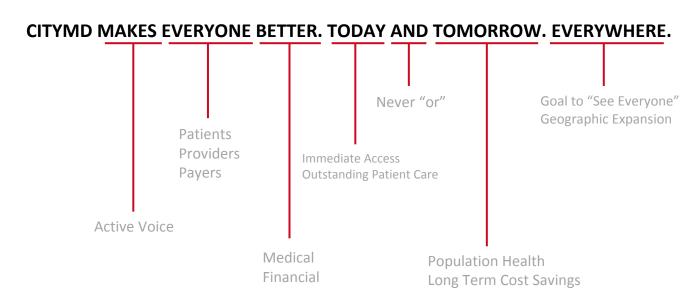


THE VISION

Our company vision is to have a world in which:



ACCESS & BRAND AWARENESS

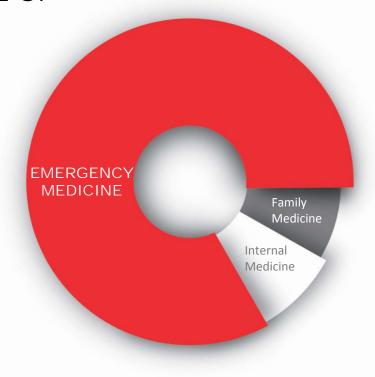


OUR SCALE





WHAT WE'RE MADE OF



TRAINING AND EXPERIENCE

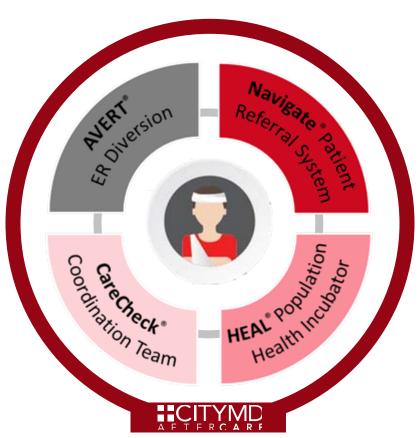
YOU MIGHT BE THINKING...

Traditional Knocks on Urgent Care

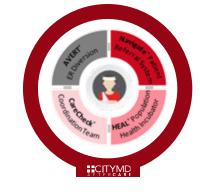


CARE COORDINATION

Turning Episodic Care Into Coordinated Care



AfterCare: OUR INVESTMENT



Our Long Island Site and Staff Who Work Behind the Scenes

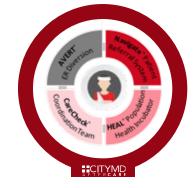






CARE COORDINATION SOLUTION I: AVERT

A Formalized Way To Be The ER Alternative



A Real-Time ER Diversion Platform:

- •Collects Patient Data
- •Calculates Patient Risk Scores
- •Alerts CityMD Doctors and AfterCare tea
- •Triggers Automatic Response and Focus



THE CARE COORDINATION SOLUTION II: NAVIGATE

Directing Patients to The Best Providers in the Right Networks

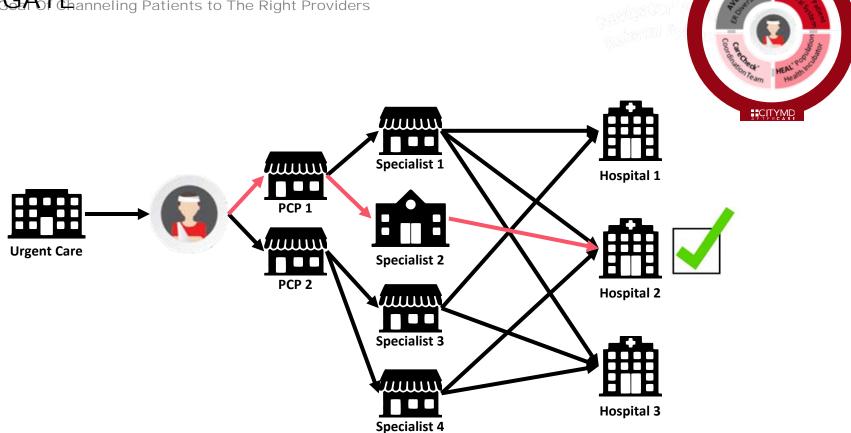
True Referral and Direction For Patients and Providers:

- •Collects Key Information: Required Doctor Type, Neighborhood, Insurance Plan, Practitioner Power Score
- •Proactively Notifies: Partner Health Systems, Physicians, and Plans Receive Notifications of Patient Visits
- •Discovers Invisible Patients: Offers new PCP relationships to unattached patients



THE CARE COORDINATION SOLUTION II:

NAMIGATE anneling Patients to The Right Providers



THE CARE COORDINATION SOLUTION III: HEAL

Exploring and Implementing Long-Term Solutions for the Greater Good

Testing New Care Platforms to Heal the Not-Yet-Sick:

•Studies Population Health: Dedicated in-house team led by the Chief Medical Officer

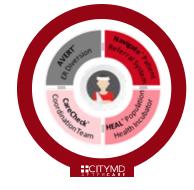
•Forms Collaborative Partnerships: Inside our organization and with outside healthcare companies

•Invests in the Future Of Care: Forms initiatives designed to treat the undiagnosed, newly diagnosed, and "not-yet-sick" populations



SAMPLE HEAL PROJECT: NOOM HEALTH

Compounding Care Value Through Partnerships









THE CARE COORDINATION SOLUTION IV: CareCheck

The Invisible Care Network Behind Our Doctors



•Complete Team Located on Long Island: Dedicated team of 100+ local MDs, PAs, and Scribes

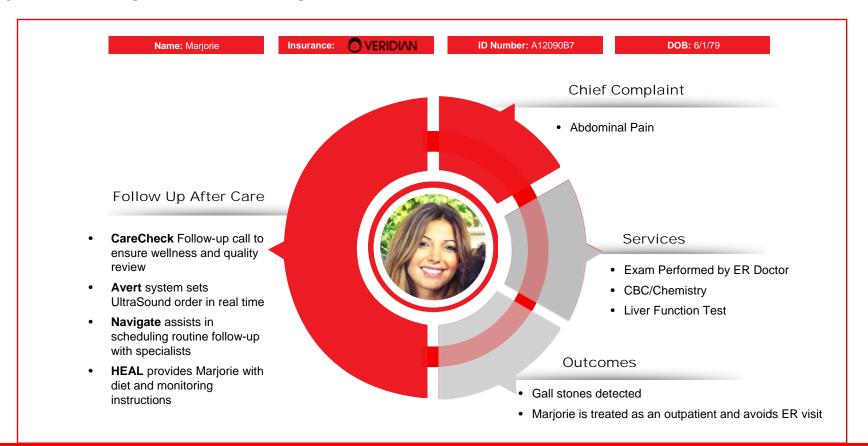
•Clinical Follow-Up Powerhouse: AfterCare makes 2.2 clinical calls per visit, to make visits more valuable

•A System of Tools and QA: Closing episodic care loop, ensuring compliance with directives, and coaching patients





AFTERCARE IS HALF OF CARE Why AfterCare Changes The Value of an Urgent Cate Visit



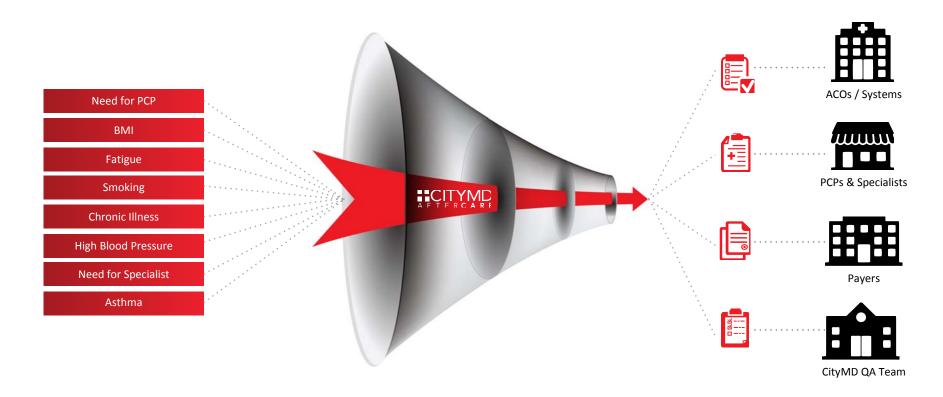


DATA INTERGRATION CityMD's Data Collection Capability

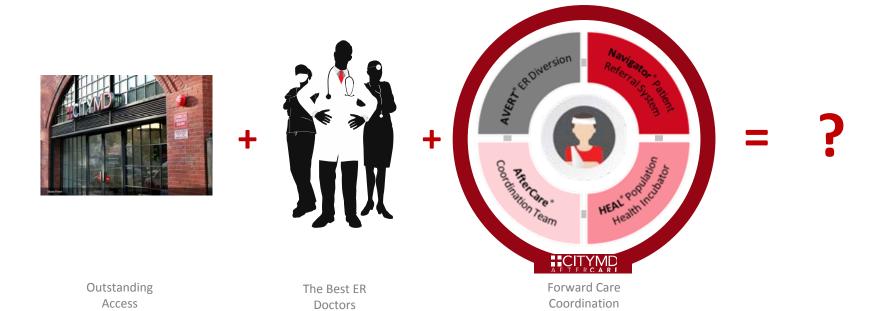




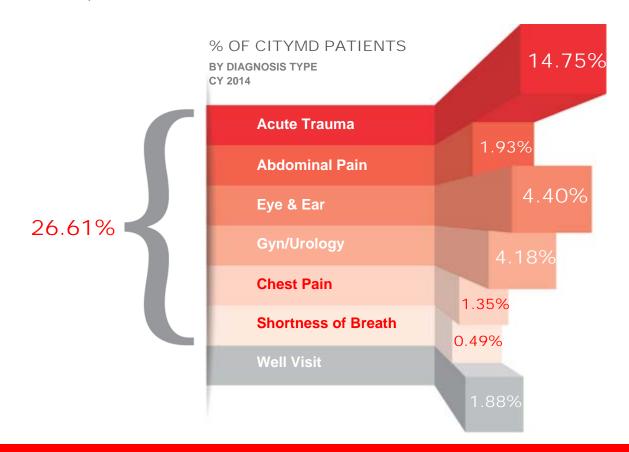
DATA INTERGRATION Our Data Distribution Team and System



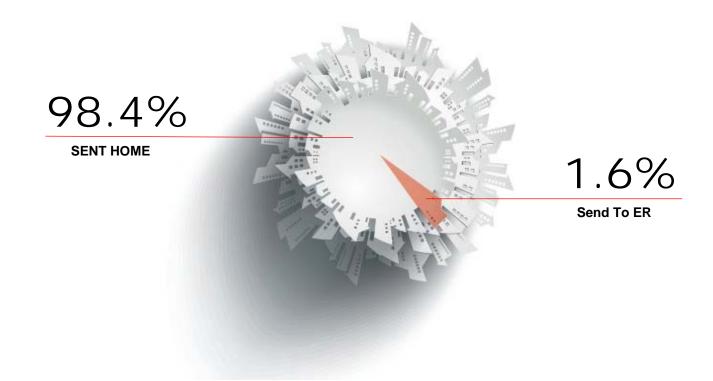
THE RECIPE
The "Above and Beyond" Components of Care



THE PROOF IS IN THE PERCENTAGE Evidence That Our Recipe Provides a True ER Alternative



OUR "DON'T SEND TO ER" RATE Despite Higher Acuity, We Get Patients Home



PARTNERING FOR QUALITY: HEDIS





PARTNERING FOR QUALITY: PATIENT CONTROL

Compounding Care by Directing Patients

REFERRALS BY THE NUMBERS:

SINGLE SITE TEST

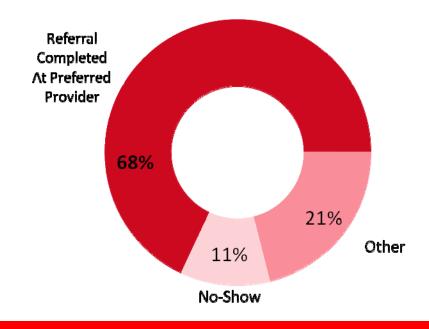
Q1 2015

	Soft Referra I	Manage d Referral
	407	267
AVERT	N/A	22%
PCP	19%	15%
Ortho	12%	15%
ENT	14%	6%
Cardiol	10.10/	F0/

√0 1%

口0/

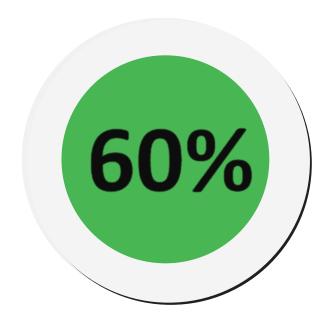
WHERE THEY GO: REFERRAL POWER SINGLE SITE TEST
Q1 2015





PARTNERING FOR QUALITY: PATIENT CONTROL

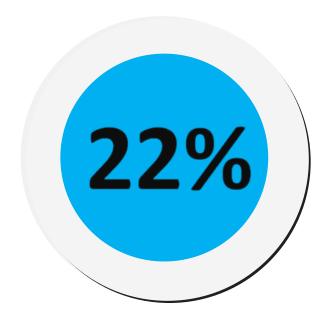
The Two Numbers That Make All The Difference



REFERRALS WITH NO KNOWN PCP OR NETWORK AFFILIATION

SINGLE SITE TEST

Q1 2015



% OF REFERRALS FOR "STAT" FOLLOW-UP SINGLE SITE TEST

ONTOLL OTTE TEOT

Q1 2015



