession in the U.S.;
   - are in the research or investigative stage, or conducted for research or similar purposes; or
   - the patient has been asked to sign or has signed a release or other document indicating that the treatment is Experimental or Investigative or other term of similar meaning.

   In determining any of the above, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institute of Health; Medicare; the Food and Drug Administration and other accepted medical authorities and sources.
9. The Company shall not be liable for:
   - Amounts Paid for claims submitted to or Paid by the Plan, more than 365 days after the services were Incurred.
   - Amounts Paid for Losses where evidence of Payment satisfactory to the Company of such Loss was submitted to the Company more than 90 days after the Benefit Period.
10. Amounts paid for Covered Persons who reside outside of the United States unless agreed to in writing by the Company.
11. Notwithstanding the clerical error provision under Miscellaneous Provisions, this Contract shall exclude any amounts Paid for Covered Persons, whose coverage is continued outside of the parameters specified by Federal Law under the Consolidated Omnibus Budget Reconciliation Act (hereafter referred to as COBRA) for any reason including clerical error of the Policyholder; who do not receive a valid COBRA extension offer within the 30 days immediately following a COBRA qualifying event; who fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from the Policyholder; or who fail to remit COBRA premium within the period specified by federal law. The Company will require written documentation that these requirements have been satisfied.
12. Salaries paid to Employees of the Policyholder or of the Third Party Administrator and any other Policyholder contracted services.
13. Amounts Paid under the Plan for a Covered Unit whose evidence of good health as a Late Entrant is not approved by the Company.

14. Amounts Paid under the Plan which would not have been Paid if benefits were coordinated according to the National Association of Insurance Commissioners (NAIC) Model COB Guidelines.
15. Amounts Paid for treatment not due to sickness or injury, including cosmetic surgery or any treatment to correct complication of cosmetic surgery except cosmetic surgery required to correct birth defect of a child born to or adopted by a Covered Person while his coverage under the Plan is in force; or cosmetic surgery to correct the result of a non-cosmetic surgery that results in deformity, trauma, infection or disease of the involved party.
16. Amounts Paid as benefits for inpatient or outpatient stays for alcohol or drug abuse and mental or nervous disorders in excess of the lessor of:
    - 30 inpatient and 30 outpatient stays during a Contract year; or
    - the number of stays or the amount payable under the Plan.
17. Claims which were Incurred prior to the start of the first Contract year, whether advised of at that time or later, unless specifically covered by the terms of this Contract.

PREMIUMS AND FACTORS

PAYMENT OF PREMIUMS: No coverage under this Contract will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent Payment as shown in the Schedule of Stop Loss for the applicable Contract Period, must be paid on or before its due date. The Policyholder is responsible for the Payment of its premiums. Premiums are not considered paid until the premium Payment is received by the Company.

GRACE PERIOD: A Grace Period of 60 days from the due date will be allowed for the Payment of each premium after the first premium Payment. During the Grace Period, the coverage will remain in effect provided the premium is paid before the end of the Grace Period. Should a premium otherwise due, not be paid during the Grace Period, this Contract will be terminated without further notice, as of the date for which premiums were last paid.

PREMIUM AMOUNT: The Policyholder's premiums will be calculated using rates determined by the Company as set forth in the Schedule of Stop Loss. The amount of total premium due is the sum obtained by multiplying each rate shown in the Schedule of Stop Loss by the Covered Units to which the rate applies.

The Policyholder will be liable for any premium taxes assessed at any time against the Company above any taxes which may be payable on the premium received by the Company.

Any correction to the Specific or Aggregate premium of the Covered Units for the preceding Contract Period, must be reported to the Company within sixty days after the last Contract month of the preceding Contract Period.

PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE: The Company may change the Policyholder's premium rate or Monthly Aggregate Factor on any of the following:

- the date when the terms of this Contract are changed; or
- the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions; or
- the date of any revision to the Employee Benefit Plan; or
- the date the geographic area in which the Policyholder has Employees or the nature of business in which the Policyholder is engaged in changes; or
- the date there is a change in enrollment exceeding 10% of the first month's enrollment of the current Contract Period or the 9th month of the prior Contract Period.

The Company reserves the right to recalculate the premium rate and the Monthly Aggregate Factor for the Contract Period, if there is more than a ten percent (10%) variance between:

- the average monthly Paid claims under the Plan for the last two months of the prior Contract Period; and
- the average monthly Paid claims under the Plan for the first ten months of the prior Contract Period.

CONTRACT TERMINATION

This Stop Loss Insurance Contract will continue in effect until the end of the Contract Period, unless coverage is terminated as set forth below.

This Contract and all benefits will terminate upon the earliest of the following dates:

- on the due date of any premium which remains unpaid at the end of the Grace Period; or
- the premium due date next following receipt by the Company of written notice from the Policyholder that this Contract is to be terminated; or
- the date of termination of the Employee Benefit Plan; or
- the date the Policyholder suspends active business operations or is placed in bankruptcy or receivership; or
- the date the Policyholder dissolves

This Contract may also be terminated at the Company's option on either of:

- the date the number of Covered Units under the Employee Benefit Plan becomes less than seventy-five;
- the date the Policyholder fails to perform the Duties of the Policyholder as set forth in this Contract; or
- the date the Third Party Administrator is changed by the Policyholder unless agreed to in writing by the Company.

The Company will not refund any portion of the premium paid by the Policyholder whose Plan terminated during the Contract Period.

AGGREGATE STOP LOSS

COVERAGE PROVISION: If the Policyholder's Losses for the Benefit Period, stated in the Schedule of Stop Loss, exceeds the Annual Aggregate Attachment Point for the Contract Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Contract including the limits set forth in the Schedule of Stop Loss, an amount;

- equal to the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Annual Aggregate Attachment Point; and
- not to exceed the Maximum Employee Benefit Plan Losses per Covered Person per Benefit Period; and
- not to exceed the Maximum Aggregate Benefit per Benefit Period.

CONDITIONS: If a Policyholder's coverage terminates before the end of the Contract Period;

- the Annual Aggregate Attachment Point will be deemed not satisfied; and
- the Company will not be liable for any Aggregate Deductible reimbursement.

CLAIM SETTLEMENTS: After the end of the Benefit Period, the Company will reimburse the Policyholder for the Aggregate Stop Loss within a reasonable period of time once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to this Stop Loss Insurance Contract. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company will have the sole authority to reimburse or deny Losses under this Contract.

SPECIFIC STOP LOSS

COVERAGE PROVISION: If the Policyholder's Losses for the Benefit Period, as shown in the Schedule of Stop Loss, exceeds the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Contract including the limits in the Schedule of Stop Loss, an amount:

- equal to the Specific Percentage Reimbursable of Specific Stop Loss times the amount by which Losses exceed the Specific Deductible amount; but
- not to exceed the Lifetime Maximum Specific Benefit.

CONDITIONS: Losses for any Covered Person during the Contract Period will be determined according to the Benefit Period as shown in the Schedule of Stop Loss.

The Specific Deductible amount as shown in the Schedule of Stop Loss applies separately to each Covered Person during a Benefit Period.

CLAIM SETTLEMENTS: The Company will reimburse the Policyholder for a Specific Stop Loss as herein provided, within a reasonable period of time once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to the Stop Loss Insurance Contract. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company will have the sole authority to reimburse or deny Losses under this Contract.

Nationwide®
is on your side

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

AGGREGATE TERMINAL RUN-OUT AMENDMENT

Policyholder: Brick Board of Education

Effective Date: August 1, 2016

Contract Basis: 11/11

The Contract is amended as described below. All other terms remain unchanged.

This Rider is only applicable when termination occurs at the end of the Contract Period and only if the Employee Benefit Plan terminates and is not replaced by another self-funded Plan.

The Annual Aggregate Attachment Point and the Benefit Period for the Aggregate Stop Loss will be revised as outlined below.

The revised Benefit Period will be limited to the losses incurred and paid by Policyholder pursuant to the Aggregate Stop Loss incurred/paid contract basis or Paid within ninety days immediately thereafter if the Policyholder chooses not to renew this policy on the anniversary date.

Calculation:

The Policyholder's Monthly Aggregate Factors, if coverage is not renewed on the 7/1/17 anniversary date, will be retroactively set at:

Employee Only: $672.85
Employee and Child: $1,143.95
Employee and Spouse: $1,480.27
Employee and Family: $2,000.02

If the Policyholder's stop loss coverage terminates for any reason prior to the last date of the Benefit Period, this Amendment will be void. No portion of premium paid will be refundable.

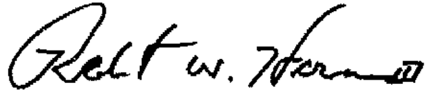
This provision takes effect only if Policyholder provides notice to the Company at least **30** days before the last date of the Benefit Period that the coverage will not be renewed.

Claims Paid by the Policyholder within 90 days immediately after the anniversary date will not be covered under this Amendment to the extent those claims exceed the total claims paid by the Policyholder within the final 90 days immediately before the anniversary date; Run-out claims subject to this Amendment may not exceed the amount of claims paid during the final 90 days of the 24 month stop loss Benefit period.

This Amendment will only be valid for the Benefit Period elected and must be reapplied for prior to all subsequent Contract or Benefit Periods.

In consideration for this Aggregate Terminal Run-Out Amendment option, the group will be required to pay an additional Aggregate premium which is included in the Aggregate Rate as stated in the Contract.

NATIONWIDE LIFE INSURANCE COMPANY



Secretay **President**