COURT OF APPEALS
STATE OF NEW YORK

UNIVERSAL AMERICAN CORP.,

Petitioner-Appellant,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Respondent-Respondent.

New York County
Index No. 650613/2010

MOTION FOR LEAVE TO APPEAL

SCHLAM STONE & DOLAN LLP
26 Broadway
New York, New York 10004
(212) 344-5400
(212) 344-7677 (facsimile)
RHD@schlamstone.com

Attorneys for Petitioner-Appellant Universal American Corp.

Dated: April 17, 2014

COURT OF APPEALS
STATE OF NEW YORK

UNIVERSAL AMERICAN CORP.,

Petitioner-Appellant,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Respondent-Respondent.

NOTICE OF MOTION

New York County
Index No. 650613/2010

SIRS OR MADAMS:

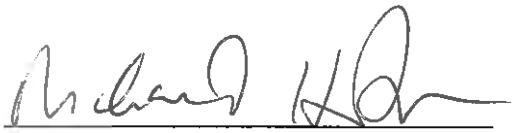
PLEASE TAKE NOTICE, that upon the papers annexed hereto, the undersigned will move this Court, on the 28th day of April, 2014, at the Court of Appeals Hall, 20 Eagle Street, Albany, New York 12207, for an order pursuant to CPLR 5602(a)(1), granting Petitioner-Appellant UNIVERSAL AMERICAN CORP. leave to appeal from the order of the Appellate Division, First Department, entered in the above-captioned action on October 1, 2013, together with such other and further relief to Petitioner-Appellant as the Court deems just and equitable.

PLEASE TAKE FURTHER NOTICE, that pursuant to Rule 500.11(a) of the Rules of this Court, this motion will be submitted on the papers herein, without oral argument or any personal appearance in support of or opposition thereto.

PLEASE TAKE FURTHER NOTICE, that opposing papers, if any, must be filed with the Court and served upon the undersigned within the time and in the manner specified in Rules 500.11(a) and 500.11(d)(2) of the Rules of this Court.

Dated: New York, New York
April 17, 2014

SCHLAM STONE & DOLAN LLP

By: 

Richard H. Dolan
Bradley J. Nash

26 Broadway
New York, New York 10004
Telephone: (212) 344-5400
Facsimile: (212) 344-7677

Attorneys for Petitioner-Appellant
UNIVERSAL AMERICAN CORP.

TO: Barbara A. Lukeman, Esq.
Nixon Peabody LLP
437 Madison Avenue
New York, NY 10022

Attorneys for Respondent-Respondent
NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

COURT OF APPEALS
STATE OF NEW YORK

UNIVERSAL AMERICAN CORP.,

Petitioner-Appellant,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Respondent-Respondent.

DISCLOSURE STATEMENT PURSUANT TO RULE 500.1(f)

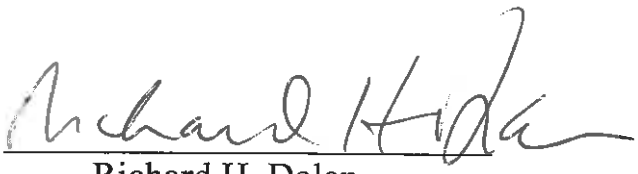
New York County
Index No. 650613/2010

Petitioner-Appellant Universal American Corp., is a publicly traded corporation organized under the laws of the state of Delaware, and maintains its principal place of business in White Plains, New York.

As of March 31, 2014, Universal American Corp. had the affiliates and subsidiaries listed on the attachment to this statement.

Dated: April 17, 2014

SCHLAM STONE & DOLAN LLP

By: 

Richard H. Dolan
Bradley J. Nash

26 Broadway
New York, New York 10004

Attorneys for Petitioner-Appellant
UNIVERSAL AMERICAN CORP.

Attachment to Disclosure Statement of Universal American Corp.

As of March 31, 2014, Universal American Corp. had the following affiliates and subsidiaries:

Universal American Corp. ("UAM")

Universal American Holdings, LLC
- American Pioneer Life Insurance Company
- American Progressive Life and Health Insurance Company of New York
- Constitution Life Insurance Company (absorbed UBIC effective 12/31/13)
- Marquette National Life Insurance Company
- The Pyramid Life Insurance Company

WorldNet Services Corp.
- Ameri-Plus Preferred Care, Inc.

Universal American Financial Services, Inc.
- NaviHealth Group Holdings, LP
- Penn Marketing America, LLC
- Premier Marketing Group, LLC
- Pyramid Marketing Services, Inc.
- Senior Resource Services, LLC.
- UAM Agent Services Corp.
- Worlco Management Services, Inc., a New York Corporation (NY)
- Worlco Management Services, Inc., a Pennsylvania Corporation (PA)
- Quincy Coverage Corp.

APS Parent, Inc.
- APS Clinics of Puerto Rico, Inc.
- APS Healthcare Bethesda, Inc.
- APS Healthcare Holdings, Inc.
- APS Heathcare Puerto Rico, Inc.
- APS Healthcare, Inc.
- CNR Partners, Inc.
- Innovative Resource Group, LLC
- UAM/APS Holding Corp.

Heritage Health Systems, Inc.
- Golden Triangle Physician Alliance

Harmony Health, Inc.
Heritage Health Systems of Texas, Inc. (Beaumont)
Heritage Physician Networks
HHS Texas Management, Inc.
HHS Texas Management, LP (Houston)
SelectCare Health Plans, Inc.
SelectCare of Maine, Inc.
SelectCare of Oklahoma, Inc.
SelectCare of Texas, Inc.
TexanPlus Health Centers, LLC
Today's Options Health Plans of Wisconsin, Inc.
Today's Options of Arkansas, Inc.
Today's Options of Georgia, Inc.
Today's Options of Kansas, Inc.
Today's Options of Missouri, Inc.
Today's Options of Nebraska, Inc.
Today's Options of New York, Inc.
Today's Options of Oklahoma, Inc.
Today's Options of Pennsylvania, Inc.
Today's Options of South Carolina, Inc.
Today's Options of Texas, Inc.
Today's Options of Virginia, Inc.

Collaborative Health Systems, LLC
Accountable Care Coalition of Alabama, LLC
Accountable Care Coalition of Caldwell County, LLC
Accountable Care Coalition of California, LLC
Accountable Care Coalition of Cedar Rapids, LLC
Accountable Care Coalition of Central and Western Massachusetts, LLC
Accountable Care Coalition of Central Georgia, LLC
Accountable Care Coalition of Charlotte, LLC
Accountable Care Coalition of Coastal Georgia, LLC
Accountable Care Coalition of Connecticut, LLC
Accountable Care Coalition of Cumberland County, LLC
Accountable Care Coalition of DeKalb, LLC
Accountable Care Coalition of East & South Central Texas, LLC
Accountable Care Coalition of East Florida Panhandle, LLC
Accountable Care Coalition of Eastern North Carolina, LLC
Accountable Care Coalition of Esca Rosa, LLC
Accountable Care Coalition of Georgia, LLC

Accountable Care Coalition of Greater Athens Georgia II, LLC
Accountable Care Coalition of Greater Athens Georgia, LLC
Accountable Care Coalition of Greater Augusta & Statesboro, LLC
Accountable Care Coalition of Greater Houston, LLC
Accountable Care Coalition of Greater New York, LLC
Accountable Care Coalition of Hawaii, LLC
Accountable Care Coalition of Kentucky, LLC
Accountable Care Coalition of Maryland Primary Care, LLC
Accountable Care Coalition of Maryland, LLC
Accountable Care Coalition of Mississippi, LLC
Accountable Care Coalition of Mount Kisco, LLC
Accountable Care Coalition of NE Tennessee & SW Virginia, LLC
Accountable Care Coalition of New Mexico, LLC
Accountable Care Coalition of North Central Florida, LLC
Accountable Care Coalition of North Texas, LLC
Accountable Care Coalition of Northwest Florida, LLC
Accountable Care Coalition of Oklahoma, LLC
Accountable Care Coalition of Queens County, LLC
Accountable Care Coalition of Rural Georgia, LLC
Accountable Care Coalition of Sheboygan, LLC
Accountable Care Coalition of South Georgia, LLC
Accountable Care Coalition of Southeast Wisconsin, LLC
Accountable Care Coalition of Syracuse, LLC
Accountable Care Coalition of Texas, Inc.
Accountable Care Coalition of the Green Mountains, LLC
Accountable Care Coalition of the JPS Physician Group, LLC
Accountable Care Coalition of the Mississippi Gulf Coast, LLC
Accountable Care Coalition of the North Country, LLC
Accountable Care Coalition of the Tri-Counties, LLC
Accountable Care Coalition of West Florida Panhandle, LLC
Accountable Care Coalition of West Michigan, LLC
Accountable Care Coalition of Western Georgia, LLC
Aspirus Accountable Care Coalition, LLC
Capital Health ACO, LLC
Essential Care Partners, LLC
Jefferson Physician Organization Accountable Care Organization, LLC
Maine Community Accountable Care Organization, LLC
Maine Primary Care Holdings, LLC
Maryland Collaborative Care, LLC
Northern Maryland Collaborative Care LLC

Southern Maryland Collaborative Care LLC
TACHC ACO Holdings, LLC
Transitional Analytical Care, LLC
Virginia Collaborative Care, LLC

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MOTION FOR LEAVE TO APPEAL ON BEHALF OF PETITIONER-APPELLANT UNIVERSAL AMERICAN CORP.

A. CONCISE STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

The questions of law that merit review by this Court are:

1. In construing a coverage provision in a standard-form insurance policy, should a reviewing court attempt to determine how the parties intended the provision to apply, or instead construe the words of the policy according to their ordinary meaning to determine whether there is any reasonable construction that would result in coverage?

2. Where an insurance policy covers any "loss resulting directly from a fraudulent . . . entry of Electronic Data" into the insured's proprietary computer system, is there any reasonable construction of the policy's words that would result in coverage for a loss resulting from the entry of fraudulent information in the insured's computerized billing system that results directly in a loss to the insured?

3. Can the words in an insurance policy covering any "loss resulting directly from a fraudulent ... entry of Electronic Data" into the insured's proprietary computer system reasonably be read to exclude any loss resulting from the fraudulent content of an entry made into the insured's proprietary computer system?

4. Did the Appellate Division err in construing the term "fraudulent entry" in an insurance policy to exclude any fraudulent content of an entry into the insured's computer system, where the core meaning of the term "fraud" includes a false statement knowingly made for the purpose of deception?

5. Was the order of the Appellate Division properly made?

B. PROCEDURAL HISTORY

Petitioner-Appellant Universal American Corp. ("Petitioner" or "Universal American") commenced this action in Supreme Court, New York County on June 14, 2010, seeking damages and declaratory relief, arising from the refusal of National Union Fire Insurance Company of Pittsburgh, Pa. ("Respondent" or "National Union") to indemnify Universal American, under a Computer Systems Fraud rider to a crime loss insurance policy (the "Computer Fraud Policy"), for an $18 million loss Petitioner had suffered as the result of the fraudulent entry of claims for payment into Universal American's computer billing system. (R. 209-217.)

On November 22, 2011, Universal American filed a motion for partial summary judgment on the issue of coverage under the Computer Fraud Policy. (R. 13-14.) National Union cross-moved for summary judgment on February 21, 2012. (R. 343-44.)

By order entered on January 8, 2013, the Supreme Court, New York County (O. Peter Sherwood, J.S.C.) denied Universal American's motion for partial summary judgment and granted National Union's cross-motion for summary judgment. (R. 7-12; reproduced in the Appendix hereto at App. 1-7.) Supreme Court's decision is reported as *Universal American Corp. v.*

National Union Fire Ins. Co. of Pittsburgh, Pa., 38 Misc. 3d 859, 959 N.Y.S.2d 849 (Sup. Ct. N.Y. Co. 2013).

By notice of appeal filed on January 16, 2013, Universal American appealed to the Appellate Division, First Department from Supreme Court's order. (R. 4-5; reproduced in the Appendix hereto as App. 8-9.)

By decision and order entered on October 1, 2013, the Appellate Division, First Department affirmed Supreme Court's order dismissing the complaint. Respondent served Petitioner with notice of entry of that order on October 2, 2013, by overnight delivery. (That order with notice of entry is reproduced in the Appendix hereto as App. 10-12.) The Appellate Division's decision is reported as *Universal American Corp. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 110 A.D.3d 434, 972 N.Y.S.2d 241 (1st Dep't 2013).

On October 30, 2013, Petitioner filed a motion in the Appellate Division, First Department for reargument, or alternatively for leave to appeal to this Court. (The notice of motion on that application is reproduced in the Appendix hereto as App. 13-15.) By order entered on March 18, 2014, the Appellate Division, First Department denied Petitioner's motion. Respondent served Petitioner with notice of entry of the Appellate

Division's order on March 20, 2014 by overnight delivery. (That order with notice of entry is reproduced in the Appendix hereto as App. 16-17.)

This motion for leave to appeal is being made within thirty (30) days of the service upon Petitioner of notice of entry of the Appellate Division's order denying Petitioner's motion for leave to appeal, and is timely pursuant to CPLR 5513.

C. JURISDICTION

This Court has jurisdiction over this motion and the proposed appeal pursuant to CPLR 5602(a)(1)(i). This proceeding was commenced in the Supreme Court, and the order of the Appellate Division finally determined the action within the meaning of CPLR 5611.

This appeal presents a question of "law only" within the meaning of CPLR 5501(b). It concerns the extent of coverage under a standard-form insurance policy that was not negotiated between the parties. The lower courts decided the case on cross-motions for summary judgment as a matter of law, and based their rulings on the words of the policy alone.

D. CONCISE STATEMENT OF THE CASE

1. The Facts

Universal American offers health care products and services to people covered by Medicare and Medicaid. (R. 319 ¶ 4.) Its family of companies

provides Medicare benefits to approximately 135,000 Americans with Medicare. (*Id.*) One of Universal American's products is Medicare Advantage Private Fee-For-Service plans ("MA-PFFS"). The MA-PFFS program is a U.S. government-regulated alternative to Original Medicare. Under the program, members enroll in health care benefit plans sponsored by private insurance companies like Universal American. (*Id.* ¶ 5.) The plans receive payments for services provided to their members from the Centers for Medicare and Medicaid Services ("CMS"), a division of the U.S. Department of Health and Human Services, and in some instances from the plan members as well. (*Id.*)

Health care providers submit claims for services rendered to a plan member much as they do under traditional indemnity health insurance policies. (*Id.* ¶ 6.) Universal American receives and processes reimbursement claims from participating health care providers through its computer systems. (*Id.* ¶ 8.) Many of these claims are auto-adjudicated, meaning they pass through the computer system and generate payment without any manual review. (*Id.*)

In 2008, Universal American purchased a Computer Fraud Policy from National Union to protect itself from the submission and payment of fraudulent claims through its computer system – the very risk to which it fell

victim here. (R. 311 ¶ 6.)

