Genesis HealthCare℠

2014 BENEFITS GUIDEBOOK

REMARKABLE PEOPLE LIVING WELL Genesis

TOOLS & ASSISTANCE

In addition to this Guidebook, Genesis offers the following tools and assistance to help you in making your benefits decisions:

Tools

Our online Interactive Benefits Counselor is here to help. Alex, the virtual host, will ask you questions about your health care needs, lifestyle, financial status and other variables to help you determine benefit options that suit you best. Visit: ***www.GenesisBenefitsCounselor.com.***

- Central Intranet: http://central.genesishcc.com/sites/HR. The "Benefits" tab provides details of all benefits discussed in this Guidebook. See sections on medical, dental, vision, life, disability, etc.

Assistance

- Your first resource is your Benefits Designee/HR Generalist, who is available to assist you with questions about your plan options and to help you with the benefit tools.
- The Corporate Benefit Services Department is also available from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday, by calling 1-888-HR-AT-GHC (1-888-472-8442).
- You may also email your questions to the Benefits Mailbox at benefits@genesishcc.com.

YOUR 2014 GENESIS EMPLOYEE BENEFITS

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Your 2014 Genesis Employee Benefits

Genesis, one of the nation's largest long-term care and rehabilitation therapy providers, is dedicated to the delivery of quality health care to the residents and patients in our skilled nursing centers, assisted living communities and rehab gyms. In order to hire and retain highly qualified employees, we continually update our program of comprehensive, affordable benefits to ensure that it remains competitive and is compliant with the Affordable Care Act (ACA).

The following benefits are available for you and your family:

Full-Time Employee Benefits

- Medical and Prescription Drug
- Incentive Wellness Program
- Dental
- Vision Care
- Flexible Spending Accounts
- Company-Paid Short-Term Disability
- Company-Paid Group Life Insurance
- Voluntary Term Life Insurance
- Voluntary Short-Term Disability
- Voluntary products through Aflac
- Group Auto and Homeowners Insurance
- 401(k) Savings Plan
- Employee Assistance Program (EAP)
- Planned Time-Off
- Modified Compensation

Part-Time Employee Benefits

- Dental
- Vision Care
- Group Auto and Homeowners Insurance
- 401(k) Savings Plan

Modified Compensation

Modified Compensation (Mod Comp) is a "Pay in lieu of Benefits" program offered to non-exempt employees in Grades 19 and below. Please see the Benefits Tab on the Genesis Central intranet site or your Benefits Designee/HR Generalist for plan details.

Eligibility

To be eligible to receive the full-time or part-time Genesis benefits listed in this Guidebook, you must be a non-bargaining unit employee. If you are in a bargaining unit position, please refer to your Collective Bargaining Agreement to determine your benefits eligibility.

You are considered a full-time employee if you are regularly scheduled to work at least 30 hours per week.

You are considered a part-time employee if you are regularly scheduled to work at least 15 hours per week, but less than 30 hours per week.

Benefits Effective Date (unless otherwise noted)

- **Group 1:** Benefits begin after a 90 day waiting period for non-exempt (hourly) employees in Grades 1 – 19 excluding non-exempt employees categorized as 15X through 19X.
- **Group 2:** Benefits begin on the first of the month following date of hire for exempt (salaried) employees in Grades 20 and above, and non-exempt employees categorized as 15X through 19X.

Please Note: Some job titles and/or grades may have enhancements that supersede waiting periods and/or benefits listed in this Guidebook. Your Manager will let you know if any enhancements apply to your position.

See your Manager if you have any questions about your grade or category.

Open Enrollment

Effective date for Open Enrollment changes is **January 1**.

Enrollment & Eligibility

Benefit Termination Dates

Termination dates for Medical, Dental, and Vision insurance are:*

- Last day of employment;
- December 31 if "waiving" coverage during Open Enrollment;
- Effective Date of "Family Status Change"

**If an employee is on an approved leave of absence, the Leave of Absence policy regarding termination of coverage will be followed.*

Insurance Benefits Enrollment: 30-Day Rule

Please submit your insurance enrollment paperwork and any necessary supporting documentation to your Benefits Designee/HR Generalist in a timely manner, as **the materials must be received by the Corporate Benefit Services Department within 30 days of your benefits effective date or family status change.** Your "benefits effective date" is the date that you may begin using your new benefits, following any waiting period identified in the "Eligibility" section. If **all** enrollment paperwork is not received within 30 days of your benefits effective date, you will have to wait to enroll until the next Open Enrollment period for a January 1st effective date.

Dependent Eligibility

Eligible dependents include:

- Spouse/domestic partner.
- Children to their 26th birthday, including biological, adopted and step-children.
- Children who are incapable of self-sustaining employment by reason of mental or physical handicap, if covered as a dependent prior to age 26.
- Children for whom the employee must provide health insurance by a qualified medical child support order (QMCSO).

Child/children will include your biological children, legally adopted children, children for whom you have legal custody, and step-children or children of your domestic partner.

See documentation requirements that follow.

Documentation Requirements for Enrolling a Spouse or Domestic Partner

If you elect to enroll an eligible spouse or domestic partner into a Genesis sponsored health plan, you will be required to provide the appropriate documentation recognizing your relationship.

Appropriate Documentation for State-Recognized Relationships

Traditional Marriage, Common Law Marriage or Non-Traditional Marriage* — any **two** of the following forms of documentation:

- Marriage license, marriage certificate, common law affidavit, civil union license, and other recognized documentation from your state
- Front page of most recent federal tax return showing your spouse (please block out income information)
- Document dated within past six months, establishing current relationship (e.g., joint bank/credit account statement, joint mortgage/lease)

Appropriate Documentation to Recognize a Domestic Partner Relationship

If you elect to enroll an eligible partner into a Genesis sponsored health plan* and you do not have a state recognized relationship document, you will be required to complete a notarized Genesis Domestic Partner Affidavit with required back-up documentation.

Please see the Genesis Central intranet site or your Benefits Designee/HR Generalist if you need a Domestic Partner Affidavit.

Please submit all required documentation to your Benefits Designee/HR Generalist.

**If you elect to enroll your domestic partner into the Medical, Dental and/or Vision plans, IRS regulations require that you are taxed on the total cost of the benefit (employee and employer portion) that applies to your domestic partner and their dependents. This does not apply to your legally married same-gender dependent and their children.*

Documentation Requirements for Enrolling Dependent Children

- If you are enrolling dependent children, please provide copies of **one** of the following to your Benefits Designee/HR Generalist:
  - Birth certificate (long form with parents' names)
  - Appropriate court order or adoption decree
  - Divorce decree granting full or joint custody
  - QMCSO or other court order showing that the employee is required to provide health care coverage
- If you are enrolling a child over the age of 25 who is mentally or physically incapacitated, medical documentation is required. Continuation of benefits under this provision will only apply if your child was covered under your prior medical plan. Please provide proof of previous coverage to your Benefits Designee/HR Generalist.

Please note that covering ineligible dependents on your health plan constitutes fraud and may result in loss of benefits and disciplinary action up to and including termination of employment.

Making Changes

Your Medical, Dental or Vision coverage will remain in effect during the entire plan year, except in the event of a qualifying "family status change." A family status change that could result in changes to your coverage includes, but is not limited to:

- Marriage or eligible domestic/civil union partner;
- Legal separation, divorce, or annulment;
- Death of a spouse, domestic/civil union partner or child;
- Birth, adoption of a child, or placement for adoption;
- Loss of a spouse's, domestic/civil union partner's or dependent's job;
- Spouse, domestic/civil union partner or dependent becomes employed;
- Dropping dependents who are no longer eligible for coverage;
- Change in your, your spouse's, domestic/civil union partner's or dependent's employment status from part-time/casual to full-time or full-time to part-time/casual;
- Leave of absence;
- A significant change in cost or change in your, your spouse's, domestic/civil union partner's or dependent's health coverage *(does not apply to medical flexible spending accounts);*
- A change due to a Qualified Medical Child Support Order *(applies to health coverage and medical flexible spending accounts only);*
- Entitlement to Medicare/Medicaid for you, your spouse, domestic/civil union partner or dependent.
- Change in eligibility under a state or federal assistance program (CHIP, Medicaid) for you or your dependents.

A status change for an employee or a dependent must affect the individual's eligibility for the Plan's benefits. Any requested change in the affected benefit must be consistent with the occurrence of the underlying status change.

If you have a family status change, the Corporate Benefit Services Department must receive the necessary documentation within 30 days of the effective date of the change. See 'Insurance Benefits Enrollment: 30-Day Rule' on page 3.

Payroll Deductions

Your initial premium deductions for insurance benefits are taken in the first pay period in which your benefit effective date falls. Full premiums are taken; they are not pro-rated; however if you terminate employment or drop benefits, the final premium is **not** deducted from your pay. If enrollment forms are not received by the Corporate Benefit Services Department prior to your effective date, retroactive deductions must be taken back to the original effective date.

All insurance benefit payroll deductions will be made on a pre-tax basis (except for Voluntary Life Insurance, Voluntary Short-Term Disability Insurance, Group Auto and Homeowners Insurance and health insurance for domestic partners) unless, when it is time to elect benefits, you choose to contribute with after-tax money. Pre-tax payroll contributions, however, will lower your income tax withholding since deductions are made prior to taxing wages.

Even though most payroll deductions reduce your salary for income and Social Security tax purposes, this reduction will **not** impact the amount of any pay-related benefits you are eligible to receive. In other words, life insurance is computed on your base annual salary and 401(k) contributions on your gross pay each pay period.

Your Medical Benefits

FULL-TIME EMPLOYEES ONLY

Genesis cares about you and your family's well-being. That's why the Company offers comprehensive, affordable medical coverage for you and your dependents. With the cost of health care continuing to rise, you need to consider your options carefully.

As an eligible employee, the following medical plans are available to you:

- Max Value Plan
- Standard Plan
- Consumer Directed High Deductible (CDHD) Plan with Health Savings Account (HSA)

How the Medical Plans Work

- **The Max Value and Standard Plans:** These plans provide services through either the Aetna Choice POS II, the Blue Cross Preferred Provider Organization (PPO) or the Cigna Open Access Plus (OAP) network of providers and is determined by where you work:

  Aetna Choice POS II – AZ, CA, CO, CT, FL, GA, KS, KY, ME, NJ, NV, NY, OH, OK, OR and WA

  Cigna OAP – AR, MD, NH, TN, UT and VT

  Blue Cross PPO – all other states

  Each time you seek care under these plans, you have the freedom of using participating network providers or using providers outside the network. If you use an in-network provider, the plan pays a higher percentage of the cost of care. All in-network preventive services are covered at 100%, including your annual wellness office visits, preventive lab/blood work, GYN visits and mammograms.* Other services, such as doctor visits and ER visits, are covered after a flat dollar copay and the plan pays the rest. For the remainder of services, you pay a percent of covered services after the deductible. If you should reach the Annual Out-of-Pocket Maximum, the plan pays most remaining covered medical expenses at 100%. If you go out-of-network, the plan pays a lower percentage, increasing your out-of-pocket costs.

Check with your medical plan preventive schedule for age and frequency limits for such services.

- **Consumer Directed High Deductible (CDHD) Medical Plan with Optional Health Savings Account (HSA):** This plan provides services through the **Aetna** network of providers, in all states.

  The plan design is similar to the Max Value and Standard plans. Preventive services are covered at 100% with no deductible.* The deductible must be met before receiving benefits for all other services, including non-preventive primary care and specialist office visits and non-preventive prescription drugs. The plan has a deductible of $2,000 for individual coverage, and $4,000 for the employee + spouse/partner, employee + child(ren) and family coverage levels. The deductible and out-of-pocket maximum include both medical and prescription drug expenses.

  This plan may be coupled with a Health Savings Account (HSA). If you elect the HSA option, an HSA will be opened and administered by Aetna/PayFlex. See page 22 for more information on Health Savings Accounts.

GHC Advantage Plan

If you are enrolled in the Max Value, Standard or CDHD Medical Plans, you and your covered family members are automatically enrolled in the GHC Advantage Plan. For the Max Value or Standard Plans, the GHC Advantage pays 100%, no deductible, for services covered under the medical plan if you or a covered family member use a Genesis Center for Skilled Nursing or Physical Therapy, Dialysis, Occupational Therapy or Speech Therapy, if available in your area and scheduling permits.

For the CDHD Plan, the GHC Advantage pays 100%, **after** deductible, for services covered under the medical plan if you or a covered family member use a Genesis Center for Skilled Nursing or Physical Therapy, Dialysis, Occupational Therapy or Speech Therapy, if available in your area and scheduling permits.

Aetna and Cigna members may use their ID card to access this benefit. For Blue Cross - member claims must be submitted to AmeriHealth Administrators, P. O. Box 992, Horsham, PA 19044-9075. If you have any questions about billing or claims call 1-800-346-2513.

Tobacco Free Wellness Reward

Research has verified that people who use tobacco products, and most likely those people living with smokers, are at greater risk for illness and, therefore, spend more health care dollars. To offset these increased expenses, Genesis charges *less* per month for employees and/or their dependents who *do not use tobacco products* and are participating in our Medical plans. All others must pay an *additional* charge which is $40.00 biweekly or $20.00 weekly. If you have answered "yes" to the question *"Do you or any dependents covered under our medical plan use tobacco products?"* this additional charge will be applied. **This question must be answered in order to be eligible to enroll in the medical plans. Falsification of this information may result in loss of benefits and disciplinary action.**

The Genesis plan is committed to helping you achieve your best health. Rewards for participating in the Living Well programs are available to all eligible employees. If you think you might be unable to meet a standard for a reward under our wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Living Well mailbox at livingwell@genesishcc.com and we will work with you, and if you wish, your doctor, to find a wellness program with the same reward that is right for you in light of your health status.

Employees who use tobacco products are also encouraged to take advantage of the tobacco/smoking cessation programs available to medical plan members. These programs provide members who have enrolled and completed the Viverae Tobacco Cessation Targeted Program the opportunity to receive nicotine replacement therapy. Call Viverae at (888) 848-3723 for information.

Spouse/Domestic Partner Surcharge

To maintain affordable health insurance premiums, employees whose spouse/domestic partner has access to health insurance from his/her own employer, but who joins the Genesis plan will incur a $50 biweekly or $25 weekly premium surcharge. This applies to *Employee + Spouse/Partner* coverage as well as *Family* coverage when the spouse/domestic partner is enrolling in a Genesis plan. This surcharge does *not* apply to employees whose spouse/domestic partner has *no other* insurance option. If you answered "yes" to the question *"Is your spouse/domestic partner employed full-time and eligible for medical benefits under his/her employer's plan, but has elected to enroll only in the Genesis medical plan?"* this additional charge will be applied. **This question must be answered in order to enroll your spouse in the medical plans.**

Situations where the surcharge will not apply are if the spouse/domestic partner is:

- enrolled in both his/her plan and the Genesis medical plan; or
- employed part-time; or
- self-employed without coverage; or
- only eligible for Limited/Mini-Med plan (not an employer-sponsored medical plan).

If your spouse/domestic partner elects medical coverage from his/her employer during our plan year, you may drop coverage under the Genesis plan (family status change) and/or request to have the surcharge removed.

Documentation to support waiver of the spouse/domestic partner surcharge will not be required except for mid-year status changes. However, Genesis reserves the right to conduct random audits to collect documentation from spouse/domestic partners that are enrolled in a Genesis sponsored medical plan and have waived the spouse/domestic partner surcharge.

Pre-certification

Pre-certification is required for all inpatient admissions and many outpatient procedures and diagnostic testing, regardless of plan chosen.

- Your in-network physician may coordinate and be responsible for the pre-certification.
- Please verify with your provider that pre-certification has taken place.
- If you go out-of-network, you must obtain approval by calling the number listed on the back of your ID card. If you do not call, you will be responsible for penalties and/or benefit reductions.

Reviewing Your Options

When reviewing your options you need to consider both benefits and costs. Page 7 contains an overview of the Max Value, Standard and Consumer Directed High Deductible (CDHD) Medical Plans. Detailed information on benefit levels for these plans is on pages 8–10. See 'Tools and Assistance' on the inside front cover of this Guidebook for additional resources to assist you in comparing plan costs for you and your family.

Your Medical Benefits

FULL-TIME EMPLOYEES ONLY

OVERVIEW OF MEDICAL COST SHARING (IN-NETWORK)

	Max Value Plan	Standard Plan	CDHD with HSA
Deductible ▸ Single ▸ All Other Coverages	▸ $1,200 ▸ $2,400	▸ $600 ▸ $1,200	▸ $2,000 ▸ $4,000 (Combined medical & Rx)
Out-of-Pocket Maximum ▸ Single ▸ All Other Coverages	▸ $5,000 ▸ $10,000	▸ $4,500 ▸ $9,000	▸ $5,950 ▸ $11,900
Coinsurance (Plan Pays)	▸ 70%	▸ 70%	▸ 90%
Office Visit ▸ PCP ▸ Specialist	▸ $35 ▸ $45	▸ $30 ▸ $40	Coinsurance applies after deductible is met
Preventive Care	Covered at 100% with no deductible		
Maximum Medical FSA Contribution*	▸ $2,500	▸ $2,500	▸ N/A
Maximum Dependent Care FSA Contribution**	$5,000 (or $2,500 if you are married and file separately)		
Maximum HSA Contribution* ▸ Single ▸ All Other Coverages	▸ N/A	▸ N/A	▸ $3,300 ▸ $6,550

Limitations apply to non-tax-qualified dependents.

****Please Note: The Dependent Care FSA annual maximum for highly compensated employees will be limited to a lower amount. For 2013 Plan Year, the limit was $2,500.***

Overview of Prescription Drug Cost Sharing — see pages 11-12.

See the Summary of Benefits and Coverage (SBC) documents as required by the Patient Protection and Affordable Care Act (PPACA) available on the Genesis Central intranet site > Benfits Tab > Medical Plans for the Max, Standard and CDHD Plans.

Your Medical Benefits

Your Max Value Plan

Benefits*	In-Network	Out-of-Network
Physician Services ▸ Primary Care Office Visits ▸ Specialist Office Visits	 ▸ Plan pays 100% after $35 copay ▸ Plan pays 100% after $45 copay	 ▸ Plan pays 50% after deductible ▸ Plan pays 50% after deductible
Preventive Care ▸ Preventive Care/Adults and Children ▸ Pediatric Immunizations ▸ Mammograms, Pap Tests	 ▸ Plan pays 100% ▸ Plan pays 100% ▸ Plan pays 100%	 ▸ Plan pays 50%, after deductible ▸ Plan pays 50%, no deductible ▸ Plan pays 50%, no deductible
Outpatient Lab and X-Ray ▸ Radiology ▸ Laboratory	 ▸ Plan pays 70% after deductible ▸ Plan pays 70%, no deductible	 ▸ Plan pays 50% after deductible ▸ Plan pays 50% after deductible
Hospital Emergency Room *(copay waived if admitted)*	▸ Plan pays 100% after $300 copay	▸ Plan pays 100% after $300 copay
Urgent Care	Plan pays 100% after $50 copay	▸ Plan pays 100% after $50 copay
Inpatient Hospitalization	Plan pays 70% after deductible, up to 365 days/year	Plan pays 50% after deductible, up to 365 days/year
Outpatient Surgery	Plan pays 70% after deductible	Plan pays 50% after deductible
Maternity Care	For initial visit, Plan pays 100% after $35 copay; for subsequent visits, physician delivery charges and hospital stay, Plan pays 70% after deductible	Plan pays 50% after deductible
Therapy Services, Physical, Speech and Occupational *(60 visits combined for all these therapies per year—combined in- and out-of-network)*	Plan pays 100% after $35 copay (visits 1-30); Plan pays 100% after $45 copay (visits 31-60)	Plan pays 50% after deductible
Nutrition Counseling *(up to 6 visits/calendar year combined in- and out-of-network)*	Plan pays 100%	Plan pays 50%, no deductible
Skilled Nursing Facility *(up to 120 days/year)* ▸ At Genesis Facilities *(if available)* ▸ Other Health Facilities	 ▸ Plan pays 100% ▸ Plan pays 70% after deductible	 ▸ Covered In-network only ▸ Plan pays 50% after deductible
Home Health Care *(16-hour max./day)*	Plan pays 70% after deductible	Plan pays 50% after deductible
Mental Health Care ▸ Inpatient ▸ Outpatient – Physician Services	 ▸ Plan pays 70% after deductible ▸ Plan pays 100% after $45 copay	 ▸ Plan pays 50% after deductible ▸ Plan pays 50% after deductible
Annual Deductible ▸ Individual ▸ Family**	 ▸ $1,200 *(Combined in-network and out-of-network)* ▸ $2,400 *(Combined in-network and out-of-network)*	
Annual Out-of-Pocket Maximum *(combined in-/out-of-network)* ▸ Individual *(includes deductible)* ▸ Family *(includes deductible)****	 ▸ $5,000 ▸ $10,000	 ▸ $10,500 ▸ $21,000
Lifetime Maximum	Unlimited	
Prescription Drugs	***See pages 11 and 12 for your In-Network Prescription Drug coverage.***	Reimbursement determined based on Restat's network reimbursement for the claim less the applicable coinsurance. Prescription Drug Claim Forms are located online at www.restat.com/genesis under 'Helpful Documents and Forms'. Form must be submitted within 60 days.

Note: Health Care Reform regulations may require updates in certain benefit categories.

*** As required by Health Care Reform legislation, qualified preventive services are covered at 100%.***

**** This deductible pertains to an employee covering one or more dependents. All family members contribute toward the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.***

***** This maximum pertains to an employee covering one or more dependents. All family members contribute toward the family out-of-pocket maximum. An individual cannot have coinsurance covered at 100% until the total family out-of pocket maximum has been satisfied.***

For Aetna provider information (Aetna Choice POS II network), contact Aetna at 1-800-994-4282, or go online at www.aetna.com.
For Blue Cross provider information (Blue Cross PPO network), contact IBC at 1-800-810-BLUE (2583), or go online at www.bcbs.com.
For Cigna provider information (Cigna OAP network), contact Cigna at 1-800-244-6224, or go online at www.cigna.com.

Your Medical Benefits

FULL-TIME EMPLOYEES ONLY

Your Standard Plan

Benefits*	In-Network	Out-of-Network
Physician Services		
▸ Primary Care Office Visits	▸ Plan pays 100% after $30 copay	▸ Plan pays 50% after deductible
▸ Specialist Office Visits	▸ Plan pays 100% after $40 copay	▸ Plan pays 50% after deductible
Preventive Care		
▸ Preventive Care/Adults and Children	▸ Plan pays 100%	▸ Plan pays 50%, after deductible
▸ Pediatric Immunizations	▸ Plan pays 100%	▸ Plan pays 50%, no deductible
▸ Mammograms, Pap Tests	▸ Plan pays 100%	▸ Plan pays 50%, no deductible
Outpatient Lab and X-Ray		
▸ Radiology	▸ Plan pays 70% after deductible	▸ Plan pays 50% after deductible
▸ Laboratory	▸ Plan pays 70%, no deductible	▸ Plan pays 50% after deductible
Hospital Emergency Room *(copay waived if admitted)*	▸ Plan pays 100% after $300 copay	▸ Plan pays 100% after $300 copay
Urgent Care	Plan pays 100% after $50 copay	▸ Plan pays 100% after $50 copay
Inpatient Hospitalization	Plan pays 70% after deductible, up to 365 days/year	Plan pays 50% after deductible, up to 365 days/year
Outpatient Surgery	Plan pays 70% after deductible	Plan pays 50% after deductible
Maternity Care	For initial visit, Plan pays 100% after $30 copay; for subsequent visits, physician delivery charges and hospital stay, Plan pays 70% after deductible	Plan pays 50% after deductible
Therapy Services, Physical, Speech and Occupational *(60 visits combined for all these therapies per year—combined in- and out-of-network)*	Plan pays 100% after $30 copay (visits 1-30); Plan pays 100% after $40 copay (visits 31-60)	Plan pays 50% after deductible
Nutrition Counseling *(up to 6 visits/calendar year combined in- and out-of-network)*	Plan pays 100%	Plan pays 50%, no deductible
Skilled Nursing Facility *(up to 120 days/year)*		
▸ At Genesis Facilities *(if available)*	▸ Plan pays 100%	▸ Covered In-network Only
▸ Other Health Facilities	▸ Plan pays 70% after deductible	▸ Plan pays 50% after deductible
Home Health Care *(16-hour max./day)*	Plan pays 70% after deductible	Plan pays 50% after deductible
Mental Health Care		
▸ Inpatient	▸ Plan pays 70% after deductible	▸ Plan pays 50% after deductible
▸ Outpatient – Physician Services	▸ Plan pays 100% after $40 copay	▸ Plan pays 50% after deductible
Annual Deductible		
▸ Individual	▸ $600 *(Combined in-network and out-of-network)*	
▸ Family**	▸ $1,200 *(Combined in-network and out-of-network)*	
Annual Out-of-Pocket Maximum *(combined in-/out-of-network)*		
▸ Individual *(includes deductible)*	▸ $4,500	▸ $10,500
▸ Family *(includes deductible)****	▸ $9,000	▸ $21,000
Lifetime Maximum	Unlimited	
Prescription Drugs	***See pages 11 and 12 for your In-Network Prescription Drug coverage.***	Reimbursement determined based on Restat's network reimbursement for the claim less the applicable coinsurance. Prescription Drug Claim Forms are located online at www.restat.com/genesis under 'Helpful Documents and Forms'. Form must be submitted within 60 days.

Note: Health Care Reform regulations may require updates in certain benefit categories.

*** As required by Health Care Reform legislation, qualified preventive services are covered at 100%.***

**** This deductible pertains to an employee covering one or more dependents. All family members contribute toward the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.***

***** This maximum pertains to an employee covering one or more dependents. All family members contribute toward the family out-of-pocket maximum. An individual cannot have coinsurance covered at 100% until the total family out-of pocket maximum has been satisfied.***

For Aetna provider information (Aetna Choice POS II network), contact Aetna at 1-800-994-4282, or go online at www.aetna.com.
For Blue Cross provider information (Blue Cross PPO network), contact IBC at 1-800-810-BLUE (2583), or go online at www.bcbs.com.
For Cigna provider information (Cigna OAP network), contact Cigna at 1-800-244-6224, or go online at www.cigna.com.

Your Medical Benefits

Your Consumer Directed High Deductible (CDHD) Plan with Optional HSA

Benefits*	In-Network	Out-of-Network
Physician Services		
▸ Primary Care Office Visits	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
▸ Specialist Office Visits	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
Preventive Care		
▸ Preventive Care/Adults and Children	▸ Plan pays 100%	▸ Not covered
▸ Pediatric Immunizations	▸ Plan pays 100%	▸ Not covered
▸ Mammograms, Pap Tests	▸ Plan pays 100%	▸ Plan pays 70% after deductible
Outpatient Lab and X-Ray		
▸ Radiology	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
▸ Laboratory	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
Hospital Emergency Room	▸ Plan pays 90% after deductible	▸ Plan pays 90% after deductible
Urgent Care	▸ Plan pays 90% after deductible	▸ Plan pays 90% after deductible
Inpatient Hospitalization	Plan pays 90% after deductible, up to 365 days/year	Plan pays 70% after deductible, up to 365 days/year
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 70% after deductible
Maternity Care	Plan pays 90% after deductible	Plan pays 70% after deductible
Therapy Services, Physical, Speech and Occupational *(60 visits combined for all these therapies per year—combined in- and out-of-network)*	Plan pays 90% after deductible	Plan pays 50% after deductible
Nutrition Counseling *Office visits (up to 6 visits/calendar year)*	Plan pays 100%, no deductible	Not covered
Skilled Nursing Facility *(up to 120 days/year)*		
▸ At Genesis Facilities *(if available)*	▸ Plan pays 100% after deductible	▸ Covered in-network only
▸ Other Health Facilities	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
Home Health Care *(16-hour max./day)*	Plan pays 90% after deductible	Plan pays 70% after deductible
Mental Health Care		
▸ Inpatient	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
▸ Outpatient	▸ Plan pays 90% after deductible	▸ Plan pays 70% after deductible
Annual Deductible *(includes medical and Rx)*		
▸ Individual	▸ $2,000 *(Combined in-network and out-of-network)*	
▸ Family**	▸ $4,000 *(Combined in-network and out-of-network)*	
Annual Out-of-Pocket Maximum *(includes medical and Rx) (combined in-/out-of-network)*		
▸ Individual *(includes deductible)*	▸ $5,950	▸ $10,000
▸ Family *(includes deductible)****	▸ $11,900	▸ $20,000
Maximum HSA Contribution****	$3,300 (single) / $6,550 (family)	
Lifetime Maximum	Unlimited	
Prescription Drugs	***For details on your In-Network Prescription Drug coverage, see the Genesis Central intranet site.***	Reimbursement determined based on network reimbursement for the claim less the applicable coinsurance.

Note: Health Care Reform regulations may require updates in certain benefit categories.

*** As required by Health Care Reform legislation, qualified preventive services are covered at 100%***

**** This deductible pertains to an employee covering one or more dependents. All family members contribute toward the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.***

***** This maximum pertains to an employee covering one or more dependents. All family members contribute toward the family out-of-pocket maximum. An individual cannot have coinsurance covered at 100% until the total family out-of pocket maximum has been satisfied.***

****** Limitations apply to non-tax-qualified dependents. See page 22 for more details.***

For Aetna provider information (Aetna Choice POS II network), contact Aetna at 1-800-994-4282, or go online at www.aetna.com.

Your Prescription Drug Coverage

FULL-TIME EMPLOYEES ONLY

Your Prescription Drug coverage uses the Restat network for all Aetna, Blue Cross and Cigna Genesis medical plans with the exception of the CDHD plan.

For details on the prescription drug coverage under the CDHD plan, go to the Benefits Tab on the Genesis Central intranet site.

- **Up to a 30-Day Supply of Non-Specialty Medications:**
  - **The Restat Align Network** contains over 20,000 pharmacies and includes retailers such as Wal-Mart and Target. Overall, using an Align pharmacy will provide the most affordable prescription drugs for you and for Genesis. **You will pay the least if you utilize these pharmacies.** To find an Align pharmacy close to you, visit www.restat.com/genesis.
  - **The National Retail Network** grants access to over 65,000 pharmacies; however, costs will be higher to you and to Genesis at these locations.
- **31- to 90-Day Supply of Non-Specialty Maintenance Medications:**
  - If you use the Align Network, you are not required to use mail order for maintenance medications.
  - **The Restat Align Network** provides you with an opportunity to fill up to a 90-day prescription at an Align pharmacy. You will find that your costs are less when you utilize this option.
  - **Catamaran Mail Order** allows you to have your order shipped directly to your home.
  - Note: You will not be able to fill a maintenance medication for greater than a 30-day supply at a National Retail Network pharmacy.
- **Specialty Medications:**
  - Specialty medications used to treat complex or chronic medical conditions such as hepatitis, multiple sclerosis, growth hormone deficiency, rheumatoid arthritis and cancer are covered only when purchased from BriovaRx Specialty Pharmacy. For more information, call BriovaRx at 855-4BRIOVA or 855-427-4682.

It is easy to go online to www.restat.com/genesis and then click on "Member Reportal Login" to compare prices at both retail and mail order pharmacies.

How to Access Member Reportal

Select the **Register Now** link and complete the registration page. To complete the registration page, you will need to have your subscriber and group/plan number from your prescription benefit card and a valid email address. If you do not have a valid email address, select the **Click Here** link located on the login page to create a free Yahoo! email account.

Generics Required. If you or your doctor request a brand-name drug when a generic is available, you will pay the brand coinsurance plus the difference in cost between the generic drug and the cost of the brand-name drug. There is no maximum that applies to this. Therefore, when possible, it is always best to use generic drugs to keep your costs most affordable. To find out if a generic equivalent is available, visit www.restat.com/genesis, then click on "Member Reportal Login" or contact Restat toll-free at 855-399-7342.

Coverage Management Programs

Certain medications are not covered by your plan without a coverage review (prior authorization). If your review is approved, you will pay the normal coinsurance for that medication.

There may be situations where quantities of specific medications are limited to ensure safe and proper utilization. Also, for certain prescriptions, members may be required to utilize a generic or preferred brand drug before a non-preferred drug, unless special circumstances exist.

Your Prescription Drug Coverage

Your In-Network Cost

For all Aetna, Blue Cross and Cigna Genesis medical plans with the exception of the CDHD plan, you pay the costs shown in the chart below (go to the Genesis Central intranet site for details on prescription drug coverage under the CDHD plan):

Up to a 30-Day Supply	**Align Retail Network**	**National Retail Network**
Generic	$4	$10 copay
Preferred Brand Coinsurance Minumum & Maximum	30% with $25 min. & $50 max.	40% with $30 min. & $80 max.
Non-Preferred Brand	50% with $40 min. & $70 max.	50% with $50 min. & $100 max.

31- to 90-Day Supply	**Align Retail Network**	**Catamaran Mail Order**
Generic	$10 copay	20% with $15 min. & $30 max.
Preferred Brand	30% with $60 min. & $110 max.	30% with $70 min. & $140 max.
Non-Preferred Brand	50% with $85 min. & $145 max.	50% with $100 min. & $170 max.

Please Note: *If you or your doctor request a brand-name drug when a generic is available, you pay the brand-name coinsurance plus the difference in cost between the generic drug and the brand-name drug.*

Up to a 30-Day Supply	**BriovaRx Specialty Pharmacy**
Specialty Medications	$75 copay

For many medications, you will pay a percentage of the total prescription drug cost. There is a minimum and maximum charge, so your cost cannot be lower or higher than these dollar limits. ***You will never be charged more than the actual cost of the drug and any applicable dispensing fees even if it is less than the minimum cost. For example, if your retail generic drug costs $4 and the minimum is $10, you would only pay $4.***

Note:

- Generic oral contraceptives and most other prescription contraceptives will be covered at no cost. Preferred brand and non-preferred brand oral contraceptives are covered at the plan coinsurance amounts shown in the chart above.
- Please see the detailed benefit summary on the Genesis Central intranet site for details on plan exclusions and limitations.

Using your QR Code app on your smartphone, scan here to download Restat's pharmacy mobile app.

Android™ **iPhone®**

Wellness Programs

Genesis is committed to your health and well-being. We realize that the daily demands of life, in addition to extended hours spent at work, can become a barrier to practicing healthy lifestyle habits. To show our dedication to you, we have made it our priority to provide you with tools and resources to achieve your personal wellness goals and take care of your most valuable possession—your health. Genesis' partnership with Viverae provides you access to a comprehensive wellness program and is detailed below, in the Living Well Program Guide available on the Genesis Central intranet site or from your Benefits Designee/HR Generalist.

