REPORT ON EXAMINATION

OF

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

AS OF

DECEMBER 31, 2018

DATE OF REPORT	**JUNE 27, 2020**
EXAMINERS:	**JOANNE CAMPANELLI, CFE** **JEFFREY L. USHER, CFE**

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NEW YORK STATE OF OPPORTUNITY. | Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Superintendent

June 27, 2020

Honorable Linda A. Lacewell
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31995, dated August 16, 2019, attached hereto, we have conducted an examination into the condition and affairs of UnitedHealthcare Insurance Company of New York, a for-profit stock accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2018. The following report is respectfully submitted thereon.

The examination was conducted at the administrative office of UnitedHealth Group Incorporated, located at 185 Asylum St., Hartford, CT.

Wherever the designations "UHICNY" or the "Company" appear herein, without qualification, they should be understood to indicate UnitedHealthcare Insurance Company of New York.

Wherever the designation "UHIC" appears herein, it should be understood to indicate UnitedHealthcare Insurance Company, the immediate parent of UHICNY.

Wherever the designation "UHG" appears herein, without qualification, it should be understood to indicate UnitedHealth Group Incorporated, a for-profit holding company and the Company's ultimate parent.

A concurrent examination was made of UnitedHealthcare of New York, Inc., an affiliated health maintenance organization, licensed pursuant to the provisions of Article 44 of the New York Public Health Law. A separate report has been submitted thereon.

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

1. SCOPE OF THE EXAMINATION

We have performed our multi-state examination of United Healthcare Insurance Company of New York, Inc. The previous examination was conducted as of December 31, 2013. This examination was a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2019 Edition* (the "Handbook") and covered the five-year period January 1, 2014 through December 31, 2018. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2018, were also reviewed.

The examiners planned and performed the examination to evaluate the Company's current financial condition, as well as to identify prospective risks that may threaten the future solvency of UHICNY.

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 Company's organizational structure, business approach and control environment was utilized to develop the examination approach. The examination evaluated the Company'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 Company'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 Company was audited annually for the years 2014 through 2018 by the accounting firm of Deloitte & Touche, LLP ("D&T"). The Company received an unmodified opinion in each of those years. Certain audit work papers of D&T were reviewed and relied upon in conjunction with this examination. A review was also made of UHG's Internal Audit function and Enterprise Risk Management program, as they relate to the Company.

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

This examination was conducted as a coordinated examination, as such term is defined in the Handbook, of the insurance subsidiaries of UHG. The examination was led by the State of Nevada as the facilitating state with participation from six additional states. Since the Lead and Participating states, as such terms are defined in the Handbook, are accredited by the NAIC, the states deemed it appropriate to rely on each other's work. The examination team representing the Lead and Participating states identified and assessed the risks for key functional activities across all UHG's insurance subsidiaries included within the examination scope. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook, of the insurance entities of UHG. The examination was led by the State of Nevada as the facilitating state with participation from six additional states. Since the Lead and Participating states, as such terms are defined in the Handbook, are accredited by the NAIC, the states deemed it appropriate to rely on each other's work. The examination team representing the Lead and Participating states identified and assessed the risks for key functional activities across all of UHG's insurance entities included within the examination scope. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

A review was made of the Company's compliance with the provisions of Insurance Regulation No. 118 (11 NYCRR 89), "Audited Financial Statements" which is based on the Model Audit Rule, as established by the NAIC. Furthermore, a review was made of compliance with Regulation 203 (11 NYCRR 82), "Enterprise Risk Management and Own Risk Solvency Assessment," which establishes the requirement that the ultimate controlling parent of an insurance company develop an Enterprise Risk function to define and mitigate risks within the

organization. The examiners also reviewed the corrective actions taken by the Company with respect to the financial comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 7 of this Report.

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

2. DESCRIPTION OF THE COMPANY

The Company is a domestic insurer licensed to write accident and health insurance, as defined in Sections 1113(a)(i) ad 1113(a)(3)(ii) of the New York Insurance Law. The Company was originally incorporated on February 8, 1995, as The MetraHealth Insurance Company of New York, and commenced business on December 28, 1995. The Company is a wholly-owned subsidiary of UnitedHealthcare Insurance Co. (formerly known as The MetraHealth Insurance Company and Travelers Insurance Company of Illinois), a Connecticut stock corporation. The ultimate parent company is UHG, a publicly held company trading on the New York Stock Exchange.

As of December 31, 2018, UHICNY reported total paid-in-capital of $300,000, comprised of 30,000 shares authorized, issued, and outstanding $10.00 par value common stock.

The Company paid the following cash dividends during the examination period to UHIC:

Year	Dividend Paid
2018	-
2017	-
2016	$ 90,000,000
2015	$ 45,000,000
2014	$ 210,000,000

The dividends were approved by the Department and recorded as a reduction to unassigned surplus in the statutory-basis statements of admitted assets, liabilities, and capital and surplus.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a Board of Directors (the "Board") consisting of no less than thirteen (13) and no more than twenty (20) members. As of the examination date, the Board was comprised of thirteen (13) members. The Board met at least four (4) times during each calendar year for the period under examination.

As of December 31, 2018, the members of the Board and their principal business affiliations were as follows:

Name and Residence	Principal Business Affiliation
Timothy C. Archer Avon, CT	Vice President, United Healthcare Services, Inc.
James F. Bedard Glastonbury, CT	Vice President, United Healthcare Services, Inc.
Phillip R. Franz Middletown, NJ	Deputy General Counsel, United Healthcare Services, Inc.

Name and Residence	Principal Business Affiliation
William J. Golden Northport, NY	Chief Executive Officer, United Healthcare Services, Inc.
Gary A Iannone East Hampton, CT	Vice President, Actuary, United Healthcare Services, Inc.
Carl A. Mattson Schenectady, NY	Retired
Michael McGuire Wyckoff, NJ	Chief Executive Officer of Health Plan, United Healthcare Services, Inc.
Thomas J. McGuire West Hartford, CT	Retired
Sandra D. B. Nichols, MD North Potomac, MD	Retired
Michael A. Santoro Trumbull, CT	Senior Vice President of Payment Integrity, United Healthcare Services, Inc.
Michael J. Specht Setauket, NY	General Manager, United Healthcare Services, Inc.
Randall H. Weinstock West Hartford, CT	Vice President, United Healthcare Services, Inc.
Vincent J. Zuccarello Sandy Hook, CT	Vice President of Healthcare Economics, United Healthcare Services, Inc.

