REPORT ON EXAMINATION

OF

CUATRO LLC

AS OF

DECEMBER 31, 2012

DATE OF REPORT **MARCH 5, 2014**

EXAMINER **ANDRE BLACKMAN**

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March 5, 2014

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31012, dated July 10, 2013, attached hereto, I have made an examination into the condition and affairs of Cuatro LLC, d/b/a Access Medicare NY, a Medicare Advantage Health Maintenance Organization ("HMO") certified pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2012. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Cuatro LLC, d/b/a Access Medicare NY, located at 93-20 Roosevelt Avenue, Jackson Heights, New York.

Wherever the designations "Cuatro" or the "Plan" appear herein, without qualification, they should be understood to indicate Cuatro LLC.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

As of December 31, 2012, the Plan was insolvent in the amount of $86,225. The Plan's minimum contingency reserve, determined using the requirements of Parts 98-1.11(e)(ii) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), was impaired in the amount of $1,803,447. Subsequent to the examination, as of June 30, 2014, the Plan cured its insolvency but remained impaired in the amount of $604,609.

1. SCOPE OF THE EXAMINATION

This is the first examination of the Plan. The financial portion of this examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2012 Edition* (the "Handbook"), covered the period from the Plan's inception, May 4, 2010, through December 31, 2012. The examination was conducted observing the guidelines and procedures detailed in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2012 were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations, and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC Annual Statement Instructions.

Information concerning the Plan's organizational structure, business approach and control environment was utilized to help develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

A limited review of the Plan's market conduct activities was also performed.

The Plan was audited annually, for the years 2011 and 2012, by the accounting firm of Baker Tilly Virchow Krause, LLP ("Baker Tilly"), formerly Holtz Rubenstein Reminisce LLP. The Plan received an unqualified opinion in each of those years. Certain audit work papers of Baker Tilly were reviewed and relied upon in conjunction with this examination.

This report on examination is confined to financial statements and comments on those matters which involve departure from laws, regulations or rules, or which require explanation or description.

2. DESCRIPTION OF THE PLAN

Cuatro, a Medicare Advantage HMO, was incorporated on March 23, 2009, and was granted a Certificate of Authority to write business pursuant to Article 44 of the New York State Public Health Law on May 4, 2010. The Plan offers Managed Medicare coverage for dual-eligible (Medicare and Medicaid) persons under three contract models: "Gold", "Platinum", and "Pearl". Direct premiums for 2012 were $19,724,717, and membership at the end of 2012 was 1,930 members.

The Plan is in its initial years of operation and experiences higher expenses to premiums ratios which result in higher unit costs that have resulted in underwriting losses since its inception and could continue to drive underwriting losses during succeeding years. Cuatro is a Limited Liability "C" Corporation for tax purposes, but operates as a partnership.

A. Management and Controls

The Plan was formed through investments by individuals purchasing share subscriptions of the Plan. Individuals who purchased shares were assigned to a class and given ownership rights based upon their respective affiliations.

There are three ownership classes, and their percentage of membership as of December 31, 2012 is as follows:

	Members	Percentage
Class A	5	3%
Class B	87	60%
Class C	53	37%
Total	145	100%

- Class A members have the right to participate in the selection of the Managing Member, and in the nomination and election of three additional members and one non-member to the board of directors of the Plan. They also participate in decisions regarding the distribution of profits and losses.

- Class B members are primary care physicians who have the right to participate in the nomination and election of one member to the board of directors of the Plan.

- Class C members are specialty physicians that have the right to participate in the nomination and election of one member to the board of directors of the Plan.

Pursuant to the Plan's operating agreement, the Plan is managed by the Managing Member. According to Article VIII of the plan's Operating Agreement, all powers are vested in the Managing Member. Section 8.1 of the agreement reads:

> *"The Managing Member shall have exclusive and complete authority and discretion to manage the operations and affairs of the company and to make all decisions regarding the business of the Company. Any action taken by the Managing Member shall constitute the act of and be binding upon the Company."*

A board of directors consisting of five people is to be appointed as described above, and performs guidance and oversight functions on behalf of the Plan. As of December 31, 2012, the board of directors consisted of four members instead of five, as set forth below.

The following individuals were members of the board of directors of the Plan as of December 31, 2012:

Names and Residence	Principal Business Affiliation
Julio Albarran, M.D. Old Tappan, NJ	Gastroenterologist
Acedo Cruz M.D. Union, NJ	Internal Medicine Practitioner

Names and Residence	Principal Business Affiliation
Juan T. Estevez, M.D. New Rochelle, NY	Pediatrician, Managing Member, CEO
Mario Paredes * New York, NY	Retired, American Bible Society

* Enrollee representative - Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(f)) requires that a minimum of twenty percent (20%) of the board of directors of an HMO be comprised of enrollee representatives. The HMO is in compliance with said Regulation.

It is recommended that the Plan comply with its Operating Agreement and fill the vacant board of director position.

The minutes of all meetings of the board of directors held during the examination period were reviewed. Board meetings were generally well attended, with all appointed board of directors attending at least one-half of the meetings they were eligible to attend.

The principal officers of the Plan as of December 31, 2012 were as follows:

Name	Title
Juan Estevez, M.D.	Managing Member and CEO
Cliff Marbut, M.D.	Chief Medical Officer
Concetta Pryor	Chief Financial Officer

Section 1411(a) of the New York Insurance Law states in part:

> "No domestic insurer shall make any loan or investment unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan."

As of December 31, 2012, the Plan held only cash and cash-equivalents as part of its investment portfolio. In the event Cuatro decides to invest in non-cash assets, the board of directors will be required to adopt a formal board-approved policy that governs such

transactions. It's noted the Plan does not currently have a formal investment policy or guidelines.

It is recommended that the Plan's board of directors develop an Investment Policy.

B. Corporate Governance

An assessment of corporate governance was performed using Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*).

Cuatro does not maintain a formal risk management program and has only a limited control structure, which lacks all of the policies and procedures needed to effectively control risk. Department Circular Letter No. 14 (2011) encourages insurers to adopt a formal Enterprise Risk Management ("ERM") function and notes the following:

> "An effective ERM function should identify, measure, aggregate, and manage risk exposures within predetermined tolerance levels, across all activities of the enterprise of which the insurer is part, or at the company level when the insurer is a stand-alone entity."

It is recommended that the Plan's board of directors develop and implement a risk management program in order to grow an effective control environment.

C. Territory and Plan of Operation

The coverage provided by Cuatro provides for a lower cost alternative to traditional Medicare for residents of its authorized operating counties of the Bronx, Queens and Manhattan. The majority of healthcare services are provided through a network of Independent Practice Associations ("IPA") and capitated vendors. These vendors provide administrative, health services, and certain delegated management functions to Cuatro.

There were no Plan members during the year 2010. At December 31, 2011, the Plan had 768 members, while at December 31, 2012, it had 1,930 members. Cuatro solicits business using the services of in-house licensed agents as direct writers. During the examination period, independent brokers were also utilized to write business for the Plan, but to a lesser degree than the in-house agents.

D. Reinsurance

For the period August 1, 2011 through July 31, 2013, Cuatro had a reinsurance agreement in place with HCC Life Insurance Company, an authorized reinsurer. The covered services ceded under the agreement were for medical services related to Cuatro's individual Medicare Advantage health insurance policies. The reinsurance agreement contained the required standard clauses, including the insolvency wording required by Section 1308(a) (2)(A)(I) of the New York Insurance Law. The reinsurance limits of liability were 90% of $2,000,000 of net loss for each member for each contract year.

Under this program, Cuatro was fully responsible up to the deductible limit of $150,000. Once a member's claims reach the deductible limit, Cuatro was reimbursed at 90% of charges.

Subsequent to the examination date, effective August 1, 2013, Cuatro changed its reinsurance carrier to Munich Reinsurance America, Inc., an authorized reinsurer, with a higher retention limit of $200,000. The individual contract maximum was also lowered from $2,000,000 to $1,000,000.

E. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis. Cuatro did not write policies in 2010, and therefore ratios are presented for operating years 2011 and 2012 only.

	Amount	%
Claims paid	$22,664,215	88.0%
Claim administration expenses	70,356	0.3%
General administration expenses	10,473,645	40.6%
Net income/(loss)	(7,544,240)	(29.3%)
Reserve for contracts	107,188	.4%
Revenue	$25,771,164	100.00%

	Ratios
Combined ratio	128.9%
Administrative expense ratio	40.9%
Liabilities to liquid assets	159.9%

F. Accounts and Records.

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with statutory accounting principles or annual statement instructions. A description of such items is as follows:

(i) Net Premium Income

The *NAIC's Accounting Practices and Procedures Manual*, Statement of Statutory Accounting Principles ("SSAP") No. 54, paragraph 5, states the following:

> "Premium income shall be increased by reinsurance premiums assumed and reduced by reinsurance premiums ceded."

The Plan did not appropriately follow the aforementioned in presenting financial amounts for Net Premium Income and Net Reinsurance Recoveries, and therefore the two accounts were not properly stated in the Plan's filed December 31, 2012 annual statement. It should be noted that, because there was no material effect, no change to the financial statements contained herein was warranted.

In Cuatro's December 31, 2012 filed annual statement, reported Net Premium Income amounts did not exclude premiums ceded to the reinsurer, as required.

It is recommended that the Plan comply with the *NAIC's Accounting Practices and Procedures Manual*, SSAP No. 54 by properly accounting for reinsurance ceded when reporting Net Premium Income and Net Reinsurance Recoveries in its filed statements and correspondence with the Department.

(ii) Notes to the Annual Statement

The NAIC's Annual Statement Instructions provide that the Plan include thirty disclosures in the Notes to the Annual Statement (the "Notes").

The Plan did not fully populate the Notes as required under the NAIC Annual Statement Instructions for years 2010, 2011, and 2012. The Notes are important because they provide readers with key information that allows them to make decisions regarding the Plan's finances and operations.

It is recommended that the Plan fully populate its Notes to the Annual Statement as required by the NAIC Annual Statement Instructions.

G. Corporate Ethics and Compliance

Annual Statement General Interrogatory question #18 asks the following:

> *"Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?"*

While the Plan answered "yes" to the question of whether the Plan has an established procedure for disclosing the conflicts of interest of its board members and trustees, it was noted that the actual policy was directed only to employees and staff, and did not include the board members or trustees of the Plan.

The Plan has a fiduciary responsibility to uphold a code of ethics for the benefit of its enrolled members and to ensure that its directors, officers and employees do not use their official positions to promote an interest which is in conflict with that of the Plan.

It is recommended as a best practice that the Plan apply its code of ethics policy to all of its directors, officers and employees, on no less than an annual basis.

H. Third-Party Providers

Circular Letter No. 9(1999) states the following in part:

> "In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations."

Cuatro engages the services of claims vendor NDCHealth Corporation, d/b/a RelayHealth. The parties are subject to a Managed Care Optimizer Agreement, dated September 26, 2011, which describes the services the vendor is to provide. The Agreement also grants the Company the right to use the vendor's "ASP" software. The services the vendor is to provide as specified in the agreement include customer service, claims operations, and those services that permit the efficient use of the vendor's licensed software, such as fee schedule updates, electronic file loading, updates of benefit packages and benefit maps, and other administrative items as described in the agreement. However, this agreement does not include audit and oversight of its vendor, and no such audit has been planned or performed. As a result, Cuatro lacks the ability to ensure that the delegated functions performed by RelayHealth are being performed in accordance with its contract.

It is recommended that Cuatro comply with Circular Letter No. 9 (1999) and strengthen its oversight over the delegated functions in the agreement with RelayHealth, and design a comprehensive audit plan around those functions.

The Plan's board and management are also ultimately responsible for attesting to the operational reliability of all of its delegated vendors as part of its routine due diligence.

It is recommended that annually, the Plan obtain an independent auditor's Statement on Standards for Attestation Engagements (SSAE 16) report for all of its delegated entities.

On October 1, 2014, subsequent to the examination, Cuatro contracted with TMG Health Inc. to replace vendor RelayHealth to provide enrollment and claims processing services beginning on January 1, 2015.

I. Information Systems

The Information Technology ("IT") review of Cuatro was conducted to help identify risks related to the Plan. The objective of the IT review was to determine whether computer-related resources are properly aligned with the Plan's objectives to ensure that significant risks (strategic, operational, reporting and compliance) arising from the IT environment are appropriately mitigated by strategies or IT controls. In order to accomplish this objective, the examiner reviewed the Plan's IT governance framework to critically assess its current use of technology. The examiner also reviewed financially significant systems and applications to ensure the Plan's automated computer controls are functioning adequately and effectively.

The IT review was performed in accordance with the Handbook. The framework for the IT review was as follows:

1. Gather necessary IT information
2. Review information gathered
3. Request control information and complete IT review planning
4. Conduct IT review fieldwork
5. Document results of IT review
6. Assist with the financial examination.

The examiner identified a number of weaknesses in the Plan's IT governance framework. General controls over IT operations were inadequate and deficient. There was no evidence the Plan had invested in system security, integrity and data confidentiality. Additionally, there was no evidence that management had dedicated resources committed to the IT environment.

The examiner also identified a number of deficiencies in the Plan's IT control environment where the documentation to support adequate controls were in place was not maintained in a manner that would show that such controls were implemented effectively. In addition, the examiner identified a number of IT general controls for which the documentation provided in the Plan's response to the Department's IT questionnaire did not sufficiently describe the effective implementation of such controls to mitigate the associated risks.

It is recommended that the Company assess its IT general controls to detect any deficiencies. Priority should be place in the areas of IT governance, system/network security, data confidentiality and the segregation of duties for IT personnel.

It is recommended that the Company enhance its information security program in the areas of identity management and access control.

It is recommended that the Company strengthen its data center's physical security and environmental controls. Sensitive IT equipment and member database shall be protected from fire, vandalism and theft.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2012, as contained in the Plan's 2012 filed annual statement, a condensed summary of operations, and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2012 filed annual statement.

Independent Accountants

The CPA firm of Baker Tilly Virchow Krause, LLP, formerly Holtz Rubenstein Reminick LLP, was retained to audit the Plan's combined statutory basis statements of financial position as of December 31 of each year in the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows.

Baker Tilly Virchow Krause, LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. There were no discrepancies noted in the balances reported in these audited financial statements.

A. Balance Sheet

Assets		
Cash and short term investments	$2,197,302	
Aggregate write-in for invested assets	165,139	
Accrued retrospective premiums	125,709	
Reinsurance recoverable	135,000	
Healthcare receivable	218,421	
Total assets		$2,841,571
Liabilities		
Claims unpaid	$3,197,117	
Unpaid claims adjustment expenses	42,000	
Aggregate health policy reserves	(708,366)	
General expenses due and accrued	317,045	
Borrowed money	80,000	
Total liabilities		$2,927,796
Capital and surplus		
Common capital stock	$9,834,921	
Required Reserves	1,717,222	
Unassigned funds (surplus)	(11,638,368)	
Total capital and surplus		($86,225)
Total liabilities, capital and surplus		$ 2,841,571

Note 1: The Internal Revenue Service has not conducted an audit of the income tax returns filed on behalf of the Plan between 2010 and 2012. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

Note 2: As of December 31, 2012, the Plan's minimum surplus requirement, as determined using the statutory requirements of Parts 98-1.11e(ii) of the Administrative Rules and Regulations of the NYS Health Department (10 NYCRR 98-1.11), was impaired in the amount of $1,803,447 and the Plan was insolvent in the amount of $86,225. Subsequent to the examination, as of June 30, 2014, the Plan cured its insolvency but remained impaired by $604,609.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus decreased during the examination period, May 4, 2010 through December 31, 2012, detailed as follows:

Revenue		
Net premium income		$25,771,164
Interest income		871
Total revenue		$25,772,035
Expenses		
Hospital/medical benefits	$ 9,850,772	
Other professional services	911,094	
Outside referrals	6,023,281	
Out of area	252,322	
Prescription drugs	5,402,839	
Incentive pool, withholds, and bonuses	35,674	
Net reinsurance recoveries	188,233	
Total hospital and medical	$22,664,215	
Administrative expenses		
Claim adjustment expenses	$ 70,356	
General administrative expenses	12,606,141	
Total administrative expenses	$12,676,497	
Increase in reserves for A&H Contracts	$ 107,188	
Total underwriting deductions		35,447,900
Net Income/(Loss)		($9,675,865)

Changes in Capital and Surplus

Capital and surplus as of May 4, 2010			$0
	Gains in Surplus	Losses in Surplus	
Net income	$	$9,675,865	
Change in non-admitted assets		247,645	
Aggregate write-ins for gains in surplus	2,364		
Paid-in capital	9,834,921		
Net decrease in capital and surplus			($86,225)
Capital and surplus per report on Examination, as of December 31, 2012			($86,225)

4. CLAIMS UNPAID

The examination liability of $3,197,117 for the above captioned account is the same as the amount reported by Cuatro, LLC as of December 31, 2012. The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices, and was based on statistical information contained in the Plan's internal records and its filed annual statements as verified during the examination.

The examination reserve was based upon actual claims payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2012.

5. PREMIUM DEFICIENCY RESERVE

A premium deficiency exists when earned premiums are not adequate to cover estimated losses, loss adjustment expenses, policy acquisition costs, and maintenance costs for that policy period.

Cuatro's liabilities, capital, and surplus filed in the 2012 Annual Statement showed aggregate health policy reserves in the amount of ($708,366). This negative liability contained Medicare Part D Settlements, a 2011 Risk Adjustment, and policy reserves. It was noted that a footnote in the Plan's annual statement shows that $0 was for premium deficiency reserve.

By Cuatro's own projection for 2013, shown in Report #5 of its 2012 Data Requirements, the Plan estimates an expected net underwriting loss of ($1,663,079). If revenues fall short of expected premiums, as occurred in both 2011 and 2012, then underwriting losses are likely to continue. Therefore, Cuatro should be holding a premium deficiency reserve as required by Statutory Accounting Principle No. 54..

It is recommended that Cuatro establish a premium deficiency reserve whenever it is anticipated that losses will exceed premiums for a given policy period.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business and fulfills its contractual obligations to enrollees. The review was general in nature and did not encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Plan relative to the licensing and appointment of its agents and their compensation. In determining the scope of this review, the examiner took into consideration that the Plan writes only Medicare Advantage and therefore its market conduct activities are generally under the regulatory purview of the Center for Medicare and Medicaid Studies ("CMS") rather than under the purview of the Department. Thus, the market conduct review was limited in its scope. The review did not result in any findings.

7. SUBSEQUENT EVENTS

As of December 31, 2012, the Plan's minimum surplus requirement, as determined using the statutory requirements of Parts 98-1.11(e)(ii) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), was impaired in the amount of $1,803,447 and the Plan was insolvent in the amount of $86,225. Subsequent to the examination, as of June 30, 2014, the Plan cured its insolvency but remained impaired by $604,609.

On October 1, 2014, Cuatro LLC entered into a Management Services Agreement (MSA) with TMG Health Inc. The agreement covers enrollment and claims processing beginning January 1, 2015. RelayHealth will continue to pay claims prior to January 1, 2015 until a full claims system conversion with TMG Health Inc. is completed on March 1, 2015.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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A.	As of December 31, 2012, the Plan was insolvent in the amount of $86,225. The Plan's minimum contingency reserve, determined using the requirements of Parts 98-1.11(e)(ii) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), was impaired in the amount of $1,803,447. Subsequent to the examination, as of June 30, 2014, the Plan cured its insolvency but remained impaired in the amount of $604,609.	2
B.	Management and Controls	
i.	It is recommended that the Plan complies with its Operating Agreement and fill the vacant board of director position.	7
ii.	It is recommended that the Plan's board of directors develops an Investment Policy.	8
C.	Corporate Governance	
	It is recommended that the Plan's board of directors develops and implements a risk management program in order to grow an effective control environment.	8
D.	Accounts and Records	
i.	It is recommended that the Plan complies with the *NAIC's Accounting Practices and Procedures Manual*, SSAP No. 54 by properly accounting for reinsurance ceded when reporting Net Premium Income and Net Reinsurance Recoveries in its filed statements and correspondence with the Department.	11
ii.	It is recommended that the Plan fully populates its Notes to the Annual Statement as required by the NAIC Annual Statement Instructions.	12

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Respectfully submitted,

_____/S/_____
Andre Blackman
Senior Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Andre Blackman**,** being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____/S/_____
Andre Blackman

Subscribed and sworn to before me

This _____ day of _____2014

APPOINTMENT NO. 31012

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Andre Blackman

as a proper person to examine the affairs of the

Cuatro LLC dba Access Medicare

and to make a report to me in writing of the condition of said

HMO

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 10th day of July, 2013

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau