STUDENT INJURY & SICKNESS INSURANCE SUMMARY OF COVERAGE

The College of New Jersey

2011 – 2012

THIS PLAN UNDERWRITTEN BY:
MONUMENTAL LIFE INSURANCE COMPANY
Administrative Office:
520 Park Avenue
Baltimore, Maryland 21201

Visit us on the Web:
www.bollingercolleges.com/**tcnj**

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Dear Parents:
This student insurance program has been arranged through Bollinger, Inc. which specializes in school programs and is underwritten by Monumental Life Insurance Company.

ELIGIBILITY

All students who are enrolled at the school named in the Schedule; and have paid all registration and tuition fees are Eligible to Enroll.

Eligible full-time students who do enroll may also enroll their Dependents. Eligible Dependents are the spouse or civil union partner and children under 26 years of age. Dependent eligibility expires concurrently with that of the Insured student. Coverage will coincide with the period for which the Insured student is covered or the date the premium and application are received by the plan administrator, whichever is later.

The Master Policy on file at the school becomes effective 12:01a.m. on September 1, 2011. Coverage becomes effective on that date. The Master Policy terminates 12:00a.m. on September 1, 2012. Coverage terminates on that date or at the end of the period through which the rate is paid, whichever is earlier.

PREMIUM REFUND

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased will not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid, and no refund will be allowed.

A covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, and any covered dependents, upon written request received by Bollinger, Inc. within 90 days of withdrawal from school.

INJURY MEDICAL EXPENSE BENEFIT

Benefits are provided up to $3,000 for accidental Injuries for which medical treatment by a Physician, surgeon, dentist, registered Nurse, Hospital services, ambulance services, or x-rays are rendered. The initial treatment must be rendered within 30 of the accident and benefits are limited to treatment rendered within 1 year of the date of the accident. Some specific benefit levels are shown below:

Hospital Room and Board: The expense actually incurred is allowed not to exceed the semi-private rate per day up to a maximum of $3,000.
Hospital Inpatient Miscellaneous Expense: The expenses actually incurred are allowed not to exceed $3,000 as the result of any one Injury.
Surgical Expense: The expense actually incurred is allowed not to exceed the Usual and Customary Charge, or $2,500 in total for all surgical operation(s) performed for any one Injury.
Day Surgery Miscellaneous Expense: The expense actually incurred is allowed up to a maximum of $1,500 per covered Injury.
Ambulance Expense: The expense actually incurred is allowed not to exceed $300 for any one Injury.
Attending Physician's Expense: Inpatient, limited to one visit per day, paid at the Usual and Customary Charge, up to $45 per visit, to a $700 maximum. Outpatient, limited to one visit per day, paid at the Usual and Customary Charge, up to $80 per visit, to an $800 maximum.
Second surgical opinions will be covered up to the expense incurred subject to a maximum of $80.
Inpatient Registered Graduate Nurse Expense: The expense actually incurred is allowed subject to a maximum benefit of $50 per 24-hour period, or $800 maximum per Injury.
Outpatient Miscellaneous Expense: The expense actually incurred is allowed subject to a maximum $1,500 as the result of any one Injury. Diagnostic procedures deemed necessary by a physician, or nurse practitioner, are covered on the same basis as any other medical condition, regardless of the results.

Dental Expense: The Company will pay up to a maximum of $800 per injury for treatment to sound and natural teeth injured in a covered Injury.
Physiotherapy Benefit: Up to $60 per visit is allowed subject to a maximum of $300 for any one Injury.
Prescription Drug Expense: The expense actually incurred is allowed up to a maximum of $300 per year (combined with Sickness).
Anesthesia Expense: The expense actually incurred is allowed up to 40% of the surgeon's allowance.
Medical Consultation Expense: The expense actually incurred is allowed up to $80 per covered Injury.

ACCIDENTAL DEATH BENEFIT

$1,000 payable when Injury results in loss of life within 180 days of the accident.

ACCIDENTAL DISMEMBERMENT BENEFIT

$1,000 payable per the schedule shown in the Master Policy.

SICKNESS MEDICAL EXPENSE BENEFIT

Benefits are provided up to $3,000 for medical expenses incurred within 52 weeks of the date of the first medical treatment for a Sickness subject to the following:

Hospital Room and Board: The expense actually incurred is allowed not to exceed the semi-private rate per day up to a maximum of $3,000.
Hospital Inpatient Miscellaneous Expense: The expenses actually incurred are allowed not to exceed $3,000 as the result of any one Sickness.
Surgical Expense: The expense actually incurred is allowed not to exceed the Usual and Customary Charge, or $2,500 in total for all surgical operations performed for any one Sickness. (Note: Treatment of impacted wisdom teeth is covered on the same basis as any other medical condition.)
Day Surgery Miscellaneous Expense: The expense actually incurred is allowed up to a maximum of $1,500 per covered Sickness.
Ambulance Expense: The expense actually incurred is allowed not to exceed $300 for any one Sickness.
Attending Physician's Expense: Inpatient, limited to one visit per day, paid at the Usual and Customary Charge, up to $45 per visit, to a $700 maximum. Outpatient, limited to one visit per day, paid at the Usual and Customary Charge, up to $80 per visit.
Second surgical opinions will be covered up to the expense incurred subject to a maximum of $80.
Inpatient Registered Graduate Nurse Expense: The expense actually incurred is allowed subject to a maximum benefit of $50 per 24- hour period or $800 as the result of any one Sickness.
Outpatient Miscellaneous Expense: The expense actually incurred is allowed subject to a maximum $1,500 as the result of any one Sickness. Diagnostic procedures deemed necessary by a physician, or nurse practitioner, are covered on the same basis as any other medical condition, regardless of the results. Additionally, the removal of nonmalignant growths will be covered, when deemed Medically Necessary.
Prescription Drug Expense: The expense actually incurred is allowed up to a maximum of $300 per year (combined with Accident).
Anesthesia Expense: The expense actually incurred is allowed up to 40% of the surgeon's allowance.
Medical Consultation Expense: The expense actually incurred is allowed up to $80 per covered Sickness.

EXTENSION OF MAXIMUM BENEFIT

For Both Accident and Sickness

After the Company pays $3,000 in basic benefits under either the accident or sickness provision of the policy for any one accident or sickness, this policy will pay 80% of the expenses incurred in excess of $3,000 up to but not exceeding $47,000 for physician's services, hospital confinement, nursing services, X-Rays, operating room, emergency room, anesthesia, laboratory service, dressings, prescription medicines, casts, use of wheel chair, crutches, or ambulance for any one covered accident or sickness. Expenses must be incurred within two years from the date of accident or sickness.

DEFINITIONS

ELECTIVE SURGERY AND ELECTIVE TREATMENT means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under the Policy.

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; allergy and allergy vials, including allergy testing; bio-feedback type services; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy, except for mastectomy and reconstructive surgery performed as treatment for breast cancer, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under this Policy; deviated nasal septum, including submucous resection and/or other surgical correction; family planning; hair growth or removal; impotence, organic or otherwise; including any services or supplies rendered for the purpose or with the intent of inducing conception, except as mandated by state laws; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind), except for the treatment of an underlying covered Sickness; premarital examinations; preventive medicines, except where required for the treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing; smoking cessation; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under the Policy. A Covered Person must begin receiving services, supplies or initial treatment within 72 hours from the time of accident in order for it to be considered a covered

Injury. All Injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

SICKNESS means an illness, or disease, or trauma related disorder due to Injury which causes a loss while the Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Pregnancy and Complications of Pregnancy.

USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered and the MDR (Medical Data Research) schedule of fees valued at the 90th percentile.

STATE MANDATED HEALTH BENEFITS

The plan will pay for the following mandated benefits and any other applicable mandate in accordance with New Jersey insurance laws: Maternity Length of Stay, Mammography, Wellness Health Examinations, Reconstructive Breast Surgery, Diabetes Treatment, Alcoholism Treatment, Home Health Care, Wilm's Tumor, Blood Products and Blood Infusion Equipment, Dose-Intensive Chemotherapy Cancer Treatments, Prostate Cancer Screening, Treatment of Inherited Metabolic Diseases, Pap Smear Coverage, Audiology and Speech-Language Pathology, Certain Dental Services, Biologically-Based Mental Illness, Diagnosis and Treatment of Infertility Benefits, Colorectal Cancer Screening, Inpatient Coverage for Mastectomy, Off-Label Drugs, Prosthetics and Orthodics, Childhood Immunization Benefit, Lead Poisoning Screening Benefit, and Prescription Female Contraceptives.

LIMITATIONS AND EXCLUSIONS

Unless covered elsewhere in the Policy or as required by New Jersey mandated benefits laws, benefits will not be paid under the plan for expenses which result from:

1. Routine screenings or tests which are not Medically Necessary for the diagnosis or treatment of your condition or which are not specifically ordered by the admitting Physician, except as mandated by law and specifically provided under this Policy;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids (except for children ages 15 and under) or prescriptions or examinations except as required for repair caused by a covered Injury;
3. Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth; or in the course of treatment for impacted and/or infected wisdom teeth.
4. War or any act of war, declared or undeclared: (1) while the Covered Person is serving in the armed forces of any country; (2) while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization; or (3) while the Covered Person is not serving in any armed Force if the Injury or Sickness occurs outside the home area. A pro-rata premium will be refunded upon request for such period not covered;
5. Committing or attempting to commit an assault or felony; or fighting, except in self defense;
6. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate contest or competition sponsored by the school, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;
7. Injury resulting from racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
8. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
9. Elective Surgery or Elective Treatment;
10. Well baby care other than Hospital nursery and related Physician's charges for a newborn or care specifically provided under this Policy;
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law;
12. Organ transplants, except as specifically provided in this Policy;
13. Assistant surgeon fees;
14. Services and supplies not Medically Necessary for the diagnosis recommended by the attending Physician.

CLAIM PROVISIONS

NOTICE OF CLAIM We must be given written notice of claim within 60 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

PROOF OF LOSS Written proof must be sent to us within 90 days after the date of service. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason if it is shown that written proof of the loss was given as soon as reasonably possible, but in no event more than one year after the date of loss.

PAYMENT OF CLAIMS Claims for benefits provided by this Policy will be paid as soon as written proof is received.

All benefits are paid directly to the Insured, unless he directs us otherwise. If a benefit is unpaid at his death or if we feel he is not able to give a valid receipt for payment, we may pay an amount up to $1,000 to any relative by blood or marriage who we deem to be equitably entitled. Any payment we make in good faith will fully discharge us to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Insured examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS No legal action may be brought to recover against this Policy within 60 days after written proof of loss has been given. No such action will be

brought after three years from the time written proof of loss is required to be given.

If a time limit of the Policy is less than allowed by the laws of the state where the Insured lives, the limit is extended to meet the minimum time allowed by such law.

CLAIM PROCEDURE

1) In the event of a non-emergency Injury or Sickness, the student is encouraged to report immediately to the infirmary if at school.
2) In the event of a Medical Emergency, the student should go immediately to the nearest Hospital. Medical Emergency means the occurrence of a sudden, serious and unexpected Sickness or Injury which, in the absence of immediate medical attention, a reasonable person believes could result in: (1) Death; (2) Placement of the Insured's health in jeopardy; (3) Serious impairment of bodily functions; (4) Serious dysfunction of any body organ or part; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

CLAIM PROCEDURE

All claims must be submitted to Bollinger, Inc. within 90 days from the date of loss. Attach all available bills at that time. If they are not available send them in at a later date, properly identifying them with the name of the student and school. If away from school, obtain the appropriate form from the school, or Plan Administrator as soon as possible.

For Information Contact:

Bollinger, Inc.
101 JFK Parkway
Short Hills, NJ 07078-0727
1-866-267-0092

PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy on file at the school contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

RESOLUTION OF GRIEVANCES

EXECUTIVE SUMMARY

Monumental Life Insurance Company's ("Company" or "Our' or "Us" or "We") Utilization Review Program consists of retrospective review of claims to determine that the services, supplies, and treatments ("Services") received by the Covered Person were Medically Necessary. The Company does not require its Covered Persons to participate in a utilization review program that includes any form of pre-certification, pre-authorization or concurrent review.

The following definitions apply:
A **Grievance** means a written protest filed by a Covered Person or a health care provider on behalf of a Covered Person with the carrier through one of the carrier's internal Grievance processes.

Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of services for the Covered Person in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

The Covered Person will be notified in writing by us if a claim or any part of a claim is denied. This notice will include the specific reason or reasons for the denial.

If the Covered Person has a question or complaint about a claim denial, the Plan Administrator can be contacted at toll Free: 1-866-267-0092; or by mail to 101 JFK Parkway, Short Hills, NJ 07078 for further explanation to informally resolve the complaint. If the Covered Person is not satisfied with the explanation of why the claim was denied, the Covered Person or an authorized representative of the Covered Person or authorized provider may request an internal review of the claim denial. The manner in which the internal review is handled depends upon the basis of the claim denial. If the Company's denial was due to an exhaustion of benefits, a plan benefit provision, or some other non-Medically Necessary related reason, then the appeal is processed internally as a standard Grievance.

Claim denials for lack of Medical Necessity follow a different appeal track. If the Company's claim denial was due to or based upon a determination that the healthcare services or payment for healthcare services did not meet the requirements for coverage based on Medical Necessity, then the appeal will be processed internally as a First Stage Internal Appeal, and if requested, subsequently as a Second Stage Internal Appeal, and if requested, finally as an external Appeal with the Independent Health Care Appeals Program (IHCAP).

The following is our standard Grievance review process:

1) The Covered Person must request in writing a benefit review within 60 days after the date that he or she receives the notice denying the claim by a Claims Administrator.

2) A decision will be made within 30 days after the receipt of any request for review or the date all information required from the Insured is received.

3) If the Claims Administrator denies the claim submitted for review and the Insured is not satisfied with the explanation for the decision, the Insured may request a first-level Grievance review. The Covered Person is not required to attend the first level review.

STAGE 1 - FIRST STAGE APPEAL FOR DENIALS BASED UPON A MEDICAL NECESSITY DETERMINATION

The first level Grievance materials must be submitted by the Covered Person or his/her provider within 180 days following the receipt of an unfavorable Grievance decision. We will accept Grievances in writing, by mail or by electronic means. The Grievance process will be coordinated by:

Bollinger, Inc.
College Department Claims Manager
101 JFK Parkway
Short Hills, NJ 07078-0727
Toll Free: 1-866-267-0092
Facsimile: 1-973-921-2876
Web-site: www.BollingerInsurance.com

The first level review is an informal one and will be done by an individual or individuals who are knowledgeable about the matters at issue in the Grievance. A first level written decision will be issued to the Covered Person and, if applicable, the Insured's providers within 5 business days of the receipt of the request for a Grievance review.

Grievances shall be reviewed with the participation of an individual(s) who did not participate in any of our prior decisions related to the Grievance, and if the issue is a clinical one, at least one of whom shall be the Medical Director or physician with appropriate expertise to evaluate the matter. The written decision will include identification of the specific information considered and an explanation of the basis for the decision. If the Grievance decision is not resolved in the Covered Person's favor, the written notice of the determination shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice and shall at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) notify the Covered Person (or an authorized representative) of his or her right to request an external adverse decision review or second level Grievance review; and (3) a description of the procedure for submitting a second level Grievance.

STAGE 2 - SECOND STAGE APPEAL FOR DENIALS BASED UPON A MEDICAL NECESSITY DETERMINATION

1) A second level Grievance review is a formal process that is available through an independent party to the Covered Person or provider dissatisfied with the first level Grievance review decision. This second level review must be initiated within 180 days following receipt of an unfavorable first level Grievance decision.

2) Within 10 days of the receipt of the request for the second level review, we will provide the following information to the Covered Person:

   A. The name, address, and telephone number of the Grievance review coordinator;
   B. A statement of the Covered Person's rights, including the right to:
      1) Request and receive from us all information relevant to the case;
      2) Present his/her case to the review panel;
      3) Submit supporting material prior to and at the review meeting;
      4) Ask questions of any member of the panel;
      5) Be assisted or represented by a person of the Covered Person's choosing, including a family member, employer representative or attorney.

3) A second-level Grievance review panel will be convened for each request. The panel shall comprise of persons who were not previously involved in any matter giving rise to the second-level Grievance, are not our employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level Grievance involving a clinical issue shall be providers and/or other health care professionals who have not been involved with the case earlier, but who have the appropriate expertise about the particular condition and service at issue.

4) A written statement of the second level Grievance review panel's decision shall be issued to the Covered Person within 20 business days from the date of receipt of the second level Grievance request. If the Grievance decision does not change after the Second Level review, the Covered Person will be notified of his/her rights and the procedures for pursuing an external appeal with the Independent Health Care Appeals Program.

STAGE 3 - EXTERNAL APPEAL

The New Jersey Department of Banking and Insurance administers the Independent Health Care Appeals Program which is an external review program. The purpose of the appeals programs is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the Covered Person. The appeal review shall not include any decisions regarding benefits not covered by the Covered Person's health benefit plan. The decisions rendered through the Independent Health Care Appeals Program (IHCAP) are binding.

A Covered Person may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a Benefit if the Covered Person has already completed our internal appeals process and the Covered Person contests the final decision by us. The Covered Person shall apply to the department within 60 days of the date the final decision was issued by us, in a manner determined by the commissioner.

As part of the application, the Covered Person shall provide the department with:

1) processing fee of $25.00, except that the commissioner may reduce or waive the fee in the case of financial hardship;
2) A copy of the evidence of certificate of coverage or other evidence of coverage issued by us;
3) A brief description of the Covered Person’s medical condition for which benefits were denied, reduced or terminated;
4) A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and
5) A written consent to obtain any necessary medical records from the carrier and, in the case of a managed care plan, any other out-of-network physician the person may have consulted on the matter.

The form and fee should be submitted to:
Office of Managed Care
Consumer Protection Services
Department of Banking and Insurance
P.O. Box 325 Trenton, NJ 08625-0325

The New Jersey Department of Banking and Insurance is also available to assist consumers with insurance related problems and questions.

WHEN MAKING A CONSUMER COMPLAINT,
DIRECT INQUIRIES TO:
Office of Managed Care
Consumer Protection Services
Department of Banking and Insurance
P.O. Box 325
Trenton, New Jersey 08625-0325
In New Jersey 1-800-446-7467; or
1-888-393-1062; or fax [609-633-0807