SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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In the Matter of the Liquidation of HEALTH REPUBLIC INSURANCE OF NEW YORK, CORP.	: : : :	Index No. 450500/2016 VERIFIED PETITION

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Maria T. Vullo, Superintendent of Financial Services of the State of New York, as Liquidator (the "Liquidator") of Health Republic Insurance of New York, Corp. ("HRINY"), by Scott D. Fischer, Special Deputy Superintendent and agent of the Liquidator, hereby petitions this court for an order (the "Order") approving a proposal designed to facilitate the distribution of the assets of HRINY to HRINY's creditors holding claims for payment under insurance policies issued by HRINY (the "Policy Claims"), pursuant to Article 74 of the New York Insurance Law (the "Claims Adjudication Procedure").

1. By order entered on May 11, 2016 (the "Liquidation Order"), HRINY, a Consumer Operated and Oriented Plan licensed under Article 43 of the New York Insurance Law to offer health service indemnity coverage, was placed into voluntary liquidation.

2. The Liquidation Order appointed the Superintendent of Financial Services, Maria T. Vullo, and her successors in office, as Liquidator.

3. The Liquidation Order charged the Liquidator with, among other things, the responsibility of:

- Marshalling HRINY's assets;
- Adjudicating the claims presented by persons who were covered by an insurance policy issued by HRINY ("Members") and health care professionals, providers and facilities that provided health care services to Members ("Providers") prior to cessation of coverage on December 1, 2015, and determining the total liabilities of HRINY;

- Otherwise liquidating HRINY's business pursuant to Article 74 of the New York Insurance Law.

4. The Liquidator is seeking, through approval of the Claims Adjudication Procedure, to facilitate the administration of the liquidation proceeding. In developing the Claims Adjudication Procedure, the Liquidator sought to balance a number of important factors, including fair and equitable treatment of creditors, interests of due process and transparency, the large number of claims involved, and the need for efficiency in light of HRINY's limited resources. The Claims Adjudication Procedure is also designed to minimize burdens on claimants by incorporating to the greatest extent possible HRINY's existing processes for adjudication of Policy Claims already set forth in Providers' contracts and Members' insurance policies. The Liquidator wishes to minimize any changes to such existing processes while facilitating the orderly and efficient adjudication of Policy Claims during HRINY's liquidation. The Liquidator believes the proposed Claims Adjudication Procedure strikes the proper balance among the factors described above, and serves the best interests of HRINY's creditors.

5. As a first step in administering the claims, the Liquidator and her agents will engage a third party to audit the existing inventory of Policy Claims (which number in the hundreds of thousands). The audit will be designed to identify and eliminate duplicative and other inappropriate Policy Claims and to maximize the accuracy of the proposed Explanations of Benefits/Allowance ("EOBs") to be issued in respect of submitted Policy Claims. Each Policy Claim will be audited for financial and payment accuracy, and to determine that claims were not inappropriately denied based on medical necessity. The goals of the audit will be to ensure proper allocation of estate resources among claimants and to minimize the cost of defending appeals to benefit determinations.

6. Under the proposed Claims Adjudication Procedure, HRINY will issue to Providers and Members on a rolling basis EOBs reflecting results of the audit. Each such EOB will allocate among HRINY, the Provider, and the Member the charges for services rendered to the Member. It is hoped that the majority of Policy Claims will be resolved through this process, given the audit. If a Member or Provider disagrees with the EOB, however, each such Member or Provider will have the opportunity to appeal such determination by submitting a written appeal and all supporting documentation within sixty (60) days after the date of mailing of the EOB. The Liquidator and her agents, utilizing the appropriate resources to investigate the appeal, will either grant or deny the appeal within sixty (60) days after the date of receipt of an appeal of the EOB. All documents submitted or generated in connection with the appeal will form the basis of any further review of the EOB, including, as applicable, any review by a mediator, external review agency, or referee.

7. Objections to the denial of an appeal of an EOB may be settled or otherwise resolved through mutual agreement of the parties or by non-binding mediation, which the Liquidator, in her sole discretion, may require. Alternatively, unresolved objections to the denial of an appeal of an EOB will be referred to a referee or external review agency, as applicable, to hear and determine (on a final basis, if the parties consent, or as a recommendation to the Court if the parties do not consent) the validity of disputed EOBs. The Liquidator will make a determination within sixty (60) days after receipt of an objection to the denial of an appeal whether to direct a disputed Policy Claim to mediation as a first step, or whether to refer the claim to a referee. The Liquidator will submit, at a future date, a request for the appointment of a panel of referees or healthcare qualified claims examiners, as applicable, to hear and determine, or report on, objections of claimants to the denial of their appeal. To facilitate parties in

interests' understanding of the proposed process and procedures, claims process maps (the "Process Map") providing a visual representation of the Claims Adjudication Procedure for Providers and Members are attached to this Verified Petition as Exhibit C.

8. Through the foregoing process, on an ongoing basis, the Liquidator will seek allowance or disallowance of Policy Claims by the Court. An "allowed" Policy Claim is a Policy Claim that has been approved by the Liquidator and/or the Court, as applicable, pursuant to the Claims Adjudication Procedure and will therefore be allowed to share in a distribution of the assets, if any, of HRINY pursuant to the priorities to be set forth in a plan of liquidation, which will be filed at a future date. A "disallowed" Policy Claim is a Policy Claim that has been rejected by the Liquidator and/or the Court, as applicable, pursuant to the Claims Adjudication Procedure, and will not be allowed to share in a distribution of HRINY's assets. The final result of the Claims Adjudication Procedure will be the allowance or disallowance of every Policy Claim.

9. The Liquidator does not intend to seek court approval to pay distributions in respect of any Policy Claims until all Policy Claims have been fully adjudicated and determined, so as to ensure a fair and equitable allocation of such distributions.

10. As provided by the Liquidator Order, the Liquidator will continue to refrain from adjudicating claims other than Administrative Expenses and Policy Claims until such time, if ever, as circumstances indicate that any amount of estate resources could be paid under Article 74 in respect of such claims.

11. The Liquidator respectfully requests that the Court schedule a hearing on this Verified Petition in accordance with the accompanying Order to Show Cause. The Order to Show Cause provides for a hearing date on the Verified Petition and establishes a procedure for the provision of notice to former policyholders and other creditors.

12. Based on the foregoing, the Liquidator respectfully requests that the Court issue an order that:

a. Approves the Claims Adjudication Procedure, which:

i. Provides for the establishment of the following deadlines:

1. the establishment of 60 days after mailing of the EOB as the deadline for any Provider or Member to file an appeal of the determination contained in the EOB;

2. the establishment of 60 days after receipt by the Liquidator as the deadline for HRINY to accept or deny any such appeal;

3. the establishment of 30 days from the date of mailing of a notice of denial of an appeal as the deadline for any Provider or Member to file an objection to the denial of any appeal;

4. the establishment of 60 days after receipt by the Liquidator as the deadline for the Liquidator to direct an unresolved objection to the denial of an appeal to mediation; and

5. the establishment of the later of (i) 60 days after the Provider or Member has filed an objection to the denial of an appeal or (ii) 30 days after the completion of any unsuccessful mediation as the deadline for the Liquidator to refer an unresolved objection to the denial of an appeal to a referee or healthcare qualified claims examiner appointed by separate order of this Court.

ii. Authorizes the Liquidator, in her sole discretion, to direct any disputed Policy Claim following the denial of an appeal to mandatory non-binding mediation; and

iii. Provides for a referee or healthcare qualified claims examiner, to be appointed by a future order of this Court, to hear and determine or report to the Court on the validity of any unresolved disputed Policy Claims following the denial of an appeal;

b. Approves the form of the revised EOB to be sent to Members and Providers, which is designed to be consistent with the Claims Adjudication Procedure, substantially in the form attached as Exhibit "1" to the Claims Adjudication Procedure;

c. Approves the Process Map outlining the Claims Adjudication Procedure substantially in the form attached to the Verified Petition as Exhibit C;

d. Authorizes the Liquidator to compromise, settle, or adjust any Policy Claim by mutual consent of the parties at any time;

e. Authorizes the Liquidator to take further actions, which she, in her discretion, deems advisable for the protection of the assets in her possession; and

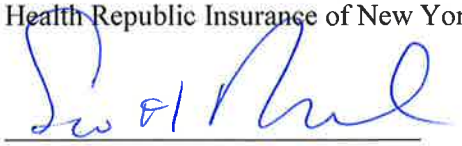
f. Provides for such other relief as is just.

13. No previous application for the relief sought herein has been made to this or any court or judge thereof.

WHEREFORE, Petitioner respectfully requests that the Order be granted and that a hearing be scheduled sufficiently far in the future for the provision of notice as provided for therein and that, upon the hearing, the Court issue an order granting the relief sought in this Verified Petition.

Dated: New York, New York
September 9, 2016

MARIA T. VULLO
Superintendent of Financial Services of the
State of New York as Liquidator of
Health Republic Insurance of New York, Corp.



Scott D. Fischer
Special Deputy Superintendent and agent
of the Superintendent of Financial Services of
the State of New York as Liquidator of
Health Republic Insurance of New York, Corp.

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

Scott D. Fischer, being duly sworn, deposes and says:

That he has read the foregoing Verified Petition, and that the same is true to his knowledge except as to the matters therein stated to be alleged on information and belief and as to those matters he believes to be true; that deponent is the duly appointed Special Deputy Superintendent and agent of the Superintendent of Financial Services as Liquidator of Health Republic of New York, Corp., and as such is acquainted with the facts alleged therein.

Deponent further says that the sources of his information and the grounds of his belief as to the matters to be alleged on information and belief are from or were derived from the records, books and papers of said Health Republic of New York, Corp. in the possession of the Liquidator and communications made to deponent by employees and agents of the Liquidator.

Scott D. Fischer
Special Deputy Superintendent and agent
of the Superintendent of Financial Services of
the State of New York as Liquidator of Health
Republic Insurance of New York, Corp.

Sworn to before me this
9th day of September, 2016

Notary Public

MICHAEL J. CAMPANELLI
Notary Public, State of New York
No 02-4996425
Qualified in Suffolk County
Certificate Filed in New York County
Commission Expires May 18, 2018

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