benefits

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Benefits Glossary

- **Administrative Period (Health Care Reform):**
  The period running from May 1 through June 30, or with respect to a New Team Member, the period running from the day after the Initial Measurement Period through the last day of the month following the month in which the Team Member's anniversary of employment occurs. This time is used to determine full-time status and to offer team members the opportunity to enroll in benefits.
- **Affordable Care Act; health care reform law:**
  A law that was passed in March 2010 to improve access to affordable health insurance for many Americans.
- **After-tax basis:**
  You pay for these benefits with after-tax dollars that come out of your pay after all applicable taxes have been determined and withheld.
- **Anniversary year:**
  The 12-month period beginning on your date of hire.
- **Annual limit:**
  A maximum amount of money your health plan will pay for a particular service, or on the number of visits that the health plan will cover for a particular service in a given year. If you reach it, you must pay all health care costs for that particular service for the rest of the year.
- **Annual medical and prescription drug deductible for CDHP options:**
  The amount you must pay each plan year for medical and prescription drug expenses (except for preventive drugs) before the plan starts to pay a portion of your costs.

  If you are covering two or more people, combined expenses for all family members must meet the "two-person or family" deductible before the plan pays any part of your costs.
- **Annual out-of-pocket limit:**
  The out-of-pocket limit is the most you pay during the July 1 through June 30 plan year before your health plan begins to pay 100% of covered services (up to the plan's allowed amount). This generally includes copays, annual deductibles and coinsurance payments. This limit never includes your premium, charges from your health care providers that are above the health plan's allowed amount, or health care your health plan doesn't cover.

  In the Consumer Directed Health Plan options, all your eligible costs, including prescription drug expenses, count toward the out-of-pocket maximum. When you cover yourself plus members of your family, the combined out-of-pocket expenses for all family members count toward the "two-person or family" out-of-pocket maximum.

- **Beneficiary:**
  For insurance—The person or persons you designate to receive payment of your Life and Accidental Death and Dismemberment (AD&D) Insurance benefits. You can name anyone as your beneficiary, and you can change your choice at any time (unless you elect to assign your insurance—see the SPD (/contacts-tools-resources/spdlegal-notices/) for details). If you do not have a designated beneficiary at the time of your death, or if your beneficiary dies before you, your insurance will be paid in a lump sum to the survivors listed below in the following order of priority:
    - Spouse
    - Child(ren)
    - Parents
    - Siblings
    - Your estate

  For the "TRU"Plan—The person or persons you designate to receive your 401(k) Savings and Profit Sharing Accounts. You can name anyone you wish as beneficiary, and you can change your beneficiary designation at any time. However, if you are married you must have your spouse's written and notarized consent to name a beneficiary other than your spouse as the only primary beneficiary.
- **Benefits eligible:**
  The ability to enroll in a Toys"R"Us health plan if you are a regular management or full-time hourly team member with 30 days of service.
- **Calendar year:**
  The 12-month period beginning on January 1 and ending on December 31, used to determine annual dental plan benefit and regional HMO limitations (deductible and annual maximum benefit).
- **Coinsurance or cost sharing:**
  This is the portion of covered health care costs for which you are financially responsible. Depending on the plan you choose, you and the plan may share the costs for services. For example, the plan may pay 80% of the cost of a service and you would pay the remaining 20%. Coinsurance does not include deductibles or copays.
- **Company matching contribution:**

The amount that the Company contributes to a team member's "TRU"Plan 401(k) Savings Account, based on a proportion of the team member's pre-tax contributions. Company matching contributions are calculated using a predetermined formula that may change periodically.

- **Copay or copayment:**
  A set amount you pay out of pocket for a particular service. The plan pays the balance.

- **Cost-sharing discounts:**
  Financial help available to people who enroll for health coverage through the Health Insurance Marketplace and who qualify for the discounts based on their household income. These discounts lower costs for things like your deductible, and the portion of expenses you have to pay after you meet the deductible. These discounts generally are not available if you are eligible to enroll in a Toys"R"Us health plan.

- **Deductible:**
  The out-of-pocket amount you must pay each calendar or plan year before the plan pays for eligible benefits. The dental plan and regional HMO plans use a calendar year; the Aetna medical plans use a plan year. If you are in a Consumer Directed Health Plan option, see also Annual medical and prescription drug deductible for CDHP options (/contacts-tools-resources/benefits-glossary/a/annual-medical-and-prescription-drug-deductible-for-cdhp-options/).

- **Domestic partner:**
  Benefits are available to same-sex and opposite-sex domestic partners of benefits-eligible employees. The Company defines domestic partners as two people who have met all of the following criteria:

  - You are not so closely related that marriage would otherwise be prohibited
  - You are not legally married to any other person and are the sole partners of each other
  - You have lived together for at least one year (six months for determining eligibility for Basic and Supplemental Life and Accidental Death and Dismemberment Insurance) in the same residence with the intention of residing together permanently
  - You are both at least 18 years old and mentally competent to enter into a contract
  - You are in a committed and mutually exclusive relationship, jointly responsible for each other's welfare and financial obligations
  - You are registered as domestic partners pursuant to a domestic partnership ordinance or law of a state or local government, or you have filed an Affidavit of Domestic Partnership with the Company

- **Earned Hours Adjusted Service Date (EHASD):**
  Your EHASD is your original hire date. Or, if you left the Company for 90 days or longer and then came back, your EHASD is your last rehire date. Please note: If you were hired prior to February 1, 1990, and did not have a break in service, your EHASD is February 1 of the year in which you were hired.

- **Eligible dependents:**
  You may cover eligible dependents under some of TRU's plans, including medical, dental, vision and life insurance. Eligible dependents include:

  - Your spouse.*†
  - Your domestic partner.*
  - Your child or your spouse/domestic partner's child of any age who is solely dependent on you for support as a result of a mental or physical disability [including children who do not live with you but for whom the Company has received a Qualified Medical Child Support Order (QMSCO)]. To extend coverage for a disabled child, you must provide written proof of the disability to the Claims Administrator within 31 days of the child's 26th birthday and when requested thereafter.
  - Other eligible children up to age 26, as shown in the chart below.
  - When adding a dependent to coverage, you must provide proof of dependent eligibility and the dependent's Social Security Number within 31 days from adding your dependents. **Important**: If you fail to provide a valid SSN and required documentation for your dependent(s), coverage for any unverified dependents will be cancelled.

** As of July 1, there is a $25 per week ($1,300 per year) surcharge for spouses/domestic partners who have medical coverage available through their employer, but choose coverage through Toys"R"Us. If you fail to truthfully certify your spouse's/domestic partner's employment or coverage status, you could face disciplinary action, up to and including termination. The surcharge does not apply if: You do not enroll your spouse/domestic partner in Toys"R"Us medical coverage, your spouse/domestic partner is not employed or your spouse/domestic partner is not eligible for medical coverage from his/her employer.*

† As a result of the 2013 Supreme Court ruling that called the Defense of Marriage Act (DOMA) unlawful, same-sex married couples are now entitled to pre-tax health benefits. Previously, the value of this benefit was treated as imputed income for domestic partners. If you currently cover a same-sex spouse, that coverage will be provided on a pre-tax basis. If you live in a state that doesn't recognize same-sex marriage, the coverage will still be considered imputed income for state tax purposes only. Please note this option is not available for opposite-sex domestic partners.

PLAN	WHO'S ELIGIBLE
Medical and Prescription Drug	You and your spouse's biological child, legally adopted child or eligible foster child up to age 26, or your domestic partner's child up to age 26. Please note: The adult child up to age 26 does not need to be a full-time student, be financially dependent on you or live with you to be eligible for coverage. The child may be married; however, his/her spouse and children are not eligible for coverage.
Dental, Vision, and Child Life	You, your spouse's or your domestic partner's unmarried dependents up to age 23. The child doesn't have to be a full-time student or be financially dependent on you to be eligible for coverage.

Detailed information about eligibility requirements for you and your dependents is included in the Eligibility and Enrollment SPD (/contacts-tools-resources/spdlegal-notices/) and Summary of Material Modifications (SMM) (/contacts-tools-resources/spdlegal-notices/#SMM).

- **Emergency:**
  A serious medical condition or symptom resulting from injury or illness that arises suddenly and requires immediate care and treatment to avoid endangering life or health.

- **Essential health benefits:**
  These are a set of services that must be covered by certain health plans. These services include:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care (for example, when a pediatrician examines a child's teeth and gums and does an in-office eye chart test)

  All health insurance plans offered through the Health Insurance Marketplace must cover these services. State Medicaid plans must cover them too. The Toys"R"Us health plan covers most of these benefits as well.

  In addition, health plans cannot put a lifetime or annual dollar limit on benefits that are available for these services. The Toys"R"Us health plan does not include lifetime or annual dollar limits on these benefits.

- **Evidence of Insurability (EOI):**
  This is sometimes called "proof of good health" and is used to qualify for certain amounts of life insurance. You will need to complete an Evidence of Insurability form in the following situations before coverage will go into effect.

  EOI will also be required if:
  - During Annual Enrollment or following a qualifying life event you request a coverage increase of:
    - Supplemental Life Insurance—more than one multiple of earnings
    - Spouse Life Insurance—more than one level (any increase over $10,000)
  - You are enrolling as a newly eligible team member:
    - Supplemental Life Insurance—you elect or increase your coverage exceeding the lesser of three times your annual earnings or $750,000
    - Spouse Life Insurance—you enroll in coverage above $25,000

  If EOI is required, you will be notified and receive instructions on how to submit the necessary documents.

- **Federal Poverty Level (FPL):**
  The FPL is a measure of income level issued annually by the Department of Health and Human Services. It matters because the government uses it to make decisions about your eligibility for certain programs and benefits that are available as a result of the health care reform law. The 2016 Poverty Guidelines can be located at:http://aspe.hhs.gov/poverty/13poverty.cfm (http://aspe.hhs.gov/poverty/13poverty.cfm)

- **Formulary brand name drug:**
  Your prescription drug cost depends on the class or group of your prescribed medication. A formulary brand name drug may have a lower copay than a nonformulary brand name drug because it has been identified by the plan as more cost-effective. You can find out how different drugs are classified by your plan by visiting the plan's website.

- **Generic drug:**
  Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand name only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand name drugs; however, they are much less expensive.

- **Health insurance marketplace/Affordable insurance exchanges:**
  This is a service set up in each state where individuals and small businesses can buy health coverage. The Health Insurance Marketplaces will offer a choice of health plans that provide different levels of benefits and that have different costs.

- **Health Savings Account:**
  After enrolling in a Consumer Directed Health Plan, you have access to a health savings account (HSA). With the HSA, you save pre-tax dollars and can roll over your balance from year to year to earn tax-free interest. The Company contributes to your HSA too, depending on which medical option and level of coverage you elect when your HSA is opened, and if you complete the wellness requirements. You can spend your money for eligible health care expenses when you need it—in an emergency, when money is tight or in retirement. With an HSA, you're in control of your health care costs.

- **Highly paid team member (for Dependent Care FSA only):**
  Anyone whose total earnings exceed the IRS compensation limit ($115,000 for 2016).

- **Imputed income:**
  Company-provided group term life insurance in excess of $50,000 for team members is considered by the Internal Revenue Service (IRS) to be a benefit that is taxable as income.

  Section 79 of the Internal Revenue Code (IRC) requires employers to calculate taxable income for employees that receive more than $50,000 in term life coverage, which must be reported on the employee's W-2 form.

  This means that team members who are covered by an Company-provided benefit of more than $50,000 must pay taxes for the "value" of the excess benefits. For example, a team member has $78,000 of group term life insurance coverage paid for by the Company. The Company would need to determine the value of the benefit to the team member. In this example, the excess coverage is $28,000 ($78,000 minus $50,000). The premium paid by the Company for the excess coverage, less any after-tax payment the team member contributes toward the coverage, is the "value" of the excess benefits that must be included in the taxable compensation for the team member each year.

- **Individual mandate:**
  The rule under the health care reform law that says you must have health insurance that meets basic minimum standards by January 1, 2014. If not, a tax penalty may apply. If you are enrolled in a Toys"R"Us health plan*, Medicaid, or Medicare then you meet the requirements of the individual mandate rule. For more information, you can refer to the definitions of Minimum Essential Coverage and Tax Penalty included in this document.

- **Initial Measurement Period (Health Care Reform):**
  The 12-month period beginning the 1st of the month coincident with or next following a team member's date of hire over which hours will be averaged for Newly Hired Team Members who are Variable Hour Team Members.

- **Initial Stability Period (Health Care Reform):**
  The 12-month period beginning on the first day of the month following the Administrative Period associated with the Initial Measurement Period.

- **In-network provider (preferred provider):**
  A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher level of benefits when you use in-network providers. Check with your plan for coverage details.

- **Job-based coverage:**
  This is health insurance that is offered to an employee (and often to his or her family) by his/her employer.

- **Maintenance drug:**
  Medication that is taken regularly to treat a chronic condition, such as asthma, arthritis or high blood pressure.

- **Medicaid:**
  This is a state-run health insurance program for low-income adults, families and children, pregnant women, the elderly, people with disabilities, and in some states, others who qualify. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States decide how they design their programs, so Medicaid (and what it is called) varies state by state. The health care reform law expands Medicaid eligibility in many states.

- **Medicare:**
  This is a federal system of health insurance for people age 65 or older and for certain younger people with disabilities or end-stage renal disease (ESRD).

- **Minimum essential coverage:**
  This is the type of coverage an individual needs to comply with the individual mandate under the Affordable Care Act. You can get it from individual market policies, job-based coverage (including a Toys"R"Us health plan), Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

- **Negotiated rates:**
  The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than usual, reasonable and customary (R&C) charges.

- **Nonformulary brand name drug:**
  Your prescription drug cost depends on the class or group of your prescribed medication. A nonformulary brand name drug generally has the highest cost because it is not on the plan's list of preferred drugs, and often has an equally effective generic or brand name drug on the formulary. You can find out how different drugs are classified by your plan by visiting the plan's website.

- **Not benefits eligible:**
  A part-time hourly team member (unless ESR hours requirement is met); or a seasonal team member; or a regular management or full-time hourly team member who is in their 30-day waiting period; is not benefits eligible.

- **Out-of-network provider:**

A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. Keep in mind, some plans do not cover care provided by out-of-network providers, so be sure to see your plan summary for coverage details.

- **Out-of-pocket costs:**
  These are your expenses for medical care that aren't reimbursed by your health plan. They include deductibles, co-insurance and co-pays for covered services, plus all costs for services that aren't covered.

- **Out-of-pocket limit (OOP):**
  The out-of-pocket limit is the most you pay during the July 1 through June 30 plan year before your health plan begins to pay 100% of covered services (up to the plan's allowed amount). This generally includes co-pays, annual deductibles and co-insurance payments. This limit never includes your premium, charges from your health care providers that are above the health plan's allowed amount, or health care your health plan doesn't cover.

  In the Consumer Directed Health Plan options, all your eligible costs, including prescription drug expenses, count toward the out-of-pocket maximum. When you cover yourself plus members of your family, the combined out-of-pocket expenses for all family members count toward the "two-person or family" out-of-pocket maximum.

- **Plan year:**
  This is the legal and reporting period for a benefit plan. For:

  - Medical (including prescription drugs), dental, vision, Flexible Spending Accounts (FSAs), Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance, Spouse Life Insurance, Child Life Insurance, Long-Term Disability (LTD) and the Employee Assistance Program (EAP), the plan year is July 1 through the following June 30.
  - "TRU" Partnership Employees' Savings and Profit Sharing Plan ("TRU"Plan), the plan year is the 12-month period beginning on January 1 and ending on December 31.

  The dental plan uses the calendar year to determine your deductible and out-of-pocket maximums.

- **Policy year:**
  The 12-month period beginning on July 1 and ending on June 30 of the following year for which benefit elections are effective for medical (including prescription drugs), dental, vision, Flexible Spending Accounts (FSAs), Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance, Spouse Life Insurance, Child Life Insurance, Long-Term Disability (LTD), Supplemental LTD and the Employee Assistance Program (EAP). The policy year is the plan year. Does not apply to the "TRU"Plan.

  You cannot change coverage in any of the benefit plans during this period unless you have a qualifying life event.

- **Preexisting condition:**
  An injury or disease for which a person received treatment or services, or took prescribed drugs or medication, within the 30 day period before his or her Toys"R"Us, Inc. coverage began. Pregnancy is not considered a preexisting condition.

- **Premium:**
  This is the amount that must be paid for your health insurance. If you get your coverage through Toys"R"Us, you and the company share the cost, and you pay your portion of the premium through paycheck deductions. If you get your coverage from the Health Insurance Marketplace in your state, you pay the total premium cost, and payments are usually due monthly.

- **Pre-tax basis:**
  You pay for these benefits with pre-tax dollars that come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers your taxable income thereby lowering the actual cost to you.

- **Preventive care:**
  Routine services like screenings, check-ups, and patient counseling that help prevent illnesses, disease, or other health problems. Under the Affordable Care Act, you and your family may be eligible for some of these services at no cost to you. Whether you get your coverage through Toys"R"Us or from another source like the Health Insurance Marketplace, your health plan will pay 100% of the cost for many preventive care services. Refer to your plan's SPD (/contacts-tools-resources/spdlegal-notices/) and SMMs (/contacts-tools-resources/spdlegal-notices/#SMM) for specific covered preventive care services.

- **Primary Care Physician (PCP):**
  A doctor you select to provide and coordinate your ongoing health care.

- **Prior authorization:**
  Your doctor must request prior authorization before certain hospital admissions and surgeries, as well as when prescribing certain types of drugs (growth hormones, weight loss medications, etc.). If you get a prescription for a medication on the prior authorization list and your doctor or pharmacist does not obtain prior authorization, the prescription drug will not be covered. In addition, there are certain medications that may have quantity limits to ensure that you are receiving the proper dose. Likewise, if a hospital admission or surgery is subject to prior authorization and none was obtained, you will be subject to a prior authorization penalty or, in some cases, your costs may not be covered by the plan.

  You can find a list of the hospital admissions, surgeries or drugs requiring prior authorization and/or which are subject to quantity standards by contacting your plan (/contacts-tools-resources/contacts/).

- **Proof of coverage:**
  A pre-existing conditions clause applies to some medical plans. (See your medical plan SPD (/contacts-tools-resources/spdlegal-notices/)and SMMs to find out if this applies to you.) Creditable coverage under another group health plan would reduce your pre-existing conditions exclusion period. If you are a new hire or a new participant in the plan, you may receive a request for proof of coverage or a certificate of creditable coverage. This is a document from your previous medical plan carrier providing information regarding your length of coverage under the previous plan.

- **Public exchanges:**
  (See Health insurance marketplace (/contacts-tools-resources/benefits-glossary/h/health-insurance-marketplaceaffordable-insurance-exchanges/))
- **Qualifying life event:**
  If you experience a qualifying life event, you may be allowed to make certain changes to your benefit elections outside of the Annual Enrollment period. You may make changes to your coverage when you have a qualifying life event; however, you must do so within 31 days of the event.

  Eligible events include:

  - A change in your legal marital status or domestic partner status*
  - The birth or adoption of a child
  - A dependent's loss of eligibility (because he/she reaches the age limit for coverage, for example)
  - Death of a dependent
  - A change in your spouse's or domestic partner's eligibility for coverage
  - A change in your employment status that affects your eligibility for coverage (e.g., seasonal to regular; part-time hourly to full-time; or full-time to part-time hourly)
  - A change in your address or work location that affects the plans that are available to you

  ***IMPORTANT:** Note that domestic partners generally are not eligible for any pre-tax benefits under federal tax law. However, after-tax elections to add or drop benefit coverage for a domestic partner are made in accordance with these qualifying life event rules, subject to any restrictions placed on mid-year election changes by an insurer.*
- **Reasonable and customary (R&C):**
  The reasonable and customary fee is the average or commonly charged fee for the particular service within a geographic area or zip code. Aetna determines the R&C rates for all out-of-network services offered and considers the R&C charge only when calculating your portion of the cost. You pay all amounts over R&C charges. Also, charges in excess of the reasonable and customary charge do not count toward the deductible or out-of-pocket maximums. If you receive out-of-network care, reasonable and customary fees are an important consideration. R&C does not apply to in-network services.
- **Required mail services:**
  Prescriptions for maintenance drugs (/contacts-tools-resources/benefits-glossary/m/maintenance-drug/) CVS Caremark will cover the initial fill and one prescription refill for a maintenance drug obtained at any of CVS Caremark's 62,000+ retail network pharmacies (up to 30-day supply). After the first refill (second fill), you must use either CVS Caremark Mail Service or one of 7,000 CVS/Pharmacy locations (Maintenance Choice program—ask your CVS/Pharmacy about this option) to fill 90 day supplies of the maintenance medication, or you will have to pay the full cost of the 30-day prescription at a retail network pharmacy.
- **Spouse:**
  The individual to whom you are legally married according to civil law in your state of residence (including a common-law spouse if recognized by state law in your state of residence), as limited by federal law. As a result of the 2013 Supreme Court ruling that called the Defense of Marriage Act (DOMA) unlawful, same-sex married couples are now entitled to pre-tax health benefits. Previously, the value of this benefit was treated as imputed income for domestic partners. If you currently cover a same-sex spouse, that coverage will be provided on a pre-tax basis. If you live in a state that doesn't recognize same-sex marriage, the coverage will still be considered imputed income for state tax purposes only. Please note this option is not available for opposite-sex domestic partners.
- **Standard Measurement Period (Health Care Reform):**
  The period beginning on May 1 and ending on April 30 of the following year during which Hours of Service will be averaged for Ongoing Team Members.
- **Standard Stability Period (Health Care Reform):**
  The 12-month period beginning each July 1 and ending the following June 30.
- **Step therapy:**
  The step therapy program applies to individuals enrolled in an Aetna medical plan option who take medication for a chronic condition such as asthma, arthritis or high blood pressure. In general, first step medications are generic formulary drugs. If you try the first step and you and your doctor are not satisfied with the results, or your doctor decides that you need a different medication for medical reasons, then you would move to the next step. Medications that are prescribed after the first step are typically brand name drugs and have a higher copay. If your doctor prescribes one of these drugs, your pharmacist should contact your doctor to begin the step therapy process. For more information and the list of drugs that require step therapy, contact your plan (/contacts-tools-resources/contacts/).
- **Subsidy (or Premium tax credit):**
  This is a form of financial assistance provided by the federal government. Under the health care reform law, those who qualify can receive this assistance in the form of a premium tax credit or cost-sharing discount when purchasing health insurance through a Health Insurance Marketplace. You qualify based on your household income. To learn more about the subsidy and to find out if you qualify, visit www.healthcare.gov (http://www.healthcare.gov/).
- **Tax filing threshold:**
  An individual whose income is below the tax filing threshold is exempt from having to pay a tax penalty. Beginning on January 1, 2014, the tax filing threshold is $10,250 for individuals and $20,500 for married couples under age 65.
- **Team member:**
  An individual who is considered an employee of the Company for purposes of federal income tax withholding.
- **Tobacco-Free Pledge:**
  When enrolling in benefits, and during each Annual Enrollment, team members can indicate whether or not they use tobacco and, if not, their premiums will be reduced. This pledge/premium reduction is not available to Hawaii team members. You can only confirm the pledge when you first enroll in benefits or during Annual Enrollment and have been tobacco free for at least six months and promise to remain so for the plan year.

By electing "No" for being a Tobacco User, you are certifying that you have not used tobacco products, which include cigarettes, cigars, and chewing tobacco, in the last six months, and pledge not to use tobacco products for the next year. Certifying you are not a tobacco user qualifies you for the Tobacco-Free Discount.

- To qualify for the discount, you and your covered dependents (if applicable) must be tobacco-free. You must elect "No" on behalf of your covered dependents (if applicable) during Annual Enrollment or upon your initial enrollment into benefits.
- The medical rate shown during enrollment and on your confirmation statement will reflect the Tobacco-Free discount.

Any team member who knowingly makes a false election regarding tobacco usage may be subject to disciplinary action up to and including termination of employment.

- **Vested:**
  When, through years of service for the Company, you earn the right to your “TRU”Plan accounts. The vesting rules are different for the 401(k) Savings Account and the Profit Sharing Account.