



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**MARKET CONDUCT
EXAMINATION REPORT**

OF

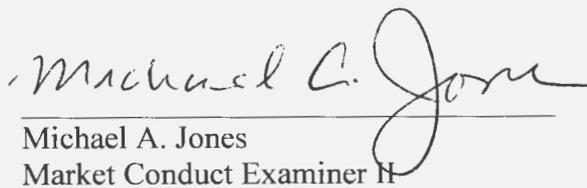
**JOHN HANCOCK LIFE
INSURANCE COMPANY (USA)**
Boston, MA

**As of: June 10, 2016
Issued: August 4, 2016**

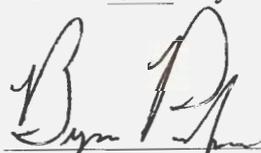
**BUREAU OF MARKET ACTIONS
LIFE, ACCIDENT AND HEALTH DIVISION**

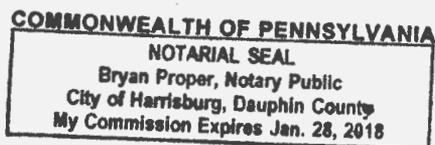
Verification

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).


Michael A. Jones
Market Conduct Examiner II

Sworn and subscribed to before
me this 10 day of June, 2016.


Notary Public



JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)

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ORDER

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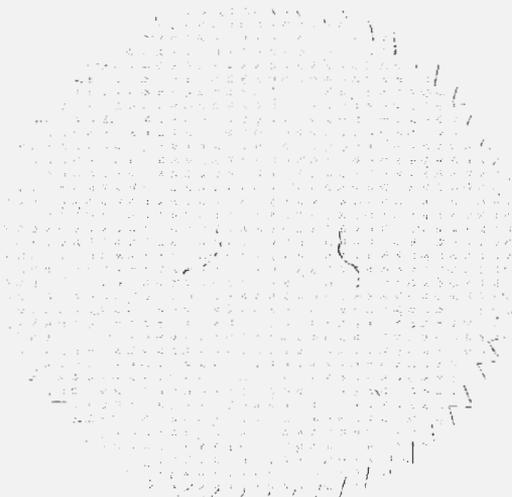
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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:
	:	
JOHN HANCOCK LIFE	:	40 P.S. §§310.72 and 323.3(a)
INSURANCE COMPANY (U.S.A.)	:	
601 Congress Street	:	40 P.S. §§991.1111a(b) and
Boston, MA 02111	:	991.1111b(a)
	:	
	:	40 P.S. §477b
	:	
	:	31 Pa. Code §§39a.9, 89a.106
	:	89a.106(a)(1), 89a.113(a)(2)(4)
	:	89a.115, 146.5 and 146.6
	:	
	:	
	:	
Respondent.	:	Docket No. MC16-06-008

CONSENT ORDER

AND NOW, this 4th day of August, 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 John Hancock Life Insurance Company, and maintains its address at 601 Congress Street, Boston, MA 02111.
- (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 June 10, 2016, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on July 14, 2016.
- (e) The Examination Report notes violations of the following:
 - (i) 40 P.S. §310.72, states an insurance entity may pay a commission, brokerage fee, service fee or other compensation to a licensee for selling, soliciting, or negotiating a contract of insurance. A licensee may pay a commission, brokerage fee, service fee or other compensation to a licensee for selling, soliciting or negotiating a contract of insurance. Except as provided in subsection (b), an insurance entity or licensee may not pay a commission, brokerage fee, service fee or other compensation to a person that is not a licensee for activities related to the sale, solicitation or negotiation of a contract of insurance;
 - (ii) 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;

- (iii) 40 P.S. §477b, prohibits issuing, selling, or disposing of any policy, contract or certificate until the forms have been submitted to, and formally approved by, the Insurance Commissioner;

- (iv) 40 P.S. §991.1111a(b), states if an insurer determines the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of the following:
 - (1) The reason the insurer determined the insured's benefit trigger has not been met.
 - (2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request.
 - (3) The insured's right to have the benefit trigger determination reviewed under the independent review process under subsection (d) after the exhaustion of the insurer's internal appeal process;

- (v) 40 P.S. §991.1111b(a), states (a) within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a

written notice acknowledging the date of receipt of the claim and one of the following:

- (1) The insurer is declining to pay all or part of the claim and the specific reason for denial; or
- (2) Additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary;

(vi) 31 Pa. Code §39a.9, requires training requirements for insurance producers

(a) General information. The training requirements of this section are separate and independent from the continuing education requirements for insurance producers. The satisfaction of these training requirements by a nonresident insurance producer in his home state shall be deemed to satisfy the training requirements in this Commonwealth.

(b) Long-term care insurance.

- (1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health and has completed the training required under paragraph (4);

(vii) 31 Pa. Code §89a.106, states each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) Notice before lapse or termination. An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice." The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

(2) Deduction Plans. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a

payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for those policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(b) Reinstatement. In addition to the requirement in subsection (a), a long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be

more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate;

(viii) 31 Pa. Code §89a.106(a)(1), states each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) Notice before lapse or termination. An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of

premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice.” The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years;

(ix) 31 Pa. Code §89a.113(a)(2)(4), states requirements for application forms and replacement coverage:

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 1103 of the Act (40 P. S. §991.1103), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

- (1) Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?
- (2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?
 - (i) If so, with which company?
 - (ii) If that policy lapsed, when did it lapse?
- (3) Are you covered by Medicaid? If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.
- (4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?
 - (b) Producers shall list health insurance policies they have sold to the applicant;
 - (1) List policies sold that are still in force.
 - (2) List policies sold in the past 5 years that are no longer in force.
 - (c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer;

- (x) 31 Pa. Code §89a.115, states a producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by sections 601 and 621 of the Act (40 P. S. §231 and 251);

- (xi) 31 Pa. Code §146.5, requires every insurer, upon receiving notification of a claim, shall within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated;

- (xii) 31 Pa. Code §146.6, states that if an investigation cannot be completed within thirty (30) days, and every forty-five (45) days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;

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. §310.72 are punishable by the following, under (40 P.S. §310.91):
- (i) suspension, revocation or refusal to issue the certificate of qualification or license;
 - (ii) imposition of a civil penalty not to exceed five thousand dollars (\$5,000.00) for every violation of the Act;
 - (iii) an order to cease and desist; and
 - (iv) any other conditions as the Commissioner deems appropriate.
- (c) Respondent's violations of 40 P.S. §477b, are punishable by the following, under 40 P.S. §625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation.
- (d) Respondent's violations of 40 P.S. §§991.1111a(b), 991.1111b(a), 31 Pa. Code 39a.9, 89a.106, 89a.106(a)(1), 89a.113(a)(2)(4) and 89a.115 are punishable under 40 P. S. §991.1114 which states an insurer or producer found to have violated the requirements relating to the regulations of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three times the amount of any commissions paid for each policy involved in the violation or \$10,000, whichever is greater.

- (e) Respondent's violations of 31 Pa. Code §§146.5 and 146.6 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.

- (f) 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;

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 Fifty Thousand Dollars (\$50,000) 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.

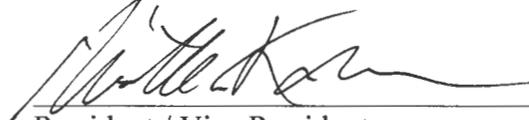
10. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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: JOHN HANCOCK LIFE INSURANCE
COMPANY (U.S.A.), Respondent



President / Vice President



Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

A market conduct examination was conducted on John Hancock Life Insurance Company (U.S.A.) (hereafter referred to as “Company”) at the Company’s office located in Boston, Massachusetts November 9, 2015 through November 13, 2015 and in the Department Offices November 12, 2015 through May 31, 2016. The subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department (hereafter referred to as the “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

Michael A. Jones
Pennsylvania Insurance Department
Market Conduct Examiner II

Sarah W. Schroeder, President
Market Conduct Examiner
Rector & Associates, Inc.

Eric C. Dercher, CFE
Market Conduct Examiner
Rector & Associates, Inc.

Randall A. Rabe
Market Conduct Examiner
Rector & Associates, Inc.

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; underwriting practices and procedures, including issued, lapsed, declined, and terminated coverage; claims; consumer complaints; and policy inquiries.

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

John Hancock Insurance Company of America (“Company”) was incorporated as a mutual life insurer under the laws of the Commonwealth of Massachusetts on April 21, 1862. Effective February 1, 2000, the Company converted from the John Hancock Mutual Life Insurance Company (U.S.A.) to a stock life insurance company, the John Hancock Life Insurance Company, and became a wholly-owned subsidiary of John Hancock Financial Services, Inc. (“JH Financial”), a holding company. Effective April 28, 2004, JH Financial merged into Manulife Financial Corporation.

The Company is licensed in forty-nine (49) states and the District of Columbia. The Company’s principal business consists of life insurance, annuities, and disability products.

In its annual statement as of December 31, 2014, for Pennsylvania, the Company reported direct premium for ordinary life and annuity of \$807,257,298 and for direct premium for accident and health insurance of \$65,272,756.

IV. PRODUCER LICENSING

A comparison was made on the individuals identified as producers on applications reviewed in the various sections of the exam. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of or as a representative of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all producer terminations to the Department. The following violations were noted:

1 Violation – 40 P.S. §310.72 Payment of commissions

a) Limitation. — An insurance entity may pay a commission, brokerage fee, service fee or other compensation to a licensee for selling, soliciting or negotiating a contract of insurance. A licensee may pay a commission, brokerage fee, service fee or other compensation to a licensee for selling, soliciting or negotiating a contract of insurance. Except as provided in subsection (b), an insurance entity or licensee may not pay a commission, brokerage fee, service fee or other compensation to a person that is not a licensee for activities related to the sale, solicitation or negotiation of a contract of insurance.

(b) Exception. — An insurance entity or licensee may pay:

(1) a renewal or other deferred commission to a person that is not a licensee for selling, soliciting or negotiating a contract of insurance if the person was a licensee at the time of the sale, solicitation or negotiation; or

(2) a fee to a person that is not a licensee for referring to a licensee persons that are interested in purchasing insurance if the referring person does not discuss specific terms and conditions of a contract of insurance and, in the case of referrals for insurance that is primarily for personal, family or household use, the referring person receives no more than

a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a sale.

An insurance entity or licensee shall not pay a commission or fee to a person under this subsection if the person is not licensed and or appointment at application.

V. FORMS

The Company was requested to provide a listing of all policy forms, endorsements, and applications used during the experience period. The forms provided were reviewed to ensure compliance with 40 P.S. §477b and 18 Pa. C.S. §4117(k), Fraud notice. No violations were noted.

VI. UNDERWRITING

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

- A. Underwriting Guidelines and Manuals
- B. Individual Issued Long-Term Care Policies
- C. Individual Not Taken Long-Term Care Policies
- D. Individual Declined Long-Term Care Policies
- E. Individual Terminated Long-Term Care Policies
- F. Group Terminated Long-Term Care Policies

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:

- OnDex – LTC Manual
- OnDex – Family History Underwriting Guidelines
- Guidelines (**Various**), Attachment 1
- Guidelines (**Various**), Attachment 3
- Ins UW Audit Program, Attachment 2

B. Individual Long-Term Care Policies Issued

The Company was requested to provide a list of individual long-term care policies issued during the experience period. The Company identified a universe of 331 individual long-term care policies issued during the experience period. A random sample of 84 issued policies were requested, received and reviewed. The files were reviewed to determine compliance with the Commonwealth of Pennsylvania's statutes and regulations with respect to long term care issuance, underwriting, disclosure, and replacement requirements. The following violations were noted:

1 Violation – 31 Pa. Code § 89a.113 (a)(2)(4) Requirements for application forms and replacement coverage

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long term care policy or certificate is intended to replace another accident and sickness or long term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 1103 of the act (40 P. S. § 991.1103), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid? If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(b) Producers shall list health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past 5 years that are no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner: The application did not include a response to the applicant's questions on whether a LTC policy is in force and whether replacement is involved in the noted file.

2 Violations – 31 Pa. Code § 89a.115 Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by sections 601 and 621 of the act (40 P. S. §231 and 251). The producers were not authorized to sell, solicit or negotiate long-term insurance without the appropriate licensing in the 2 noted files.

1 Violation - 40 P.S. §477b

It shall be unlawful for any insurance company, doing business in the Commonwealth of Pennsylvania, to issue, sell, or dispose of any policy, contract, or certificate, covering life insurance, or use application, riders, or endorsements, in connection therewith, until the forms have been submitted to, and formally approved by, the Insurance Commissioner.

The Company did not provide evidence that the referenced form was filed prior to use and was formally approved by the Insurance Commissioner in the noted form.

3 Violations - §39a.9 Training requirements for insurance producers

(a) *General information.* The training requirements of this section are separate and independent from the continuing education requirements for insurance producers. The satisfaction of these training requirements by a nonresident insurance producer in his home state shall be deemed to satisfy the training requirements in this Commonwealth.

(b) *Long-term care insurance.*

(1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health and has completed the training required under paragraph (4). The producers were found to have had their appointment terminated or were not yet in effect at application in the 3 noted files.

C. Individual Long-Term Care Policies Declined

The Company was requested to provide a list of individual long-term care policies declined during the experience period. The Company identified a universe of 129 individual long-term care policies declined during the experience period. A random sample of 79 individual declined policies were requested, received and reviewed. The files were reviewed to determine compliance with the Commonwealth of Pennsylvania's Statutes and Regulations with respect to long-term care issuance, underwriting, disclosure, and replacement requirements. The following violation was noted:

1 Violation – 40 P.S. §323.3(a)

(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 and ascertain whether the company or person has complied with the laws of this Commonwealth. Among the items missing was the long term care worksheet.

D. Individual Long-Term Care Policies Not taken

The Company was requested to provide a list of individual long-term care policies not taken during the experience period. The Company identified a universe of 19 individual long-term care policies issued during the experience period. All 19 individual not taken policies were requested, received and reviewed. The files were reviewed to determine compliance with the Commonwealth of Pennsylvania's Statutes and Regulations with respect to long-term care issuance, underwriting, disclosure, and replacement requirements. No violations were noted.

E. 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 869 individual long-term care policies terminated during the experience period. A random sample of 113 individual terminated long-term care policies were requested, received and reviewed. The files were reviewed to determine compliance with the Commonwealth of Pennsylvania's Statutes and Regulations with respect to long-term care issuance, underwriting, disclosure, and replacement requirements. The following violation was noted:

1 Violation – 31 Pa. Code §89a.106 (a)(1)

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) *Notice before lapse or termination.* An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice." The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years. The Company did not provide sufficient evidence of proper notification to the insured and those persons designated at the address provided for purpose of receiving notice of termination in the noted file.

F. Group Long-Term Care Policies Terminated

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 308 group long term policies terminated during the experience period. A random sample of 84 group long term care terminated policies was requested, received and reviewed. The files were reviewed to determine compliance with the Commonwealth of Pennsylvania's Statutes and Regulations with respect to long term care issuance, underwriting, disclosure, and replacement requirements. The following violations were noted:

15 Violations – 31 Pa. Code §89a.106 Unintentional lapse

(a) Each insurer offering long term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) *Notice before lapse or termination.* An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice." The insured shall be able to change the written designation at any

time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

(2) *Deduction plans.* When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for those policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) *Lapse or termination for nonpayment of premium.* No individual long-term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(b) *Reinstatement.* In addition to the requirement in subsection (a), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

The Company did not provide the premium due notice and or the proper notification to the insured and any designated persons of the policy lapse or termination of coverage in the 15 noted files.

G. Long Term Care Policy Inquiries

The Company identified 29,338 policy inquiries during the relevant time period. A sample of 116 long term care policy inquiries were requested, received, and reviewed. The inquiries were reviewed to ensure compliance with the long term care and unfair or deceptive acts or practices laws and regulations. No violations were noted.

VII. CLAIMS MANUALS & ELIGIBILITY DETERMINATIONS

This review consisted of three general segments:

- A. Claims Manuals
- B. Denied Long-Term Care Eligibility Determinations
- C. Approved Long-Term Care Eligibility Determinations

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 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. Long-Term Care Eligibility Determinations – Denied

The Company was requested to provide a list of long-term care eligibility determinations that were denied during the experience period. The Company identified a total of 21 eligibility denials, and all 21 were requested, received and reviewed. The files were reviewed to determine compliance with 31 Pa. Code §146 and 40 P.S. §991.1111b (Prompt Payment of Claims). The following violations were noted:

4 Violations – 31 Pa. Code §146.6

Every insurer shall complete its investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within that time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer

shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete its investigation or failed to provide timely status letters to the insured within 30 days and every 45 days thereafter as needed, in the 4 noted files.

17 Violations – 40 P.S. § 991.1111a (b)

If an insurer determines the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of the following:

- (1) The reason the insurer determined the insured's benefit trigger has not been met.
- (2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request.
- (3) The insured's right to have the benefit trigger determination reviewed under the independent review process under subsection (d) after the exhaustion of the insurer's internal appeal process. For the 17 noted files, the Company's benefit eligibility denial letters failed to notify the insured of his or her right to have the benefit trigger determination reviewed under the independent review process after the exhaustion of the insurer's internal appeal process. The Company did not provide evidence to show that a clear, written notice was provided to the insured and the insured's authorized representative when a benefit trigger has not been met in the 17 noted files.

C. Long-Term Care Eligibility Determinations – Approved

The Company was requested to provide a list of long-term care eligibility determinations that were approved during the experience period. The Company identified a total of 265 benefit eligibility approvals. A sample of 82 files was identified and requested. After those files were received, it was discovered that one of the files was actually a benefit eligibility denial (No. 22 on the initial list). That file was added to the list of denials reviewed and a

new file (No. 83) was added to complete the sample of 82, all of which were reviewed. The files were reviewed to determine compliance with 31 Pa. Code §146 and 40 P.S. §991.1111b (Prompt Payment of Claims). The following violations were noted:

3 Violations – 31 Pa. Code §146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice. 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 the notification for the request for eligibility in 10 working days for the 3 noted files.

8 Violations – 31 Pa. Code §146.6

Every insurer shall complete its investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within that time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete its investigation or failed to provide timely status letters to the insured within 30 days and every 45 days thereafter as needed, in the 8 noted files.

VIII. CLAIMS

This review consisted of one segments

A. Paid Long-Term Care Claims

A. Long-Term Care Claims Paid

The Company was requested to provide a list of requests for benefit payments received during the experience period. The Company identified 12,203 long-term care benefit payments. A sample of 109 long-term care benefit payments was requested, and all were received and reviewed. The claim payment files were reviewed for compliance with 31 Pa. Code §146 and 40 P.S. §991.1001, et seq. The following violation was noted:

1 Violation – 40 P.S. § 991.1111b (a)

Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following: (1) The insurer is declining to pay all or part of the claim and the specific reason for denial; or (2) Additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary. For the one noted file, the Company failed to pay or acknowledge the noted claim for benefits within (30) business days as required. The Company did not complete its investigation or it did not show evidence that they provided timely status letters to the insured within 30 days and every 45 days thereafter as needed, in the noted file.

IX. CONSUMER COMPLAINTS

A. 2013 Consumer Complaints

The Company was requested to provide copies of long-term care consumer complaint logs for 2013 and 2014 and a listing of all long-term care consumer complaints received from Pennsylvania consumers and claimants and of any complaints referred to the Department from January 1, 2014 through June 30, 2015. The Company identified 19 consumer complaints received during 2013. All 19 complaint files were requested, received and reviewed. The Company also provided the requested complaint logs. 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). No violations were noted.

B. Consumer Complaints from January 1, 2014 through June 30, 2015

The Company was requested to provide copies of long-term care consumer complaint logs for 2013 and 2014 and a listing of all long-term care consumer complaints received from Pennsylvania consumers and claimants and of any complaints referred to the Department from January 1, 2014 through June 30, 2015. The Company identified 22 consumer complaints received from January 1, 2014 through June 30, 2015. All 22 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. No violations were noted.

X. 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. No violations were noted.

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.

XI. 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 internal control procedures to ensure compliance with 31 Pa Code, Chapter 39a. Producer requirements and continuing education.
2. The Company must review internal control procedures to ensure compliance with 31 Pa Code, Chapter 89a. Long Term Care Insurance Model Regulation.
3. The Company must review and revise internal control procedures to ensure compliance with 31 Pa Code, Chapter 146, Unfair Claims Settlement Practices.
4. The Company must review and revise Insurance Producers payment of commissions to ensure compliance with Section 672-A of the Insurance Department Act of 1921 (40 P.S. §310.72).
5. The Company must review and revise procedures to ensure compliance with 40 P.S. §323.3(a), to ensure compliance with record retention requirements.
6. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §991.1111, Long-Term Care.
7. The Company must implement procedures to ensure compliance the requirements of 40 P.S. §477b forms filings.

XII. COMPANY RESPONSE

John Hancock Financial Services

Litigation, Alternative Dispute Resolution and Bankruptcy

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July 14, 2016

VIA ELECTRONIC & U.S. MAIL

Debra L. Sweigard
Division Chief
Pennsylvania Insurance Department
Bureau of Market Actions
Life, Accident and Health Division
1321 Strawberry Square
Harrisburg, PA 17120

Re: Report of Examination of John Hancock Life Insurance Company (U.S.A.)

Dear Ms. Sweigard:

I am writing on behalf of John Hancock Life Insurance Company (U.S.A.) to comment on the revised "Report of Examination of John Hancock Life Insurance Company (U.S.A.)" that you sent to me on July 12, 2016 (the "Report"). I would like to thank both you and Michael Jones for making some of the changes to the Report that I had requested in my June 30, 2016 letter to you. As to the current version of the Report, I have the following comments:

Section VI: Group Long-Term Care Policies Terminated – 31 Pa. Code §89a.106

As I previously indicated, in Exit Summary Section E.6, the Department asserted 27 violations of 31 Pa. Code §89a.106. On behalf of the Company, I responded to these allegations in my letter to you dated May 27, 2016. Thereafter, in the Report, the Department eliminated 12 of the 27 alleged violations. However, as I stated in my June 30, 2016 letter, I did not know which of the alleged violations were eliminated or why, given the nature of issue raised by the Department and my response, 15 of the allegations remained.

The original allegation advanced in the Exit Summaries was that, "The Company did not provide the required notice of lapse or termination of coverage for nonpayment of premium at least 30 days before the effective date of the lapse or termination in a clear and understandable manner." I responded to this allegation in my letter of May 27, 2016. Therein, I questioned the Department's interpretation of 31. Pa. Code §89a. 106 relative to "clear and understandable" language. In the current version of the Report, the Department has eliminated all references to

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“clear and understandable” language in the notice. Instead, the allegation has been changed to read, “The Company did not provide the premium due notice and or the proper notification to the insured and any designated persons of the policy lapse or termination of coverage in the 15 noted files.” That is a new and quite different allegation than what was alleged before. Previously, the allegation was not that the notice had failed to go out in a timely manner, but instead, that the language utilized in the notice was inadequate from the Department’s perspective.

During our call on Monday, although he did not specify which 15 files were at issue, I believe that Mr. Jones indicated that some or perhaps all of the 15 remaining files had notices dated in 2015. I looked back at the documentation I provided to you in May and I still cannot determine which files are the subject of this new allegation by the Department. As a matter of due process, the Company has a right to know the specifics of the allegations being made against it. Respectfully, the mere fact that a notice may have been sent out in 2015 in advance of a subsequent termination, does not necessarily equate to a violation of 31 Pa. Co §89a.106. For each file, I need to know the alleged date of the notice and the alleged date of termination. Without this information, the Company does not have the facts it needs to prepare a meaningful response to the allegations. Given the time constraints we discussed during our recent call, I believe that equity and fairness require that these alleged violations be withdrawn from the Report. I respectfully request that the Department do so.

Single Violations/ Recommendations

In the Report, there are five violations of law asserted that involve only a single alleged offense. In this regard, only one violation of the following provisions of law has been alleged:

1. 40 P.S. §310.72
2. 31 Pa. Code §89 a.113(a)(2)(4)
3. 40 P.S. §323.3(a)
4. 31 Pa. Code §89a.106(a)(1)
5. 40 P.S. §991.1111b(a)

Section 904 of the Insurance Department Act is entitled “Conduct of Examinations” Section 904(a) states in pertinent part, “In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiner’s Handbook adopted by the NAIC.” The NAIC’s Market Regulation Handbook sets forth sampling techniques and error tolerance ratios in recognition of the fact that notwithstanding robust and efficacious policies and procedures, random errors may occur. It is seldom appropriate for a single alleged violation to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance a company’s otherwise effective policies and procedures. In this regard, I would respectfully request that the above-referenced violations and corresponding recommendations be withdrawn and deleted from the Report. In the alternative, if the Department is unwilling to remove the violations alleged, I would respectfully request that the corresponding recommendations be eliminated. If the Department is unwilling to do either, I request that an appropriate caveat be included in the Report that reflects the context in which these violations and recommendations have been included over the objection of the Company.

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The Company remains hopeful that the Department will give appropriate consideration to the Company's comments and that where appropriate, the final adopted Report will be modified accordingly. Alleged violations or references in the Report which have not been specifically addressed in this response are not necessarily accepted nor admitted as accurate. The Company specifically reserves all rights afforded to it by Pennsylvania law. The Company looks forward to working with the Department and to resolve this Examination, including the corresponding Consent Order, in an expeditious and amicable manner.

Thank you for your attention to this matter.

Very truly yours,

A handwritten signature in black ink, appearing to read "William A. Gottlieb", with a long horizontal line extending to the right.

William A. Gottlieb

WAG/ash

cc: Michael Ciaffone