2016-2017 Employee Benefits

Fox Associates, L.L.C., Metropolitan Tickets, Inc. and Fox Theatricals, LLC

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the plan documents shall govern.

2016-2017 Benefits Guide

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CONTACT INFORMATION

Contact Information

Vendors	Phone Number	Website
Cigna *(Base Medical Plan)* Group Number:	800.244-6224	mycigna.com
Cigna *(Buy Up Medical Plan)* Group Number:	800.244-6224	mycigna.com
Humana Dental (Dental) Group Number:	888.371.9538	myhumana.com
United Healthcare (Vision) Group Number: 7R3554 & 534522	800.432.4966	myuhcvision.com
UNUM *(Life/AD&D)* Group Number: 206913	800.421.0344	unum.com
UNUM *(Voluntary Life/AD&D)* Group Number: 206913	800.421.0344	unum.com
UNUM *(Voluntary LTD)* Group Number: 206912	800.421.0344	unum.com
UNUM *(Long Term Care)* Group Number: 226550	800.421.0344	unum.com
H&H Health Associates *(EAP)*	314.845.8302 800.832.8302	hhhealthassociates.com
Aflac	800.99-Aflac	aflac.com
CBIZ *(FSA)*	800.815.3023, press 4	myplans.cbiz.com
CBIZ *(COBRA Services)*	800.815.3023, press 6	enroll.cbiz.com

Benefits Team	Phone	Email
Consultant Sara R. Miller Tina Borge	314.692.2249 800.844.4510	samiller@cbiz.com tborge@cbiz.com

ENROLLING IN THE PLANS

ENROLLING IN THE PLANS IS FAST AND EASY - HERE'S HOW:

- Read your materials and make sure you understand all of the options available.
- Log in to **secure.ipsonline.net/ta/foxa.login** using your *Username* and *Password* by the date provided by HR.
- Select *My Account* from the top ribbon, then select *My Benefits*. Select *Review/Select* benefits, then select *Life Change Event* on the bottom ribbon. Select *Newly Eligible* and enter your hire date.
- Review each tab carefully, make your benefit selections, and provide requested information as required on each tab.
- Review and confirm your elections and information on the last tab. If accurate, click *Submit Request*. You will be asked to sign electronically by entering your password.
- Print your confirmation statement for your records.

For help with completing the information, or if you have any questions regarding the benefits offered, please contact the Human Resources Department.

IMPORTANT NOTE:

It is very important that you complete your enrollment by the due date provided by HR. If you do not complete your enrollment by that date, you will, by default, be enrolled in last year's plan.

ELIGIBILITY

Joining the Plan:

If you are a new hire, you will become eligible for coverage the first of the month following 60 days of full time employment. This will be the date on which your coverage becomes effective.

You may submit your enrollment forms/applications and complete enrollment anytime before this date, but you must complete the enrollment process within 30 days of the effective date. If you do not submit your enrollment information within 30 days after your effective date you will need to wait until the next annual open enrollment to make your benefit elections.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Legally married spouse / Domestic Partner
- Natural or adopted children under 26 years old
- Children under your legal guardianship
- Your stepchildren
- Children under a qualified medical child support order
- Disabled children 26 years or older

Ineligible:

- Divorced or legally separated spouse
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

DOMESTIC PARTNER COVERAGE

Fox Associates, L.L.C., Metropolitan Tickets, Inc. and Fox Theatricals, LLC offers coverage for Domestic Partners in our medical, dental, vision, and voluntary life plans. Domestic Partners include both same-sex and opposite sex partners. The Company has adopted a policy for eligibility. The official policy will be provided to you upon submitting a request to Christal Rogers at (314) 657-5038, however, a **brief summary** of the eligibility requirements are:

Both partners have registered and provide proof of such registration of domestic partnership. If domestic partner registration is not obtained, the employee and domestic partner must complete, sign, and notarize a Declaration of Domestic Partnership, and attest to **all** the following:

1. Reside together in the same residence for 6 consecutive months, and intend to do so indefinitely.
2. Each partner is at least 18 years of age, and mentally competent to consent to the declaration.
3. Not related by blood or marriage to a degree of closeness that would prohibit legal marriage.
4. Both employee and domestic partner are jointly financially responsible for basic living expenses such as food and shelter.
5. Neither person has a different domestic partner now nor has neither person had a different domestic partner within the last 6 months.
6. Neither person is currently legally married to or legally separated from anyone else.

In addition to all of the above, at least **two** of the following criteria must be maintained at all times:

1. Execution of domestic partnership agreement.
2. Employee has named his/her domestic partner as a beneficiary under his/her will or the domestic partner has named the employee as a beneficiary under his/her will.
3. Employee has granted his/her domestic partner powers under a durable power of attorney, or the domestic partner has granted the employee powers under a durable power of attorney.
4. Employee has named his/her domestic partner as beneficiary on his/her life insurance policy, or the domestic partner has named the employee as a beneficiary on his/her life insurance policy.
5. The partners have a joint bank account.
6. The partners are co-signers of a lease or deed.
7. The partners are named on the same car insurance policy.

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the open enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 30 days of the qualifying event or you will have to wait until the next annual open enrollment period.

EXAMPLES OF QUALIFYING EVENTS?

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

HOW OFTEN ARE BENEFIT DEDUCTIONS TAKEN FROM MY PAYCHECK?

Payroll deductions will be based on 26 pay periods.

PRE-NOTIFICATION INFORMATION

Cigna will require notification before you receive certain covered health services. In general, Network providers are responsible for notifying Cigna before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying Cigna and as a rule Cigna should be notified of all Out-of-Network services. Services for which you must provide pre-service notification are identified in the Schedule of Benefits within each Covered Health Service Category.

CIGNA PROVIDERS

With Cigna's Find a Doctor online tool, it's simple to look for medical providers in your area.

1. Go to cigna.com
2. At the top, right of the page, select Find a Doctor.
3. Choose "For plans that are offered through work."
4. Choose a provider type.
5. Enter your zip code.
6. Select your plan—Open Access Plus.
7. Hit Search.

Once you are a Cigna member, you can find a participating provider by using mycigna.com.

OUT OF NETWORK PROVIDERS

Even if a hospital, ambulatory surgery center or other facility contracts with Cigna and belongs to the Cigna network, the facility may have physicians and other health care professionals providing services at their facility that do not participate in the network.

When you get medical care from these facility-based physicians—anesthesiologists, emergency room physicians, radiologists and pathologists—the amount you pay (your out of pocket expenses) - may be higher. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan.

MEDICAL INSURANCE - Open Access Plus - Base

Benefit Plan	Base Plan In-Network	Base Plan Out-of-Network
Deductible (calendar year)		
Single	$3,000	$9,000
Family	$6,000	$18,000
Coinsurance (plan pays/you pay)		
	100% / 0%	70% / 30%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,250	$12,500
Family	$12,500	$25,000
Copayments		
Primary Physician Visit	$25 co-pay	Deductible, then you pay 30%
Specialist Physician Visit	$70 co-pay	Deductible, then you pay 30%
Preventive Care	Plan pays 100%	Deductible, then you pay 30%
Major Diagnostic Lab	100% after deductible	Deductible, then you pay 30%
Hospital—Inpatient Stay	100% after deductible	Deductible, then you pay 30%
Hospital—Outpatient Surgery	100% after deductible	Deductible, then you pay 30%
Emergency Room Visit	$300 co-pay	$300 co-pay
Urgent Care Center Visit	$100 co-pay	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy	$10/30/50	Plan Pays 40% / You Pay 60%
Mail Order Pharmacy- 90-Day	$20/80/140	

2016-2017 Employee Base Plan Medical Contributions

Employee Cost	Monthly Cost	Per Paycheck
Employee	$0.00	$0.00
Employee & Spouse	$435.10	$200.82
Employee & Child(ren)	$312.64	$144.30
Employee & Family	$667.11	$307.90

MEDICAL INSURANCE - Open Access Plus Buy Up Plan

Benefit Plan	High Plan In-Network	High Plan Out-of-Network
Deductible (calendar year)		
Single	$500	$1,500
Family	$1,000	$3,000
Coinsurance (plan pays/you pay)		
	100% / 0%	70% / 30%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,250	$12,500
Family	$12,500	$25,000
Copayments		
Primary Physician Visit	$25 co-pay	Deductible, then you pay 30%
Specialist Physician Visit	$70 co-pay	Deductible, then you pay 30%
Preventive Care	Plan pays 100%	Deductible, then you pay 30%
Major Diagnostic Lab	100% no deductible	Deductible, then you pay 30%
Hospital—Inpatient Stay	100% after deductible	$500 per admission deductible, then Medical Plan Deductible, then you pay 30%
Hospital—Outpatient Surgery	100% after deductible	$500 per admission deductible, then Medical Plan Deductible, then you pay 30%
Emergency Room Visit	$300 co-pay	$300 co-pay
Urgent Care Center Visit	$100 co-pay	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy	$10/30/50	Plan Pays 40% / You Pay 60%
Mail Order Pharmacy - 90-Day Supply	$20/80/140	

2016-2017 Employee Buy Up Medical Contributions

Employee Cost	Monthly Cost	Per Paycheck
Employee	$96.15	$44.38
Employee & Spouse	$550.51	$254.08
Employee & Child(ren)	$436.90	$201.65
Employee & Family	$988.11	$456.05

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Cigna and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by The FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- **Better alternatives that may cost you less**
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for the Company and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Cigna. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov.

WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (co-payment, coinsurance or deductible), when delivered by in network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in network pharmacy.

DENTAL INSURANCE

Humana Dental

Benefit/Service	In-Network	Out-of-Network Benefit
Preventive	100%	100%
Basic	90%	80%
Major	60%	50%
Deductibles & Maximums		
Deductible Individual *	$50	$50
Deductible Family *	$150	$150
Annual Maximum Per Person	$1,000**	

* Does not apply to preventive services.

** After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)

In-Network Services

If you utilize the In-Network providers, you will receive the advantage of contracted fees negotiated between Humana and the dentist.

Out-of-Network Services

If you elect a non-participating dentist, benefits are paid based on Humana's maximum plan allowance. You may experience balance billing and higher out of pocket expenses.

2016-2017 Employee Dental Contributions

Dental Employee Cost	Monthly Cost	Per Paycheck Cost
Employee	$0.00	$0.00
Employee & Spouse	$13.84	$6.39
Employee & Child(ren)	$28.25	$13.04
Employee & Family	$54.45	$25.13

Make Regular Dental Visits a Priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke. Your Humana Dental PPO plan focuses on prevention and early diagnosis, providing four exams and cleaning every calendar year: two regular and two periodontal.

Go to MyDental IQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

VISION INSURANCE

UHC Voluntary Vision

Benefit/Service	In-Network Benefit	Out-of-Network Benefit
Examination	$10 Co-pay	$40 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses:	$25 Co-pay then:	Reimbursement:
Single	100%	$40
Bifocal	100%	$60
Trifocal	100%	$80
Frames	Covered 100% up to $150 Retail Allowance	$45
Contacts:		Reimbursement
Necessary	Covered at 100%	$210
Cosmetic	$150 Allowance	$150

United Healthcare Vision offers its vision program through a national network including both private practice and retail chain providers.

Always identify yourself as a United Healthcare Vision customer when making your appointment. This will assist your provider in obtaining a claim authorization before your visit.

Your participating provider will help you determine which contact lenses are available in the United Healthcare Vision selection.

To access the Provider Locator service, visit their web site at myuhcvision.com and use the Provider Quick Search feature or call (800) 839-3242, 24 hours a day, seven days a week.

2016-2017 Employee Vision Contributions

Vision Employee Cost	Monthly	Per Paycheck
Employee	$0.00	$0.00
Employee & Spouse	$7.43	$3.43
Employee & Child(ren)	$9.93	$4.58
Employee & Family	$17.84	$8.23

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

This benefit is paid by the Company for all benefit eligible employees. It is administered through UNUM. In the event of your death, your beneficiary will receive $50,000. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit. Benefit reductions apply upon attaining certain age levels.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Your voluntary life/AD&D is administered through UNUM. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children. You may purchase voluntary AD&D coverage for yourself regardless of whether or not you purchase voluntary life coverage.

VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month)	
Age Band	**Employee/Spouse Rate per $1,000***
Under 30	$0.081
30-34	$0.093
35-39	$0.136
40-44	$0.209
45-49	$0.336
50-54	$0.553
55-59	$0.879
60-64	$1.169
65-69	$1.857
70-74	$3.250
75+	$5.768
EE Vol. AD&D	$0.020/$1,000
Child Life	$0.082/$1,000

***Benefit reductions apply at certain age brackets**

Employees can purchase up to 5 times salary, not to exceed $500,000 of coverage, in $1,000 increments with a minimum of $10,000. The Guarantee Issue amount for newly eligible employees is $100,000.

Spousal/Domestic Partner coverage is available in $1,000 increments not to exceed 100% of the employee amount up to a maximum of $500,000. There is a $5,000 minimum. The Guarantee Issue amount for newly eligible spouses is $30,000. Coverage is available for children from birth to 6 months in the amount of $1,000. Children age 6 months up to age 19, or 26 if a full-time student, can purchase coverage in $2,000 increments up to a $10,000 maximum.

Voluntary AD&D coverage is only available for the employee. Coverage can be purchased up to 5 times salary, not to exceed $500,000, in $10,000 increments. Voluntary AD&D coverage is not available for the spouse or child(ren). All amounts of AD&D coverage are guarantee issue.

Please note: Each year you and your spouse may purchase additional life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Otherwise, you will be required to complete an Evidence of Insurability form and be approved by UNUM before coverage becomes effective.

UNUM provides value added services such as Worldwide Emergency Travel Assistance Services, when you travel more than 100 miles from home, and Life Planning Financial & Legal Resources, which provides financial consulting upon the death of your covered spouse. Contact HR for more information about these available programs.

VOLUNTARY LONG TERM DISABILITY

Long term disability is intended to protect your income for a long duration after you have depleted short term disability or any sick leave your company may offer.

After the 90th day of an illness or injury, you may be eligible for long term disability benefits through UNUM. The disability benefit is a monthly benefit and covers 60% of your monthly salary to a maximum of $5,000. Our disability benefit allows coverage for up to two years should you be unable to work at your own occupation. If you are unable to work at any occupation due to your disability, the benefit will continue until you reach your normal social security retirement age. (This monthly income benefit is subject to a 3/3/12 pre-existing condition limitation.)

If you did not elect coverage when first eligible, you can do so now by completing an evidence of insurability form and being approved by UNUM.

VOL. LONG TERM DISABIILTY MONTHLY RATES	
Age Band	**Employee Monthly Rate per $100**
Under 25	$0.11
25-29	$0.18
30-34	$0.23
35-39	$0.35
40-44	$0.53
45-49	$0.66
50-54	$1.05
55-59	$1.21
60-64	$1.15
65+	$0.94

VOLUNTARY WORKSITE BENEFITS

Aflac offers voluntary products that are used to compliment your medical benefits by helping you cover your expenses until your deductible is satisfied. Most products are eligible for pre-tax payroll deductions. The Short Term Disability policy comes out after tax.

Accident Indemnity Advantage—This plan helps you cover your out of pocket expenses associated with an accident. Cash benefits are paid directly to you based on a schedule.

Cancer Care—This plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment.

Hospital Protection—This plan pays a cash benefit based on hospitalization confinement, exams, surgeries, and more.

Short-Term Disability Insurance—This plan provides income protection should you become disabled due to an illness or injury and are unable to work.

These Aflac plans have pre-existing condition waivers and terms. For Aflac coverage(s), employees must meet with an Aflac representative to complete your application. These plans are portable. Please contact HR if you have any questions.

LONG TERM CARE

If an accident, a serious illness, or a cognitive impairment prevented you or a loved one from being able to perform what were once normal activities of daily life, you may find yourself in a situation that requires long term care services. Fox Associates values the importance of planning for this risk and is proud to provide an employer paid base plan to all benefit eligible employees.

The Company's long term care insurance policy offered through Unum will provide coverage for care received in an assisted living facility, a nursing home or even in your own home should you need assistance with two out of the six Activities of Daily Living or become cognitively impaired.

Benefit Features	Employer-Paid Base Plan	Available Plan Options
Monthly Benefit Amount Nursing Home Facility Assisted Living Facility Home Health Care	$1,000	$1,000 to $9,000* in $1,000 increments *Same coverage for all levels of care*
Lifetime Maximum Duration	6 Years	3 Years, 6 Years or Unlimited*
Inflation Protection	None	None, 5% Simple or 5% Compound
Elimination Period	90 days; cumulative service days	
Guaranteed Issue	*Newly hired or newly benefit eligible employees applying within their initial new hire enrollment period are not required to answer medical questions if applying within the plan limits. Applying for the $7,000, $8,000 or $9,000 Monthly Benefit amounts or the Unlimited duration require a medical questionnaire regardless of when you apply.*	
Medical Underwriting	*The Evidence of Insurability Form (a medical questionnaire) is required for all applicants, including spouses/domestic partners and eligible family members for all levels of coverage with the exception of employees eligible for guaranteed issue during their new hire eligibility period.*	

Eligible family members include spouse/domestic partner, parents, grandparents, in-laws, siblings 18+ and children 18+.

Coverage is portable!

No one likes to imagine themselves in need of long term care; however, in an otherwise very difficult situation, having a long term care insurance policy can mean maintaining a quality of life without the significant financial burden or the need to rely on loved ones to provide care.

For additional plan design information and questions, please visit www.unuminfo.com/Fox.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Through our EAP contract with our service provider, H&H Health Associates (H&H), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Managing stress and change
- Family and relationship concerns
- Parenting issues
- Legal concerns
- Budgeting and debt management
- Substance abuse
- Care management for aging parents
- Locating child and elder care resources
- Identifying school/college resources
- Emotional and personal conflicts
- Depression and grief
- Lifestyle weight management
- Work performance issues
- Retirement issues
- Health and wellness issues
- Financial planning

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at hhhealthassociates.com.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The FSAs have a plan year of January 1st to December 31st.

TYPES OF ACCOUNTS

SECTION 125 MEDICAL SPENDING ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription and non-prescription (used to treat personal injuries or sickness only) drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited. You cannot establish the FSA if you also contribute to a Health Savings Account (HSA).

DEPENDENT CARE EXPENSE ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Maximum Contributions	
Section 125 Medical Account	$2,550 max
Dependent Care Expense Account	$5,000 max

ACCOUNT STATEMENTS

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto myplans.cbiz.com to view account balances, view the expenses that have been paid, and see any other account information.

HOW THE ACCOUNT WORKS

When you have eligible expenses not covered under the health insurance plan, such as co-payments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. For expenses not directly related to a health plan claim, you may submit a FSA claim form with your receipt and a reimbursement payment is issued to you directly or you may use your CBIZ FSA Debit Card to pay for out-of-pocket expenses at qualified vendors.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider.

FLEXIBLE SPENDING ACCOUNTS (FSAs) - con't

Plan your contribution carefully. The IRS requires you to forfeit any unused dollars in your Section 125 Medical or Dependent Care Expense Accounts at the end of the plan year. This is called "use it or lose it". You have 90 days after the end of the plan year to be reimbursed for expenses you incurred in the previous year.

ELIGIBLE EXPENSES

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.

Alcoholism treatment	Ambulance	Artificial limbs
Braces	Chiropractors	Coinsurance and co-payments
Contact lens solution	Contraceptives	Crutches
Deductible amounts	Dental expenses	Dentures
Dermatologists	Diagnostic expenses	Laboratory fees
Eyeglasses, including exam fee	Handicapped care and support	Nutrition counseling
Hearing devices and batteries	Hospital bills	Orthopedic shoes
Licensed osteopaths	Licensed practical nurses	Prescription drugs
Orthodontia	Obstetrical expenses	Psychologist expenses
Oxygen	Podiatrists	Smoking cessation programs
Prescribed vitamin supplements	Psychiatric care	Surgical expenses
Routine physical	Seeing-eye dog expenses	
Sterilization and reversals	Substance abuse treatment	

IMPORTANT NOTICES

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact your HR Department.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Notice of Material Modification

Fox Associates, L.L.C., Metropolitan Tickets, Inc. and Fox Theatricals, LLC has amended the medical and dental benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to your HR Department.

Notice of Privacy Practices

The Fox Associates, L.L.C., Metropolitan Tickets, Inc. and Fox Theatricals, LLC is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting your HR Department.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2016. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 31, 2017. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

You'll need a 1095 form to complete your annual Federal tax return.

Marketplace Options

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Fox Associates, LLC.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Medicaid CHIP Notice

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-267-2323

Medicare Part D Creditable Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium. *Cigna* has determined that the prescription drug coverage offered by *Fox Associates Medical Plan* is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment or you experience a qualifying event.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).