July 1, 2011
Summary of Material Modifications
Toys"R"Us, Inc. Benefit Program

This document serves as a Summary of Material Modifications ("SMM") and supplements or modifies the information contained in the Toys"R"Us Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii. This SMM is adopted to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act") and shall be effective as of July 1, 2011 (the "Effective Date"). All other provisions of the SPD will remain unchanged. If there are any discrepancies between the information contained in this SMM and the official written Plan documents, the Plan documents will govern.

1. The following information modifies information in the Toys"R"Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii.

   Lifetime Dollar Limits

   Any lifetime dollar limit under the Plan shall not apply to any essential health benefit.

   Enrollment

   Team members and/or eligible dependents whose coverage was terminated when reaching a lifetime limit under the Plan are eligible to re-enroll in coverage. Team members may re-enroll in coverage during Annual Enrollment (April 21-May 23, 2011). Coverage for individuals who re-enroll due to reaching a lifetime dollar limit will be effective July 1, 2011.

2. The following information modifies information in the Toys"R"Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan and Aetna Indemnity Health Plan

   Annual Dollar Limits

   Any annual dollar limits under the Plan shall not apply to any essential health benefit.

3. The following information modifies information in the Toys"R"Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan and Aetna Indemnity Health Plan

   Prohibition on Pre-Existing Conditions for Children Under Age 19

   Pre-existing condition limitations under the Plan shall not apply to any covered individual under the age of 19.

4. The following information modifies information in the Toys"R"Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii Plans

   Rescission

   The Plan Administrator may rescind or void the coverage of an individual under the Plan only if (i) the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud or (ii) the individual (or person seeking coverage on behalf of the individual) makes an intentional misrepresentation of a material fact.

In the event of a rescission of coverage, the Plan Administrator will provide 30-days advance written notice of such rescission to each affected individual.

The term “rescission” shall mean a cancellation or discontinuance of coverage retroactively, but does not include a retroactive cancellation for non-payment of premiums.

5. The following information modifies information in the Toys“R”Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii Plans.

Extension of Dependent Coverage to Age 26

Definition of Child

Coverage for your adult children shall continue until such child attains age 26, regardless of the child’s financial dependency, tax dependency, marital status, residency with you or any other person, student status, or employment status. A child includes your natural child, your step child, an adopted child or an eligible foster child otherwise eligible for coverage under the Plan.

Special Enrollment

If your child was terminated from the Plan prior to July 1, 2011 due to failure to satisfy the dependent eligibility requirements under the Plan, but is now eligible under the Plan based on the revised definition above, then such child and his/her parent team member (if not already enrolled) may enroll adult children during Annual Enrollment (April 21-May 23, 2011). Coverage will become effective July 1, 2011. When you enroll an adult child in coverage, you will need to provide supporting documentation as required by the Plan Administrator such as a birth certificate, marriage certificate, or notice of guardianship/legal adoption to verify eligibility. If you do not submit adequate documentation within the required timeframe, coverage for the adult child will not become effective.

6. The following information modifies information in the Toys“R”Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii Plans

Preventive Services

In addition to any other preventive benefits described in the Plan, the Plan shall cover certain preventive services as required under the Affordable Care Act at 100% and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following preventive services:

Evidence-based preventive services

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (the “Task Force”) with respect to the individual involved, except that with respect to breast cancer screening, mammography, and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Prevention for Children

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: http://www.healthcare.gov/center/regulations/prevention/recommendation.html. For a paper copy, please contact the Plan Administrator.

7. The following information modifies information in the Toys"R"Us, Inc. Benefit Program Summary Plan Description dated 2009: Aetna Choice POS II Health Plan, Aetna Indemnity Health Plan, Kaiser HMO Hawaii Plans

Choice of Provider

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan carriers, Aetna or Kaiser Permanente, at:

Aetna 1-800-589-4811 www.aetna.com	or	Kaiser Permanente 1-808-432-5955 (HI) 1-800-966-5955 (HI – Neighbor Islands) http://my.kp.org/toysrus

If you need further assistance contacting Aetna or Kaiser Permanente for provider information, contact the Plan Administrator at:

Toys"R"Us, Inc. Attention: Benefits Department One Geoffrey Way Wayne, NJ 07470 1-973-617-3500	*and*	Toys"R"Us, Inc. Attention: Legal Department One Geoffrey Way Wayne, NJ 07470 1-973-617-3500

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the health plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan carriers, Aetna or Kaiser Permanente, at:

Aetna 1-800-589-4811 www.aetna.com	or	Kaiser Permanente 1-808-432-5955 (HI) 1-800-966-5955 (HI – Neighbor Islands) http://my.kp.org/toysrus

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8. The following information modifies information in the Toys“R”Us, Inc. Benefit Program Summary Plan Description dated 2009: Administrative and Legal Information

Internal Claims

The following claims and appeals procedure provisions shall apply to medical claims under the plan:

- An adverse benefit determination shall also include a rescission of coverage

- The plan shall notify a claimant as to its determination (whether adverse or not) of a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan.

- A claimant shall be permitted to review the claim file and to present evidence as part of the internal claims and appeals process. The claimant shall be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date in which the notice of final internal adverse benefit determination to give the claimant a reasonable opportunity to respond prior to such determination.

- The plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

- Notices to claimants will include:

    - Disclosure of information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount;

    - In the case of an internal adverse benefit determination, the reason or reasons for the determination and the denial code (and its corresponding meaning);

    - In the case of a notice of final internal adverse benefit determination, a discussion of the decision in the reason for denial; and

    - A description of the internal and external appeals review processes, including information regarding how to initiate an appeal.

9. The following information modifies information in the Toys“R”Us, Inc. Benefit Program Summary Plan Description dated 2009: Administrative and Legal Information

External Review Appeal

The following external review procedure applies only to the self-insured medical benefit options offered under the plan (alternate options may be available for insured benefits and HMO coverage). The plan’s external review process provides you the opportunity to have certain coverage denials reviewed by independent physician reviewers. A level-two appeal* is eligible for external review if the following are satisfied:

- The level-one and level-two appeals have been exhausted,
- The decision on appeal relates to a matter of medical judgment or rescission of coverage; and
- The appeal is made by you or your authorized representative within four months after the receipt of a notice of final claims denial (i.e., after your level-two appeal is denied)

If, upon the level-two appeal, the plan upholds the claim denial and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

Upon determination that your claim is eligible for external review, the plan will refer the claim to an independent review organization (IRO). After you have submitted all necessary information, the external review requests will be decided within 45 days from the date the IRO receives the request for external review.

* All references to “level-two appeal” shall be replaced with “level-one appeal” if the plan provides for only one level of appeal.

Expedited External Review

Expedited reviews are available if the decision relates to medical judgment and your physician certifies that a delay in service would jeopardize your life or health. Upon receipt of a request for expedited external review, the plan will immediately send a notice to you regarding claim eligibility. If your claim is eligible for external review, the plan will assign an IRO to review your claim. The IRO will provide notice of the external review decision no later than 72 hours after the IRO receives the request for an expedited external review.

You will not be charged a fee for external review. However, you are responsible for compiling and sending information that you wish to be reviewed by the IRO. If an IRO affirms your claim denial, you have a right to bring civil action under ERISA.

If you challenge the external review decision, a review by a court of law will be limited to the facts, evidence, and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in Federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived. Any suit for benefits must be filed within the applicable time period under the plan after the date the claims administrator has made a final denial of your claim.