Program Overview

Category	Incentive Wellness Program
Eligibility	Full-time employees enrolled in a Genesis medical plan
Website	Viverae's online website, MyViverae.com
Health Center	Free, unlimited and confidential access by phone (888-848-3723) or secure messaging (via email) to a variety of highly trained health professionals and clinicians. **Viverae Health Center Hours:** ▸ Monday - Thursday: 8:00 am - 8:30 pm EST ▸ Friday: 8:00 am - 7:00 pm EST ▸ Saturday - Sunday: Closed
Health Report	A Member Health Report and Health Score is generated from your Member Health Assessment (MHA) and Biometric Screening numbers.
Biometric Screening	Biometric Screening Options: ▸ Onsite screening (where offered) ▸ LabCorp screening ▸ Physician/Lab form filled out by your personal physician ▸ Home Kit (self-test) Screening*
Chronic Condition Management (CCM)	Chronic Condition Management (CCM) Program for those identified with certain chronic health conditions
Wellness Participation Reward	Wellness Participation Reward in 2015 (received by earning 100 points in wellness activities by October 31, 2014)

**Only available to employees who do not have an onsite screening offered at their location.*

The confidentiality of your personal health information is protected by the Health Insurance Privacy & Accountability Act (HIPAA)

- **Genesis does not receive individual personal health information. We do receive summary data by location.**
- **Genesis does not receive the number of points you earned for specific activities. We do receive a listing of employees that have met the point requirements for the Wellness Participation Reward.**
- **HIPAA does permit covered entities to use and disclose PHI, without an individual's authorization, for Health Care Operations. Section § 164.501 of the law defines Health Care Operations to include "...population based activities relating to improving health or reducing health care costs..." PHI for Genesis' members is sent from our medical and pharmacy vendors to Viverae to improve health and reduce health care costs, therefore individual authorization is not required.**

Using your QR Code app on your smartphone, scan here for more information regarding your wellness program from Viverae.

Biometric Screenings

Onsite biometric screenings will be held at many Genesis locations. If you work at a location where screenings are not offered or if you are unable to attend your location's onsite screening, the following options are available:

- Contact Viverae at 888-848-3723 to register for LabCorp testing (you will need to self-report your height, weight and blood pressure to Viverae in order to earn points for the screening)
- Print the Physician Lab & Screening Collection Form from the Genesis Central intranet site or from the Viverae website to take to your personal physician - www.MyViverae.com
- Contact Viverae at 888-848-3723 to order a Home Kit—only available for employees who do not have an onsite screening event at their location

Please note: Check your medical plan's preventive schedule before utilizing the Physician Lab & Screening Collection Form. You will be responsible for any copay, deductible or coinsurance amounts if you do not meet the plan's age and frequency limits for such services.

Biometrics measured during the onsite screening include:

- Height and weight
- Body mass index
- Waist circumference
- Blood pressure check
- Finger Stick
  - Glucose test
  - Lipid profile, including total cholesterol, HDL, LDL, triglycerides and cardiac risk ratio

For most accurate results, it is recommended that you fast for 8 to 9 hours prior to your screening.

The onsite health screenings are conducted by skilled health assessment technicians and supervised by Viverae personnel. Screening assessments provide immediate individual results and a confidential personal consultation with Viverae Health Professionals.

Member Health Assessment (MHA)

- You will have the option to complete a Member Health Assessment by logging on to www.MyViverae.com, calling Viverae or attending an onsite screening event.
- The assessment is self-reported and focuses on general health, lifestyle, nutrition, physical activity, stress and clinical information.

Chronic Condition Management (CCM)

The Chronic Condition Management program provided by Viverae is for employees with certain chronic conditions (such as asthma, diabetes, heart disease and lung disease) and is intended to complement your doctor's treatment plan.

Participants in this program are identified through Member Health Assessments and medical/pharmaceutical claims information. If you are identified for this program, a Viverae Health Professional will call you to discuss the program and help you manage your health.

If you are identified for the CCM Program, you will need to talk to a CCM coach to earn 40 required points towards the 2015 Wellness Participation Reward.

Wellness Programs

FULL-TIME EMPLOYEES ONLY

Incentive Wellness Program

If you are a full-time employee enrolled in a Genesis medical plan on January 1, 2014, you will need to earn a total of 100 points by October 31, 2014 (70 Required Points and 30 Other Program Activity Points) to earn or keep the 2015 Wellness Participation Reward. You can keep track of your points on the www.MyViverae.com homepage or by calling the Viverae Health Center at 888-848-3723.

If you are enrolled in a Genesis medical plan after January 1, 2014 and before September 2, 2014, you will need to complete a member Health Assessment to keep the 2015 Wellness Participation Reward.

Note: For those employees enrolled in a Genesis medical plan in 2013, points earned November to December 2013 will carry over into the 2014 program year and count toward your 2015 reward. You may track your 2014 points beginning November 1, 2013 (or as soon as you are enrolled in a medical plan after November 1, 2013) by logging onto www.MyViverae.com or calling Viverae.

Required Activities (70 points)	Incentive Program Point Value
Member Health Assessment	30
Biometric Screening	30
Member Health Report - viewed online or by calling the Viverae Health Center - for those not identified for the CCM program	10
OR	
Chronic Condition Management (CCM) Participation - for those identified for the CCM program*	10
Other Program Activities (30 Points)	**Point Value**
Coaching Session (based on 2014 Health Score) ▸ ≥ 80 Health Score ▸ 70 - 79.9 Health Score ▸ < 70 Health Score	 20 each/20 max 10 each/20 max 5 each /20 max
Health-e Challenges™	5 each/10 max
Health-e Beginnings™ Online Courses	2 each/10 max
Health-e Insights™ Webinars	2 each/10 max
Health-e Focus™ Supplemental Questionnaires	2 each/10 max
Health-e Steps™ Targeted Programs	5 each/10 max
Preventive Care Compliance *(self-reported)*	5 each/10 max
Community Event *(self-reported)*	2 each/10 max
Physical/Nutritional Commitment *(self-reported)*	10 each/10 max

For more information regarding the Living Well Program, please make sure to check out the Living Well materials on the Genesis Central intranet site or talk to your Benefits Designee/HR Generalist.

***The Genesis Living Well Program is committed to helping you achieve your best health. Rewards for participating in these programs are available to all employees. If you think you might be unable to meet a standard for a reward under the program, you might qualify for an opportunity to earn the same reward by different means. Contact the Health Center at 888-VIVERAE (848-3723) and we will work with you, and if you wish, your doctor, to find a wellness program with the same reward that is right for you in light of your health status.**

Your Dental Plan Coverage

Genesis knows that dental care is an important part of your overall health and offers three dental options to fit your coverage needs:

- **Cigna Managed DHMO:** With the Cigna Dental Care DHMO, you choose a primary care dentist who manages all of your dental care within Cigna's network (a network must be available in your area for you to choose this option). You must enter a valid six-digit managed dental office number when enrolling in this plan.*

  The DHMO requires no deductibles, annual or lifetime maximums, and you pay pre-determined copays for covered services. You'll know exactly what you pay, even for specialty care with a referral approved for payment. Of course, no benefits are payable if you go outside the network.

- **Cigna Participating DPPO:** Each time you seek care under the Participating DPPO, you have the freedom of using participating network dentists or using dentists outside the network. After you meet the deductible, if applicable, the plan pays a percentage of covered services.

  If you use an in-network provider, the plan pays a higher percentage of the cost of care than if you used an out-of-network dentist.

- **Cigna Non-Participating DPPO:** If you reside in an area with limited access to Cigna providers, or if your dentist is not in the Cigna network, you have the option to enroll in the Non-Participating DPPO, which, for most services, provides a higher benefit level than the Participating DPPO Out-of-Network coverage.

You may request pre-treatment estimates from your dentist for both DPPO plans when extensive dental work (in excess of $200) is proposed.

Cigna Wellness Plus Program: If you are enrolled in either DPPO plan and you receive preventive and diagnostic services at least once in a calendar year, your Annual Maximum Benefit will increase $100 (capped at $1,550) for all services (except orthodontia) for the following plan year.

To locate a dentist in your area, contact Cigna Dental at 1-800-Cigna-24 (244-6224), or go to www.Cigna.com (under dental network selection, choose "Core").

Your Dental Plan Options

	Cigna Participating DPPO		Cigna Non-Participating DPPO	Cigna Managed DHMO
	In-Network	Out-of-Network		
Annual Deductible Individual Family	$25 $75	$75 $225	$50 $150	None None
Annual Combined Maximum Benefit	$1,250 per person	$1,250 per person	$1,250 per person	None
Preventive and Diagnostic Oral exams *(2/year)* Routine cleanings *(2/year)* Full mouth x-rays *(1 complete set/3 years)* Bitewing x-rays *(2/year)* Panoramic x-rays *(1 every 3 years)* Sealants *(limited to 1 treatment per posterior tooth /every 3 years)* Space maintainers Fluoride application *(1/year up to age 19)*	Plan pays 100%, no deductible	Plan pays 90%, no deductible	Plan pays 100%, no deductible	Plan pays 100% for most expenses
Basic Services Fillings Root canal Oral surgery Periodontal scaling/root planing Denture adjustments/repairs Simple extractions Anesthesia Crown repairs	Plan pays 80% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	See Following Copay Chart
Major Services Crowns Bridges Dentures Implants	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	See Following Copay Chart
Orthodontia Services For children and adults	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	See Following Copay Chart
Orthodontia Lifetime Maximum	$1,250 per person	$1,250 per person	$1,250 per person	

DPPO Missing Tooth Provision: the amount payable is 50% of the amount otherwise payable for the first replacement of teeth that are missing when a person becomes insured for these benefits. The limit no longer applies after a person is continuously insured for 24 months.

Your DHMO Copay Chart — L1-09

The following is an overview of your copay for different DHMO dental procedures. The complete schedule will be sent to you after you enroll.

DIAGNOSTIC/PREVENTIVE	COST
Office Visit Fee Per Patient, Per Office Visit in Addition to Any Other Applicable Patient Charges	No Charge
Oral Cancer Screening Using a Special Light Source	$50
Pulp Vitality Tests	$14
Diagnostic Casts	No Charge
Pathology Report	No Charge
Cleaning — Adult *(Limit 2 per calendar year)*	No Charge
Additional Cleaning — Adult *(In addition to the 2 allowed per calendar year)*	$45
Cleaning — Child *(Limit 2 per calendar year)*	No Charge
Additional Cleaning — Child *(In addition to the 2 allowed per calendar year)*	$30
Topical Fluoride Application — Child *(Up to 19th birthday) (Limit 2 per calendar year)*	No Charge
Oral Hygiene Instructions	No Charge
Sealant — Per Tooth	$17
Space Maintainer — Fixed Unilateral	$110
Space Maintainer — Fixed Bilateral	$170
RESTORATIVE *(Fillings)*	
Amalgam — One Surface, Primary or Permanent	$6
Amalgam — Two Surfaces, Primary or Permanent	$6
Amalgam — Three Surfaces, Primary or Permanent	$12
Amalgam — Four or More Surfaces, Primary or Permanent	$18
Resin-Based Composite — One Surface, Anterior	$6
Resin-Based Composite — Two Surfaces, Anterior	$13
Resin-Based Composite — Three Surfaces, Anterior	$18
Resin-Based Composite — Four or More Surfaces or Involving Incisal Angle *(Anterior)*	$88
Resin-Based Composite Crown, Anterior	$88
Resin-Based Composite — One Surface, Posterior	$47
Resin-Based Composite — Two Surfaces, Posterior	$59
Resin-Based Composite — Three Surfaces, Posterior	$82
Resin-Based Composite — Four or More Surfaces, Posterior	$115

CROWN AND BRIDGE **All charges for crown and bridge are per unit** *(each replacement or supporting tooth equals one unit)* **— Replacement limit 1 every 5 years.**	COST
Inlay — Metallic — One Surface	$380
Crown — Porcelain/Ceramic Substrate	$460
Crown — Titanium	$430
Recement Inlay, Onlay or Partial Coverage Restoration	$12
Recement Cast or Prefabricated Post and Core	$12
Recement Crown	$12
Prefabricated Stainless Steel Crown — Primary Tooth	$92
COMPLEX REHABILITATION **Additional charge per unit for multiple crown units/complex rehabilitation** *(Six or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit — ask your dentist for the guidelines)*	$135
Recement Fixed Partial Denture	$12
ENDODONTICS *(Root canal treatment, excluding final restorations)*	
Pulp Cap — Direct or Indirect *(Excluding final restoration)*	$14
Pulpotomy — Removal of Pulp *(Not part of a root canal)*	$89
Pulpal Debridement *(Not to be used when root canal is done on the same day)*	$83
Anterior Root Canal *(Permanent tooth) (Excluding final restoration)*	$275
Bicuspid Root Canal *(Permanent tooth) (Excluding final restoration)*	$320
Molar Root Canal *(Permanent tooth) (Excluding final restoration)*	$440
Treatment of Root Canal Obstruction; Non-Surgical Access	$130
Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$130
Internal Root Repair of Perforation Defects	$130
PERIODONTICS *(Treatment of supporting tissues [gum and bone] of the teeth)*	
Comprehensive Periodontal Evaluation — New or Established Patient	$45
Gingivectomy or Gingivoplasty — 4 or More Teeth, Per Quadrant	$240
Gingivectomy or Gingivoplasty — 1 to 3 Teeth, Per Quadrant	$105
Gingival Flap, Including Root Planing — 4 or More Teeth, Per Quadrant	$305
Gingival Flap, Including Root Planing — 1 to 3 Teeth, Per Quadrant	$165
PROSTHETICS *(Removable tooth replacement — dentures) (Includes up to four adjustments within first six months after insertion) (Replacement limit one every five years)*	
Full Upper or Lower Denture	$535
Immediate Full Upper or Lower Denture	$575

Your Dental Plan Coverage

PROSTHETICS	COST
Upper or Lower Partial Denture — Resin Base *(Including Clasps, Rests and Teeth)*	$400
Upper or Lower Partial Denture — Cast Metal *(Including clasps, rests and teeth)*	$625
Upper or Lower Partial Denture — Flexible Base *(Including clasps, rests and teeth)*	$430
Adjust Partial or Complete Denture — Upper or Lower	$38
REPAIRS TO PROSTHETICS	
Repair Broken Complete Denture Base	$71
Replace Missing or Broken Teeth — Complete Denture *(Each Tooth)*	$71
Repair Resin Denture Base	$71
Repair or Replace Broken Clasp	$88
Replace Broken Teeth — Per Tooth	$71
Add Tooth to Existing Partial Denture	$71
Add Clasp to Existing Partial Denture	$88
DENTURE RELINING *(Limit 1 every 36 months)*	
Rebase Complete Upper or Lower Denture	$210
Rebase Upper or Lower Partial Denture	$210
INTERIM DENTURES *(Limit 1 every 5 years)*	
Interim Upper or Lower Complete Denture	$305
Interim Upper or Lower Partial Denture	$255
IMPLANT/ABUTMENT SUPPORTED PROSTHETICS – *All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant[s] equals one unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to one every five years.*	
Per Tooth Charge for Crowns, Inlays, Onlays, Post and Cores, and Veneers if your dentist uses same-day in-office CAD/CAM (ceramic) services	$150
Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$835
Abutment supported Porcelain/Ceramic Crown	$760
Implant Supported Porcelain/Ceramic Crown	$760
Abutment Supported Retainer for Porcelain/ Ceramic Fixed Partial Denture	$760
Implant Supported Retainer for Ceramic Fixed Partial Denture	$760
Recement Implant/Abutment Supported Crown	$51
Abutment Supported Crown (Titanium)	$720
ORAL SURGERY *(Includes routine post-operative treatment)* Surgical removal of impacted tooth — not covered for ages below 15 unless pathology *(disease)* exists.	
Extraction of Coronal Remnants — Deciduous Tooth	$12
Extraction, Erupted Tooth or Exposed Root *(Elevation and/or forceps removal)*	$12
Surgical Removal of Erupted Tooth — Removal of Bone and/or Section of Tooth	$89
Removal of Impacted Tooth — Soft Tissue	$71
Removal of Impacted Tooth — Partially Bony	$145
Removal of Impacted Tooth — Completely Bony	$185
Removal of Impacted Tooth — Completely Bony, Unusual Complications *(Narrative required)*	$200

ORAL SURGERY	COST
Surgical Removal of Residual Tooth Roots *(Cutting Procedure)*	$89
Oroantral Fistula Closure	$200
Primary Closure of a Sinus Perforation	$200
Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	$14
ORTHODONTICS *(Tooth movement)* **Orthodontic Treatment** *(Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)*	
Interceptive Orthodontic Treatment of the Primary Dentition *(Banding)*	$480
Interceptive Orthodontic Treatment of the Transitional Dentition *(Banding)*	$480
Comprehensive Orthodontic Treatment of the Transitional Dentition *(Banding)*	$500
Comprehensive Orthodontic Treatment of the Adolescent Dentition *(Banding)*	$515
Comprehensive Orthodontic Treatment of the Adult Dentition *(Banding)*	$515
Pre-Orthodontic Treatment Visit	$67
Periodic Orthodontic Treatment Visit *(As part of contract)*	
Children *(Up to 19th Birthday):*	
24 Month Treatment Fee	$2,280
Charge Per Month for 24 Months	$95
Adults:	
24 Month Treatment Fee	$3,000
Charge Per Month for 24 Months	$125
Orthodontic Retention *(Removal of Appliances, Construction and Placement of Retainer(s))*	$345
Unspecified Orthodontic Procedure, By Report *(Orthodontic Treatment Plan and Records)*	$195
GENERAL ANESTHESIA/IV SEDATION — *General Anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV Sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is one hour per appointment. There is no coverage for General Anesthesia or IV Sedation when used for the purpose of anxiety control or patient management.*	
General Anesthesia — First 30 Minutes	$190
General Anesthesia — Additional 15 Minutes	$84
IV Conscious Sedation — First 30 Minutes	$190
IV Conscious Sedation — Additional 15 Minutes	$73
EMERGENCY SERVICES	
Palliative *(Emergency)* Treatment of Dental Pain — Minor Procedure	No Charge
Office Visit — After Regularly Scheduled Hours	$66

Questions

For more information contact Cigna Dental at 1-800-Cigna-24 (244-6224), or go online at www.Cigna.com.

Your Vision Plan Coverage

Your eyesight is important, so Genesis offers you substantial savings on your eye care and eyewear needs at any one of VSP's thousands of provider locations.

How the Plan Works

VSP is a vision care network. When you use a VSP network provider or Affiliate Provider, you pay less than if you go outside the network. In addition, VSP doctors and Affiliate Providers take care of all the paperwork — there are no claims to file. If you do not use a VSP provider, you will receive an allowance toward your eye care expenses. You pay for the services and submit a claim for reimbursement. All claims must be filed within six months of the date of service.

Finding a Provider Near You

For details on your VSP coverage, information on laser surgery, or to find a VSP provider, call 1-800-877-7195 or go online at www.vsp.com.

Please Note: You will not receive a vision ID card, VSP providers will have your information on-line.

Extra Discounts and Savings

Receive 30% savings (on average) for lens extras, such as scratch resistant coating, anti-reflective coating and progressives. You can also receive 20% off additional prescription glasses and sunglasses. Receive up to a 15% discount off the cost of a contact lens exam (fitting and evaluation).

Your Vision Service Plan (VSP)

VSP Benefits	What's Covered	
▸ Examination	Once every 12 months	
▸ Lenses/Contacts	Once every 12 months	
▸ Frames	Once every 24 months	
Provider Services	**Network or Affiliate Provider* Benefit**	**Non-Network Provider Benefit**
▸ Examination	No charge after $10 copay	Up to $52 reimbursement
▸ Single Vision Lenses	No charge after $10 copay	Up to $55 reimbursement
▸ Bifocal Lenses	No charge after $10 copay	Up to $75 reimbursement
▸ Trifocal Lenses	No charge after $10 copay	Up to $95 reimbursement
Contact Lenses *(in lieu of glasses)*	Plan pays 100% up to $120 allowance	Reimbursement up to $120
Frames	Plan pays 100% up to $160 allowance	Reimbursement up to $47
Laser Vision Correction	Discounted Services	None

Coverage with a retail chain affiliate may be different from above. Visit www.vsp.com for details.

FULL-TIME EMPLOYEES ONLY

Pre-Tax Flexible Spending Accounts

Genesis offers you the opportunity to participate in either or both of the following pre-tax flexible spending account options:

- Medical FSA*
- Dependent Care FSA

Flexible spending accounts allow you to set aside money each calendar year to pay for qualified non-reimbursable expenses on a pre-tax basis — *before* the money in your paycheck is taxed.

When you have an eligible expense**, simply submit a claim form or use your new WageWorks Debit Card (for Medical FSA only) and you'll be reimbursed with tax-free dollars from your account. It's the easiest way to cut your taxes. When you pay fewer taxes, you have more money in your pocket to save or spend. It's so easy that 'flexible' is part of the name.

You can track claims, check account balances and download forms at www.wageworks.com. First time users will need to register their account. Call WageWorks at 1-877-924-3967 for more information.

**** If you are enrolled in the Consumer Directed High Deductible (CDHD) Plan, you are not eligible to participate in the Medical FSA. Instead, you may participate in the HSA.***

***** All expenses must be incurred after your benefit eligibility date.***

How Much Can You Contribute?

	Medical FSA Annual Limit	Dependent Care FSA Annual Limit***
Annual Maximum	**$2,500**	$5,000 *(or $2,500 if you are married and file separately)*

****** Please Note: The Dependent Care FSA annual maximum for highly compensated employees will be limited to a lower amount. For 2013 Plan Year, the limit was $2,500.***

Using your QR Code app on your smartphone, scan here for more information from WageWorks.

Reasons to Enroll in a Flexible Spending Account

Using an FSA can pay for your health care and dependent care expenses and save money in taxes at the same time!

Assume that your annual salary is $30,000 and you contribute $2,500 to your Medical FSA. Here's how it works:

	Without FSA	With FSA
Annual Salary	$30,000	$30,000
Pre-Tax FSA Contribution	$0	$2,500
Taxable Income	$30,000	$27,500
Estimated Taxes (30%)	$9,000	$8,250
After-tax Health Care Expenses	$2,500	$0
Annual Take Home Pay	$18,500	$19,250
Tax Savings	N/A	$750

Note: This example is for illustrative purposes only. Actual tax savings will vary depending on your tax circumstances.

Medical FSA

You can use your Medical FSA to pay for qualified expenses not covered by your medical, dental and vision plans, such as deductibles, copays, coinsurance, non-covered vision and hearing expenses and non-covered prescription and over-the-counter medications for which you have a physician's prescription. In general, anything considered a medical expense for income tax purposes is eligible.

Examples of expenses **not** eligible for your Medical FSA include teeth whitening, non-prescription vitamin supplements, cosmetic surgery, marriage counseling, insurance premiums and over-the-counter medications for which you do not have a physician's prescription.

Please note: Medical FSA funds can only be used for tax-qualified dependents, as defined by federal law. Domestic partners and their children are not considered to be tax-qualified dependents, based on IRS regulations. This does not apply to your legally married same-gender dependent and their children.

Pre-Tax Flexible Spending Accounts FULL-TIME EMPLOYEES ONLY

Dependent Care FSA

Through the Dependent Care FSA, you can use tax-free dollars to pay for the cost of day care for your children (under age 13) or other eligible dependents, such as an elderly parent or disabled spouse. You must supply the Social Security Number or tax ID number of your provider to use this benefit.

Expenses that may qualify for reimbursement include:

- Care at licensed nursery schools, day camps, and child day care centers;
- Care at licensed adult/elder care centers; or
- Care provided inside or outside of your home by a person other than your tax dependent or your children age 18 or younger.

Dependent Care FSA Tax Facts

Depending on your personal tax situation, you should determine which is more beneficial to you—the Dependent Care FSA or the dependent care tax credit on your federal income tax form. It's always a good idea to check with your tax advisor to see which program is best for you.

How Your Money Is Reimbursed

- **Medical FSA** – To obtain reimbursement for eligible expenses you may either use the WageWorks Debit Card when you make purchases, or you may file a claim.
- **Dependent Care FSA** – To obtain reimbursement for eligible expenses, you will need to submit a receipt with each claim form. Dependent Care contracts will not be accepted.

Note: WageWorks mobile app can be downloaded to smart phones to access personal FSA information and submit claims or go to www.WageWorks.com to access FSA account information online in real time to check balances and claim status, verify FSA eligible health care expenses and more.

See the Genesis Central intranet site or your Benefits Designee/HR Generalist for claim forms or more information.

Keep These Important FSA Rules in Mind

The government imposes a **"use it or lose it"** rule on Flexible Spending Accounts to give you pre-tax advantages. **Because of this "use it or lose it" rule, it is important for you to carefully estimate the money you set aside.**

- **For Dependent Care FSA only:** You lose any unused portion of your account balance remaining at the end of the year (December 31). You have until April 15 of the following year to submit expenses for reimbursement.
- **For Medical FSA only:** If you reach the end of the plan year (December 31) but have not used all the funds that you have set aside, you will be given a special two-month and 15-day extension/grace period. During that period (January 1 – March 15), you may incur eligible expenses to offset monies set aside for the previous plan year. As an example, receipts dated 01/01/15 through 03/15/15 may be used to offset monies set aside for the 01/01/14 – 12/31/14 plan year.

  Please Note: You must be a plan participant as of December 31 to receive this special extension/grace period, and you must submit the receipts by April 15. <u>This grace period is not available if you elect the CDHD Plan with HSA for 2014.</u>
- Balances cannot be transferred between any of the flexible spending accounts.
- Over-the-counter drugs require a prescription from your doctor to be eligible.
- **Mid-Year Enrollments:** The Pre-Tax Flexible Spending Accounts run on a calendar year basis; therefore, if you are enrolling in benefits mid-year and elect this plan, your deductions will begin on the first pay in which your effective date falls and run through the end of the calendar year. Please see the GHC Pre-Tax Spending Account Program Enrollment Instructions located on the Genesis Central intranet site for more details.

Note: Your WageWorks Debit Card for Medical FSA expenses can be used for the 2013 grace period and 2014 plan year.

FULL-TIME EMPLOYEES ONLY

Health Savings Account

The Health Savings Account (HSA) is only available if you are enrolled in the Consumer Directed High Deductible (CDHD) Plan, **not** enrolled in Medicare Part A or Part B, **not** enrolled in any other medical plan (with the exception of a high deductible medical plan) and **not** enrolled in an Aflac non-HSA compatible Hospital Indemnity or Critical Illness plan. An HSA will be opened after you elect the HSA option. Account fees will apply.

Any payroll pre-tax contributions you elect will be directly deposited into your HSA. Money available in your HSA can be used for qualified health care expenses incurred by you, your spouse or eligible dependents. You can access funds via debit card, online bill pay and online withdrawal. Contact Aetna/PayFlex for information regarding investment options. Any interest or investment earnings on the funds in the HSA are tax-free. Unlike the Medical FSA, there is no "use it or lose it" provision. All balances in the HSA roll over from one year to the next and you will not forfeit any dollars in your HSA even if you move to another company.

Your maximum allowable 2014 calendar year contribution to the HSA—$3,300/single or $6,550/all other coverage levels (and an additional $1,000 in 'catch-up' contributions if you are age 55 or older)—will be prorated if you are not enrolled in the CDHD plan for the entire plan year. If you enroll in the CDHD/HSA after January 1, see the Genesis Central intranet site or your Benefits Designee/HR Generalist for the maximum payroll contributions allowed for the partial plan year.

Your maximum HSA contribution will be determined by the number of tax-qualified dependents covered under the CDHD plan. Additionally, HSA funds can only be used for eligible health expenses for tax-qualified dependents. This does not apply to your legally married same-gender dependent and their children. Domestic partners and their children, as well as adult children who are not tax dependents, are not considered to be tax-qualified dependents, based on IRS regulations.

Note: If you currently have an HSA with JPMorgan Chase or another banking institution, you may rollover your HSA funds into your new HSA. Please see the Genesis Central intranet site for additional information or contact Aetna/PayFlex at 1-888-678-8242.

Short-Term Disability (STD)

FULL-TIME EMPLOYEES ONLY

No one plans to become disabled, but if an unexpected accident or injury renders you unable to work, you have the security of Company-Paid Short-Term Disability coverage.

Eligibility

You are eligible for Short-Term Disability after one year of continuous employment in which you worked at least 1,250 hours in the 12 months prior to the date of your disability.

How the Plan Works

Benefits begin on the 16th day of an off-the-job accident or sickness. Your STD benefit pays you 50% of your regular base salary up to a maximum annual salary of $50,000. You will use all available sick, personal and vacation time (paid at 100%) prior to receiving disability pay at 50%. Benefits continue for up to 26 weeks* inclusive of sick, vacation and personal time.

Please Note: If you work in a state with mandatory Short-Term Disability benefits (including CA, NJ, NY, RI or HI), this STD benefit will be reduced by any other state-mandated benefits you are entitled to receive.

**** Based on the guidelines established by the Medical Disability Adviser, STD for pregnancy is limited to six weeks for normal delivery (vaginal or caesarean).***

Your Life Insurance

FULL-TIME EMPLOYEES ONLY

Company-Paid Group Life Insurance

In most cases, Genesis automatically provides Term Life Insurance coverage at one times your base salary at no cost to you.

Voluntary Term Life Insurance

The Voluntary Term Life Insurance plans provide policies of up to (but not more than 5 times your annual salary) $500,000 for you, $250,000 for your spouse; and $5,000 for your children age 14 days up to 19 years (or 23, if full-time student). When you first become eligible, you are entitled to a "guaranteed issue" policy (based on age) which allows you to elect coverage up to $100,000 and/or up to $25,000 for your spouse/domestic partner, regardless of any pre-existing conditions or prior medical history.

Some of the advantages of Voluntary Term Life are:

No health questions. You can purchase up to the guaranteed issue limit with no health questions, if you enroll when **first eligible**.

Family coverage. You can elect coverage for yourself, your spouse and your children.

Low premium cost. If applying at a young age. Costs increase as you and your dependents age.

Employee and Spouse Rates (Monthly)

Age Band	Rate per $5,000
Under 25	$0.21
25 – 29	$0.25
30 – 34	$0.33
35 – 39	$0.37
40 – 44	$0.42
45 – 49	$0.66
50 – 54	$1.08
55 – 59	$1.99
60 – 64	$3.06
65 – 69	$5.70
70 and over	$8.72
Child(ren) rates: the cost covers all eligible children.	$0.60

Conversion of Company-Paid or Voluntary Term Life Insurance

If your coverage ends, you may convert the amount of coverage that ends to a permanent individual life insurance policy. **You have 31 days after your coverage ends to apply for an individual policy and make the first premium payment.**

Please refer to your plan booklet on the Genesis Central intranet site for more information on conversion.

Portability of Voluntary Term Life Insurance

Portability allows you to keep your Voluntary Term Life Insurance Coverage with affordable group rates if you ever leave Genesis (for reasons other than injury or illness). Please note, if you have a medical condition that has a material effect on life expectancy, your life insurance coverage will not be eligible for portability. It may, however, be eligible for conversion. **You have 31 days after your coverage ends to apply for an individual policy and make the first premium payment.**

Please refer to your plan booklet on the Genesis Central intranet site for more information on portability.

FULL-TIME EMPLOYEES ONLY

Voluntary Products Through Aflac

To enroll, waive, add or make changes to the Voluntary Aflac products listed below, contact your Benefits Designee to meet with your Aflac Representative. Genesis Rehab services and floater employees will be contacted via email on how to obtain information or enroll through the Aflac call center.

Voluntary Short-Term Disability

You may choose to participate in a voluntary Short-Term Disability program. This program provides additional financial security in case of a disability. Your policy is tailored to fit your individual needs. Cost varies according to the monthly benefit level, duration of benefit and elimination period you select. This plan does not require one year of service eligibility rule.

Voluntary Personal Accident Insurance

The voluntary Personal Accident Plan is designed to help cover the expenses associated with an accidental injury and provides direct cash benefits for emergency treatment, hospitalizations, specific injury treatments, accidental death, etc. regardless of any other insurance you may have.

Voluntary Hospital Confinement Indemnity Insurance*

The Voluntary Hospital Confinement Plan provides cash benefits for hospitalization for sickness and injury, diagnostic procedures and outpatient surgery.

Voluntary Critical Event Coverage*

Voluntary Critical Event Coverage is designed to pay cash in the event that you or your covered family member is diagnosed with a critical illness, such as heart attack, coma, end-stage renal failure, stroke, paralysis or major human organ transplant. It also includes the option of covering any type of cancer, including Hodgkin's, Leukemia and Skin Cancer. Benefits include both inpatient and outpatient services along with an annual wellness benefit.

Due to IRS regulations, if you participate in an HSA, you will be limited to HSA-compatible plans. Please see your Aflac representative for details.

Group Auto and Homeowners

FULL-TIME & PART-TIME EMPLOYEES

You are eligible for discounted insurance through the Liberty Mutual Auto and Home Program. Coverage types available include auto, home, condo and renters insurance. Advantages are special savings, great coverage options and convenient payment methods - credit card, EFT and direct billing. Payroll deduction is available to full-time employees. Please call 1-800-524-9400 or visit www.libertymutual.com/genesishealthcare for your free quote. Please mention client #120205. To the extent permitted by law, applicants are individually underwritten. Not all applicants may qualify.

Long-Term Care Insurance

FULL-TIME & PART-TIME EMPLOYEES

Long-Term Care insurance is protection against the costs of care when you can no longer care for yourself. It is a voluntary benefit available through individual policies for you and your eligible family members. For more details on this benefit, contact Barry Widen at 1-828-398-9018.

Your 401(k) Plan

The Genesis HealthCare 401(k) Plan provides you with a convenient way to save for retirement on a tax-deferred basis. Tax-deferred means you do not pay federal—and in most cases, state and local—income taxes on the money you save until you make a withdrawal.

Eligibility

Full-time and part-time Genesis employees become eligible to join the 401(k) Plan after completing 60 days of employment. Casual employees become eligible after working one year and working 1000 hours in a calendar year.

Eligible employees may enroll or change their contribution percentage at any time by calling **Wells Fargo at 1-800-377-9188** (press "0" to talk to a Customer Service Representative), or by visiting the Wells Fargo website at www.WellsFargo.com/401k.

Employee Contributions

You may contribute between 1% and 50% of your pre-tax pay through regular payroll deductions, up to the annual maximum established by the IRS. If you are age 50 and older, you may contribute additional "Catch-Up" tax-deferred dollars. Your contributions and investment earnings grow tax-deferred until the money is withdrawn. All contributions may be directed to any or all of several investment options.

The deferrals of highly compensated employees, as defined by the IRS, are capped to comply with non-discrimination testing requirements.

For additional information and/or assistance in reference to the 401(k) plan, please call Wells Fargo at 1-800-377-9188 or a Genesis Retirement Plan Coordinator at 1-888-HR-AT-GHC (1-888-472-8442).

Company-Matching Contributions

Genesis may make discretionary matching contributions. If a match is made, you must be employed on the last day of the year (December 31) to qualify. The match will be allocated proportionally on the first 6% of salary you contribute to the 401(k) Plan. The maximum match is 1.5% of salary.

Vesting

You are always 100% vested in the value of your own contributions. You become vested in the Company Matching Contributions according to the following schedule:

Years of Service*	Vesting Percentage
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

**Years of Service is defined as a Plan Year in which you work at least 1,000 hours.*

If you leave the Company before you become fully vested, you will receive all of your contributions and your vested portion of Company Matching contributions upon distribution. To request a distribution, contact Wells Fargo.

Loans

The Genesis HealthCare 401(k) Plan allows participants the opportunity to borrow from their account in the form of a loan once a vested balance of $2,000 or more has been accumulated. You may borrow up to $50,000 or 50% of your vested balance, whichever is less. The minimum loan amount is $1,000. A one-time loan initiation fee of $75 will be charged. Loans are repaid through a payroll deduction—all principal and interest goes back to your 401(k) account. Once an existing loan has been paid in full, there is a six-month waiting period until a new loan may be taken. Participants may have one outstanding loan at a time. For additional information, please contact Wells Fargo.

Note: Casual employees are not eligible for loans.

See plan fee information in Appendix I.

Other Important Programs

Planned Time-Off Benefits

As a Genesis employee, you are a dedicated and respected member of our family. We understand that you will be at your best when you are able to meet your personal needs and enjoy regular rest and relaxation. That is why Genesis is pleased to offer planned time-off to our employees. You will receive information about these benefits during your Welcome Program/Orientation. See your manager or Benefits Designee/HR Generalist for details.

Employee Assistance Program

(Full-Time Employees Only)

The EAP, provided through Human Management Services (HMS), offers confidential telephone assessment and three face-to-face assessment meetings, as well as referral services to help you and your eligible dependents successfully manage life's problems. Your EAP counselor will listen to your concerns, help you identify the source of your problems and work with you to find practical solutions. You can turn to your EAP for help with issues that interfere with your personal or work life, such as stress management, marital or relationship issues, parenting, depression, grief or loss, alcohol and drug problems, child or elder care, and financial concerns. The EAP counselors are available 24 hours a day, 7 days a week. Most importantly, the EAP is strictly confidential. The direct toll-free number for HMS is 1-800-343-2186.

Genesis Employee Foundation

The Genesis Employee Foundation (GEF) was started in 2005 as a 501(c)(3) tax exempt organization separate from Genesis HealthCare. The Foundation, which is funded almost completely by employee contributions, provides assistance to Genesis employees whose financial situations have been severely impacted by medical emergencies, natural disasters/fire, domestic violence and burial expenses for loved ones. Since inception, the GEF has assisted more than 3,300 employees and provided over $4.1 million dollars in grants. The Foundation also helps connect employees to local and national resources that can help them through their specific situations. If you are already contributing, the Genesis Family thanks you! If you would like to begin contributing, see your Benefits Designee/HR Generalist to make an online donation through GENSERV. To learn more visit: www.GenesisEmployeeFoundation.org.

ElderCare Benefit Program

Under the ElderCare Benefit, you may be eligible for a 5% reimbursement on out-of-pocket expenses associated with services for eligible dependents by Genesis providers. These services include skilled nursing and rehab, and SelectCare (private duty home care).

For more information on skilled nursing and rehab services, call the toll-free number for your CareLine representative at 1-866-745-CARE (2273). For SelectCare, call 1-800-480-3225, option 3.

The 5% reimbursement will be considered taxable income to you, the employee, due to IRS regulations related to non-tax-qualified dependents.

PEER Program

Employees can donate vacation time to co-workers who are absent due to a personal emergency and have exhausted all available benefit time through the PEER Program (Personal Emergency Employee Relief Program).

A personal emergency includes medical or family emergencies or other hardship situations that require an employee's absence from work for a prolonged period of time. To donate vacation time or to apply, contact your Benefits Designee/HR Generalist.

Other Important Programs

Perks @ Work

Genesis has partnered with various retail/service providers to offer discounted services and products to you. Programs include:

- **Genesis Bank@Work Partnerships (BB&T, Bank of America, Wells Fargo, PNC, National Penn and Citi):** Receive special benefits on checking/savings accounts, online banking, mortgages, loans, lines of credit, CD's, IRA's plus you are eligible to receive financial education from a Relationship Banker. Visit any one of these participating Bank@Work providers in your local area to learn more about discounts for Genesis employees. You will be required to show your employee ID.
- **Discount Shopping Programs for BB&T Bank@ Work Participants:** Discounts available at over 500 merchants and thousands of national brands, theme parks and much more. Visit the following website for more information: www.BBT.com/pluspackage (user name and password can be found in your New/Existing Member Account Kit).
- **Car Rental Discount (Enterprise and National):** Eligible for a 5% discount at all locations throughout the country, using discount code 17C5498, (pin # "gen" when booking online).
- **Wireless Service Discount: (AT&T, Sprint and Verizon):** Eligible for up to 25% discount on calling plans. Visit a local store and provide proof of employment (AT&T: Genesis Code #03306321; Sprint: Genesis Code #HCINN_GHC_ZZZ; Verizon: no code—show proof of employment and a valid driver's license).
- **Group Auto and Homeowners:** You are eligible for discounted insurance through the Liberty Mutual Auto and Home Program. Coverage types available include auto, home, condo and renters insurance. See page 24 for more details.
- **Tuition Discounts** are available to you and your family members at the following University Partners (Drexel University = 10-25%, Kaplan University = 10-20%, Capella University = 10%, The University of Phoenix = 6% and the The College Network = 10%). Go to the Genesis Central intranet site > Clinical > University Partners for additional information.
- **CE Direct** is available to full-time and part-time licensed nurses and social workers in our Genesis Centers. CE Direct offers unlimited, online access to more than 1,000 ANCC hours of content including over 100 video webinars. Courses range from 1 to 30 contact hours. Each online course provides real time testing and instant receipt of a printable CE certificate. Courses can also be taken in a paper version through Nurse.com or as Podcast and audio courses.

COBRA

If you or your dependents lose health coverage in a Genesis-sponsored health plan, you/they may have an opportunity for a temporary extension of health coverage at group rates. This is called COBRA. Notification of these COBRA rights will automatically be provided to you and your family once you elect or lose health coverage.

See COBRA Initial Notification information on the Genesis Central intranet site.

Women's Health and Cancer Act

The Women's Health and Cancer Act ("Women's Health Act") was signed into law on October 21, 1998. This law requires that all medical plans cover breast reconstruction following a mastectomy.

Under this law, if an individual has had a mastectomy and elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending medical provider and the patient.

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for physical complications at all stages of the mastectomy, including lymphedemas.

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services.

Summary of Benefits and Coverage (SBC)

Summary of Benefits and Coverage (SBC) documents for the Max Value, Standard and CDHD Plans are available on the Genesis Central intranet site or see your Benefits Designee/HR Generalist.

Health & Welfare Plan Document and Summary Plan Description (SPD)

The Genesis HealthCare LLC Health & Welfare Summary Plan Description is available on the Genesis Central intranet site or you may request a hard or soft copy from your Benefits Designee/HR Generalist or by calling the Benefits Services Department at 888-HR-AT-GHC (888-472-8442).

Other important notices and documents are detailed in the SPD and include the following:

- ERISA Rights Statement
- Important Information about Your Health Information Plan Privacy
- Maternity and Newborn Coverage
- Claim Procedure Details
- Designation of Primary Care Providers by Participants or Beneficiaries
- Plan's Grandfathered Status
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

Medicare Part D – Creditable Coverage

Important Notice Only for Individuals Eligible for Medicare

Based on information from the Centers for Medicare and Medicaid Services (CMS), this notice is about Medicare Part D and your prescription drug coverage under the following Genesis HealthCare sponsored medical plans:

- Max Value Plans
- Standard Plans
- Kaiser Plans
- Consumer Directed High Deductible (CDHD) Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with one of the plans listed above and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this section.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. All the plans listed earlier have determined that the prescription drug coverage is, on average for all plan participants, expected to pay as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

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

What Happens to Your Current Coverage If You Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan and drop your medical and prescription drug coverage listed earlier, be aware that you and your dependents will be dropping not just prescription drug coverage but medical coverage as well, and may not be able to get that coverage back until the next Open Enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should know that if you drop or lose your current coverage with one of the plans listed earlier and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your prescription drug plan at the number listed on your ID card.

Please Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under the Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227)
  TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember to keep this notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this 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).

Date:	October 1, 2013 (notice for the 2014 Plan Year)
Company:	Genesis HealthCare LLC
Contact:	Benefit Services Department
Address:	515 Fairmount Avenue Towson, MD 21286
Phone Number:	1-888-472-8442

Health Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that 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 that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for 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 that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or visit the Benefits tab at http://central.genesishcc.com/sites/HR.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about Health Coverage Offered by Genesis HealthCare

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Genesis HealthCare LLC
4. Employer Identification Number (EIN): 27-3237296
5. Employer Address: 101 E. State Street
6. Employer Phone Number: 1-888-472-8442
7. City: Kennett Square
8. State: PA
9. ZIP Code: 19348
10. Whom can we contact about employee health coverage at this job? Benefit Services Department
12. Email Address: benefits@genesishcc.com

Here is some basic information about health coverage offered by this employer (If you are in a bargaining unit position, please refer to your Collective Bargaining Agreement to determine medical plan eligibility):

- As your employer, we offer a health plan to some employees. Eligible employees are employees with a job classification of full-time and who have completed their benefit waiting period.
- With respect to dependents, we do offer coverage. Eligible dependents are spouse/domestic partner, children to their 26th birthday, children who are incapable of self-sustaining employment by reason of mental or physical handicap, if covered as a dependent prior to age 26, children for whom the employee must provide health insurance by a qualified medical child support order (QMCSO).
- This coverage meets the minimum value standard, and the cost of this coverage is intended to be affordable to most of our employees based on employee wages. The law currently defines our plan as affordable as long as 9.5% of your household taxable income (referred to as MAGI by the government) is more than the lowest employee only (single) payroll contribution. Whether or not the plan is affordable in 2014 will be based on our 2014 employee contributions, so the income at which the plan is affordable may vary in 2014.

When you fill out the Marketplace application, a number called “modified adjusted gross income” (MAGI) will be used. MAGI is generally your household’s adjusted gross income plus any tax-exempt Social Security, interest and foreign income you have. It’s used to determine your eligibility for lower costs on Marketplace coverage, and for Medicaid and the Children’s Health Insurance Program (CHIP). (Your adjusted gross income is your income minus your tax deductions.) You don’t have to figure out this income yourself. The math will be done for you when you apply through the Marketplace or your state agency.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Appendix I: Genesis 401(k) Plan Fee Information

The table below contains information about the investment options available in your plan. You can see how these investments have performed over time and compare them with an appropriate benchmark for the same time periods. This table also shows:

- Annual operating expenses (expenses that reduce the rate of return of an investment)
- Shareholder-type fees (these are in addition to total annual operating expenses)
- Investment limitations, restrictions, or both

You can make changes to your investment options at www.wellsfargo.com/401k, or you can call the Retirement Service Center at **1-800-377-9188** and speak to a representative Monday through Friday from 7:00 a.m. to 11:00 p.m. Eastern Time.

The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor's website for an example showing the long-term effect of fees and expenses at http://www.dol.gov/ebsa/publications/401k_employee.html. Fees and expenses are only one of many factors to consider when you decide to invest in an option. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals. Give careful consideration to the importance of a balanced and well-diversified portfolio, taking into account all your assets, income, and investments.

Asset Class **Fund Name** **Type of Fund** *Benchmark*	**Performance** (as of 3/31/2013) **3-Month**	 **1-Year**	 **5-Year**	 **10-Year/Since Inception***	**Annual Operating Expenses** **Gross Percentage/ per $1,000**	 **Net Percentage**/ per $1,000**
Stable Value/Money Market						
Federated Capital Preservation ISP	**0.26%**	**1.29%**	**2.50%**	**3.19%**	**0.68%/ $6.80**	**0.68%/ $6.80**
USTREAS T-Bill Cnst Mat Rate 3 Yr	*0.09%*	*0.80%*	*1.91%*	*2.79%*		
Bonds						
PIMCO Total Return Admin	**0.54%**	**7.65%**	**7.50%**	**6.39%**	**0.71%/ $7.10**	**0.71%/ $7.10**
Barclays US Agg Bond TR USD	*-0.12%*	*3.77%*	*5.47%*	*5.02%*		
Balanced/Lifestyle						
Vanguard Wellington Adm	**7.05%**	**12.11%**	**6.63%**	**9.43%**	**0.17%/ $1.70**	**0.71%/ $1.70**
Morningstar Moderately Aggr Target Risk	*6.82%*	*10.91%*	*5.36%*	*9.79%*		
Trust Asset Fees: 20.00 bps for fund market value of $0.00 and greater. Transfers of $0.01 or more OUT of this fund prohibit you from transferring $0.01 or more INTO this fund for 60 calendar day(s).						
Target Date Funds						
Wells Fargo Advantage DJ Target Today R4	**0.27%**	**N/A**	**N/A**	***0.27%**	**0.74%/ $7.40**	**0.45%/ $4.50**
DJ Target Today TR USD	*0.40%*	*N/A*	*N/A*	**1.30%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						

Appendix I: Genesis 401(k) Plan Fee Information

Asset Class Fund Name Type of Fund *Benchmark*	Performance (as of 3/31/2013) 3-Month	1-Year	5-Year	10-Year/Since Inception*	Annual Operating Expenses Gross Percentage/ per $1,000	Net Percentage**/ per $1,000
Target Date Funds (continued)						
Wells Fargo Advantage DJ Target 2010 R4	**0.97%**	**N/A**	**N/A**	***1.23%**	**0.75%/**	**0.47%/**
Target Date 2010					**$7.50**	**$4.70**
DJ Target 2010 TR USD	*1.13%*	*N/A*	*N/A*	**4.21%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2015 R4	**1.98%**	**N/A**	**N/A**	***2.61%**	**0.75%/**	**0.48%/**
Target Date 2015					**$7.50**	**$4.80**
DJ Target 2015 TR USD	*2.13%*	*N/A*	*N/A*	**8.47%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2020 R4	**3.03%**	**N/A**	**N/A**	***4.05%**	**0.72%/**	**0.50%/**
Target Date 2020					**$7.20**	**$5.00**
DJ Target 2020 TR USD	*3.32%*	*N/A*	*N/A*	**13.58%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2025 R4	**4.29%**	**N/A**	**N/A**	***5.76%**	**0.74%/**	**0.50%/**
Target Date 2025					**$7.40**	**$5.00**
DJ Target 2025 TR USD	*4.59%*	*N/A*	*N/A*	**19.21%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2030 R4	**5.47%**	**N/A**	**N/A**	***7.37%**	**0.74%/**	**0.51%/**
Target Date 2030					**$7.40**	**$5.10**
DJ Target 2030 TR USD	*5.82%*	*N/A*	*N/A*	**24.88%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2035 R4	**6.52%**	**N/A**	**N/A**	***8.78%**	**0.76%/**	**0.52%/**
Target Date 2035					**$7.60**	**$5.20**
DJ Target 2035 TR USD	*6.88%*	*N/A*	*N/A*	**29.93%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2040 R4	**7.29%**	**N/A**	**N/A**	***9.80%**	**0.75%/**	**0.52%/**
Target Date 2040					**$7.50**	**$5.20**
DJ Target 2040 TR USD	*7.66%*	*N/A*	*N/A*	**33.71%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						

Appendix I: Genesis 401(k) Plan Fee Information

Asset Class / Fund Name / Type of Fund / *Benchmark*	Performance (as of 3/31/2013) 3-Month	1-Year	5-Year	10-Year/Since Inception*	Annual Operating Expenses Gross Percentage/ per $1,000	Net Percentage**/ per $1,000
Target Date Funds (continued)						
Wells Fargo Advantage DJ Target 2045 R4	**7.74%**	**N/A**	**N/A**	***10.41%**	**0.77%/**	**0.52%/**
Target Date 2045					**$7.70**	**$5.20**
DJ Target 2045 TR USD	*8.05%*	*N/A*	*N/A*	**35.66%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2050 R4	**7.70%**	**N/A**	**N/A**	***10.44%**	**0.76%/**	**0.52%/**
Target Date 2050					**$7.60**	**$5.20**
DJTarget 2050 TR USD	*8.09%*	*N/A*	*N/A*	**35.85%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Advantage DJ Target 2055 R4	**7.62%**	**N/A**	**N/A**	***10.29%**	**3.91%/**	**0.52%/**
Target Date 2051+					**$39.10**	**$5.20**
DJ Target 2055 TR USD	*8.09%*	*N/A*	*N/A*	**35.85%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Stock						
MFS Value R4	**12.12%**	**16.04%**	**5.51%**	***6.37%**	**0.71%/**	**0.71%/**
Large Value					**$7.10**	**$7.10**
Russell 1000 Value TR USD	*12.31%*	*18.77%*	*4.85%*	**5.33%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Wells Fargo Enhanced Stock Market Fund N[1]	**11.26%**	**14.96%**	**6.16%**	**9.04%**	**0.13%/**	**0.13%/**
Large Blend					**$1.30**	**$1.30**
S&P 500 TR	*10.61%*	*13.96%*	*5.81%*	*8.53%*		
Trust Asset Fees: 25.00 bps for fund market value of $0.00 and greater						
JPMorgan Large Cap Growth R5	**6.41%**	**2.32%**	**N/A**	***20.13%**	**0.71%/**	**0.71%/**
Large Growth					**$7.10**	**$7.10**
Russell 1000 Growth TR USD	*9.54%*	*10.09%*	*N/A*	**19.97%*		
Dreyfus MidCap Index	**13.30%**	**17.18%**	**9.37%**	**11.95%**	**0.51%/**	**0.50%/**
MidCap Blend					**$5.10**	**$5.00**
S&P MidCap 400TR	*13.45%*	*17.83%*	*9.85%*	*12.45%*		
Royce Pennsylvania Mutual Svc	**10.08%**	**12.28%**	**7.06%**	***6.69%**	**1.20%/**	**1.20%/**
Small Growth					**$12.00**	**$12.00**
Russel 2000 Growth TR USD	*13.21%*	*14.52%*	*9.04%*	**7.33%*		

Appendix I: Genesis 401(k) Plan Fee Information

Asset Class Fund Name Type of Fund *Benchmark*	Performance (as of 3/31/2013) 3-Month	1-Year	5-Year	10-Year/Since Inception*	Annual Operating Expenses Gross Percentage/ per $1,000	Net Percentage**/ per $1,000
Stock (continued)						
T. Rowe Price New Horizons	**13.42%**	**13.63%**	**13.74%**	**14.30%**	**0.81%/**	**0.81%/**
Small Growth					**$8.10**	**$8.10**
Russell 2000 Value TR USD	*13.21%*	*14.52%*	*9.04%*	*11.61%*		
Transfers of $0.01 or more OUT of this fund prohibit you from transferring $0.01 or more INTO this fund for 30 calendar day(s).						
American Funds Capital World Growth & Income Fund (R4)	**6.44%**	**14.06%**	**2.19%**	**11.54%**	**0.80%/ $8.00**	**0.80%/ $8.00**
World Stock						
MSCI World NR USD	*7.73%*	*11.85%*	*2.23%*	*8.88%*		
Transfers of $5000.00 or more OUT of this fund prohibit you from transferring $5000.00 or more INTO this fund for 30 calendar day(s).						
Thornburg International Value R5	**2.46%**	**6.65%**	**0.24%**	***7.16%**	**1.06%/**	**0.99%/**
Foreign Large Blend					**$10.60**	**$9.90**
MSCI EAFE NR USD	*5.13%*	*11.25%*	*-0.89%*	**4.31%*		

[1] A collective investment fund is a pooled investment vehicle that is exempt from SEC registration as an investment company under Section 3(c)(11) of the Investment Company Act of 1940 and maintained by a bank or trust company for the collective investment of qualified retirement plans. CIFs are authorized by the Office of the Comptroller of the Currency (OCC) and are also known as "A2" funds, referring to the section in OCC rules that defines them. **The Fund is not a mutual fund and not subject to the same registration requirements and restrictions as mutual funds.**

[2] The Funds contained in this document show unitized returns that operationally accounts for accrued interest in the net asset value (NAV). This method of accounting allows participants the benefit of accrual of income and eliminates the need to allocate residual interest after a participant has chosen to transfer out of the account or receive a distribution of account units during the month. The NAV treatment does not affect the funds reported performance or investment objectives.

*Returns are since inception for funds that are less than ten years old.

**Investment options that show a net percentage lower than the gross percentage under total annual expenses have certain fee waivers in effect which reduce the expenses for that investment option. Net expenses per $1,000 presume (but do not guarantee) that the fee waiver is in effect for the one-year period. For more information about any fee waiver, including its duration, see the investment prospectus or similar disclosure document. Any amounts that may have been rebated back to the plan from an investment option's total annual operating expenses are not taken into account in the net percentages or net expenses per $1,000.

Unless noted in the investment chart above, a plan fiduciary is responsible for voting, tender, and other similar rights for the plan's designated investment options.

Please visit www.wellsfargo.com/401k for more information about the investments in your plan, including the most up-to-date investment performance and annual expense information. For a free copy of this information, or for further information, contact the Retirement Service Center at www.wellsfargo.com/401k. For a free paper copy of this information, or for further information contact the Retirement Service Center at 1-800-377-9188 or write to Institutional Retirement and Trust, D1116-055, 1525 West WT Harris Boulevard, Charlotte, NC 28262. In addition, a glossary of investment related terms is available on the website to help you better understand your investment options.

Figures quoted represent past performance, which is no guarantee of future results. Investment return and principal value and yields of an investment will fluctuate so that an investor's shares, when redeemed, may be worth more or less than their original cost. Current performance may be lower due to market volatility. These returns include reinvestment of dividends and capital gains. Government bonds are not insured or guaranteed by the U.S. Government.

Benchmarks are not investments and are shown for performance comparison purposes only. The benchmark shown represents an appropriate broad-based securities market index. In cases where two benchmarks are provided, the first is the broad-based benchmark and the second is an alternative benchmark for further comparison information.

Fund information contained herein (including performance information) is obtained from reliable sources including Morningstar and/or mutual fund companies, but is not guaranteed as to accuracy, completeness and timeliness. Provider shall not be liable for any errors in content or for any actions taken in reliance thereon. Certain funds listed may impose redemption fees on shares that are transferred or exchanged out of the applicable fund before the applicable minimum holding period. An investor should consider the funds' investment objectives, risks, charges and expenses carefully before investing or sending money. This and other important information about the investment company can be found in the fund prospectus, when available. To obtain a copy of the prospectus, please contact the fund company or call a retirement service representative. Please read the prospectus carefully before investing.

Investment in retirement plans:

NOT FDIC INSURED ▪ NO BACK GUARANTEE ▪ MAY LOSE VALUE

Appendix I: Genesis 401(k) Plan Fee Information

Additional Fee Information

The table below summarizes additional fees that may be charged to your account. Fees actually charged to your account will be shown on the Account Summary section of the statement.

Fee Paid By	Fee	Fee Amount	Allocation Method/Frequency
Participant[1]	Florida Stamp Tax	0.35%	Each
Participant[1]	LUMP SUM	$20.00	Each
Participant[1]	MA Morningstar(MS) Fee*	13.00 bps	Annually Charged Monthly
Participant[1]	MA Wells Fargo(WF) Fee*	50.00 bps	Annually Charged Monthly
Participant[1]	New Loan Fee	$75.00	Each
Plan	In Kind Distribution	$30.00	Per Participant/Each
Plan	Per Participant Charge	$3.00	Per Participant/Per Year

The fees noted above are paid to service providers for plan administration, such as loan processing, legal, accounting, and recordkeeping services. These fees vary each year based on different factors. Your employer has discretion to pay plan administration expenses from its own assets or from the plan's assets, and may change its decision on how such expenses are paid at any time. Other fees, such as a fee for a new service, may apply. Fees that are charged to the plan, or to your account directly, will be shown on your quarterly statement. *Some of the plan's administrative expenses for the preceding quarter may have been paid from the total annual operating expenses of one or more of the plan's designated investment alternatives.*

*In addition to the AdviceTrack fee(s) noted above, participants utilizing AdviceTrack pay the total annual operating expenses of the funds in which their account is invested, less amounts rebated back to the fund in certain situations.

Pro Rata: This term refers to the practice of charging a proportion of a fee for a fraction of a unit that the fee applies to. A fee charged for a period of time can be prorated for the actual number of days that the fee applied to in the fee period. A fee charged for a unit (such as a block of shares) can be prorated for the actual number of shares involved. In practice, formulas are sometimes used to approximate or round off the quantities applied to prorated fees. These actual formulas are typically spelled out in the plan documents or prospectus. In the context of an employer-sponsored retirement plan, this term usually refers to the practice of charging fees proportionately across retirement plan participant accounts. In practice, a fee is assessed against a plan participant's account in proportion to the size of his account relative to the size of all other participants' accounts in the retirement plan.

[1]Fees paid by participants also include any asset or redemption fees noted in the investment performance and operating expenses chart.

Notes

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HAVE QUESTIONS?

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410-832-8376
410-494-4976 (Fax)

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