Under the Computer Fraud Policy, National Union must indemnify Universal American for:

> Loss resulting directly from a fraudulent
>
> (1) entry of Electronic Data or Computer Program into, or
>
> (2) change of Electronic Data or Computer Program within the Insured's proprietary Computer System . . .
>
> provided that the entry or change causes
>
> (a) Property to be transferred, paid or delivered
>
> . . . .

(R. 249 (emphasis added).) The Computer Fraud Policy is a standard form agreement. (R. 311 ¶ 5.) It appears that the same standard form has been widely used since at least 2004 by the insurance industry for issuing policies covering computer fraud. *See, e.g., Hudson United Bank v. Progressive Casualty Ins. Co.,* 112 Fed. Appx. 170, 173, 175 (3d Cir. 2004) (involving a fidelity bond and a computer systems fraud rider having the same language as in the Computer Fraud Policy here); *F.D.I.C., as Receiver v. St. Paul Companies,* 634 F. Supp. 2d 1213, 1216 (D. Colo. 2008) (same).

In December 2008, Universal American discovered that it was the victim of a massive fraud perpetrated through the computer system it uses to

process and pay claims for reimbursement to health care providers. (R. 320 ¶¶ 9-12.) The scheme to which Universal American fell victim involved dozens of doctors and clinics in Florida, Georgia and Louisiana. The United States Department of Justice pursued criminal prosecutions of a number of the perpetrators, some of whom received lengthy prison sentences.

All told, as a result of the fraud, Universal American paid some $18 million in fraudulent claims for medical services that were never provided; Universal American was not able to recover any of that loss from the perpetrators. The losses for which Universal American seeks coverage are the direct result of fraudulent entries of phony Medicare claims into Universal American's computer system, and fall squarely within the terms of the Computer Fraud Policy. National Union refused to indemnify Universal American, taking the position that the Computer Fraud Policy does not apply to losses from "'Medicare fraud,' namely fraud perpetrated upon Universal [American] by providers (medical doctors or medical organizations) who submit bills and obtain payment from medical services that were not actually performed." (R. 24 ¶ 16; R. 41.) Instead, National Union claimed the Policy only applied where a "hacker" or other "unauthorized" user improperly gains access to the computer system – two terms never used in the Computer Fraud Policy, which refers only to a loss resulting from "a

fraudulent entry of Electronic Data" into Universal American's computer system.

2. The Decisions Below

In granting National Union's cross-motion for summary judgment, Supreme Court found that the insuring clause in the Computer Fraud Policy – stating that it provides coverage for all "[l]oss resulting directly from a fraudulent … entry of Electronic Data . . . into . . . [Universal American's] proprietary Computer System," (R. 249) – "does not extend as far as providing coverage for fraudulent claims which were entered into the computer system by authorized users." (R. 11.) Supreme Court offered two justifications for its narrow reading of the Computer Policy.

First, Supreme Court interpreted the phrase "'fraudulent entry' of data" in the Policy's insuring clause to mean "an *unauthorized* entry into the system, i.e. by an unauthorized user, such as a hacker, or for unauthorized data, e.g., a computer virus." (*Id.* (emphasis added).) Supreme Court concluded that "[n]othing in this clause indicates that coverage was intended where an authorized user utilized the system as intended, i.e. to submit claims, but where the claims themselves were fraudulent." (*Id.*)

Second, Supreme Court stated that its narrow reading of the Computer Fraud Policy was supported by the language of the Policy's

"headings": "Computer Fraud" and "Computer Systems Fraud." Although the terms used in those headings are not separately defined in the Computer Fraud Policy, Supreme Court understood them to connote that the Policy is "directed to misuse or manipulation of the system itself rather than at situations where the fraud arose from the content of the claim." (*Id.*)

The Appellate Division affirmed, holding that "the unambiguous plain meaning" of the policy language "was intended to apply to wrongful acts in manipulation of the computer system, i.e., by hackers, and did not provide coverage for fraudulent content consisting of claims by bona fide doctors . . . authorized to use the system . . . ." (App. 11-12, reported as *Universal American Corp. v. National Union,* 110 A.D.3d at 434, 972 N.Y.S.2d at 242.)

As we show below, the Appellate Division erred in two fundamental ways: (1) by ignoring the ordinary meaning of the language of the Computer Fraud Policy, and instead attempting to divine how the policy was intended to apply; and (2) by failing to inquire whether there is any reasonable construction of the policy's words that would result in coverage.

E. REASONS FOR GRANTING LEAVE TO APPEAL

Leave to appeal is normally granted where a case involves: (a) questions that are likely to arise frequently, (b) important questions of

statutory construction, (c) questions concerning which there is a conflict of decision between different appellate divisions, (d) a question that is novel and of first impression, (e) questions of law which are of public importance, (f) principles that are important to others than the parties to the action, (g) complicated questions of law, or (h) points of law that are involved in numerous other pending proceedings. 11 Carmody Wait 2d, *Cyclopedia of New York Practice* § 71:72; *see also* 22 N.Y.C.R.R. § 500.22(b)(4). Universal American's proposed appeal meets those criteria.

As shown below, in affirming the grant of summary judgment to National Union, the Appellate Division departed from the settled rules governing the construction of any insurance policy, by substituting an inquiry into the parties' imagined intent in lieu of the proper inquiry focusing on whether the ordinary meaning of the words used in the policy can reasonably be construed to cover the loss at issue.

This case raises important questions regarding the meaning and scope of a standard form agreement for a computer fraud insurance policy. This Court has often granted leave to construe the coverage provisions in insurance policies because of the wide public impact that results from the denial of coverage under such policies, which (as here) are usually presented on standard insurance industry forms.

This appeal is particularly worthy of this Court's consideration given the prevalence of computer fraud in the national economy today. The Appellate Division's misapplication of the appropriate legal standards is likely to influence other courts in interpreting similar policy language. The First Department's mistakenly restrictive reading of this standard policy language will impact not only the parties to this case, but the public generally given the prevalence of similar crime loss policies. The harmful effect of the First Department's erroneous construction of the standard policy language defining the coverage of a Computer Fraud Policy will be heightened by that court's unique position as the intermediate appellate court covering the State's commercial and financial center.

For all these reasons, Petitioner's motion for leave to appeal should be granted.

1. The Legal Standards Governing The Interpretation of Insurance Policies

In New York, the interpretation of insurance policies is "highly favorable to insureds." *Pioneer Tower Owners Ass'n v. State Farm Fire & Cas. Co.*, 12 N.Y.3d 302, 306, 880 N.Y.S.2d 885, 886 (2009). "If the language of the policy is doubtful or uncertain in its meaning, any ambiguity must be resolved in favor of the insured and against the insurer." *Westview Assoc. v. Guaranty Nat'l Ins. Co.*, 95 N.Y.2d 334, 340, 717 N.Y.S.2d 75, 78

(2000); *accord Dean v. Tower Ins. Co. of New York*, 19 N.Y.3d 704, 708, 955 N.Y.S.2d 817, 818 (2012) ("[A]mbiguities in an insurance policy are to be construed against the insurer[.]").

As a result, "[i]n order for the insurer to prevail [in a coverage action], it must demonstrate not only that its interpretation is reasonable but that it is the only fair interpretation." *City of New York v. Evanston Ins. Co.*, 39 A.D.3d 153, 156, 830 N.Y.S.2d 299, 302 (2d Dep't 2007) (*citing Primavera v. Rose & Kiernan*, 248 A.D.2d 842, 843, 670 N.Y.S.2d 223, 225 (3d Dep't 1998)); *see also Raner v. Security Mutual Ins. Co.,* 102 A.D.3d 485, 486, 958 N.Y.S.2d 342, 343 (1st Dep't 2013) (to defeat coverage, insurance company must that "establish that its interpretation is the only reasonable interpretation [of the policy]").

The Appellate Division purported to base its ruling on "the unambiguous plain meaning of defendant's computer systems fraud rider," from which it attempted to divine the intent of the parties in drafting the insurance policy. But (a) the parties neither drafted nor even discussed this policy language; and (b) the Appellate Division ignored both the ordinary meaning of the policy's words, as well as the fundamental rule that "[t]he test for ambiguity is whether the language of the insurance contract is 'susceptible of two reasonable interpretations.'" *State v. Home Indem. Co.*,

66 N.Y.2d 669, 671, 495 N.Y.S.2d 969, 971 (1985) (citation omitted); *accord, Essex Ins. Co. v. Vickers*, 103 A.D.3d 684, 687, 959 N.Y.S.2d 525, 528 (2d Dep't 2013).

The Appellate Division held that the phrase "a fraudulent entry of Electronic Data" could only refer to "wrongful acts in manipulation of the computer system," but not "fraudulent content consisting of claims by bona fide doctors." This was doubly wrong. The fundamental mistake was the Appellate Division's failure to apply the legal principles that should have guided its analysis.

Rather than attempting to determine the parties' intent, the Appellate Division should have looked to the ordinary meaning of the words used in the policy and asked, not whether there was an interpretation that supported the insurer's position, but instead whether those words could be read reasonably to find coverage. Indeed, contrary to that court's holding, the proper test to determine whether the words used in the policy were ambiguous is simply whether those words permit two reasonable constructions.

2. The Appellate Division Ignored The Ordinary Meaning Of The Policy Language

The ordinary meaning of the word "fraudulent" is a knowingly false factual statement made with intent to deceive. *See Eurycleia Partners LLP*

v. Seward & Kissel LLP, 12 N.Y.3d 553, 559, 883 N.Y.S.2d 147, 150 (2009) ("The elements of a cause of action for fraud require a material misrepresentation of a fact, knowledge of its falsity, an intent to induce reliance, justifiable reliance by the plaintiff and damages."). Other courts have noted that the words "false" or "fraudulent," when used in connection with a billing system such as Universal American's, connote "an intentional misrepresentation . . . for the purpose of inducing another in reliance upon it to part with some valuable thing." *Mikes v. Straus*, 274 F.3d 687, 696 (2d Cir. 2001) (construing statutory phrase "false or fraudulent" in federal False Claims Act). Since this Computer Fraud Policy provides coverage only for losses for which "the [fraudulent] entry ... causes Property to be transferred, paid or delivered," that reading is both reasonable and natural here.

Accepting that ordinary meaning of the word "fraudulent," the provision "covering loss from a fraudulent 'entry of electronic data' or 'change of electronic data' within the insured's proprietary computer system" is easily susceptible of a reasonable reading covering Universal American's loss. To see why that is so, it is enough to look at a simple example of the ordinary usage of those same words. Take, for example, an indictment charging an accountant with making "a fraudulent entry of electronic data" into a client's computerized billing records, in order to

generate fake invoices that caused the client to make unearned payments to him or an affiliate. No one would suggest that the nature of the accusation of fraud against the accountant was that he had acted as a hacker; everyone would understand those words to mean that the accountant had created "fraudulent content consisting of claims" – *i.e.*, the fake invoices – for "services that were not provided."

By the same token, no one would suggest that, in accusing the accountant of making "a fraudulent entry of electronic data" into a client's computerized billing records, the indictment was misusing any of the words that framed its charge.

More generally, because the fraudulent nature of a statement turns on its truth or falsity, any inquiry about whether the statement was "fraudulent" necessarily focuses on what the statement says, *i.e.*, its content, but not on the manner in which the statement was made, and even less the "authorization" of the person making the statement. While a hacker is, by definition, not authorized to make a particular entry in a computer system, his status as a hacker does not mean that any entry he might make is fraudulent. The latter question, concerning fraud, can only be determined by looking at the content of the entry and the purpose for which it was made,

i.e., was it true or false, and, if false, was it made for the purpose of deceiving someone?

For that reason, many cases have held that an unauthorized act is not necessarily a fraudulent act. *See, e.g.*, *Waters v. Horace Waters & Co.*, 130 A.D. 678, 685, 115 N.Y.S. 432, 438 (1st Dep't 1909) ("[u]nauthorized acts are not necessarily fraudulent."); *Hecht v. Components International, Inc.*, 22 Misc. 3d 360, 369, 867 N.Y.S.2d 889, 898 (Sup. Ct. Nassau Co. 2008) (same); *see also McPeters v. Edwards*, 806 F. Supp. 2d 978, 990 (S.D. Tex. 2011) ("Even if Defendants' actions are unauthorized by law, that would not automatically make them fraudulent."); *Mowles v. Commission on Governmental Ethics & Election Practices*, 958 A.2d 897, 904 (Me. 2008) (a politician's "unauthorized use of an endorsement is not necessarily fraudulent"); *Burns v. Prudential Secs.*, 116 F. Supp. 2d 917, 925 (N.D. Ohio 2000) (distinguishing between "unauthorized trading" by a securities broker and "a fraudulent scheme" under federal securities law); *Pross v. Baird, Patrick & Co.*, 585 F. Supp. 1456, 1460 (S.D.N.Y. 1984) (same).

In the Appellate Division, National Union dismissed the distinction between "fraudulent" and "unauthorized" as "immaterial," Affirm. in Opp. To Mot. for Reargument ("Opp. Affirm.") ¶ 19, but its own argument shows why the Appellate Division's construction of the policy improperly conflates

these two terms. National Union stated that the Appellate Division had used the word "authorized" as "a descriptive term to make clear that the act of entering the computer system was not fraudulent because the providers had the necessary credentials to submit electronic invoices." *Id.* But that is precisely the point: whether a submitting party has (or lacks) "credentials" to enter an invoice in Universal American's computer system, on its own, has no bearing on whether the submission is "fraudulent." Whether any particular "entry of data" was "fraudulent" depends on the truth or falsity of the submission, and therefore necessarily on its content.

Thus, the distinction that the Appellate Division drew between "wrongful acts in manipulation of the computer system, i.e., by hackers," and "fraudulent content consisting of claims by bona fide doctors," cannot be squared with the ordinary meaning of the policy's words. In order to determine whether any entry was "fraudulent," the inquiry necessarily starts with a question about whether the content of the entry was true or false. Of course, a hacker might make a false entry about his identity – but that too could only be determined by examining the content of the entry.

Nor do the policy's words suggest that coverage varies depending on differences in the type of "fraudulent content" at issue – *i.e.*, fraudulent content relating to the identity of the person making the entry is covered but

fraudulent content relating to the services rendered by the person making the entry is not. *Any* "fraudulent entry of electronic data" is sufficient to trigger coverage, provided the insured's loss results "directly" from that fraudulent entry and "causes Property to be transferred, paid or delivered."

In contrast to the unsupportable construction of the term "fraudulent entry" adopted by the Appellate Division, Universal American offered a reasonable alternative reading of the policy's language. The phrase "fraudulent entry" can reasonably be read to refer to the content of the entry since one of the ordinary meanings of the word "entry" is "something entered: as (1): a record or notation of an occurrence, transaction or proceeding (2): a descriptive record (as in a card catalog or an index)." *See* Merriam-Webster's Collegiate Dictionary (10th ed. 1993) at p. 387. Indeed, this is the more plausible reading, given the Policy's use of the indefinite article in the phrase, "a fraudulent entry," indicating that "entry" as used in the policy is a noun (referring to the matter entered) rather than a verb (referring to the act of making the entry). Under this reading, coverage is triggered by the submission of fraudulent content (i.e., by the fact that a

"fraudulent entry" was made into Universal American's computer system), which is precisely what happened in this case.[1]

Under that reading, which is perfectly reasonable (and Universal American need not show more), coverage is triggered by the submission of fraudulent content (i.e., by the input of "a fraudulent entry") in the computer system. If the policy's words "fraudulent entry" are given their ordinary meaning – i.e., an entry that is "an intentional misrepresentation . . . for the purpose of inducing another in reliance upon it to part with some valuable thing," *Mikes v. Straus*, *supra* – then the false Medicare claims entered into Universal American's computer system easily qualify as "fraudulent entries

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[1] Supreme Court also erred in focusing on the headings "Computer Systems" and "Computer Systems Fraud" as "indicat[ing] that coverage is directed at misuse or manipulation of the system itself[,] rather than at situations where the fraud arose from the content of the claim, and the system was otherwise properly utilized, e.g., a fraudulent claim submitted by an authorized user." (R. 11.) But a section heading cannot by implication create limitations on coverage not expressed in the text of the policy, as this Court has made clear. *See, e.g., Rivers v. Sauter*, 26 N.Y.2d 260, 262, 309 N.Y.S.2d 897, 898 (1970) ("By accepted canons of construction the generalities of the article heading must yield to the specifics of the section itself."). In all events, Supreme Court incorrectly presumed that the term "Computer Fraud" (which is not defined in the Policy) can only mean "misuse or manipulation of the system itself" – i.e., computer hacking. An equally plausible interpretation would encompass fraud committed through a computer – e.g., through fraudulent entries of data in a computer system, such as happened in this case. *See, e.g., Owens, Schine & Nicola v. Travelers Cas. & Surety Co. of America*, 2010 WL 4226958, at *4 (Conn. Super. Ct. Sept. 20, 2010) (rejecting argument that a policy covering losses from "Computer Fraud" was limited to incidents of "hacking").

of Electronic Data": they were (1) intentional misrepresentations of the services the health care providers performed that were (2) intended to induce Universal American to make payments to the providers.

Tellingly, at no point in this litigation has Respondent ever attempted to show why Universal American's construction is not a reasonable reading of the policy's words, whether or not there are other and different reasonable readings.

3. The Lower Courts Failed To Inquire Whether There Is Any Reasonable Construction Of The Policy Language That Would Result In Coverage

The second fundamental error committed by the Appellate Division was to focus its inquiry on how the policy was "intended to apply," and in doing so, brushing aside the rule that, if two reasonable readings are permissible, the insurance policy will be construed in favor of coverage. National Union effectively conceded this error in its opposition to Petitioner's motion for reargument, claiming that "absent an ambiguity, or an exclusionary clause, there are no special canons of construction that apply to insuring agreements." Opp. Affirm. ¶ 10. The suggestion that the rule requiring a court to construe insurance contracts in favor of coverage applies only to exclusionary clauses is simply wrong. As recently as last December, this Court, in a case that did not involve an exclusionary clause, affirmed the

settled principle that, in interpreting an insurance policy, "*any* ambiguity . . . must be construed against [the insurance company]." *Raggins v. Hosp. Ins. Co., Inc.*, 22 N.Y.3d 1019, 1022, 981 N.Y.S.2d 640, 641 (2013) (emphasis added). Respondent's bald assertion that Universal American's policy is not ambiguous simply begs the question, as "[t]he test for ambiguity is whether the language of the insurance contract is susceptible of two reasonable interpretations." *Home Indem. Co.*, 66 N.Y.2d at 671, 495 N.Y.S.2d at 961 (citation omitted). Neither the Appellate Division nor National Union ever offered a reason why Universal American's interpretation is not a reasonable construction of the policy. Indeed, as shown above, it is the only reasonable construction that accords with the ordinary meaning of the policy language.

Instead of attempting to divine how the Computer Fraud Policy "was intended to apply," the Appellate Division should have focused its inquiry on whether the words of the policy, construed according to their ordinary meaning, permitted a reasonable construction consistent with coverage. Once the inquiry was focused on the truth or falsity of the "entry of Electronic Data" and whether the "entry" was made with intent to deceive, there would have been no basis to conclude that the loss that occurred here was not covered. In short, had the lower courts asked the proper question,

the conclusion necessarily followed that the insured's loss was covered by the policy.

4. The Lower Courts' Construction Of The Policy Language Resulted In Negating Any Coverage At All

In any billing system, an unauthorized user – the hacker imagined by Respondent, which under the Appellate Division's reading of the policy was the intended object of the computer fraud rider – could cause a loss to the insured only if the hacker were working in concert with a medical provider. The only point of making a fraudulent entry in Universal American's billing system would be to cause Universal American to pay out money for medical services, and a hacker could do that only by inserting the name and identifying information of a medical provider to whom the payment should be sent. The policy's words underscore the latter concern, since the policy provides coverage only for losses for which "the [fraudulent] entry … causes Property to be transferred, paid or delivered." In short, a hacker who damages an insured's computer system maliciously, but does not seek to cause it to make a payment or otherwise deliver Property to him, would not generate a covered loss.

In the real world, that would only happen if the hacker and a medical provider were working together. But a medical provider seeking payment for services actually rendered has no need to work with a hacker; and,

similarly, a medical provider seeking payment for services it had never rendered would also have no need to work with a hacker (as the facts of the loss in this case show dramatically). Thus, if the policy were intended to apply only to the "hacker" scenario, the computer systems fraud rider covered essentially nothing.

Nor is there any basis for a concern that, if Universal American's reading of the policy were adopted, Respondent would be responsible for every minor instance of overbilling by a medical provider. The policy deals with that concern by providing that each "Single Loss" is subject to a $250,000 deductible. For purposes of the computer fraud rider, any "loss or series of losses involving the fraudulent acts of one individual, or involving fraudulent acts in which one individual is implicated" is treated as a Single Loss, subject only to one deductible. (R. 251.) In short, as the Computer Fraud Policy makes clear when read as a whole, it excluded minor instances of overbilling, and instead provided coverage for just the kind of massive organized fraud, perpetrated by the making of fraudulent entries into Universal American's automated billing system for non-existent services, that occurred here and resulted in almost a $20 million loss to Universal American.

5. Leave to Appeal Should Be Granted Because This Appeal Raises Important Issues Of First Impression That Are Likely To Recur in Other Cases

The issues raised by this case are important and merit review by this Court because the insurance policy at issue here was a standard industry form found in many similar policies, and the erroneous ruling below will have a harmful impact far beyond its effect on the parties to this case. Because computer fraud is now a major problem impacting almost every sector of the national economy, the Appellate Division's decision is likely to lead to many erroneous rulings in the lower courts construing similar policy language and then denying coverage.

Allowing the Appellate Division's decision to stand would have serious consequences for countless other insurance policy holders with similar computer fraud policies, since the Appellate Division's interpretation has the practical effect of rendering the policy essentially useless in covering any actual loss. As explained above, under the 'hacker' scenario to which the Appellate Division limited coverage, this policy would have value to a policy holder only if the policy covered losses for malicious damage, *see generally Georgitsi Realty LLC v. Penn-Star Ins. Co.*, 21 N.Y.3d 606 (2013). But the policy by its terms is limited to losses for property "transferred, paid or delivered," which do not arise in the 'hacker' scenario.

Thus, if allowed to stand without further review, the Appellate Division's decision would not only render Computer Fraud Policies essentially a "heads I win, tails you lose" proposition for insurers, but would also invite other courts to repeat the Appellate Division's erroneous approach to deciding these coverage disputes. Indeed, those consequences are quite likely to occur unless this Court grants review because the Appellate Division's decision has already been incorporated in a leading treatise on New York law for the following rule:

> Insurance policy's computer systems fraud rider, covering loss from a fraudulent "entry of electronic data" or "change of electronic data" within the insured's proprietary computer system, was designed to cover wrongful acts in manipulation of the computer system by hackers, and thus did not provide coverage for fraudulent content consisting of claims by bona fide doctors and other health care providers authorized to use the system.

68A N.Y. Jur. 2d, INSURANCE § 818 (Feb. 2014 Supp.).

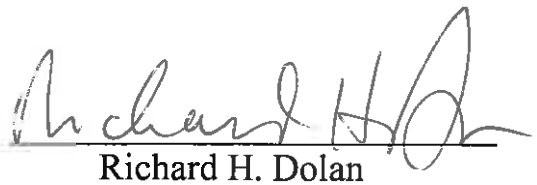
This Court should grant leave to appeal to correct the Appellate Division's fundamental errors, and to protect the rights of New York policyholders to the benefit of the bargain they made when purchasing computer fraud policies employing the standard industry form at issue here.

CONCLUSION

For all of the foregoing reasons, this Court should grant Petitioner's motion for leave to appeal from the Appellate Division's order.

Dated: New York, New York
April 17, 2014

SCHLAM STONE & DOLAN LLP

By: 
Richard H. Dolan
Bradley J. Nash

26 Broadway
New York, New York 10004
Telephone: (212) 344-5400
Facsimile: (212) 344-7677

Attorneys for Petitioner-Appellant
UNIVERSAL AMERICAN CORP.

Appendix: **Page**

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

PRESENT: O. PETER SHERWOOD Justice PART 49

UNIVERSAL AMERICAN CORP.,

Plaintiff,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA,

Defendant.

INDEX NO. 650613/2010

MOTION DATE Sept. 28, 2012

MOTION SEQ. NO. 001

MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion for partial summary judgment.

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answering Affidavits — Exhibits	
Replying Affidavits	

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that the motion for partial summary judgment is decided in accordance with the accompanying decision and order.

Dated: January 7, 2013

O. PETER SHERWOOD, J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☑ FINAL DISPOSITION ☐ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: COMMERCIAL DIVISION PART 49

----------X

UNIVERSAL AMERICAN CORP.,

Plaintiff,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA,

Defendant.

----------X

DECISION AND ORDER

Index No.: 650613/2010

O. PETER SHERWOOD, J.:

This is an insurance coverage action by plaintiff Universal American Corp. (Universal) in connection with a "Computer Systems Fraud" insurance policy (Policy) issued to plaintiff by defendant National Union Fire Insurance Company of Pittsburgh, PA (National Union). Universal moves, pursuant to CPLR 3212, for an order granting partial summary judgment and declaring that certain losses that Universal suffered from the entry of electronic data into its computer system are covered by the Policy. National Union cross-moves for an order granting summary judgment dismissing the complaint. For the reasons stated below, the motion is denied, the cross motion is granted and the complaint is dismissed.

Factual Background

According to the complaint, Universal is a health insurance company which provides Medicare managed-care plans, Medicare prescription drug benefits and other insurance products. Universal's offerings include "Medicare Advantage Private Fee-For-Service" plans (MA-PFFS), which are government-regulated alternatives to Medicare. Essentially, members enroll in health care plans offered by private insurers, which plans receive reimbursement payments from the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The plans also receive payments from plan members themselves. Under such plans, health care providers submit claims for services provided to plan members, similar to traditional health insurance policies. In Universal's case, many of the claims are "auto-adjudicated" through Universal's computer system, with payments rendered without any manual review.

Rider #3 to a Financial Institution Bond (the "Bond") issued to Universal by National Union on July 29, 2008, provided insurance coverage to Universal against a variety of losses. The Rider is titled "Computer Systems Fraud" and provides indemnification for:

> Loss resulting directly from a fraudulent
> (1) entry of Electronic Data or Computer Program into, or
> (2) change of Electronic Data or Computer Program within the Insured's proprietary Computer System...provided that the entry or change causes
> (a) Property to be transferred, paid or delivered,
> (b) an account of the Insured, or of its customer, to be added, deleted, debited or credited, or
> (c) an unauthorized account or a fictitious account to be debited or credited.

The term "Computer Program" was defined as "related electronic instructions which direct the operations and functions of a computer...which enable the computer...to receive, process, store or send Electronic Data." The term "Electronic Data" was defined as "facts or information converted to a form usable in a Computer System by Computer Programs, and which is stored on magnetic tapes or disks, or optical storage disks or other bulk media."

The Rider has a policy limit of $10 million with a $250,000 deductible for each "single loss." The Rider provided that a series of losses arising from the fraudulent acts of one individual, or of several unidentified individuals using the same method of operation, would constitute a single loss under the policy.

Universal states that, in late 2008, it suffered approximately $18,321,296 in losses from fraudulent claims made against its MA-PFFS plans. Most of these claims were submitted, by providers, directly into Universal's computer system and processed through the system. In some cases, the perpetrators enrolled new members in the MA-PFFS plan with the person's cooperation, in return for which the member received a kickback from the provider. In some cases, the provider used the member's personal information without that person's knowledge. In either event, the provider itself did not enroll in the plan. Instead, they were able to submit claims after obtaining a National Provider Identifier (NPI) from CMS. In some cases, the NPI was obtained for a fictitious provider, in other cases it was fraudulently taken from a legitimate provider.

Universal states that approximately 80% of the losses at issue resulted from claims submitted to its computer system. In February of 2009, it submitted a proof of loss to National Union. That claim was eventually denied. In June of 2010, Universal commenced this action, asserting claims for breach of contract and for a declaratory judgment stating that its losses are covered by the Policy and are not subject to any exclusions. Plaintiff alleges losses of $7,764,211, after the application of the deductible.

Discussion

A party moving for summary judgment is required to make a prima facie showing that it is entitled to judgment as a matter of law, by providing sufficient evidence to eliminate any material issues of fact from the case (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]; *Grob v Kings Realty Assoc.*, 4 AD3d 394 [2d Dept 2004]). The party opposing must then demonstrate the existence of a factual issue requiring a trial of the action (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]).

The central issue here is the meaning of the clause which states that Universal shall be indemnified for "[l]oss resulting directly from a fraudulent...entry of Electronic Data...into [Universal's] proprietary Computer System...". Universal contends that this clause covers the entry of fraudulent information, e.g. fraudulent claims, even by an authorized user such as a provider with a valid NPI. National Union argues that this clause in Rider #3 does not cover such data. Instead, it argues that the policy provides coverage against computer hackers, i.e. situations in which an unauthorized user accessed the system and caused money to be paid out. In reply, Universal argues that, if the clause is ambiguous, then the court must construe it against National Union as the drafter, and determine that there is coverage (*see Gould Invs., L.P. v Travelers Cas. & Sur. Co. of Am.*, 83 AD3d 660, 661 [2d Dept 2011]).

Interpretation of the provisions of contracts, including insurance policies, is a matter of law for the court, including interpreting whether a given term is ambiguous (*see Ashwood Capital, Inc. v OTG Mgt., Inc.*, 99 AD3d 1, 7-8 [1st Dept 2012]); *Seaport Park Condominium v Greater N.Y. Mut. Ins. Co.*, 39 AD3d 51, 54 [1st Dept 2007]). "[T]he terms of an insurance contract are not ambiguous merely because the parties interpret them differently" *Board of Mgrs. of Yardarm Condominium II v Federal Ins. Co.*, 247 AD2d 499, 500 (2d Dept 1998), citing *Mount Vernon Fire Ins. Co. v Creative Hous.*, 88 NY2d 347, 352 (1996). "In determining whether a policy provision is

ambiguous, the focus is on the reasonable expectations of the average insured upon reading the policy" *Villanueva v Preferred Mut. Ins. Co.*, 48 AD3d 1015, 1016 (3d Dept 2008) (citations and internal quotation marks omitted).

The parties have not cited to any New York cases interpreting the clause at issue here, i.e. "loss resulting directly from a fraudulent...entry of electronic data" into Universal's computer system. In support of its motion, plaintiff relies on the decision in *Owens, Schine & Nicola, P.C. v. Travelers Cas. and Sur. Co. of Am.*, 2010 WL 4226958, 2010 Conn Super Lexis 2385 (Conn Super, 2010). In that case, the policy covered loss resulting from "computer fraud," which included "the use of any computer to fraudulently cause a transfer" of property (*see* Westlaw at *6, Lexis at *15). The means by which a fraudulent transfer could be initiated included written, telephonic, telegraphic, fax, electronic, cable, or teletype instructions. The court found that the policy was ambiguous as to how much computer use was required, and, as such, the policy was not restricted to incidents of computer hacking (*see* Westlaw at *7, Lexis at *19).

The *Owens* decision is not directly analogous. Among other things, the policy did not use the specific term, "fraudulent entry of electronic data," that is used here. Moreover, the computer fraud clause at issue there was much broader than the clause here in that it did not define how much computer use was required or in what manner the computer had to be used.

In support of the cross-motion, National Union relies on *Morgan Stanley Dean Witter v Chubb Group of Ins. Cos.*, 2004 WL 5352285 (NJ Super L), *affd in part, revd in part, Morgan Stanley Dean Witter v Chubb Group of Ins. Cos.*, 2005 WL 3242234, 2005 NJ Super Unpub Lexis 798 (NJ Super AD Dec 02, 2005) (NO. A-4124-03T2). In that case, the insurer agreed to indemnify the insured for losses arising from the fraudulent input of Electronic Data into a customer communication system. The customers were provided with software which enabled them to submit instructions regarding their accounts directly into the insured's computer system. The policy contained an exclusion for losses resulting from the input of Electronic Data at an authorized terminal by a customer or other authorized person. The exclusion was not limited to fraud, but applied to any authorized input of data.

The lower court found that there was no coverage in that action based on the exclusion, because it barred coverage anytime a customer or authorized person input Electronic Data via a Customer Communication System. The court stated that "[s]hould someone other than a customer

or authorized representative, like an imposter or hacker, input data into the Customer Communication System, it would constitute fraud and coverage is provided" *id* at 11. The court also stated that "the overall thrust of the policy [was] to insure against computer hackers or imposters..." *id* at 10. This determination was affirmed on appeal (*see Morgan Stanley Dean Witter & Co.*, 2005 WL 3242234, at *3.

The decisions in *Morgan Stanley* are instructive in that each court found that coverage was limited to situations in which the data was input by an unauthorized user. There was no coverage where the user was authorized to input the data.

The clause at issue in this case is not ambiguous. The policy does not extend as far as providing coverage for fraudulent claims which were entered into the system by authorized users. The Rider has two headings, "Computer Systems" and "Computer Systems Fraud." It has no headings which refer to the content of medical claims submitted to the system. Thus, the headings indicate that the coverage is directed at misuse or manipulation of the system itself rather than at situations where the fraud arose from the content of the claim, and the system was otherwise properly utilized, e.g. a fraudulent claim submitted by an authorized user. Further, the Rider states that it covers "fraudulent entry" of data or computer programs into Universal's computer system which resulted in a loss. This indicates that coverage is for an unauthorized entry into the system, i.e. by an unauthorized user, such as a hacker, or for unauthorized data, e.g. a computer virus. Nothing in this clause indicates that coverage was intended where an authorized user utilized the system as intended, i.e. to submit claims, but where the claims themselves were fraudulent.

Plaintiff's interpretation of the policy would expand coverage to any fraudulent underlying claim that was entered into its computer system by any user, even by an authorized user. This interpretation is not supported by the language of the Rider.

Accordingly, it is

ORDERED that the motion for summary judgment by plaintiff, Universal American Corp., is denied; and it is further

ORDERED that the cross-motion by defendant, National Union Fire Insurance Company of Pittsburgh, PA, for summary judgment is granted and the complaint is dismissed with costs and disbursements to defendant as taxed by the Clerk upon the submission of an appropriate bill of costs; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly.

This constitutes the decision and order of the court.

DATED: January 7, 2013

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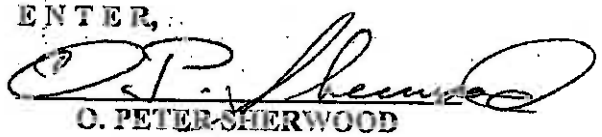


O. PETER SHERWOOD
J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 49

UNIVERSAL AMERICAN CORP., *Plaintiff,* *-against-* NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA., *Defendant.*	Index No: 650613/2010 Sherwood, J. **NOTICE OF APPEAL**

PLEASE TAKE NOTICE that Plaintiff Universal American Corp. ("Universal American") appeals to the Appellate Division, First Department, from the Order entered in this action in the Office of the Clerk of New York County on January 8, 2013 (upon a Decision and Order of the Hon. O. Peter Sherwood, dated January 7, 2013, a true and complete copy of which is attached hereto), and each and every portion thereof, including without limitation those portions of the Decision and Order that denied Universal American's motion for partial summary judgment, and granted defendant's cross-motion for summary judgment.

Dated: New York, New York
January 16, 2013

SCHLAM STONE & DOLAN LLP

By: Bradley J. Nash
Richard H. Dolan
Bradley J. Nash
26 Broadway
New York, New York 10004
Telephone: (212) 344-5400

Attorneys for Plaintiff Universal American Corp.

TO:

Barbara Lukeman, Esq.
NIXON PEABODY LLP
437 Madison Avenue
New York, NY 10022
(212) 940-3000

Attorneys for Defendant National Union Fire Insurance Company of Pittsburgh, Pa.

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

UNIVERSAL AMERICAN CORP.,

Plaintiff-Appellant,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Defendant-Respondent.

Index No: 650613/2010

NOTICE OF ENTRY

PLEASE TAKE NOTICE that the within is a true and complete copy of the Opinion and Order duly entered in the above-captioned matter in the Office of the Clerk for the Supreme Court, Appellate Division, First Department, on October 1, 2013.

Dated: October 2, 2013
New York, New York

NIXON PEABODY LLP

By: _____
Barbara A. Lukeman, Esq.
437 Madison Avenue
New York, New York 10022
(212) 940-3000
(212) 940-3111 (fax)

Attorneys for Defendant-Respondent, National Union Fire Insurance Company of Pittsburgh, Pa.

TO:

SCHLAM STONE & DOLAN LLP
Richard H. Dolan, Esq.
Bradley J. Nash, Esq.
26 Broadway
New York, New York 10004

Attorneys for Plaintiff-Appellant, Universal American Corp.

Andrias, J.P., Sweeny, Acosta, Saxe, Clark, JJ.

10648 Universal American Corp.,
Plaintiff-Appellant,

Index 650613/10

-against-

National Union Fire Insurance
Company of Pittsburgh, PA.,
Defendant-Respondent.

Schlam Stone & Dolan LLP, New York (Richard H. Dolan of counsel), for appellant.

Nixon Peabody LLP, New York (Barbara A. Lukeman of counsel), for respondent.

Order, Supreme Court, New York County (O. Peter Sherwood, J.), entered January 8, 2013, which denied plaintiff insured's motion for summary judgment and granted defendant insurer's cross motion for summary judgment, unanimously modified, on the law, to declare that the policy does not provide coverage for the claimed loss, and otherwise affirmed, without costs.

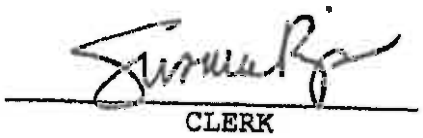
The motion court properly interpreted the policy as a matter of law (*see Dean v Tower Ins. Co. of N.Y.*, 19 NY3d 704, 708 [2012]; *White v Continental Cas. Co.*, 9 NY3d 264, 267 [2007]). The court correctly found that the unambiguous plain meaning of defendant's computer systems fraud rider, covering loss from a fraudulent "entry of electronic data" or "change of electronic

data" within the insured's proprietary computer system, was intended to apply to wrongful acts in manipulation of the computer system, i.e., by hackers, and did not provide coverage for fraudulent content consisting of claims by bona fide doctors and other health care providers authorized to use the system for reimbursement for health care services that were not provided.

We modify solely to declare the rights of the parties in this action for declaratory relief (*see Lanza v Wagner*, 11 NY2d 317, 334 [1962], *cert denied* 371 US 901 [1962]).

THIS CONSTITUTES THE DECISION AND ORDER
OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

ENTERED: OCTOBER 1, 2013



CLERK

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

UNIVERSAL AMERICAN CORP.,

Plaintiff-Appellant,

-against-

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Defendant-Respondent.

New York County
Index No. 650613/2010

NOTICE OF MOTION FOR REARGUMENT OR ALTERNATIVELY LEAVE TO APPEAL TO THE COURT OF APPEALS

SIRS:

PLEASE TAKE NOTICE that, upon the Order of this Court entered on October 1, 2013, modifying, and as so modified, affirming the order of the Supreme Court, New York County, which denied the motion by Petitioner-Appellant UNIVERSAL AMERICAN CORP. for partial summary judgment, and granted the cross-motion by Defendant-Respondent NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA., for summary judgment; and upon the briefs, record on appeal and all prior papers and proceedings herein; and upon the accompanying Affirmation of Richard H. Dolan, affirmed on October 30, 2013; Petitioner-Appellant UNIVERSAL AMERICAN CORP. will move this Court, at the Courthouse, 27 Madison Avenue, New York, New York, at 10:00 a.m. on November 20, 2013, for an order, pursuant to 22 N.Y.C.R.R. § 600.14(a) granting reargument and upon reargument, modifying the order below to grant the motion by Petitioner-Appellant UNIVERSAL AMERICAN CORP. for partial summary judgment, and deny in all respects the cross-motion by Defendant-

Respondent NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA., for summary judgment; or alternatively pursuant to 22 N.Y.C.R.R. § 600.14(b) and CPLR 5602(b)(1), granting leave to appeal to the Court of Appeals the following questions of law presented by this Court's order, and for such other and further relief to by Petitioner-Appellant UNIVERSAL AMERICAN CORP. as this Court deems just and proper.

The questions of law that merit review by the Court of Appeals are:

1. In construing a coverage provision in an insurance policy, should a reviewing court attempt to determine how the parties intended the provision to apply, or instead construe the words of the policy according to their ordinary meaning to determine whether there is any reasonable construction that would result in coverage?

2. Where an insurance policy covers any "loss resulting directly from a fraudulent ... entry of Electronic Data" into the insured proprietary computer system, is there any reasonable construction of the policy's words that would result in coverage for a loss resulting from the entry of fraudulent information in the insured's computerized billing system that results directly in a loss to the insured?

3. Can the words in an insurance policy covering any "loss resulting directly from a fraudulent ... entry of Electronic Data" into the insured proprietary computer system reasonably be read to exclude any loss resulting from the fraudulent content of an entry made into the insured's proprietary computer system?

4. Did this Court err in construing the term "fraudulent entry" in an insurance policy to exclude any fraudulent content of an entry into the insured's computer system, where the core meaning of the term "fraud" includes any false statement knowingly made for the purpose of deception?

5. Was the order of this Court, entered on October 1, 2013, properly made?

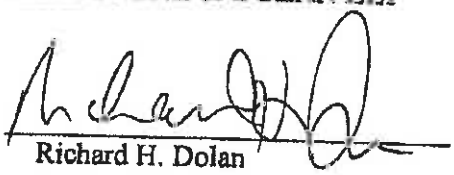
PLEASE TAKE FURTHER NOTICE, pursuant to CPLR 2214(b), that

answering papers must be served so as to be received by the undersigned at least seven days before the time this motion is noticed to be heard.

Dated: New York, New York
October 30, 2013

Respectfully submitted,

SCHLAM STONE & DOLAN LLP

By: 
Richard H. Dolan
Bradley J. Nash

26 Broadway
New York, New York 10004
Telephone: (212) 344-5400
Facsimile: (212) 344-7677

Attorneys for Petitioner-Appellant
Universal American Corp.

TO: Barbara A. Lukeman, Esq.
Nixon Peabody LLP
437 Madison Avenue
New York, NY 10022

Attorneys for Respondent-Respondent
National Union Fire Insurance Company
Of Pittsburgh, PA.

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

UNIVERSAL AMERICAN CORP.,

Plaintiff-Appellant,

- against -

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Defendant-Respondent.

Index No: 650613/2010

NOTICE OF ENTRY

PLEASE TAKE NOTICE that the within is a true and complete copy of the Decision and Order duly entered in the Office of the Clerk for the Supreme Court, Appellate Division, First Department, on March 18, 2014 in the above-captioned matter.

Dated: March 20, 2014
New York, New York

NIXON PEABODY LLP

By: _____
Barbara A. Lukeman, Esq.
437 Madison Avenue
New York, New York 10022
(212) 940-3000
(212) 940-3111 (fax)

Attorneys for Defendant-Respondent, National Union Fire Insurance Company of Pittsburgh, Pa.

TO:

SCHLAM STONE & DOLAN LLP
Richard H. Dolan, Esq.
Bradley J. Nash, Esq.
26 Broadway
New York, New York 10004

Attorneys for Plaintiff-Appellant, Universal American Corp.

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At a Term of the Appellate Division of the Supreme Court held in and for the First Judicial Department in the County of New York on March 18, 2014.

PRESENT: Hon. John W. Sweeny, Jr., Justice Presiding,
Rolando T. Acosta
Richard T. Andrias
David B. Saxe
Darcel D. Clark, Justice.

Universal American Corp.,
Plaintiff-Appellant,

-against-

National Union Fire Insurance
Company of Pittsburgh, PA,
Defendant-Respondent.

M-5690
Index No. 650613/10

Plaintiff-appellant having moved for reargument of or, in the alternative, for leave to appeal to the Court of Appeals from the decision and order of this Court entered on October 1, 2013 (Appeal No. 10648),

Now, upon reading and filing the papers with respect to the motion, and due deliberation having been had thereon,

It is ordered that the motion is denied.

ENTER:

CLERK