REPORT ON EXAMINATION

OF

ALPHACARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2015

DATE OF REPORT **JULY 12, 2017**

EXAMINER **JERRY L. KENNEDY, CFE**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

July 12, 2017

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31494, dated June 13, 2016, attached hereto, I have made an examination into the condition and affairs of AlphaCare of New York, Inc., a for-profit health maintenance organization (HMO), licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2015, and submit the following report thereon.

The examination was conducted at the administrative office of AlphaCare of New York, Inc., located at 14100 Magellan Plaza, St. Louis, Missouri.

Wherever the designation the "Plan" appears herein, without qualification, it should be understood to indicate AlphaCare of New York, Inc.

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

Wherever the designation, "MHI" appears herein, without qualification, it should be understood to indicate Magellan Health, Inc., the Plan's ultimate parent.

1. SCOPE OF THE EXAMINATION

This is the first examination of the Plan. This examination, is a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2016 Edition* (the "Handbook"), and covers the period from the Plan's inception, July 11, 2013, through December 31, 2015. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2015, 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 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

The examination also evaluated the Plan's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The Plan was audited annually for the years 2013 through 2015 by the accounting firm of Loeb and Troper ("L&T"). The Plan received an unmodified opinion in each of those years. Certain audit work papers of L&T were reviewed and relied upon in conjunction with this examination.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work among the

examiners), of the insurance subsidiaries of Magellan Health, Inc. The examination was led by the state of Pennsylvania with participation from six other states: Delaware, Florida, Illinois, Nebraska, New Jersey, and New York. Since the lead state and participating states are accredited by the NAIC, all states deemed it appropriate to rely on each other's work. The examination team, representing the Lead State (as such term is defined in the Handbook) and participating states, identified and assessed the risks for key functional activities across all of the Magellan Health, Inc. insurance subsidiaries. The examination team also assessed the relevant prospective risks as they related to the various insurance/managed care entities.

During this examination, a review was made of the Plan's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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. EXECUTIVE SUMMARY

The analysis and review of the Plan's reserve liabilities as of December 31, 2015, by Department actuarial personnel, noted a Claims Unpaid reserve deficiency in the amount of $1,229,630 and an Unpaid Claims Adjustment Expenses reserve deficiency in the amount of $321,673.

3. DESCRIPTION OF THE PLAN

The Plan was incorporated as a health maintenance organization (HMO) pursuant to Article 44 of the New York State Public Health Law on August 14, 2012, and received a Health Maintenance Organization Certificate of Authority from the New York State Department of Health ("DOH") on February 13, 2013. The Plan operates as a for-profit, independent practice association model, and commenced operations on July 11, 2013.

AlphaCare Holdings, LLC, was the original holder of all of the Plan's voting capital stock. Magellan Health Services, Inc. ("Magellan"), as the ultimate parent, initially made a strategic investment in AlphaCare Holdings, LLC, acquiring a 7% stake in 2013. In 2014, Magellan changed its corporate name to Magellan Health, Inc. During 2013, AlphaCare Holdings, LLC, merged with and into AlphaCare Holdings, Inc. and, following that merger, MHI acquired additional shares of AlphaCare Holdings, Inc., increasing its ownership stake to approximately 75% as of year-end 2013. During the first quarter of 2015, MHI acquired an additional $23.6 million of Series B and Series C participating preferred stock of AlphaCare Holdings, Inc., bringing its ownership percentage to 82.4%.

As part of the 2013 purchase agreement, MHI had the option to purchase the remaining portion of stock outstanding at a formula-determined price beginning on January 1, 2017. The current non-controlling interest shareholders of AlphaCare Holdings, Inc., also have the right to sell their interests to MHI beginning on January 1, 2017, at the same agreed upon formula.

The Plan's Articles of Incorporation provide that the authorized capital of the Plan is $1, consisting of 100 shares of $.01 par value voting common stock. At December 31, 2015, the Plan

had issued and outstanding capital stock and paid-in surplus totaling $54,220,672, which consisted of 100 shares of voting common stock and gross paid-in and contributed surplus totaling $54,220,671.

Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98.10(c)) states in part:

> "The commissioner's and… the superintendent's prior approval shall be required for the following transactions between a controlled MCO and any person in its holding company system: sales, purchases, exchanges, loans, extensions of credit or investments the aggregate of which involves five percent or more of the MCO's admitted assets at last year-end".

The Plan was formed with initial paid-in surplus of $987,063, but received surplus contributions in each of the years from 2013-2015 as follows:

March 2015	$ 22,000,000
February 2015	1,603,820
December 2014	4,396,275
November 2014	1,570,362
November 2014	2,929,652
May 2013	733,434
May 2013	20,000,065
	$ 53,233,608

It is noted that the Plan did not obtain the required approval for the three contributions made during 2014 and the contribution made during March 2015, which were each in excess of the cited limits. It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1.10(c)) and obtain prior approval from the Commissioner and Superintendent for any capital contributions equal to 5% or greater of the prior year's Admitted Assets.

Enterprise Risk Management

MHI has adopted an Enterprise Risk Management ("ERM") framework for proactively addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (Understanding the Corporate Governance Structure) was utilized by the examiner as guidance for assessing corporate governance. It appears that the Plan's Board of Directors (the "Board") and key executives maintain an effective control environment. Additionally, the examiner reviewed for compliance with New York Insurance Regulation No. 203 (11 NYCRR 82) and found no areas of disagreement.

Internal Audit Department

MHI has an established Internal Audit Department ("IAD") function, which is independent of management, to serve the MHI Audit Committee of the Board (the "Audit Committee"). It also serves the Plan. In addition, the Audit Committee was established to address the requirements of New York Insurance Regulation No. 118 (11 NYCRR 89) – Audited Financial Statements, New York's version of the NAIC's Model Audit Rule, and assist management at the local level with any insurance regulatory reviews. During the course of this examination, consideration was given to the significance and potential impact of certain IAD and Risk Control and Assurance ("RCA") findings. To the extent possible, the examiner relied upon the work performed by the IAD, as prescribed by the Handbook

A. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a board of directors consisting of not less than three nor more than nine members. As of the

examination date, the board of directors was comprised of five members. The directors as of December 31, 2015, were as follows:

Name and Residence	Principal Business Affiliation
Edward J. Christie Thornton, Pennsylvania	Chief Operations Finance Officer, Magellan Health Services, Inc.
Andrew M. Cummings Cos Cob, Connecticut	Senior Vice President & Associate General Counsel, Magellan Health, Inc.
David S. Harrington * Glencoe, Illinois	DASH Business Group, Consultant
Joel Landau Brooklyn, New York	Care to Care, LLC, Managing Director
Anne M. McCabe Saratoga Springs, New York	President – Public Markets, Magellan Health Services, Inc.

*= Enrollee representative – Part 98-1.11(g) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the Board of an HMO be comprised of enrollee representatives. As of December 31, 2015, the Plan was in compliance with the referenced regulation.

The Board met at least five times during 2014 and 2015 respectively, including quarterly meetings. Article III, Section 5 of the Plan's Bylaws specify that the Board is to meet at least quarterly. The Board met less frequently during 2013, the Plan's initial year of operation.

The minutes of all meetings of the Board of Directors held during the examination period were reviewed. There were no committees.

A review of the attendance records of the Board of Director's meetings held during the examination period revealed that meetings were well attended, with only one absence recorded during the twelve meetings held during 2014 and 2015.

The principal officers of the Plan as of December 31, 2015, were as follows:

Name	Title
Joel Landau	President
Daniel Parietti	Chief Executive Officer
Scott Markovich	Secretary
Edward J. Christie	Treasurer
Tom Nicholich	Chief Financial Officer

On January 4, 2016, Scott Ptacek replaced Daniel Parietti as Chief Executive Officer.