A review of the minutes of the attendance records at the Company's Board meetings held during the period under examination demonstrated that the meetings were generally well attended with all members.

The principal officers of the Company as of December 31, 2018 were as follows:

Name	Title
William J. Golden	President
Peter M. Gill	Treasurer
Thomas J. McGuire	General Counsel
Timothy C. Archer	Chief Financial Officer
Carl A. Mattson	Vice President
John J. Matthews	Secretary
Steven M. Burstein	Assistant Secretary
Heather A. Lang	Assistant Secretary
Jessica L. Zuba	Assistant Secretary

It should be noted that certain members of the Board and senior management of UHICNY are also members of the Board and senior management of other affiliated companies.

UHIC, the parent company of UHICNY, has established an Audit Committee ("UHIC AC"), which has been designated as the Audit Committee for UHICNY. To facilitate effective corporate governance, the UHIC AC coordinates certain activities with the Company's ultimate parent, UHG, and UHG's own Audit Committee. It is the responsibility of the UHIC's AC to communicate significant deficiencies or material weaknesses in financial reporting internal controls to the UHG's Audit Committee.

B. Enterprise Risk Management

UHG is a publicly traded, diversified health company subject to the Sarbanes-Oxley Act ("SOX") of 2002 and is required to be compliant with Insurance Regulation 203 (11 NYCRR 82)-Enterprise Risk Management ("ERM") and Own Risk and Solvency Assessment ("ORSA"). ERM and Internal Audit are enterprise-wide functions; thus, unless otherwise noted, references to UHG are applicable to the Company.

UHG has adopted an ERM framework for addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiners as guidance for assessing corporate governance. Overall, it was determined that the Company's corporate governance structure is adequate, sets an appropriate "tone at the top," supports a proactive approach to operational risk management, and contributes to an effective system of internal controls. It was found that the Company's Board and key executives encourage integrity and ethical behavior throughout the Company, and that senior management promotes a corporate culture that acknowledges, understands and maintains an effective control environment.

The Company's management has an adequate approach to identifying and mitigating risks across the organization, including prospective business risks. The Company deals proactively with its areas of risk, and its management is knowledgeable about mitigation strategies. Through risk discussions and other measures, the Company's management discusses significant issues and reacts to changes in the environment with a clear commitment to address risk factors and manages the business accordingly. It was determined that the Company's overall risk management process takes a proactive approach to identifying, tracking, and dealing with significant current and emerging risk factors.

C. Internal Audit Department

UHG has an established Internal Audit Department ("IAD"), which is independent of management, to serve the UHG Audit Committee ("UHG AC"). The UHG AC is comprised entirely of external directors.

During the examination period, a significant amount of UHG's Internal Audit work was outsourced to, and therefore executed by, Ernst & Young ("E&Y"), an independent accounting firm. E&Y possesses experience consistent with industry norms, and all E&Y manager-level and above resources maintain applicable industry certifications. The IAD directs and supervises all Internal Audit work performed by E&Y. The IAD, with the outsourced assistance from E&Y, reviews and tests financial and operational controls and processes established by management to ensure compliance with laws, regulations and UHG policies. The scope of the IAD's program is coordinated with UHG's independent certified public accountants to ensure adequate coverage and maximum efficiency.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD findings. To the extent possible, the examiners relied upon the work performed by the IAD, as required by the Handbook.

D. Territory and Plan of Operation

UHICNY is licensed to sell accident and health insurance in the State of New York as defined in Sections 1113(a)(3)(i) and 1113(a)(3)(ii) of the New York Insurance Law and primarily issues group accident and health insurance contracts to employers and associations. UHICNY is licensed in New York under Article 42 of the New York Insurance Law.

The Company conducted business through four (4) UHG business segments: UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, and Empire Behavioral Health Plan, which was marketed through Optum Health.

The Company serves as a plan sponsor, offering Medicare Advantage and Medicare Part D prescription drug insurance coverage under a contract with the Centers for Medicare and Medicaid Services ("CMS"). Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the year; CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share and CMS coverage gap discount program.

On April 13, 2007, UHG entered into an agreement to extend and expand its relationship with the AARP through December 31, 2014. The agreement was expanded to give UHG the right to use the AARP brand on Medicare Advantage offerings and to extend UHG's arrangement to use the AARP brand on UHG Medicare Supplement products and services and Medicare Part D offerings. During 2014, UHG signed a new long-term agreement with AARP that extended the relationship through December 31, 2020.

The following schedule shows direct premiums written in the State of New York compared to the total direct premiums written by UHICNY in all states during the period under examination:

Year	New York	Total Direct Written Premiums	Percentage
2018	3,346,097,277	$3,348,362,344	99.93%
2017	3,495,872,421	$3,498,724,078	99.91%
2016	3,312,735,871	$3,314,186,054	99.95%
2015	2,855,705,839	$2,856,716,573	99.96%
2014	2,676,584,710	$2,677,711,692	99.95%

E. Growth of the Company

At December 31, 2018, the Company had a total of 1,400,005 members. The Company's membership increase/ decrease, by number and percentage, during the examination period was as follows:

	2018	2017	2016	2015	2014
Members	1,400,005	1,406,992	1,392,851	1,390,200	1,349,050
Growth	(0.50)%	1.02%	0.19%	3.05%	(44.04)%

The Company's net written premiums, net paid health claims, net income, policyholder surplus and ratio of net premiums written to surplus during the period under examination were as follows:

Year	(Net) Premiums Written	(Net) Paid Health Claims	Net Income	Policyholders Surplus	Ratio of Net Premiums Written to Surplus
2018	$2,235,043,192	$1,804,354,396	$102,188,085	$601,386,435	3.72
2017	$1,742,452,649	$1,457,796,372	$ 52,179,603	$506,324,110	3.44
2016	$1,654,972,130	$1,314,496,849	$ 61,409,187	$446,469,670	3.71
2015	$1,401,174,948	$1,146,384,918	$ 48,161,380	$474,400,108	2.95
2014	$1,354,119,032	$1,080,338,595	$ 55,500,397	$475,126,429	2.85

F. Reinsurance

The Company participates in various reinsurance agreements in order to limit potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with affiliated and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The reinsurance agreement with UHIC is the most significant reinsurance arrangement, which accounts for approximately 99.99%of the total ceded premiums for calendar year 2018.

Effective January 1, 1998, the Company entered into a quota share reinsurance agreement whereby the Company cedes 50% of all group health insurance contracts, net of unaffiliated reinsurance and on a funds-withheld basis, to UHIC. The following table shows the underwriting results for UHICNY's Quota-Share Agreement with UHIC during the examination period:

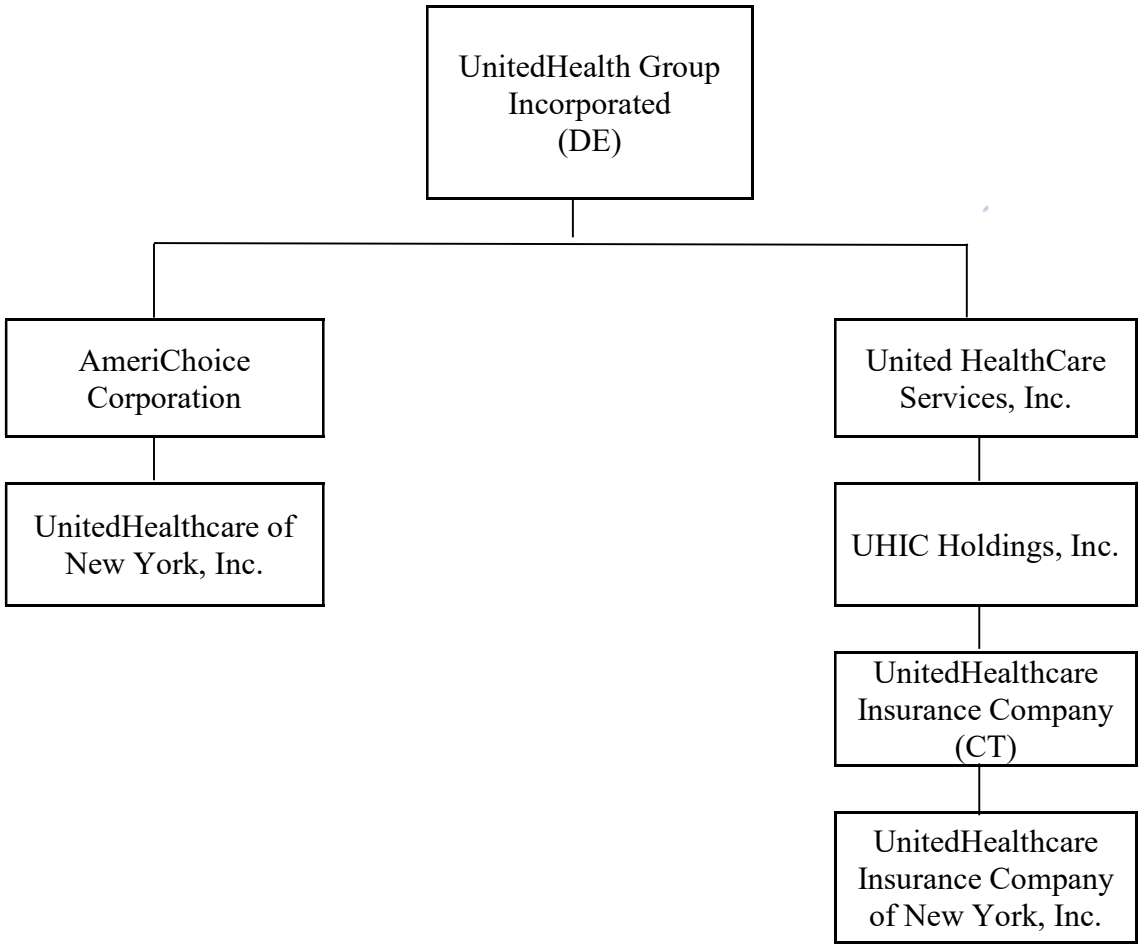
Year	Ceded Premiums	Ceded Claims	Ratios
2018	$1,112,621,216	$881,053,892	79.19%
2017	$1,754,791,127	$1,460,754,613	83.24%
2016	$1,658,373,043	$1,318,082,177	79.48%
2015	$1,454,595,738	$1,148,807,630	78.98%
2014	$1,307,893,851	$1,080,314,617	82.60%

G. Holding Company System

UHICNY is a wholly-owned subsidiary of UHIC, and its ultimate parent is UHG, a publicly traded corporation domiciled in the State of Minnesota.

As a member of a holding company system, UHICNY is required to file registration statements pursuant to the requirements of Section 1503 of the New York Insurance Law and Insurance Regulation No. 52 (11 NYCRR 80). All pertinent filings made during the examination period regarding the aforementioned statutes were reviewed, and no exceptions were noted.

The following is an excerpt of the organizational chart of the Company's holding company system as of December 31, 2018:



The following is a summary of UHICNY's relationship with several of its affiliates shown above:

- UHG is a Delaware corporation and the ultimate parent of UHIC, UHICNY, United HealthCare Services, Inc. ("UHS"), and over one hundred and fifty (150) other affiliated companies.
- UHS is a management services company within UHG that provides administrative, financial, management, accounting, underwriting, marketing, legal, medical provider, member services, medical management, agency development, employee management and benefit, information systems, and other general and administrative services to affiliated companies within UHG's holding company system. Most of the Directors and Officers of UHICNY and various UHG companies are considered employees of UHS rather than the individual insurers under UHG's holding company system.

H. Intercompany Transactions and Agreements

The Company is party to numerous intercompany agreements with its affiliates, which are subject to the Department's review and approval. These agreements involve activities such as administrative services, cash management, investment management, tax allocation, revolving credit, pharmacy benefits management, and reinsurance.

Below is a brief summary of some of the Company's key agreements.

Management and Administrative Services Agreements

Effective January 1, 2014, the Company entered into a Management and Administrative Services Agreement with UHS, which replaced and superseded its June 1, 2002, Service Agreement with UHS. Under the Management and Administrative Services Agreement, UHS provides management and operational support to UHICNY that includes but is not limited to underwriting, claims processing, financial management and accounting. The Management Services Agreement was submitted to the Department on May 7, 2013 and was approved on October 28, 2013.

Effective January 1, 2015, UHICNY entered into the First Amendment to the Management Services Agreement with UHS. The First Amendment updated the Agreement to comply with UHICNY's regulatory requirements. The First Amendment was submitted to the Department on November 12, 2014 and was approved on December 3, 2014.

Effective March 1, 2017, UHICNY entered into the Second Amendment to the Management Services Agreement, whereby the Amendment implemented an updated methodology for calculating management fees. Specifically, the updated language implemented

a current year true-up, which would yield more accurate results and ensure that adjustments were applied in the current year. The Second Amendment was submitted to the Department on January 17, 2017 and was approved on February 15, 2017.

Premium Allocation Agreement

Effective June 1, 2001, UHCNY and UHICNY entered into a Premium Allocation Agreement. Pursuant to the Premium Allocation Agreement, UHICNY sells group medical insurance and out of network insurance coverage for point of service products marketed in conjunction with HMO contracts offered by its HMO affiliate, UHCNY. Both UHCNY and UHICNY are entitled to receive consideration for insurance coverage marketed and issued in conjunction with products marketed and issued by UHCNY. The Premium Allocation Agreement was submitted to the Department on July 1, 2004 and approved on December 17, 2004.

Pharmacy Benefits Management Agreement

Effective January 1, 2013, the Company entered into a Pharmaceutical Benefits Management ("PBM") Agreement with an affiliated entity, OptumRx. Pursuant to this Agreement, OptumRx provides UHICNY with core prescription drug benefit services and mail order pharmacy services. Under the core prescription drug benefit services, OptumRx establishes and maintains a network of pharmacies to service the benefit plans, provide claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services and finance and analytical support services. Under the mail order pharmacy services, OptumRx provides UHICNY with mail order network prescription services. UHICNY remains ultimately responsible for the pharmacy benefit administration services provided to its members. Fees related to the PBM Agreement are calculated on a per-claim basis.

The PBM Agreement was approved by the Department on October 15, 2012 and was replaced by a First Amended Medicare Prescription Drug Benefit Administration Agreement. The new agreement was submitted to the Department on November 30, 2017 and was approved on January 2, 2018. The Mail Order Agreement previously filed with the 2013 Agreement will remain in place and is incorporated as an exhibit to the new Agreement.

Amended and Restated Subordinated Revolving Credit Agreement

The Company holds a $225,000,000 Amended and Restated Subordinated Revolving Credit Agreement with UHG at an interest rate of LIBOR plus a margin of 0.50%. This Credit Agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The Credit Agreement shall continue until terminated by either party with 60 days notice. There were no amounts outstanding under the Credit Agreement as of December 31, 2018. The Subordinated Revolving Credit Agreement was submitted to the Department on April 11, 2012 and was approved on May 21, 2012. The same was also submitted to the Department of Health on April 11, 2012 and approved on September 20, 2012.

On January 31, 2019, subsequent to the examination period, UHICNY borrowed $2,000,000 from its ultimate parent, UHG. On February 5, 2019, UHICNY repaid the loan, including interest in the amount $836.53.

Tax Allocation Agreement

On October 2, 1995, the Company entered into a Tax Allocation Agreement (‘TAA”) with UHG and as a result, is included in a consolidated federal income tax return with UHG and some of its affiliates. Federal income taxes are paid to/or refunded by UHG pursuant to the

terms of the TAA and equates to approximately the amount each party to the Agreement would be responsible for, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for taxable losses incurred in that year, to the extent that losses can be utilized in the consolidated federal income tax return of UHG. UHG currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The TAA was submitted to the Department on February 7, 1996.

In addition to the agreements described above, the Company maintains several other agreements with its affiliates.

I. Accounts and Records

Evaluation of Controls in Information Systems

The Company's Information Systems ("IS") applies to UHG and all of its wholly-owned subsidiaries. The IS function is managed broadly and includes the operations of UHICNY. UHG is responsible for maintaining the overall technology infrastructure utilized for data processing by the business segments within the Company.

The IS portion of the examination was performed in accordance with the Handbook, utilizing the Exhibit C (*Evaluation of Controls in Information Technology*) approach. The examiners' review of the IS controls included: IS management and organizational controls; application and operating system software change controls; system and program development controls; overall systems documentation; logical and physical security controls; contingency planning; local and wide area networks; personal computers; and mainframe controls.

The examiners evaluated the IS internal control testing performed by UHG's SOX function, the Internal Audit Department ("IAD") and its independent auditors, D&T, and performed a review of end user computing and IS outsourcing controls. As a result of the procedures performed, the examiners concluded that the Company's Information Technology ("IT") general controls and general application controls were functioning as management intended and that an effective system of internal controls is in place and conducive to the accuracy and reliability of financial information processed and maintained by the Company.

There were no significant deficiencies or material adverse findings as a result of the review.

J. Significant Operating Ratios

The following ratios have been computed as of December 31, 2018, based upon the results of this examination:

Description	Ratio
Net Change in Capital and Surplus	18.8%
Liquid Assets & Receivables to Current Liabilities	179.1%
Premium and Risk Revenue to Capital and Surplus	3.8 to 1
Medical Loss Ratio	79.9%
Combined Loss Ratio	94.5%
Administrative Expense Ratio	14.5%

The above ratios fell within the benchmark ranges set forth in the Financial Analysis Solvency Tools ("FAST") scoring ratios of the NAIC.

The underwriting ratios below are on an earned-incurred basis and encompass the five-year period covered by this examination:

	Amounts	Ratios
Total hospital and medical expenses	$ 6,803,364,271	79.8%
Claim adjustment expenses	$ 327,639,871	3.8%
General administrative expenses	$ 944,410,281	11.1%
Increase in reserves for life and accident and health contracts	$ 146,713	0%
Net underwriting gain	$ 455,536,289	5.3%
Net premium income	$ 8,531,097,425	100.0%

The Company's authorized control level Risk-Based Capital ("RBC") was $47,970,257 at December 31, 2018. Its total adjusted capital was $601,386,435, yielding an RBC ratio of 1,253.7% for calendar year 2018.

3. MEDICAL LOSS RATIO

UHICNY's 2018 Medical Loss Ratio ("MLR") Annual Reporting Form for the State of New York was examined to assess compliance with the requirements of Title 45 of the Code of Federal Regulations ("CFR"), Part 158, which implements Section 2718 of the Public Health Service Act ("PHS Act"). Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance companies to submit to the Secretary of the U.S. Department of Health and Human Services ("HHS"), an annual report on their MLRs. The MLR is the proportion of premium revenue expended by a company on clinical services and activities that improve health care quality in a given market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard (82% in the New York individual and small group markets, 85% in the New York large group market, and 80% for the student health plans market).

This is the first examination of the Company's MLR Annual Reporting Form performed by the Department. This examination of the Company's 2018 MLR Annual Reporting Form covered the reporting period January 1, 2016 through December 31, 2018, including 2016, 2017 and 2018 experience and claims run-out through March 31, 2019.

The examination was conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures ("MLR AUPs"). The MLR AUPs set forth the procedures for performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Annual Reporting Form, and the accuracy and timeliness of any rebate payments, if applicable. The examination included assessing the principles used and significant estimates made by the Company, evaluating the reasonableness of expense allocations, and determining compliance with relevant statutory accounting standards, MLR regulations and guidance, and the MLR Annual Reporting Form Filing Instructions.

Title 45 CFR §158.110(b) requires that a report for each MLR reporting year be submitted to the Secretary of HHS by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiners' review, the 2018 MLR Annual Reporting Form filed by the Company contained some elements that were not fully compliant with the requirements of Title 45 CFR §158, as more fully described in the sections below.

Title 45 CFR §§158.210 (a), (b) and (c) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR below the required amount (82% in the New York individual and small group markets and 85% in the large group market for New York).

The Company's three-year aggregate numerator and denominator for each market, along with the resulting Credibility-Adjusted MLR and rebate obligation, for the 2018 MLR Annual Reporting Form, as adjusted during the examination, were as follows:

MLR Components	Individual Market[1]		
	Filed	Examination Adjustments	Recalculated
Adjusted Incurred Claims	$2,312,883	$(188,784)	$2,124,099
Plus: Quality Improvement Expenses	$15,521	$0	$15,521
Less: Cost-sharing reductions	$0	$0	$0
Less: Federal Transitional Reinsurance Program payments expected from HHS	$0	$0	$0
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$646,050	$0	$646,050
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	$0
MLR Numerator	**$1,682,354**	**$(188,784)**	**$1,493,570**
Premium Earned	$2,299,828	$(223,464)	$2,076,364
Less: Federal and State Taxes and Licensing/ Regulatory	$98,987	$0	$98,987
MLR Denominator	**$2,200,841**	$(223,464)	**$1,977,377**
Preliminary MLR before Credibility–Adjustment[1]	82.0%		82.0%
Credibility–Adjustment	0.0%	0.0%	0.0%
Credibility–Adjusted MLR	**82.0%**		**82.0%**
MLR Standard	82.0%		82.0%
Rebate Amount	**$0**	**$0**	**$0**

[1]The Individual Market is considered to be non-credible, and therefore the MLR is presumed to meet or exceed the applicable MLR standard, as the Company reported fewer than 1,000 life-years, in the aggregate, in that market.

MLR Components	Small Group Market		
	Filed	**Examination Adjustments**	**Recalculated**
Adjusted Incurred Claims	$63,354,750	$188,784	$63,543,534
Plus: Quality Improvement Expenses	$608,054	$0	$608,054
Less: Federal Risk Adjustment Program net payments expected from HHS	$(915,980)	$0	$(915,980)
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	$0
MLR Numerator	**$64,878,784**	**$188,784**	**$65,067,568**
Premium Earned	$81,248,436	$223,464	$81,471,900
Less: Federal and State Taxes and Licensing/ Regulatory Fees	$6,699,069	$0	$6,699,069
MLR Denominator	**$74,549,367**	$223,464	**$74,772,831**
Preliminary MLR before Credibility–Adjustment	87.0%		87.0%
Credibility–Adjustment	2.6%	0.0%	2.6 %
Credibility–Adjusted MLR	**89.6%**		**89.6%**
MLR Standard	82%		82%
Rebate Amount	**$0**	**$0**	**$0**

MLR Components	Large Group Market		
	Filed	**Examination Adjustments**	**Recalculated**
Adjusted Incurred Claims	$1,757,550,605	$0	$1,757,550,605
Plus: Quality Improvement Expenses	$19,479,003	$0	$19,479,003
MLR Numerator	**$1,777,029,608**	**$0**	**$1,777,029,608**
Premium Earned	$2,304,867,228	$0	$2,304,867,228
Less: Federal and State Taxes and Licensing/ Regulatory Fees	$161,690,738	$0	$161,690,738
MLR Denominator	**$2,143,176,490**	$0	**$2,143,176,490**
Preliminary MLR before Credibility–Adjustment	82.9%		82.9%
Credibility–Adjustment	0.0%	0.0%	0.0 %
Credibility–Adjusted MLR	**82.9%**		**82.9%**
MLR Standard before Credibility–Adjustment	85%		85%
Rebate Amount	**$12,983,995**	**$0**	**$12,983,995**

MLR Components	Student Health Plans Market		
	Filed	Exam Adjustments	Recalculated
Adjusted Incurred Claims	$85,855,944	$0	$85,855,944
Plus: Quality Improvement Expenses	$718,650	$0	$718,650
MLR Numerator	**$86,574,594**	**$0**	**$86,574,594**
Premium Earned	$100,963,214	$0	$100,963,214
Less: Federal and State Taxes and Licensing/ Regulatory Fees	$5,110,102	$0	$5,110,102
MLR Denominator	**$95,853,112**	$0	**$95,853,112**
Preliminary MLR before Credibility–Adjustment	90.3%		90.3%
Credibility–Adjustment	1.1%	0%	1.1%
Credibility–Adjusted MLR	**91.4%**		**91.4%**
MLR Standard	80%		80%
Rebate Amount	**$0**	**$0**	**$0**

A. Market Classification

According to Title 45 CFR §158.103, the applicable definitions of individual market, small group market and large group market according to Section 2791(e) of the Public Health Service Act ("PHS Act") are codified and applicable to the MLR calculation. Section 2791(e) of the PHS Act requires that small and large group market classifications be based on the *average number of employees on the business days of the calendar year preceding the coverage effective date*. Additionally, according to Title 45 CFR §158.120, the MLR report must aggregate data separately for the large group market, the small group market and the individual market, for each entity licensed within the state where each health care coverage contract was issued.

Annually the Company issues surveys to certain employer groups with coverage subject to MLR, requesting the number of employees from each group in order to verify that the group's MLR market classification is accurate. A separate survey is issued to employer groups that include two or less enrollees to determine whether or not the group meets the definition of a sole

proprietor, and therefore required to be classified as part of the individual market. To be considered a group health plan, the health plan must have "employees" among its participants, for which Federal Law does not classify an individual and his or her spouse as employees when the trade or business is wholly owned by the individual or by the individual and his or her spouse. Thus, where a sole proprietor and/or a spouse-employee are the only employees, the related health plan experience would be aggregated with the issuer's individual market experience and not with the issuer's small group market experience.

The employer group responses to the sole proprietor survey are used by the Company to reclassify experience for employer groups that it believes meet the definition of a sole proprietor. The examiners noted that the Company's sole proprietor survey requested the number of employees "eligible" for healthcare coverage, which is not consistent with the Federal definition (*the average number of employees on the business days of the calendar year preceding the coverage effective date)* required to be used for group size determination. As a result, the examiners determined that the Company failed to employ standards consistent with the requirements of Title 45 CFR §158.103 in assigning the correct market classification of its sole proprietor policies. Because the Company utilized the incorrect survey responses to support its reclassification of sole proprietor experience for the purpose of the MLR calculation, the examiners have reversed the reclassification entries, resulting in a transfer from the individual market to the small group market three-year aggregate incurred claims of $188,784 and earned premium of $223,464.

It is recommended that the Company adopt and implement procedures to ensure that it obtains and maintains accurate information from its employer groups in order to determine the correct group size and market classification of its sole proprietor policies, as defined by Section

2791 of the PHS Act and the applicable requirements of Title 45 CFR §158 and related technical guidance. This should include, but not be limited to, obtaining and maintaining accurate documentation related to the average total number of employees for the calendar year preceding the coverage effective (or renewal) date. The Company should utilize this information to properly determine the market classification of its sole proprietor policies, in accordance with the requirements of Title 45 CFR §158.103.

The examiners reviewed a sample of individual and group policies to verify that the appropriate group size and market classification determination was applied by the Company in accordance with 45 CFR §158.103. With the exception of two (2) sole proprietor policies inappropriately classified in the individual market, the samples of all other policies, claims and other items tested during the examination were correctly assigned to the appropriate state, markets and lines of business in accordance with Title 45 CFR §158.103 and Title 45 CFR §158.120.

B. MLR Numerator

According to Title 45 CFR §158.221(b), the numerator of the MLR calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, expenditures for activities that improve health care quality as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151, Cost Sharing Reductions Program as defined in Title 45 CFR §158.140(b)(1)(iii) and Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii), as applicable.

Incurred Claims

The examiners reviewed the accuracy and appropriateness of the amounts reported within incurred claims as defined by Title 45 CFR §158.140, including the verification of the data used by the Company to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by the Company.

Based on the procedures performed, it was determined that the Company's incurred claims were accurately reported on the Company's MLR Annual Reporting Form.

Quality Improvement Activities ("QIA")

In accordance with Title 45 CFR §158.221(b)(8), effective with the 2018 MLR reporting year, the Company reported QIA expenses equal to 0.8% of earned premium in all markets in lieu of reporting the actual expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150 and Title 45 CFR §158.151.

The examiners reviewed the calculation of health care quality improvement expenses reported on the Company's 2018 MLR form, to ensure conformity with Title 45 CFR §158.221 and the 2018 MLR Annual Reporting Form Filing Instructions, and to confirm consistency with the calculation among the Company's individual, small group, large group and student health plan markets, as well as all affiliated issuers.

Based upon the procedures performed, it was determined that the Company properly calculated and reported its QIA expenses in accordance with Title 45 CFR §158.221.

Cost Sharing Reductions ("CSR")

In accordance with Title 45 CFR §158.140(b)(1)(iii), cost-sharing reduction payments received from HHS must be deducted from incurred claims to the extent not reimbursed to the provider furnishing the item or service.

The Company correctly reported that there were no advanced payments of CSR received from HHS as a deduction from incurred claims on the Company's MLR Annual Reporting Form.

Federal Premium Stabilization Programs

The examiners reviewed the accuracy of the amounts reported for Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Program as defined by Title 45 CFR §158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Company's transactional records.

Based on the procedures performed, it was determined that the Company's Federal Premium Stabilization Programs amounts were accurately reported on the Company's MLR Annual Reporting Form.

C. MLR Denominator

According to Title 45 CFR §158.22(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in Title 45 CFR §158.130, minus Federal and State Taxes and Licensing/ Regulatory Fees, described in Title 45 CFR §158.161(a), and Title 45 CFR §158.162(a)(1) and (b)(1).

Earned Premiums

The examiners reviewed the accuracy and appropriateness of the amounts reported within earned premiums as defined by Title 45 CFR §158.130, including the verification of the data used by the Company to calculate earned premiums and the validation of a sample of policy premiums reported by the Company.

Based on the procedures performed, it was determined that the Company's earned premiums were accurately and appropriately reported on a direct basis and the data elements underlying the 2016, 2017 and 2018 premiums, as reported on the Company's 2018 MLR Annual Reporting Form, were compliant with Title 45 CFR §158.130.

Federal and State Taxes and Licensing/ Regulatory Fees

The examiners reviewed the accuracy and appropriateness of Federal and State Taxes and Licensing/ Regulatory Fees, including confirmation that the allocation methodology was reasonable and complied with the requirements set forth by Title 45 CFR §158.170 and that taxes were reported in accordance with the provisions of Title 45 CFR §158.161 and Title 45 CFR §158.162.

Based on the procedures performed, it was determined that the Company's allocation methodology is reasonable, and the Federal and State Taxes and Licensing/Regulatory Fees were accurately and appropriately reported for each market segment on the Company's MLR Annual Reporting Form.

D. Credibility–Adjustment

According to Title 45 CFR §158.232, the Credibility–Adjustment is the product of the base credibility factor multiplied by the deductible factor. The examiners reviewed the underlying data utilized in the determination of the base credibility and deductible factors, tested the accuracy of the calculation of the base credibility and deductible factors and the resulting Credibility–Adjustment for the individual, small group, large group and student health plan markets. The Company elected to use a deductible factor of 1.0, in lieu of calculating a deductible factor, which has no impact on the Credibility–Adjusted MLR.

Based on the procedures performed, it was determined that the Company's base credibility factor, deductible factor and Credibility–Adjustment were accurately calculated and reported for each market segment on the Company's MLR Annual Reporting Form.

E. Credibility–Adjusted MLR

According to Title 45 CFR §158.221(a), MLR is the ratio of the numerator to the denominator, plus the Credibility Adjustment. The examiners calculated the Credibility–Adjusted MLR in accordance with Title 45 CFR §158 and the applicable MLR Annual Reporting Form Filing Instructions and determined the Company's Credibility–Adjusted MLR amounts were accurately calculated for each market segment on the Company's MLR Annual Reporting Form.

F. Rebate Disbursement and Rebate Notice

According to Title 45 CFR §158.240, a rebate is required to be paid, no later than September 30th, following the MLR reporting year if an insurer's credibility-adjusted MLR is

less than the MLR standard (82% for the individual and small group markets, 85% for the large group market, and 80% for the student health plans market, in the State of New York). Title 45 CFR §158.250 requires, for each MLR reporting year, an issuer to provide each policyholder who receives a rebate and subscribers whose policyholder receives a rebate, a Notice of Rebate.

Based on the examiners' review of the 2018 Credibility–Adjusted MLR for the individual and small group markets, it was determined that the Company exceeded the New York MLR premium percentage for each market segment, and thus was not required to pay rebates to its enrollees in these markets.

It should be noted that the Company reported a 2018 Credibility–Adjustment MLR, for its large group market, of 82.9% and thus was required to and did pay rebates of $12,983,995 in this market.

The Company reported rebates owed in its large group market in calendar year 2018, and based upon the procedures performed by the examiners, it was determined that the Company issued timely rebates in accordance with Title 45 CFR §§158.240-244.

Additionally, in accordance with Title 45 CFR §158.250, the Company issued the 2018 Rebate Notices for its large group market in a timely manner.

G. Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact on a company's Risk-Based Capital ("RBC") level requires notification by the Department to the Secretary of the HHS. Based on the examiners' review, it was determined that the Company's Credibility–Adjusted MLR exceeded the minimum percentage for the individual, small group

market and student health plans segments, and no rebates were issued, therefore there was no impact on the Company's RBC level that would warrant notification to the Secretary of HHS. The examiners determined that rebate payments in the large group market during 2018 did not have an adverse impact on the Company's RBC level: therefore, no notification was required to the Secretary of HHS.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and capital and surplus as of December 31, 2018, as contained in the Company's December 31, 2018 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for the years under review. The examiners' review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its December 31, 2018 filed annual statement.

Independent Accountants

The firm of Deloitte & Touche, LLP ("D&T") was retained by the Company to audit the Company's combined statutory basis financial statements of financial position as of December 31st for each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

D&T concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets	Examination
Bonds	$ 799,253,655
Preferred stocks	2,030,000
Cash and short-term investments	59,665,198
Receivable for securities	2,243
Investment income due and accrued	5,498,077
Uncollected premiums and agents' balances in the course of collection	124,772,494
Accrues retrospective premiums	97,442,711
Amounts recoverable from reinsurers	68,671,456
Other amounts receivable under reinsurance contracts	10,512,553
Amounts receivable relating to uninsured plans	40,770,168
Net deferred tax asset	9,541,046
Health care and other amounts receivable	131,540,967
Aggregate write-ins for other than invested assets	727,075
Total assets	$ 1,350,427,643

Liabilities	
Claims unpaid	$ 331,883,526
Accrued medical incentive pools and bonus amounts	7,903,639
Unpaid claims adjustment expenses	4,977,181
Aggregate health policy reserves	102,902,987
Aggregate health claim reserves	21,097,271
Premiums received in advance	25,409,224
General expenses due or accrued	12,248,858
Current federal and foreign income tax payable and interest thereon	7,002,243
Ceded reinsurance premiums payable	151,054,031
Remittance and items not allocated	417,422
Amounts due to parent, subsidiaries and affiliates	17,358,901
Funds held reinsurance treaties with unauthorized reinsurers	29,638,200
Liability for amounts held under uninsured plans	36,304,284
Aggregate write-ins for other liabilities	843,441
Total liabilities	$ 749,041,208

Capital and surplus	Examination
Common capital stock	300,000
Gross paid-in and contributed surplus	77,131,198
Unassigned funds (surplus)	523,955,237
Total capital and surplus	$ 601,386,435
Total liabilities, capital and surplus	$ 1,350,427,643

Note 1: The Internal Revenue Service has conducted audits of the income tax returns filed on behalf of the Company through tax year 2016. Calendar years 2017, 2018 and 2019 are under review by the IRS under its Compliance Assurance Program. The examiners are unaware of any potential exposure of the Company to any tax assessments, and no liability has been established herein relative to such contingency.

Note 2: UHICNY files its tax returns on a consolidated basis with other affiliated companies within the UHG holding company.

B. Statement of Revenue and Expenses and Capital and Surplus

The Company's capital and surplus decreased by $14,372,624 during the five-year examination period, January 1, 2014 through December 31, 2018, detailed as follows:

Revenue		
Net premium income	$ 8,387,761,951	
Change in unearned premium reserves and reserve for rate credits	143,221,348	
Aggregate write-ins for other health care related revenues	127,667	
Aggregate write-ins for other non-health revenues	(13,541)	
Total revenue		$ 8,531,097,425
Hospital and Medical Expenses		
Hospital/medical benefits	$ 10,339,122,675	
Other professional services	236,208,185	
Prescription drugs	2,002,055,720	
Incentive pools, withhold adjustments and bonus amounts	31,395,513	
Net reinsurance recoveries	(5,805,417,822)	
Total hospital and medical expenses	$ 6,803,364,271	
Claims adjustment expenses	327,639,871	
General administrative expenses	944,410,281	
Increase in reserves for life and accident and health contracts	146,713	
Total underwriting deductions		8,075,561,136
Net underwriting gain		$ 455,536,289
Net investment income earned		78,192,747
Net realized capital gains		9,316,141
Net gain from agents' or premium balances charged off		(14,339,100)
Aggregate write-ins for other expenses		(119,357)
Net income before federal income taxes		528,586,720
Federal and foreign income taxes incurred		209,225,396
Net income		$ 319,361,324

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2013			$ 615,759,059
	Gains in Surplus	Losses in Surplus	
Net income	$ 319,361,324		
Change in net unrealized capital gains	63,724		
Change in net unrealized foreign exchange capital gain	3,420		
Change in net deferred income tax		$ 6,666,647	
Change in nonadmitted assets	1,392,029		
Change in paid-in surplus		24,056	
Dividends to stockholders		345,000,000	
Increase in surplus as a result of merger*	16,497,582		
Net loss in capital and surplus			(14,372,624)
Capital and surplus, per report on examination, as of December 31, 2018			$ 601,386,435

*Effective May 10, 2017, Health Net Insurance of New York ("HNINY"), a New York domiciled company, was merged into the Company under a statutory merger.

5. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liabilities of $455,883,784 for the above captioned accounts are the same as the amounts reported by UHICNY in its filed December 31, 2018annual statement.

The examination analysis of the aggregate reserves and claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in UHICNY's internal records and in its filed annual statements as verified during the examination. 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 UHICNY's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2018.

6. SUBSEQUENT EVENTS

COVID-19

On March 11, 2020, The World Health Organization declared the spreading coronavirus (COVID-19) outbreak a pandemic. On March 13, 2020, COVID-19 was declared a national emergency in the United States. The epidemiological threat posed by COVID-19 is having disruptive effects on the global supply chain as well as the demand for labor, products and services in the U.S. The economic disruptions caused by COVID-19 and the increased uncertainty about its magnitude has also caused extreme volatility in the financial markets. While the full effect of COVID-19 is still unknown at the time of this report, the Department and all insurance regulators, with the assistance of the NAIC, are monitoring the situation through a coordinated effort and will continue to assess the impacts of COVID-19 on U.S. insurers.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2013, contained the following four (4) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that those Board members who do not fulfill their fiduciary responsibility to the Company by attending the majority of board meetings, resign or be replaced. *The Company has complied with this recommendation.*	8
2.	It is recommended that the Company's board meeting minutes accurately reflect the attendance of the board members. In addition, it is recommended that the board minutes accurately reflect changes made to the board membership. *The Company has complied with this recommendation.*	9
	Corporate Governance	
3.	It is noted that Part 89.12 of Insurance Regulation No. 118 (11 NYCRR 89.12) includes a clause permitting insurers to request a hardship waiver to the requirement that the Audit Committee be independent, as defined in that regulation. *The Company submitted such a request for waiver on March 4, 2013.*	12
	Information Systems	
4.	It is recommended that management: a) continue to make progress related to aligning operational Information Technology practices with existing policies, including the introduction of processes and technologies that can help ensure policy compliance; and b) incorporate a monitoring component into the policy to ensure that the ASK database remains up to date and to ensure that any new data elements (i.e., from M&A activity or enhancements to existing applications) are incorporated into the database timely to ensure policy compliance. *The Company has complied with this recommendation.*	25

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	MLR - Market Classification	
	It is recommended that the Company adopt and implement procedures to ensure that it obtains and maintains accurate information from its employer groups in order to determine the correct group size and market classification of its sole proprietor policies, as defined by Section 2791 of the PHS Act and the applicable requirements of Title 45 CFR §158 and related technical guidance. This should include, but not be limited to, obtaining and maintaining accurate documentation related to the average total number of employees for the calendar year preceding the coverage effective (or renewal) date. The Company should utilize this information to properly determine the market classification of its sole proprietor policies, in accordance with the requirements of Title 45 CFR §158.103	26

Respectfully submitted,

_____/S/_____
Joanne Campanelli, CFE

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

Joanne Campanelli, being duly sworn deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____/S/_____
Joanne Campanelli, CFE

Subscribed and sworn to before me
this _____ of _____ 2020.

Respectfully submitted,

_____/S/_____
Jeffrey Usher, CFE

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

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

_____/S/_____
Jeffrey Usher, CFE

Subscribed and sworn to before me
this _____ of _____ 2020.

APPOINTMENT NO. 31995

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***LINDA A. LACEWELL****, 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:*

Exam Resources, LLC

as a proper person to examine the affairs of the

UnitedHealthcare Insurance Company of New York

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

Company

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 16th day of August, 2019

LINDA A. LACEWELL
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau