Aetna Life Insurance Company
Summary of Coverage

Employer:	Toys"R"Us, Inc.
Group Policy:	GP-802234
SOC:	1A
Issue Date:	April 22, 2016
Effective Date:	July 1, 2016
Coverage Year:	July 1st to June 30th

The benefits shown in this *Summary of Coverage* are available for you and your eligible dependents.

Eligibility

Your employer determines the criteria that are used to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to your employment. **Aetna** will rely upon the representation of the employer as to your eligibility for coverage under this plan and as to any fact concerning such eligibility.

To be covered by this plan, the following requirements must be met:

- You will need to be in an eligible class, as defined below;
- You have reached your eligibility date; and
- You have completed any waiting period or probationary period required by the employer.

You are in an eligible class if you are a regular full-time or part-time employee, as defined by your employer.

Once you enter an eligible class, you will need to complete a probationary period, as defined by your employer, before your coverage under this plan begins.

You become eligible for the plan on your eligibility date, which is determined as follows,

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, and you had previously satisfied the plan's probationary period, your coverage eligibility date is the effective date of this plan. If you are in an eligible class on the effective date of this plan, but you have not yet satisfied the plan's probationary period, your coverage eligibility date is the date you complete the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your eligibility date is the date you enter the eligible class.

After the Effective Date of the Plan

If you are in an eligible class on the date of hire, your eligibility date is the date you complete the probationary period. If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you complete the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Dependents

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**.
- Your dependent children.
- Your domestic partner who meets the rules set by your employer.

As used throughout your *Booklet-Certificate*, "spouse" includes relationships entered outside of New Jersey that provide substantially all of the rights and benefits of marriage and are valid under the laws of the jurisdiction in which the civil union partnership was created.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

To be eligible, a dependent child must be under 31 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; and
- Any other child with whom you have a parent-child relationship.

Coverage for a Domestic Partner

To be eligible for coverage, a domestic partnership shall be established when all of the following requirements are met:

- Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:

    - a joint deed, mortgage agreement or lease;
    - a joint bank account;
    - designation of one of the persons as a primary beneficiary in the other person's will;
    - designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
    - joint ownership of a motor vehicle;

- Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
- Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
- Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
- Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- Both persons are at least 18 years of age;

- Both persons file jointly an Affidavit of Domestic Partnership; and
- Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with New Jersey law.

Keep in mind that you cannot receive coverage under the plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Enrollment Procedure

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions. Plan contributions are subject to change.

You will need to enroll within 31days of your eligibility date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period. If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.
Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on:

- The date you are eligible for coverage; and
- The first day of the month after you enroll.

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, then that dependent will not be able to participate in the plan until the next annual enrollment period.

Late Enrollee

A **late enrollee** is a person (including yourself) for whom you do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

Late Enrollee Enrollment Procedure

You may elect coverage for a **late enrollee** only during the annual late entrant enrollment period established by your Employer.

Coverage for a **late enrollee** will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the **late enrollee**.

Any preexisting condition limitation will apply to a **late enrollee**.

Exceptions

A person will not be considered to be a **late enrollee** if all of the following are met:

- you did not elect coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  - the person was covered under other **creditable coverage**; and
  - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
  - the person loses such coverage because:

    1. of termination of employment in a class eligible for such coverage;
    2. of reduction in hours of employment;
    3. your spouse/**civil union partner** dies;
    4. you and your spouse divorce or are legally separated;
    5. you and your **civil union partner** end the partnership;
    6. such coverage was COBRA continuation and such continuation was exhausted; or
    7. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If you are not considered a **late enrollee**, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a **late enrollee** if you did not elect, when the person was first eligible, coverage for:

- A spouse/**civil union partner** or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage or a new domestic partnership, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse /**civil union partner** and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse/**civil union partner**, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition; will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption because they may affect contributions. If you do not report the child within 31 days of his or her eligibility date, that child will not be able to participate in the plan until the next annual enrollment period.

Coverage for the child will become effective on the date the child is placed with you for adoption.

Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition; will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage.

Coverage for the child will become effective on the dates specified by your employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Facility Indemnity Coverage for You and Your Dependents

Your *Booklet-Certificate* spells out the Facility Indemnity Benefits. These benefits apply separately to each covered person.

This is an ERISA plan, and you have certain rights under this plan. Please contact your employer for additional information.

Benefits and Benefit Maximums

Read the coverage sections in your *Booklet-Certificate* for a complete description of benefits available.

Inpatient Indemnity Benefits

This Plan will pay Benefits as set forth below for each **stay**:

Per Initial Day of a Stay	$1,000
Maximum **Stays** per **Coverage Year**	1
Private or Semi-private Board and Room	
Daily Benefit for each day of a **Stay** after the initial day	$50
Maximum Days per **Coverage Year**	100

Adjustment Rule

If for any reason a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This *Summary of Coverage* replaces any *Summary of Coverage* previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this *Summary of Coverage* cannot be accepted.

The insurance described in this *Booklet-Certificate* will be provided under Aetna Life Insurance Company policy form GR-96172.

KEEP THIS SUMMARY OF COVERAGE

WITH YOUR BOOKLET-CERTIFICATE

Additional Information Provided by

Toys"R"Us, Inc.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your *Booklet-Certificate*. Your Plan Administrator has determined that this information together with the information contained in your *Booklet-Certificate* is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Toys"R"Us Employee Benefit Plan

Employer Identification Number:
22-3260693

Plan Number:
501

Type of Plan:
Hospital Indemnity Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
SVP, Tax CFO
Toys "R" Us, Inc
One Geoffrey Way
Wayne, NJ, 07470
Telephone Number: 973-617-3500

Agent For Service of Legal Process:
Toys "R" Us, Inc
One Geoffrey Way
Wayne, NJ, 07470

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
June 30th

Source of Contributions:
Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the SVP, Tax CFO.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.