B. Territory and Plan of Operation

Pursuant to Article 44 of the New York State Public Health Law, the New York State Department of Health issued a Certificate of Authority ("COA") to the Plan, effective February 13, 2013. The latest amendment to the COA was dated May 23, 2013, authorizing the Plan to transact Medicare and Medicaid Managed Long-Term Care business on a direct basis in the counties of Bronx, Kings, New York, Queens and Westchester. The Plan also provided Fully Integrated Duals Advantage ("FIDA") coverage during 2015 but subsequently discontinued the line of business.

The Plan does not use a companion insurer for Point-of-Service ("POS") products. The Plan writes business only in New York State with 2015 total direct premiums written in the amount of $102,422,038. Direct written premiums for 2014 totaled $40,273,846, while direct written premiums for 2013 totaled $3,289,331.

Pursuant to a partially capitated contract with the New York State Department of Health, the Plan offers Managed Long Term Care ("MLTC") programs to prospective members in the authorized New York counties listed above. The Plan's initial contract was effective June 1, 2013,

through December 31, 2014. As of the examination date, the Plan operates under a recently received amendment effective January 1, 2015 through December 31, 2016.

As of December 31, 2015, the Plan had 3,432 members. Enrollment in each line of business at each respective year-end since the Plan's inception is shown as follows:

	FIDA	MLTC	Medicare	Totals
2015	47	2,106	1,279	3,432
2014	0	1,411	1,063	2,474
2013	0	240	0	240

C. Reinsurance

As of December 31, 2015, the Plan was a party to single, non-affiliated, ceded reinsurance agreement with Westport Insurance Corporation ("Westport"), a member of the Swiss Re group of companies. Westport is a licensed insurer in the State of New York. The agreement was made effective January 1, 2015, and is for a one year period. The agreement includes an insolvency clause in accordance with New York Insurance Law section 1308(a)(2)(A)(i) and (ii). Either party may terminate the agreement upon the giving of sixty days' notice, with such notice also given to the Department. The agreement with Westport replaced a 2014 agreement with Ironshore Indemnity Inc.

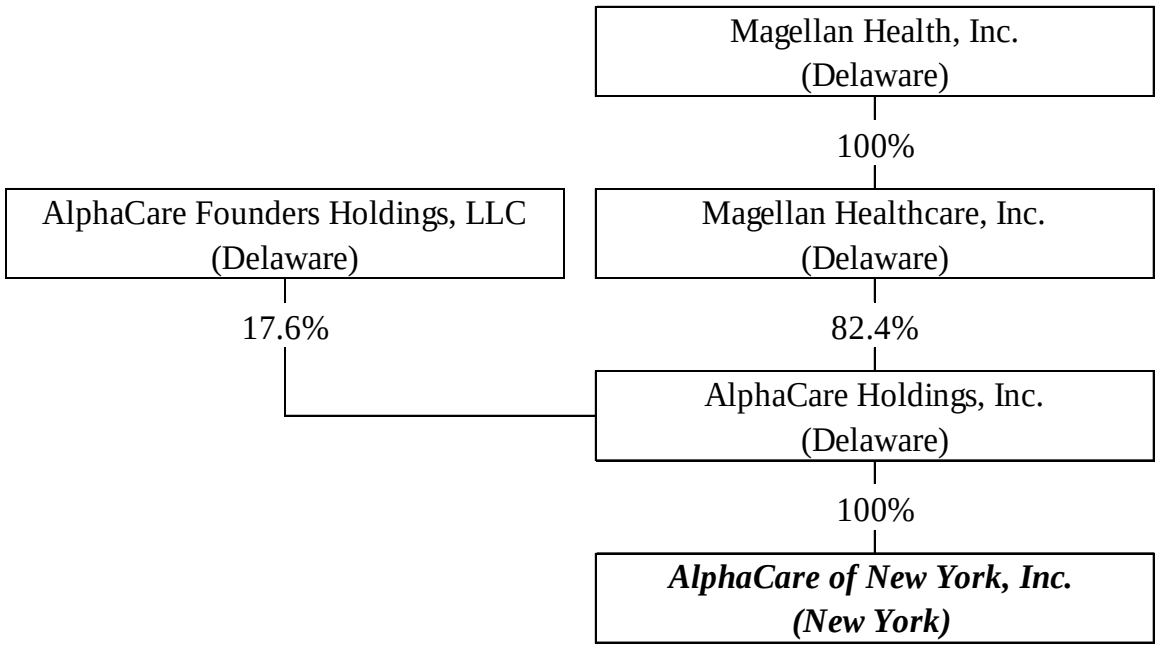
The agreement in place as of December 31, 2015, is an excess of loss agreement, covering all products issued by the Plan, with a specific retention of the first $150,000 of an incurred loss. In addition to the specific retention, the Plan retains scheduled percentages of certain covered services, generally at 10% of the loss incurred. Reinsurance premiums consist of scheduled Per Member Per Month ("PMPM") rates that vary by product and per claim, as follows:

Coverage	Rate PMPM
MAPD (Medicare Advantage)	$9.69
DSNP (Dual Special Needs) & FIDA (Full Integrated Dual Advantage)	$20.12
ISNP (Institutionalized Special Needs)	$24.59

The agreement also includes an experience refund provision under which the Plan is to receive 35% of the net profit (as defined within the agreement), provided that written reinsurance premiums for the agreement period equal or exceed $1,000,000, and the loss ratio is equal to or less than 70%. Any deficit arising from the calculation is carried forward to the subsequent agreement term. As ceded premiums under the agreement did not equal or exceed the minimum premium threshold, there have been no experience refunds. The agreement was not required to be submitted to the New York State Department of Health pursuant to Part 98-1.5(b)(7) of the Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.5), as it was not subject to the regulation, having been entered into after the issuance of the Plan's Certificate of Authority.

D. Holding Company System

The Plan is part of a holding company system as depicted in the following organizational chart:



The ultimate controlling person of the group is MHI, a publicly held company traded on the New York Stock Exchange under the ticker symbol "MGLN." The 2015 Proxy Statement (as of March 31, 2016) for MHI disclosed BlackRock, Inc., as the beneficial owner of 10% of its voting capital stock. By letter dated August 8, 2016, the New York State Department of Health acknowledged a March 16, 2016, disclaimer of control filing made on behalf of BlackRock, Inc., and The PNC Financial Services Group, Inc. The holding company system includes approximately eighty-seven legal entities, of which thirteen are insurers/managed care entities (including the Plan).

As noted in the preceding organizational chart, AlphaCare Founders Holding, LLC, owns the remaining 17.6% interest in AlphaCare Holdings, Inc. AlphaCare Founders Holding, LLC, is owned by the following members:

David Harrington	8.57%
Jack Basch	13.66%
Joel Landau	59.55%
Liebel Rubin	9.11%
Marvin Rubin	9.11%
	100.00%

Joel Landau serves as the managing director of AlphaCare Founders Holding, LLC.

Management Services Agreement

Effective December 1, 2014, the Plan became a party to an agreement with MHI, under which MHI agreed to provide itself, or through one or more affiliates, all management and administrative services necessary to conduct the Plan's day-to-day operations. Such services include, but are not limited to: accounting and financial services administration, human resources, government relations, internal audit, information technology infrastructure, marketing communications, medical information and analytics, regulatory and compliance affairs, legal, and claims administration, which is presently outsourced by the Plan to NDCHealth Corporation, doing business as RelayHealth.

As compensation for services rendered by dedicated staffing and related expenses, the Plan is to pay a provisional PMPM fee in accordance with an Exhibit attached to the agreement. As compensation for services rendered by non-dedicated staffing and related expenses, the Plan shall also pay a provisional PMPM fee in accordance with an Exhibit attached to the agreement. Both

PMPM fees are to be trued-up to actual within thirty days of each fiscal year-end the agreement is in effect. As required by Part 98-1.11(m) of the Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), the term of the agreement is for five years, subject to one year renewals thereafter, if so authorized by the New York State Department of Health Commissioner. The initial agreement was approved on November 17, 2014.

Sublease Agreement

Effective May 17, 2013, the Plan entered into a sublease agreement with AS Realty Management LLC, under which the Plan leased office space to serve as its principal place of business in Brooklyn, New York. The lease expires on November 26, 2019, and calls for annual fixed rental payments in accordance with the terms of the agreement. The agreement did not require the approval of the Department or the New York State Department of Health.

E. Significant Operating Ratios

The following schedule, obtained from information contained in the annual statements for the period under review, reflects the Plan's operating results:

Year	Net Premiums Written	Net Paid Health Claims	Net Income	Policyholder Surplus	Ratio of Net Premiums Written to Surplus
2015	$102,193,979	$84,631,288	($10,882,717)	$14,991,738	681.7%
2014	$ 39,887,620	$24,764,560	($16,332,221)	$23,675,048	168.5%
2013	$ 3,289,331	$ 566,616	($ 9,575,769)	$10,027,871	32.8%

The underwriting ratios for 2015 are presented below on an earned-incurred basis:

	Amounts	Ratios
Claims	$ 83,184,382	81.4%
Claim adjustment expenses	5,802,863	5.6%
General administrative expenses	24,066,869	23.6%
Net underwriting gain (loss)	(10,860,135)	(10.6)%
Premium revenue	$102,193,979	100.0%

The Plan's authorized control level Risk-Based Capital ("RBC") was $3,606,729 as of December 31, 2015. Its total adjusted capital was $14,991,738, yielding an RBC ratio of 415.7% at December 31, 2015. At December 31, 2015, the Plan's contingency reserve, as required by Part 98-1.11(e)(1) of the Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), totaled $5,293,264. At December 31, 2015, the Plan's escrow account balance, as required pursuant to Part 98-1.11(f)(1) of the Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.11), which was maintained through Manufacturers and Traders Trust Company, totaled $10,269,482.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, capital and surplus as of December 31, 2015, as contained in the Plan's 2015 filed annual statement, a condensed summary of operations and a reconciliation of the 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, 2015 filed annual statement. The analysis and review of the Plan's reserve liabilities as of December 31, 2015, by Department actuarial personnel noted a Claims Unpaid reserve deficiency in the amount of $1,229,630 and an Unpaid Claims Adjustment Expenses reserve deficiency in the amount of $321,673, for a total reduction to surplus of $1,551,303.

Independent Accountants

The firm of Loeb & Troper was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

Loeb & Troper concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

Assets	Examination	Plan	Surplus Increase/ (Decrease)
Cash and short-term investments	$ 44,983,499	$ 44,983,499	
Interest income due and accrued	288,521	288,521	
Uncollected premiums in the course of collection	2,682,708	2,682,708	
Electronic data processing equipment	259,628	259,628	
Total assets	$ 48,214,356	$ 48,214,356	
Liabilities			
Claims unpaid	$ 12,634,792	$ 11,405,162	$ (1,229,630)
Unpaid claims adjustment expenses	399,181	77,508	(321,673)
Aggregate health policy reserves	4,341,477	4,341,477	
General expenses due and accrued	945,234	945,234	
Amounts due to parents, subsidiaries and affiliates	14,918,279	14,918,279	
Liability for amounts held under uninsured plans	849,139	849,139	
Aggregate write-ins for other liabilities	685,820	685,820	
Total liabilities	$ 34,773,922	$ 33,222,619	$ (1,551,303)
Capital and Surplus			
Capital stock	$ 1	$ 1	
Aggregate write-in for special surplus funds	284,906	284,906	
Gross paid in and contributed surplus	54,220,671	54,220,671	
Aggregate write-ins for other than special surplus funds	10,269,482	10,269,482	
Unassigned funds	(51,334,625)	(49,783,322)	(1,551,303)
Total capital and surplus	$ 13,440,435	$ 14,991,738	(1,551,303)
Total liabilities, capital and surplus	$ 48,214,357	$ 48,214,357	

The Internal Revenue Service did not audit the tax returns filed by the Plan for the period under examination. The examiner is unaware of any potential exposure of the Plan to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased $13,746,724 during the examination period, July 11, 2013, through December 31, 2015, detailed as follows:

Revenue		
Net premium income	$ 145,370,930	
Aggregate write-ins	6,004	
Total revenue		$ 145,376,934
Hospital and Medical Expenses		
Hospital/medical benefits	$ 115,912,755	
Other professional services	3,196,903	
Emergency room and out-of-area	472,596	
Prescription drugs	1,785,371	
Total hospital and medical expenses	$ 121,367,625	
Administrative expenses		
Claims adjustment expenses	8,491,270	
General administrative expenses	52,209,150	
Total underwriting deductions		$ 182,068,045
Net underwriting loss		$ (36,691,111)
Aggregate write-ins		60
Net investment income earned		34,194
Net loss from agents' or premium balances charged off		(56,773)
Net loss before taxes		$ (36,713,630)
Federal income taxes		77,077
Net loss		$ (36,790,707)

Changes in Capital and Surplus

Surplus, as of July 11, 2013			$ (306,288)
	Increases	Decreases	
Net loss	$ 0	$36,790,707	
Paid in capital	53,233,608		
Change in non-admitted assets		1,144,875	
Examination adjustments		1,551,303	
Net increase in surplus			$13,746,723
Surplus, per report on examination, as of December 31, 2015			$ 13,440,435

5. CLAIMS UNPAID AND UNPAID CLAIM ADJUSTMENT EXPENSES

The examination amount of $12,634,792 for Claims Unpaid is $1,229,630 greater than the $11,405,162 reported by the Plan as of December 31, 2015.

The examination amount of $399,181 for the Unpaid Claims Adjustment Expense liability is $321,673 greater than the $77,508 reported by the Plan as of December 31, 2015.

The examination analysis of the captioned account 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 in its filed annual and quarterly statements, as well as additional information provided by the Plan.

The examination reserve was based upon actual 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, 2015.

6. SUBSEQUENT EVENTS

A. Capital Contribution

Subsequent to the examination date, on June 29, 2016, MHI made a cash capital infusion of $7,500,000. In its annual Quarterly Statement as of September 30, 2016, the Plan reported sufficient surplus to meet its minimum requirements under NYCRR 98-1.11(e). However, such financial statement has not been examined by the Department.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Description of the Plan	
	It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1.10(c)) and obtain prior approval from the Commissioner and Superintendent for any capital contributions equal to 5% or greater of the prior year's Admitted Assets.	6
B.	Claims Unpaid and Unpaid Claims Adjustment Expenses	
	The examination amount of $12,634,792 for Claims Unpaid is $1,229,630 greater than the $11,405,162 reported by the Plan as of December 31, 2015.	19
	The examination amount of $399,181 for the Unpaid Claims Adjustment Expense liability is $321,673 greater than the $77,508 reported by the Plan as of December 31, 2015.	

Respectfully submitted,

_____/S/_____
Jerry Kennedy, CFE
Insurance Examiner

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

Jerry Ehlers, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Jerry Kennedy, CFE

Subscribed and sworn to before me
this _____ day of_____2017.

APPOINTMENT NO. 31494

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Acting 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:*

Examination Resources LLC

as a proper person to examine the affairs of

AlphaCare of NewYork, Inc.

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

HMO

with such other information as they 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 13th day of June, 2016

MARIA T. VULLO
Acting Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau