Community	County NV 10001		Effective Date: 04/01/2015	Prepared On: 2/23/20
Prepared By: Clifford Gre	ekin Inc (631)963-6020		Report ID: 27966431	SIC: 00
	Aetna NYC Community PlanSM \$20 ID: 14025430 (EPO) (UC		Aetna =N/A) NYC Community PlanSM \$30 ID: 14025431 (EPO) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs				
Drug Card	10/50/50%to\$750/TCS		10/50/50%to\$750/TCS	
Cost Share Information				
ndividual/Family Deductible	D-N/A; ND-\$5,000/\$10,000 embedded		D-N/A; ND-\$5,000/\$10,000 embedded	
ndividual/Family OOP Limit	D-\$1,000/\$2,000; ND-\$5,250/ \$10,500 (incl ded)		D-\$1,000/\$2,000; ND-\$5,250/ \$10,5000 (incl ded)	
Co-Insurance	D-N/A; ND-30%		D-N/A; ND-30% after ded	
Office Visits				
Primary Care	D-\$20; ND-30% after ded		D-\$30; ND-30% after ded	
Specialist	D-\$35; ND-30% after ded		D-\$50; ND-30% after ded	
Maternity Prenatal/Postnatal Care	Pre-No charge; Post-refer to carrier		Pre-No charge; Post-refer to carrier	
Chiropractic Care	D-\$35; ND-30% after ded		D-\$50; ND-30% after ded	
npatient Services				
npatient Hospital	D-\$500/admit; ND-30% after ded		D-\$1,000/admit; ND-30% after ded	
Nental Health Inpatient	D-\$500/admit; ND-30% after ded		D-\$1,000/admit; ND-30% after ded	
Substance Abuse Inpatient	Detox: D-\$500/admit; ND-30% after ded Rehab: D-\$500/admit; ND-30% after ded		Detox: D-\$1,000/admit; ND-30% after ded Rehab: D-\$1,000/admit; ND-30% after ded	
Outpatient Services				
Dutpatient Facility	Refer to Outpatient Surgery		Refer to Outpatient Surgery	
.ab/X-Ray	Lab-D-No charge ND-30% after ded; X-ray-D-\$35 ND-30% after ded		Lab-D-No charge ND-30% after ded; X-ray-D-\$50 ND-30% after ded	
Advanced Radiology	D-\$35; ND-30% after ded		D-\$50; ND-30% after ded	
Mental Health Outpatient	D-\$35; ND-30% after ded		D-\$50; ND-30% after ded	
Substance Abuse Outpatient	Detox: D-\$35; ND-30% after ded Rehab: D-\$35; ND-30% after ded		Detox: D-\$50; ND-30% after ded Rehab: D-\$50; ND-30% after ded	
Emergency Care				
Emergency Room	\$100 (waived if admitted)		\$150 (waived if admitted)	
Ambulance	\$100		\$100	
Jrgent Care	D-\$35; ND-30% after ded		D-\$35; ND-30% after ded	
Recovery/Special Needs				
lome Health Care	D-\$20; ND-25% ded waived 40 visits/cal yr		D-\$30; ND-25% ded waived 40 visits/cal yr	
Skilled Nursing	D-\$500/admit; ND-30% after ded		D-\$1,000/admit; ND-30% after ded	
Durable Medical Equipment	50%		50%	
Single	1 x \$565.00		1 x \$562.11	
EE with Spouse	0 x \$1,129.99		0 x \$1,124.22	
EE with Child(ren)	0 x \$960.50		0 x \$955.59	
Family	1 x \$1,610.24		1 x \$1,602.02	
Monthly Cost	2 \$2,175.24		2 \$2,164.13	

The rates and benefits in this report are for discussion and estimation purposes only and are not valid without approval from the insurance carriers. Final rates must be based on insurance carrier confirmation and final enrollment. Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible