pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

The Prudential Life Insurance Company of America
Newark, NJ

As of: March 31, 2016
Issued: May 24, 2016

BUREAU OF MARKET ACTIONS
LIFE AND HEALTH DIVISION

Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Douglas A. Freeman, AMCM, CIE, JD
Examiner-In-Charge

Sworn to and Subscribed Before
me This 11 of March, 2016

MIKELYN KIEFER
Notary Public - Notary Seal
STATE OF MISSOURI
St. Charles County
My Commission Expires: June 15, 2017
Commission # 13824752

Notary Public

PRUDENTIAL LIFE INSURANCE COMPANY

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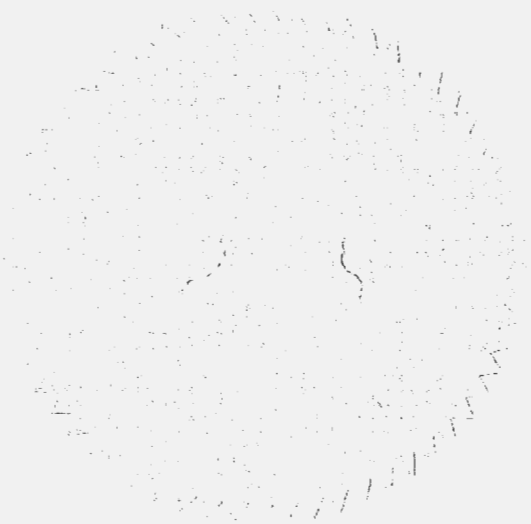
ORDER

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 13th day of November, 2015, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Christopher R. Monahan, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Teresa D. Miller
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
THE PRUDENTIAL LIFE INSURANCE COMPANY OF AMERICA	:	40 P.S. §323.3(a)
751 Broad Street Newark, NJ 07102-3777	:	40 P.S. §§1171.5(a); 1171.5(a)(1)(i) and 1171.5(a)(7)(ii)
	:	
	:	31 Pa. Code §146.5(a)
	:	
	:	
Respondent.	:	Docket No. MC16-04-001

CONSENT ORDER

AND NOW, this 24th day of May, 2016, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an

order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

3. Respondent neither admits nor denies the Findings of Fact or Conclusions of Law contained herein. No acts by Respondent that are alleged to be violations of Pennsylvania law in the referenced provisions were the result of any conscious policy to evade the requirements of Pennsylvania law.

FINDINGS OF FACT

4. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is The Prudential Life Insurance Company of America, and maintains its address at 751 Broad Street, Newark, NJ 07102-3777.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2014 to December 31, 2014.

(c) On March 30, 2016, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on April 29, 2016.

(e) The Examination Report notes violations of the following:

(i) 40 P.S. §323.3(a), requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily ascertain whether the company has complied with the laws of this Commonwealth;

(ii) 40 P.S. §1171.5(a) states "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: (i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; … (2) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading;

(iii) 40 P.S. §1171.5(a)(1)(i), states "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: (i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(iv) 40 P.S. §1171.5(a)(7)(ii) states "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: ... Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any manner whatever;

(v) 31 Pa. Code §146.5(a), states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

CONCLUSIONS OF LAW

5. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Respondent's violations of 40 P.S. §§1171.5(a), 1171.5(a)(1)(i) and 1171.5(a)(7)(ii) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. §1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(c) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did

not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

(d) Respondent's violations of 31 Pa. Code §146.5(a) are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(e) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

6. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Forty Five Thousand Dollars ($45,000) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to April Phelps,

Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

7. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

10. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

12. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: THE PRUDENTIAL LIFE INSURANCE COMPANY OF AMERICA, Respondent

~~President~~ Vice President

Secretary / Treasurer

COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on the Prudential Life Insurance Company (hereafter referred to as "Company") at the Company's office located in Newark, New Jersey October 5, 2015 through October 16, 2015 and in the Department Offices October 19, 2015 through March 11, 2016. The subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination Company officials were provided status memoranda which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found. The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the examination and in the preparation of this Report.

Debra Sweigard
Pennsylvania Insurance Department
Market Conduct Division Chief

Gary L. Boose, LUTC, MCM
Pennsylvania Insurance Department
Market Conduct Examiner

Douglas A. Freeman, AMCM, CIE, JD
Dixon Hughes and Goodman, LLC
Examiner-In-Charge
Market Conduct Examiner

Yvonne Sainsbury, AIE, MCM, AIRC
Dixon Hughes and Goodman, LLC
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 40 P.S. §§323.3 and 323.4 of the Insurance Department Act and covered the experience period of January 1, 2014, through December 31, 2014, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the market conduct activities in areas such as: Forms, Consumer Complaints, Underwriting Practices and Procedures including surrenders and replacements, Long Term Care and Data Integrity.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance category of Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

The Prudential Insurance Company of America ("PICA" or "The Company") began as the Prudential Friendly Society, founded by John Fairfield Dryden in Newark, New Jersey in 1875. In 1877, the Company name was changed to PICA. Prudential Financial, Inc. Common Stock began trading on December 13, 2001 on the New York Stock Exchange under the symbol "Pru."

The Company is licensed in all states and the District of Columbia. The Company's principal business is conducted through three divisions: the U.S. Retirement Solutions and Investment Management Division, the U.S. Individual Life and Group Insurance Division and the International Insurance Division. The Company refers to the businesses that comprise their three operating divisions and their Corporate and Other operations, collectively, as their "Financial Services Businesses."

As of the Annual statement for the year 2014, for Pennsylvania, PICA reported direct written premium of $795,125,910.

IV. COMPANY OPERATIONS AND MANAGEMENT

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation.

The following Guidelines and Manuals were reviewed:

1. Long Term Care Underwriting Manual 3.13.2014.
2. Long Term Care Underwriting Manual 6.30.2014.
3. Long Term Care Underwriting Manual 7.30.2014.
4. Long Term Care Underwriting Manual 9.30.2014.
5. Long Term Care Underwriting Manual 10.30.2014.
6. Long Term Care Underwriting Manual 11.30.2014.
7. Long Term Care Underwriting Manual 12.30.2014.
8. Comprehensive Handling of Equipment (Harvest Policies).
9. Continued Nursing Home Benefit While Out of the Facility (Harvest Policies).
10. Harvest Policy Dueling Maximums.
11. Multiple Harvest Policy Handling.
12. Producer Compliance Manual.
13. Long Term Care – Standard Operating Procedures.
14. Clinical Unit Training.
15. Fraud Training.
16. Periodic File Review Training.
17. Hospice Training – Initial Eligibility Benefit.

The Company was also requested to provide information documenting its management and operational procedures in areas for which they conduct business for the Commonwealth of Pennsylvania. The following areas were reviewed:

- General Procedures and Company History
- Internal Audit and Compliance Procedures
- Controls of Computer Information
- Antifraud and Disaster Recovery Plans
- Outsourcing and Monitoring of Management Services
- Retention of Records
- Information: Collection, Use, & Disclosure (including Privacy of Personal Info)

These areas were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulation. No violations were noted.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided were reviewed in various underwriting sections of the exam to ensure compliance with 40 P.S. §477b and 18 Pa. C.S. §4117(k), Fraud notice. No violations were noted.

VI. CONSUMER COMPLAINTS

2013 Consumer Complaints

The Company was requested to identify all Long Term Care consumer complaints received during the experience period and provide copies of consumer complaint logs for 2013 and 2014. The Company identified 7 consumer complaints received during 2013. Of the 7 complaints identified, 2 were forwarded from the Department. All 7 complaint files were requested, received and reviewed. The Company also provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with 31 Pa. Code §146.5(b)(c). The following violation was noted:

1 Violation – 40 P.S. §1171.5(a)(1)(i)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: (i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy.

The Company admitted in writing in an April 29, 2013 letter regarding the following 2013 Consumer Complaint that "...there was an error in the Personalized Long-Term Care Insurance Rate Sheet you received during the recent 2013 Upgrade offer...We apologize

that the Personalized Long-Term Care Insurance Rate Sheet was misleading, and for any inconvenience that has caused you. However, we cannot provide a discount to any insured first enrolled from February 1, 1992 through December 31, 2001, because that plan of coverage never had premium discounts available...".

2014 Consumer Complaints

The Company was requested to identify all Long Term Care consumer complaints received during the experience period and provide copies of consumer complaint logs for 2013 and 2014. The Company identified 33 consumer complaints received during 2014. Of the 33 complaints identified, 17 were forwarded from the Department. All 33 complaint files were requested, received and reviewed. The Company also provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log. The following violations were noted:

5 Violations – 40 P.S. §1171.5(a)(7)(ii)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: ... Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any manner whatever. The Company's written procedures state (contrary to the actions of the complaints reviewed) that when a formal complaint is received, the Company should respond to the complaint within 10 business days. The 5 noted complaints were not responded to within 10 business days, as it is written in the Company's procedures.

VII. UNDERWRITING

The Underwriting review is comprised of individual and group underwriting areas and consists of 4 general segments.

A. Underwriting Guidelines Manuals
B. Individual Long Term Care Policies Terminated
C. Group Long Term Care Policies Terminated
D. Policy Inquiries

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Underwriting Guidelines and Manuals

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following Guidelines and Manuals were reviewed:

1. Long Term Care Underwriting Manual 3.13.2014.
2. Long Term Care Underwriting Manual 6.30.2014.
3. Long Term Care Underwriting Manual 7.30.2014.
4. Long Term Care Underwriting Manual 9.30.2014.

5. Long Term Care Underwriting Manual 10.30.2014.

6. Long Term Care Underwriting Manual 11.30.2014.

7. Long Term Care Underwriting Manual 12.30.2014.

8. Comprehensive Handling of Equipment (Harvest Policies).

9. Continued Nursing Home Benefit While Out of the Facility (Harvest Policies).

10. Harvest Policy Dueling Maximums.

11. Multiple Harvest Policy Handling.

12. Producer Compliance Manual.

13. Long Term Care – Standard Operating Procedures.

14. Clinical Unit Training.

15. Fraud Training.

16. Periodic File Review Training.

17. Hospice Training – Initial Eligibility Benefit.

B. Individual Long Term Care Policies Terminated

The Company was requested to provide a list of individual long term care policies terminated during the experience period. The Company identified a universe of 247 individual long term care policies terminated during the period. A random sample of 20 terminated policies was requested, received and reviewed. The files were reviewed to determine compliance with record retention, long term care acts and practices and lapse and termination requirements of statutes and regulations. No violations were noted.

C. Group Long Term Care Terminations

The Company was requested to provide a list of group long term care policies terminated during the experience period. The Company identified a universe of 284 individual long term policies terminated. A random sample of 20 terminated policies was requested, received and reviewed. The files were reviewed to determine compliance with record retention, long term care acts and practices and lapse and termination requirements of statutes and regulations. No violations were noted.

D. Policy Inquiries

The Company was requested to provide a list of long term care policy inquiries received that did not result in a claim during the experience period. The Company provided a list of 12 such inquiries. All 12 records were requested, received and reviewed. The files were reviewed to determine compliance with record retention, long term care acts, practices and benefit trigger requirements of statutes and regulations. The following violations were noted:

1 Violation – 40 P.S. §323.3(a)

Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. Per Guidelines for Retention of Records by Insurers and Other Entities Subject to Examinations Conducted by the Insurance Department; Notice No. 2011-10, insurers are not prohibited from using paperless filing technology as long as their records are readily accessible and useable for examination purposes.

Records for one insured is needed to ensure compliance but was not maintained or provided.

12 Violations – 40 P.S. §1171.5(a)

No person shall engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act. "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (1) Making, publishing, issuing or

circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: (i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; ... (2) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

The Company's "Model Scripting of Initial Benefit Access Discussion" stated in the section "Discussing the Assessment," that the Company ". . . will send you a letter and a brochure that further explain the eligibility criteria and claim process." The letter was found in the files, but the brochure was not, nor was it listed as an enclosure in any of the letters.

VIII. CLAIMS & CLAIMS MANUALS

The Claim review consisted of 3 general segments:

A. Claims Manuals

B. Individual and Group Long Term Care Claims Paid

C. Individual and Group Long Term Care Claims Denied

A. Claim Manuals

The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided a total of 82 direct source informational guidelines and claim manuals including underwriting documents, Benefit Access Assessments and Reassessments, Special Handling, various claims scenarios guidelines, Caregiver Training, Nursing Home Stays, Medical Director Review, Claims Death Benefit Processing Instructions, etc.

The claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

B. Individual and Group Long Term Care Claims Paid

The Company was requested to provide a list of claims received during the experience period. The Company identified 1,701 individual and group long term care claims paid. A random sample of 50 claims were requested, received and reviewed. The claim files

were reviewed for compliance with 31 Pa. Code §146 and 40 P.S. §991.1111b (Prompt Payment of Claims). The following violations were noted:

2 Violations – 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge a claim within 10 working days for the noted claims.

C. Individual and Group Long Term Care Claims Denied

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 248 individual and group long term care claims denied. A random sample of 40 claims were requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

5 Violations – 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge the noted claims within 10 working days.

IX. INTERNAL AUDIT & COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures for the experience period. Additionally, the Company was requested to provide a narrative statement explaining internal control methods or systems used to control and assure compliance with underwriting guidelines and proper rating. The documents provided were reviewed to ensure compliance with 40 P.S. §625-5.

The Company provided the following:

- Narrative statements explaining internal control methods or systems used to control and assure compliance with underwriting guidelines and proper rating.
- Copies of market conduct reports completed in the previous few years from other states.
- New business mailing procedures.

No violations were noted.

X. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise consumer complaints procedures to ensure compliance with 40 P.S. §1171.5(a)(1)(i), regarding unfair methods of competition and unfair or deceptive acts or practices.

2. The Company must review and revise consumer complaints procedures to ensure compliance with 40 P.S. §1171.5(a)(7)(ii), regarding discrimination as it relates to amounts charged for a policy.

3. The Company must review and revise procedures to ensure compliance with 40 P.S. §323.3(a), to ensure compliance with record retention requirements.

4. The Company must review and revise procedures to ensure compliance with 40 P.S. §1171.5(a), regarding the misrepresentation of sales materials.

5. The Company must review and revise procedures relating to acknowledging within 10 working days paid claims per 31 Pa. Code §146.5(a).

6. The Company must review and revise procedures relating to acknowledging within 10 working days denied claims per 31 Pa. Code §146.5(a).

XI. COMPANY RESPONSE

Michael A. Kmiecik
Vice President, Compliance

The Prudential Insurance Company of America
213 Washington Street, Newark NJ 07102
Tel 973 802-5685 Fax 973 367-8571
michael.kmiecik@prudential.com

May 23, 2016

Via E-Mail and UPS Express

Office of Market Regulation
Bureau of Market Actions
Life and Health Division
1321 Strawberry Square
Harrisburg, PA 17120
Attn: Debra L. Sweigard
Division Chief, Life, Accident & Health Division

Re: The Prudential Insurance Company of America
Examination Warrant Number: 15-M21-019

Dear Ms. Sweigard:

The Prudential Insurance Company of America (the "Company" or "Prudential") is in receipt of your e-mail earlier today enclosing the Pennsylvania Insurance Department's (the "Department") final report on the market conduct examination (the "report") of Prudential. Enclosed with this letter please find Prudential's response for filing with the report and the consent order signed by representatives of Prudential. The $45,000 payment to the Department as provided in the consent order will follow as soon as possible.

Please provide me with a copy of the consent order when it is signed by a representative of the Department and let me know if you have any questions or require anything further.

Thank you.

Sincerely,

Michael A. Kmiecik
VP Compliance

Enclosure

Response of The Prudential Insurance Company of America to the Pennsylvania Insurance Department Report on Examination Dated May 13, 2016

2013 Consumer Complaints

Report Finding: An error in information provided to a consumer who initiated a complaint constituted an "unfair method of competition" or "unfair or deceptive act or practice." 40 P.S. §1171.5 (a) (1) (i).

Company Response: The Company respectfully disagrees with this finding.

The Company acknowledged in its response to the consumer's complaint that there had been an error. The error was inadvertent and we provided corrected information when it was brought to the Company's attention. In our view, an inadvertent error that was subsequently corrected does not rise to the level of an "unfair method of competition" or "unfair or deceptive act or practice."

2014 Consumer Complaints

Report Finding: The Company did not respond to five (5) complaints within its standard of ten (10) business days. 40 P.S. § 1171.5 (a) (7)(ii)

Company Response: The Company respectfully disagrees with this finding.

The Company has an internal service standard of 10 business days to respond to a "formal" complaint. The Director of LTC Operations may grant an extension to this internal service standard to ensure that the responses are accurate, complete and substantive.

As previously advised, the complaints in question were handled in accordance with the Company's procedures in that the Director of LTC Operations granted a verbal extension of the 10 day internal service standard in each case. The Company acknowledged that the files contained no written documentation concerning an extension and, as a result, we have enhanced our procedures to require written documentation for extensions granted for responding to "formal" complaints.

The Company established a 10 day internal service standard, with permitted exceptions, as a best practice which was followed in the cases in question. We acknowledge that the exceptions were not properly documented and that a recommendation to enhance our procedures to address this

concern (as we have done) would have been appropriate. However, we disagree that our handling of the cases in question amounts to an "unfair method of competition" or "unfair or deceptive act or practice."

Policy Inquiries

Report Finding: The Company did not maintain an Intake Form in one (1) file. 40 P.S. § 323.3(a)

Company Response: The Company acknowledges that it did not maintain an Intake Form in one (1) of the twelve (12) files provided to the examiner. We submit that this is an isolated instance and not indicative of any pattern or practice.

Report Finding: A Company brochure referenced within a call script was not found in twelve (12) or listed as an enclosure in any of the letters to the consumers. 40 P.S. §1171.5(a)

Company Response: The Company respectfully disagrees with this finding.

The brochure in question was no longer in use at the time these inquiries were handled and thus, a copy was not maintained in any of the referenced files or listed as an enclosure in the letters to the consumers. We submit that a reference within an internal document to a discontinued brochure does not amount to an "unfair method of competition" or "unfair or deceptive act or practice."

Nonetheless, the Company has revised the script in question to remove the reference to the discontinued brochure.

Individual and Group Long Term Care Claims Paid

Report Finding: The Company did not acknowledge receipt of two (2) claims within ten (10) days. 31 PA Code §146.5(a)

Company Response: The Company acknowledges that 2 requests for claim payment were not acknowledged within 10 business days but offers the following explanation in mitigation.

The examiner reviewed 50 individual and group long term care claim files and found 2 instances where the Company did not acknowledge receipt of a claim for payment within ten business days. In these cases, the Company paid the claims within 11 and 18 working days, respectively.

As previously advised, the Company typically makes payment of covered claims within 10 business days of receipt, so that a separate acknowledgement is unnecessary. Moreover, many of the 50 files in the sample involved multiple, timely claim payments.

Nonetheless, as we also previously advised, the Company has updated its procedures to provide that claims are acknowledged to the insured within 10 working days unless they are processed (i.e., paid or denied) within that time frame and staff has been trained accordingly.

Individual and Group Long Term Care Claims Denied

Report Finding: The Company did not acknowledge receipt of five (5) claims within ten (10) days. 31 PA Code §146.5(a)

Company Response: The Company acknowledges that five (5) requests for claim payment were not acknowledged within 10 business days but offers the following explanation in mitigation.

The examiner reviewed 40 individual and group long term care claim denied files and found 5 instances where the Company did not acknowledge receipt within 10 business days. Based on the examiner's calculation, the average period of delay amounted to 3.2 days.

As previously advised, the Company typically makes payment of covered claims within 10 business days of receipt, so no separate acknowledgement would be necessary. Notably, within the cases cited in the report were multiple instances of timely claim payments, with a single instance of a late acknowledgement per file. For example, in one case, the Company made over 100 claim payments; the acknowledgement in question was that benefits were exhausted.

Nonetheless, as we also previously advised, the Company has updated its procedures to provide that claims are acknowledged to the insured within 10 working days unless they are processed (i.e., paid or denied) within that time frame and staff has been trained accordingly.

May 23, 2016