REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

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

AS OF DECEMBER 31, 2016

Conducted from September 13, 2017

through

July 25, 2019

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 01-0233346
NAIC: 65838

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

I, Brant Lyons, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of John Hancock Life Insurance Company as of December 31, 2016, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2020-00027 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 16th day of March, 2020.

Brant Lyons

Brant Lyons
Examiner in Charge

REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

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

AS OF DECEMBER 31, 2016

Conducted from September 13, 2017

through

July 25, 2019

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 01-0233346
NAIC: 65838

TABLE OF CONTENTS

Section Page

I. SCOPE OF EXAMINATION 1

II. EXECUTIVE SUMMARY 2

III. COMPANY HISTORY 5

IV. ADVERTISING 7

LIFE INSURANCE ADVERTISING 8

V. POLICY AND OTHER FORMS 19

POLICIES 19
APPLICATIONS/ENDORSEMENTS 21
ACCIDENT AND SICKNESS RATE FILING 22
EXPLANATION OF BENEFITS (EOB) 22

VI. AGENTS 23

LICENSED AGENT REVIEW 24
APPOINTED AGENT REVIEW 24
COMMISSIONS 25
TERMINATED AGENT APPOINTMENT REVIEW 25
LONG-TERM CARE PARTNERSHIP AGENT TRAINING REVIEW 26

VII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT 27

UNDERWRITING REVIEW 27
UNDERWRITING PRACTICES – AIDS 29
MECHANICAL RATING REVIEW 29
NOTICE OF INSURANCE INFORMATION PRACTICES (NIP) 30
NOTICE OF FINANCIAL INFORMATION PRACTICES 30
DISCLOSURE AUTHORIZATION FORMS 31
ADVERSE UNDERWRITING DECISIONS (AUD) 31
DISCLOSURE OF RATING PRACTICES 35
OUTLINE OF COVERAGE 36
SHOPPER'S GUIDE 36
PARTNERSHIP PROGRAM AND DISCLOSURE NOTICES 36
POLICY SUMMARY 37
LONG-TERM CARE INSURANCE 38

VIII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST 41

PREMIUM NOTICES 41
REINSTATEMENTS 42
POLICY LOANS AND LOAN INTEREST 42

IX. CANCELLATIONS/NONRENEWALS 44

LIFE INSURANCE 44
LONG-TERM CARE INSURANCE 46

X. COMPLAINTS 48

XI. CLAIM PRACTICES 49

GENERAL HANDLING STUDY 49
PAID CLAIM REVIEW 49
LIFE INSURANCE 49
LONG-TERM CARE INSURANCE 49
INTEREST – LONG-TERM CARE INSURANCE 51
DENIED CLAIM REVIEW 51
UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW 52
LONG-TERM CARE INSURANCE 54
THREATENED LITIGATION 55
DISCLOSURES FOR RETAINED ASSET ACCOUNTS 55

XII. CORRECTIVE ACTION PLAN 58

XIII. ACKNOWLEDGMENT 64

XIV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET 65

I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of John Hancock Life Insurance Company (U.S.A.) (hereinafter referred to as “John Hancock” or “the Company”) was conducted under the authority of § 38.2-1317 of the Code of Virginia (hereinafter referred to as “the Code”). The examination included a detailed review of John Hancock’s individual life and group and individual long-term care insurance coverage for the period beginning January 1, 2016 through December 31, 2016. The examination was conducted at the office of the State Corporation Commission’s Bureau of Insurance (hereinafter referred to as the “Bureau”) from September 13, 2017 through July 25, 2019.

The purpose of the examination was to determine whether John Hancock was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code (hereinafter referred to as “VAC” or “regulations”).

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to John Hancock during the course of the examination.

II. EXECUTIVE SUMMARY

During the course of the examination, the examiners reviewed advertisements, policy forms, agents, underwriting, premium notices, reinstatements, policy loans, cancellations, nonrenewals, rescissions, conversions, complaints, and claim practices, to determine compliance with the Code, the applicable regulations, the terms of John Hancock's insurance contracts, and the Company's policies and procedures.

The current examination revealed that John Hancock failed to file for approval its explanation of benefits (EOB) forms, as required by § 38.2-3407.4 A of the Code. This violation could be construed as knowing, as the Bureau previously corresponded with John Hancock regarding EOB filing requirements.

There are 426 violations and instances of non-compliance noted in this Report. The review of advertisements revealed that the Company's life advertisements included broad and sweeping statements without parameters regarding the benefits of the products being advertised. John Hancock also used the terms "financial representative" and "financial advisor" to refer to its agents in life advertisements in a manner considered to be misleading.

The policy forms review revealed that, while a few violations resulted from the failure to file life forms for approval, the majority of violations were the result of life forms that received approval initially and were subsequently modified by John Hancock outside of the permitted variability.

The underwriting review revealed that some of the Company's life and long-term care adverse underwriting decision (AUD) notices were not substantially similar to the prototype notice specified in the Bureau's administrative letter; the Company failed to provide AUD notices in the case of certain closed files; and the Company failed to provide

AUD notices in the case of certain files where a rider to the base policy was declined or coverage was issued at a lower benefit level or higher rate than applied for.

The cancellations review revealed that John Hancock failed to maintain copies of its lapse notices as required by the long-term care regulation. The Company has, however, taken action subsequent to the examination time frame to begin implementation of a process ensuring these notices are maintained.

There were 261 violations and instances of non-compliance noted during the Claims review, with 238 involving long-term care claims and 23 involving life claims. The long-term care claims review revealed that charges submitted on invoices for services that were excluded/non-covered under the policy were omitted altogether from the EOBs, which resulted in the failure of the EOB to clearly and accurately disclose the method of benefit calculation, as required by § 38.2-514 B of the Code. The long-term care claims review also revealed that several EOBs failed to clearly describe which benefit category in the policy claims were being paid under, resulting in additional violations of § 38.2-514 B of the Code. The life claims review revealed instances where John Hancock failed to acknowledge the receipt of notification of claims within 10 working days, as required by 14 VAC 5-400-50 A, and failed to advise claimants of acceptance of claims within 15 working days, as required by 14 VAC 5-400-60 A. The Company attributed several of these instances to a temporary disruption of its payment process caused by system updates.

While John Hancock exited the standalone long-term care market in December of 2016 and is not currently issuing new policies under this line of business, the Company is still responsible for compliance with Virginia's statutes and regulations, as well as applicable contract provisions, in transactions involving in force business. The Company also continues to offer long-term care riders attached to its life policies.

A corrective action plan (CAP) that must be implemented by John Hancock was established to address these issues and others discussed in the Report.

III. COMPANY HISTORY

John Hancock was incorporated on August 20, 1955 in the state of Maine as the Maine Fidelity Life Insurance Company and commenced writing business on January 31, 1956. On December 30, 1982, the Company became a wholly owned subsidiary of The Manufacturers Life Insurance Company ("MLI") when MLI acquired all of the then-issued and outstanding shares of the Company. The Company subsequently changed its name to The Manufacturers Life Insurance Company (U.S.A.) on July 31, 1990 and redomesticated to Michigan as of December 30, 1992.

On January 1, 2002, the Company merged with its immediate parent, Manulife Reinsurance Corporation (U.S.A.), a Michigan insurer, and its wholly owned subsidiary, The Manufacturers Life Insurance Company of North America, a Delaware insurer, with the Company surviving.

Also, on January 1, 2002, by way of assumption reinsurance, the Company assumed all of the insurance business, including all assets and liabilities, of its wholly owned subsidiary, The Manufacturers Life Insurance Company of America, which was subsequently merged with and into the Company on December 5, 2005.

Following the April 28, 2004 merger between Manulife Financial Corporation ("MFC") and John Hancock Financial Services, Inc., the Company changed its name to John Hancock Life Insurance Company (U.S.A.), effective January 1, 2005.

On December 31, 2009, the Company merged with its affiliates, John Hancock Life Insurance Company and John Hancock Variable Life Insurance Company, both Massachusetts insurers, with the Company surviving.

Net admitted assets as of December 31, 2016 totaled $229,892,290,373. As of December 31, 2016, total life insurance premiums in Virginia were $103,158,250, and total long-term care insurance premiums in Virginia were $84,592,302.

IV. ADVERTISING

A review was conducted of John Hancock's advertisements to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-41-10 et seq., Rules Governing Advertisement of Life Insurance and Annuities, 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-41-30 B and 14 VAC 5-90-50)

14 VAC 5-41-150 C and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed that John Hancock was in substantial compliance.

A sample of 50 life and 20 long-term care advertisements was originally selected from a population of 740 life and 41 long-term care advertisements distributed in Virginia during the examination time frame. As 1 life advertisement distributed in Virginia in 2017 was added to the review based on a referral, a total sample of 71 advertisements was reviewed.

The review revealed that 15 of the advertisements contained violations. In the aggregate, there were 21 violations, which are discussed in the following paragraphs.

LIFE INSURANCE ADVERTISING

14 VAC 5-41-30 B states that an advertisement shall be truthful and not misleading in fact or by implication. The form and content of an advertisement shall be sufficiently accurate, complete, and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. The review revealed 10 violations of this section. An example is discussed in Review Sheet AD02-LW, where the advertisement included the statement "Life insurance that protects you and your family no matter what life brings." John Hancock disagreed, stating that:

> This statement, and the communication it was contained in, does not violate 14 VAC 5-41-30 B or the 'overall impression' standard noted within. In addition, this language is not an overstatement in the context of the entire presentation, and does not have the capacity to mislead or deceive any reader as to "the extent of the protection provided by the policy."
>
> Advertisements must be read in their totality and under 14 VAC 5-41-30 B, when reviewing advertisements, one must look at the entirety of their content to determine balance, completeness, clarity, and whether an average reader would understand the messaging, content, and tone. To do otherwise, and selectively or exclusively focus on the phrasing in a single bullet leads to overbroad conclusions being drawn. In addition, looking to the manner in which a communication may be distributed, as well as the underlying audience for that communication, can help with determining compliance with states' advertising laws.
>
> For this item in question, your office was provided a fifty-four (54) page PDF of a supplemental illustration (pages 1-3) and illustration report (pages 4-54). Policy illustrations are only provided to potential customers by licensed agents, appointed with John Hancock, whose licensing status has been verified, for purposes of even providing them access to our illustration reports in the first instance. Invariably, when a personalized illustration is run for a customer, it is at that point in an agent's solicitation process when he / she has already had preceding discussions with the customer about insurance products (and the product the illustration correlates to). Pages 1-3 are a supplemental report that if used, would accompany the underlying new business illustration for the policy (here, our Protection Survivorship Indexed Universal Life policy), which is seen on pages 4-54 of this sample (template). Note that this three (3) page supplemental report can *only* be

provided to a potential customer if and when a producer runs a policy illustration to provide to an individual. In no other instance would a producer be able to access this supplemental report. The new business illustration will always be provided to our customer as the basis for any sale, as this is a requirement under state law and with our company policy for reviewing applications and making underwriting determinations (and a decision whether to issue a policy or not).

You are referencing a five (5) word phrase on the first page of the entire illustration report, which states "no matter what life brings," and suggesting that this is an overstatement that is misleading or deceptive as to the entire illustration report and the extensive content within, so that a customer at this point in a solicitation process, would not know "the extent of the protection provided by the policy." First, this bullet statement is qualified by language immediately preceding it, which states "Protection SIUL with Vitality offers:" Second, based on an additional read of the optional report (pages 1-3), and the basic illustration (template pages 4-54), it is certainly not the case that this statement is misleading as to the extent of protection provided by the policy. New business illustrations are subject to state law requirements regarding content, and as is the case with the illustration in this example, the following (among other things) are listed on a personalized report for any customer:

- Death benefit / face amount of the policy
- On the actual illustration (ledger) pages, for any given policy year - a summary of premiums due, policy values, net surrender value, net death benefit, etc.
- A clear statement that '[t]he life insurance provided in this illustration reflects a Total Initial Death Benefit of $1,000,000
- Type / Category / name of product
- features / benefits of the policy (including the Healthy Engagement Rider and Vitality)
- Illustration assumptions, including illustrated rate(s) and charges
- Important Reminders
- Descriptions of how varying things like charges, loans, withdrawals, can impact a policy
- The customer's name, age, state the customer lives in

Regarding the first three pages of the supplemental report, they also provide context, balance, and a summary on the extent of protection provided by the illustrated policy. The values on this report are pulled from the basic illustration. The 2nd page lists:

- the prospective customer's illustrated coverage amount (being applied for)
- guaranteed death benefit durations
- underwriting assumptions and potential premium amounts (to pay)
- and the applicants' sex and age….

The examiners responded that the language in question is a broad and sweeping statement with no parameters or qualifiers and that the extent and impact of “no matter what life brings,” as well as the extent and impact of the benefits provided by the product being advertised, is dependent upon many factors. The examiners maintain that the advertisement has the capacity to mislead or deceive the reader.

14 VAC 5-41-40 B states that if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, these terms shall be accompanied by a further disclosure of equal prominence and juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD01-LW, where the advertisement stated “No medical exam required.” It further stated “No medical exams,” “No lengthy forms,” and “Just a few simple questions and an answer in 3-5 days.” A disclosure on the back of the form advised that “Policy issuance is not guaranteed…” and that “John Hancock will obtain additional information, including but not limited to medical records….” However, the initial statements include no footnote directing the reader to the disclosure on the next page, and the disclosure is not juxtaposition (side by side/adjacent) to the statements to which it is applicable. John Hancock disagreed with the examiners’ observations, stating that:

> This letter is compliant with Virginia law as it does not make untrue, deceptive or misleading statements under Section 38.2-502 of the Code of Virginia, and its content and formatting is not misleading, deceptive, or untrue. In addition, it is compliant with the content and prominence standards seen in 14 VAC 5-41-40 B. Regarding 14 VAC 5-41-40 B, the intent of this code section is to ensure that advertisements aren’t creating the impression that a guaranteed issue product is being promoted, when in fact, that is not the case.
>
> As information on how this letter was generated and used, it was not put into use until December 2016. This letter was a high-level invitation to

inquire - sent by a firm to prospective customers. This letter's offer was structured to apply to any John Hancock single life policies available for sale (including our "Vitality" products), which we would then employ a streamlined underwriting process to and review for eligibility to issue (only up to a maximum face amount of $500,000, as noted in the letter). You will see that no specific product type or product category was mentioned in this letter, and in fact we stated that "[w]e offer many life insurance options and will help you find the right product for your needs." As part of this streamlined underwriting process we offered, no medical exam was required of the audience that this letter was sent to. In the letter we purposely stated there were "no medical exams" for those individuals to take - because this was a true statement based on the process we would employ.

Given this fact, not only was the language we used throughout the body of the letter purposeful, it clearly met the intent behind 14 VAC 5-41-40B (preventing against a customer believing they are being offered a "guaranteed issue" product). Specifically, preceding the body of the letter, we clearly state the individual is (merely) *invited to apply* for up to $500,000 in coverage, as opposed to saying something like "you will receive up to $500,000 in coverage." In addition, looking to the body of the letter, we never used the words or phrasing "guaranteed issue," "guaranteed acceptance," "instant issue," "automatic acceptance," and did not imply or state anything else in that vein. Additionally, we use language in the letter (1st page) that states we can provide "an ***answer*** in 3-5 days" (not an issued policy in 3-5 days, not an acceptance in 3-5 days), and that customers could call the agency to "discuss the solutions that ***could*** help" with their possible insurance needs" (emphasis on the word 'could' - where again – we never state or imply any policy issuance is guaranteed).

In addition, looking to the language we used on page 2 of the letter, that also met the intent behind 14 VAC 5-41-40B. The *first thing* a customer reads on that (back) page of the letter, is that for any policy a customer may inquire about, the policy has a description of coverage, varying exclusions and limitations, and that customers should contact an agent or John Hancock for more information and complete details on coverage (in fact, we state that *again*, at the bottom of page 2). This language does not state or imply a policy is guaranteed issue / acceptance, and as your Observation notes, this section of our letter further states the exact opposite ("Policy issuance is not guaranteed ….").

Regarding your observations, and more specifically the prominence standard in 14 VAC 5-41-40 B, this code section does not state that there is a requirement to use footnotes on any given piece. For this 1 sheet letter (front & back page), the following points show how our disclosure was of greater or equal prominence to the statement regarding no medical exams. Specifically:

- The first thing the reader sees on the 2nd page is a block disclosure
- This block disclosure is in a prominent 12 point font

- This disclosure references, two times, an application and medical review process (underwriting & obtaining additional information)
- This disclosure specifically states that policy issuance is not guaranteed

Looking at what 14 VAC 5-41-40B actually says, the following:
if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, ***these terms shall be accompanied by a further disclosure of*** *equal prominence and* ***juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application****.*
(emphasis of bolded text, added).

The language we used in the disclosure section on page two (2) of the letter, counter-balances the page one (1) phrasing of 'no medical exams.' The meaning of the "juxtaposition to the effect that" language highlighted in bold text immediately above - refers to the substance and content of any contrast and comparison language that one must use to address phrasing like 'no medical exams.' The VAC section, however, does *not* state that any disclosure must be in "close proximity" as your Observation implies, and 14 VAC 5-41-40B does not use the terms "close proximity" or "minimized", or any similar phrasing, at all. Our letter's language, contrasting and comparing to the 'no medical exam' phrasing, is compliant as to its substance and placement, as we state to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application – where we reference an application and the review of medical information, two times:

- "any life insurance purchase is subject to completion of an application and underwriting approval"
- "John Hancock will obtain additional information, including but not limited to medical records, to evaluate your application … and … identify any misrepresentation in the application."

The examiners maintained their findings. In the version of the advertisement provided with John Hancock's response, the disclosure is not only on the back of the referenced statements, but it is in a smaller font and in regular type, while the referenced statements are in bold type. Further, the reader must read through half of the untitled, unreferenced disclosure paragraph before reaching information stating that "Policy issuance is not guaranteed as any life insurance purchase is subject to completion of an application and underwriting approval." The disclosure is neither of equal prominence nor juxtaposition to the statements to which it is applicable.

14 VAC 5-41-80 B states that an advertisement of a particular policy shall not use the phrase "inexpensive," "low cost" or any similar term unless that fact is capable of being demonstrated to the satisfaction of the commission. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD04-JA, where the terms “affordable” and “low premiums” were not substantiated or demonstrated to be true in the advertisement. The terms are used to generally describe the policy’s rates; therefore, the examiners requested evidence to support the claim that the coverage advertised was affordable to the target audience and requiring low premiums based on financial data, demographic studies, or other documentation. John Hancock disagreed, stating:

> This advertisement does not violate 14 VAC 5-41-30 B or the ‘overall impression’ standard noted therein. We believe the phrasing in this piece is balanced and can demonstrate, along with the additional documentation requested in your observation, that this piece is compliant under Virginia state law. We disagree with the assertion that the 1x use of the term ‘low premiums,’ and the referenced use of the term ‘affordable,’ need to be based on the recipient of the advertisement’s ability to pay (for insurance and this particular policy).
>
> In looking at this piece in its entirety, and contextually reviewing all of its content relative to all statements made within it, this piece is balanced and sufficiently clear and complete so as not to be misleading or deceptive. Regarding the use of the referenced term ‘affordable,’ it is used in this immediate sentence:
> “John Hancock Term offers you an affordable way to help prevent financial hardship in the event of your untimely death.” (PDF page 4 of 8).
>
> This statement, intended to pique any reader’s interest in insurance or this particular product, is postioned [*sic*] to have the reader consider whether or not insurance is affordable relative to the hypothetical questions presented to the reader on the prior page (PDF page 3 of 8). More specifically, whether the reader could otherwise - without insurance coverage - afford to: replace lost income, make tuition payments, pay toward one’s mortgage, continue a business, etc.
>
> In addition, the phrasing in the sentence itself, refers to the manner in which insurance could be affordable, and clearly does not state that this product is affordable for every reader. The statement says: “John Hancock Term ***offers*** you an ***affordable way to help prevent*** financial hardship,” and then

> this piece immediately and subsequently refers to how the premium obligation for this policy (type) is for a fixed amount, and for a fixed duration. For term insurance, a fixed premium for the referenced 10, 15, 20 year duration – is for a shorter timeframe than a premium obligation on a permanent policy whose premiums are typically in the marketplace, at least to life expectancy of the insured or even lifetime (commonly known as being over age 100 or even to age 121). Use of the word affordable in this context is not deceptive.
>
> As part of an analysis to determine an advertisement's compliance with state law, and here, both 14 VAC 5-41-30 B and 14 VAC 5-41-80 B, one has to have an understanding of how term products are positioned in the marketplace. Industrywide, term products are often positioned as low-cost and affordable. Our company could readily produce multiple examples from either 2016 or even today, which show our competitors positioning term insurance in the way John Hancock did within this guide in question, and where they also use terms like "affordable," "the most affordable option," or "lowest initial price." For our term product and this guide in question, it did offer low and affordable premiums – and as seen in the provided quote and illustration (see PDFs provided) – this 20 year Term 2016 product for a 35 year old preferred male would have been $612 in annual premium; whereas our Protection UL 16' permanent product for 20 years on the same insured would have been $2,571 annually….

The examiners maintained their findings and stated that without substantiation of the affordability of the rates or the "low premiums," the advertisement is considered to have the capacity or tendency to mislead or deceive.

14 VAC 5-41-90 J states that an insurer or agent shall not use the terms "financial planner," "investment advisor," "financial consultant," "financial counseling" or other similar terms in a way that implies that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales unless that is actually a fact. No person engaged in the business of insurance shall hold himself out, directly or indirectly, to the public as a "financial planner," "investment advisor," "financial consultant," "financial counselor" or any other specialist engaged in the business of giving complete financial planning advice relating to investments, insurance, real estate, tax matters, and trust and estate matters unless that person in fact is engaged in that business and renders those services. The review

revealed 5 violations of this section. An example is discussed in Review Sheet AD04-LW, where the disclosures section of the advertisement instructed the reader to “Please consult your financial representative as to how premium savings may affect the policy you purchase” and to “Please consult your financial representative as to product availability.” Five lines down, the advertisement stated “Please contact a licensed agent or John Hancock for more information, costs, and complete details on coverage,” thus giving the impression that the “financial representative” and the “licensed agent” were different individuals with different functions. Use of the term “financial representative” in referring to the licensed agent implies that the “financial representative” is generally engaged in an advisory business with compensation unrelated to sales. John Hancock disagreed, stating, in part:

> Your observation states: “The use of such terms in referring to an agent implies that the agent is generally engaged in an advisory business with compensation unrelated to sales.” This assertion is untrue and a close examination of it reveals it has circular logic, it is an argument that assumes its own conclusion. Specifically, you are stating that when a term like financial representative is used, its mere use always means (and automatically implies) “that an agent is generally engaged in an advisory business.” This is not true under 14 VAC 5-41-90.J. Here is what this VAC section actually says:
>
> *an insurer or agent shall not use the terms "financial planner," "investment advisor," "financial consultant," "financial counseling" or other similar terms* ***in a way that implies*** *that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales unless that is actually a fact.* [emphasis added].
>
> Unquestionably, 14 VAC 5-41-90.J does not have an absolute prohibition against use of the term in question (or for that matter, terms like “financial planner” listed in the code), and had the Virginia Department of Insurance wished to state otherwise in the VAC (i.e. - that use of such terms or similar terms in all instances would imply a person engaged in the insurance business is also generally engaged in an advisory business), it could have easily done so by different ways of phrasing this section.
>
> Looking beyond the observation’s misinterpretation of the VAC, as a factual matter we reject the idea that the term “financial representative” has the

same meaning as the specifically noted examples in the VAC, "financial planner," "investment advisor," "financial counseling," or "financial consultant." Regardless, even looking at the use of the term in question here ("financial representative"), there is no way within either the context of the piece itself, or the sentences you have referenced and extracted, that this term per se and even how it is used in any sentence in the piece, is used "in a way that implies [a person] who is engaged in the business of insurance, is generally engaged in an advisory business …." As noted earlier in our response, this (or any piece) must be read in its totality and in context, relative to among other things, its primary / secondary / overall messaging, and its tone. This is an educational piece, an FAQ document written about the John Hancock Vitality program for John Hancock life insurance policies, and it was written for potential customers. That is the extent of the content of the piece – there is no content in it to suggest that a 'financial representative' is engaged in an advisory business. Also, while this piece was written by John Hancock, it was not (is not) distributed directly to customers by John Hancock. It is generic in nature in that the only way customers could receive it, is if it was given to them by a licensed and appointed representative who sells our products, and who has been granted access to this piece through a verified account with John Hancock. This piece, like the majority of our print pieces, is created for any 'accountholder' agent to access and distribute – but it is not personalized to any individual, nor is it formatted so it could be personalized by anyone (as it's a locked PDF), so it cannot imply any status or title so that an individual agent could be perceived as holding himself out in a manner that is prohibited by the VAC.

Looking at the three (3) examples where you noted how the phrase "financial representative" is used, in those sentences themselves there is no messaging that conveys or implies an individual is "generally engaged in an advisory business in which compensation is unrelated to sales." Here are the sentences, two of which are in a *disclosure section* on our piece, and what they (and their intent) communicates:

1) Text in flyer: "Please consult your financial representative to determine if the program is available on your existing policy." Translation: inquire for more information on whether Vitality is available with the life insurance products listed in the "Additional Information" FAQ # 16.

2) Disclosure in flyer (FN marker #1): "Please consult your financial representative as to how premium savings may affect the policy you purchase." Translation: inquire as to how lowering your premiums and any savings realized, could affect your policy.

3) Disclosure in flyer (FN marker # 5): "Please consult your financial representative as to product availability." Translation: this disclosure is used to meet varying states' disclosure requirements, we are asking current or potential customers to confirm whether or not a

> policy manufactured by John Hancock would even be available for them to purchase, before further inquiring on that product….

The examiners responded that it is their position that the term "financial representative" is substantially similar to the terms referenced in 14 VAC 5-41-90 J such as "financial planner" and "financial consultant." Further, 2 disclosures instructing the reader to **consult** [emphasis added] his or her "financial representative" immediately followed by an instruction to **contact** [emphasis added] "a licensed agent or John Hancock" implies that the "financial representative" is a different individual and provides a different service and function than the "licensed agent." While mere use of the terms referenced in the regulation is not prohibited, the regulation does prohibit using them in a way that implies that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales. The examiners maintain that the manner in which the term "financial representative" is used in this advertisement is in non-compliance with the requirements of 14 VAC 5-41-90 J.

SUMMARY

John Hancock violated 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, and 14 VAC 5-41-90 J, placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

Filing Requirements for Long-Term Care Insurance Advertising

14 VAC 5-200-160 A states that every insurer providing long-term care insurance or benefits in this Commonwealth shall provide a copy of any long-term care insurance advertisement, as defined in 14 VAC 5-90-30, intended for use in this Commonwealth whether through written, radio or television or other electronic medium to the Commission. To the extent that it may be required or permitted under the laws of this Commonwealth, the Commission may review or review for approval all such advertisements. The review

revealed that 3 advertisements were not filed with the Commission, in violation of this section in 3 instances. An example is discussed in Review Sheet AD16-JA, where John Hancock altered the filed version of an advertisement by inserting additional language. John Hancock disagreed and stated:

> …this language was inserted because it was thought to be allowed-for under a statement of variability, and the language was an educational fact that provided objective information which was neither a marketing point nor a "material change" relative to any possible marketing content in these pieces.

The examiners responded that the standards regarding variability of information specified by the Insurance Product Regulation Commission state that any change in content other than that described in the statement of variability requires prior approval. This change was not approved and does not appear in the statement of variability.

V. POLICY AND OTHER FORMS

A review was conducted to determine if John Hancock complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms. Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia. 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the applicable filing and approval requirements for long-term care policies. 14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued.

POLICIES

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of policy forms prior to use.

Life Insurance

The examiners reviewed a sample of 100 from a population of 921 individual life policies issued during the examination time frame. The examiners also reviewed the policy forms used in the individual term life conversions sample files and the policy forms used as part of the 1035 exchanges included in the individual life surrenders sample files.

The review revealed 4 violations of §§ 38.2-316 A and 38.2-316 C 1 of the Code where John Hancock issued the 4 policy forms listed in the table below that were not filed with and approved by the Commission as required.

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATIONS	REVIEW SHEET
ICC10_09ACCUL	Flexible Premium Adjustable Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF04-JA
ICC08_08MAJVULX	Flexible Premium Variable Adjustable Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF04-JA
ICC12 12PROVUL	Flexible Premium Variable Universal Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF01-BB
S0682va	Survivorship Term Life Policy	38.2-316 A 38.2-316 C 1	PF03-JA

An example is discussed in Review Sheet PF04-JA, where John Hancock altered the approved version of the policy to remove text referencing time periods under the "RIGHT TO RETURN" provision of the policy. John Hancock disagreed and stated:

> … Unfortunately, we did not identify MVULX as a policy that required update, and recognize that this was an oversight on our part. It is our understanding that the forms are compliant with ICC standards, as well as VA's free look standards, it is our position that we are in compliance. The language that was removed is redundant language, and we respectfully request that this observation be removed as immaterial.

The examiners responded that a form must be submitted in its final form, and the policy had been modified from the filed and approved format that did not allow for such variability.

Long-Term Care Insurance

The examiners reviewed a sample of 53 from a population of 274 individual long-term care policies issued during the examination time frame.

The review revealed that the policy forms used by John Hancock were filed with and approved by the Commission.

APPLICATIONS/ENDORSEMENTS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and endorsement forms prior to use.

Life Insurance

The review revealed 10 violations of each of these sections where John Hancock used the 10 application/endorsement forms listed in the table below that were not filed with and approved by the Commission as required.

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	REVIEW SHEET
NB5171US (04/2011)	Medical Exam Continuation Page	38.2-316 B 38.2-316 C 1	PF03-JA
NB5136VA (12/2013) Version 05/2015	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
NB5136VA (12/2013) Version 05/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
ICC16 NB6016 (03/2016) Version 05/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
ICC16 NB6016 (03/2016) Version 10/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
None listed	Application Supplement	38.2-316 B 38.2-316 C 1	PF05-JA
None listed	Changes Not Otherwise Ratified Provision	38.2-316 B 38.2-316 C 1	PF05-JA
None listed	Endorsement	38.2-316 B 38.2-316 C 1	PF05-JA
S432-9VA	Supplementary Benefit Four Year Term	38.2-316 B 38.2-316 C 1	PF06-JA
S134-1VA	Supplementary Benefit Accelerated Benefit Rider	38.2-316 B 38.2-316 C 1	PF06-JA

Examples are discussed in Review Sheet PF05-JA, where John Hancock used the "Application Supplement," "Changes Not Otherwise Ratified Provision," and

"Endorsement" forms but failed to file them for approval. John Hancock agreed with the examiners' observations.

Long-Term Care Insurance

The review revealed that the application/endorsement forms used by John Hancock were filed with and approved by the Commission.

ACCIDENT AND SICKNESS RATE FILING

Sections 38.2-316 A and 38.2-316 C of the Code set forth the requirements for the filing of rates and rate changes. 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the filing of rate and rate changes for long-term care insurance policies.

The review revealed that John Hancock was in substantial compliance.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval by the Commission.

The examiners' review of the sample long-term care claims revealed that the EOB forms issued had not been filed with and approved by the Commission. These violations are discussed in Review Sheet PF01-BL. John Hancock's use of an EOB that had not been filed with and approved by the Commission placed the Company in violation of § 38.2-3407.4 A of the Code in 4 instances. John Hancock agreed with the examiners' observations and noted that 3 of the 4 EOBs had been subsequently filed with and approved by the Commission on May 23, 2018 and that the Company is in the process of filing the other EOB for approval.

Due to the fact that the Bureau discussed the EOB filing requirements set forth in § 38.2-3407.4 A of the Code with John Hancock during a prior examination of a carrier for which John Hancock administered long-term care coverage, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

VI. AGENTS

The purpose of this review was to determine compliance with various Sections of Title 38.2, Chapter 18 of the Code and the applicable agent training requirements included in 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

A sample of 10 from a population of 828 agent and agency appointments in effect during the examination time frame was selected for review. The writing agents or agencies designated in the 100 life and 53 long-term care sample new business files were also reviewed, as well as those designated in the term life conversions sample files and the 1035 exchanges included in the life surrenders sample files.

LICENSED AGENT REVIEW

Section 38.2-1822 A of the Code prohibits a person from acting as an agent prior to obtaining a license to transact the business of insurance in the Commonwealth.

The review revealed that John Hancock was in substantial compliance with this section.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 2 violations of this section. An example is discussed in Review Sheet AG02-JA, where an individual who had executed an application on behalf of an agent had not been appointed by John Hancock. John Hancock disagreed, stating that the individual had been allowed to sign on behalf of the agent that was paid a commission on the sale as a manager-approved accommodation. The examiner responded that although the individual in question had not been paid a commission on

the sale, he was acting as an agent in the solicitation of an application/policy and had not been appointed by John Hancock.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that was not appointed or licensed at the time of the transaction.

The review revealed 1 violation of this section. As discussed in Review Sheet AG01-JA, an agency that did not have an active appointment at the time of the transaction was paid a commission. John Hancock disagreed, stating that the agency "…was licensed and appointed at the time the policy was underwritten and issued." The examiners responded that the agency's appointment was administratively terminated on October 7, 2015, but the agency received a commission for an application executed on June 2, 2016.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment.

A sample of 25 from a population of 2,330 agent and agency terminations processed during the examination time frame was selected for review.

The review revealed 3 violations of this section. An example is discussed in Review Sheet AG01-HW, where the agent's appointment was terminated on February 10, 2016, but the only notification sent to the agent was prior to the termination on December 9, 2015. John Hancock agreed with the examiners' observations.

LONG-TERM CARE PARTNERSHIP AGENT TRAINING REVIEW

14 VAC 5-200-205 E requires that an individual may not sell, solicit or negotiate a partnership policy unless the individual is a licensed and appointed insurance agent in accordance with provisions of Chapter 18 (§ 38.2-1800 et seq.) of Title 38.2 of the Code of Virginia and has completed an initial training component and ongoing training every 24 months thereafter. 14 VAC 5-200-205 F requires that insurers offering a partnership policy shall obtain verification that an agent has received the training required by subsection E of this section before the agent is permitted to sell, solicit or negotiate the insurer's partnership policy.

The review revealed 1 violation of each of these sections. As discussed in Review Sheet AG05-JA, an agent sold a partnership policy without completing the required training, placing John Hancock in violation of 14 VAC 5-200-205 E and 14 VAC 5-200-205 F. John Hancock disagreed, stating that the agent had completed the training prior to the application being submitted. The examiners responded that while the agent did complete the initial training, more than 24 months had passed since the agent's last refresher course at the time the application was accepted.

VII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of John Hancock's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; Long-Term Care Insurance, §§ 38.2-5200 through 38.2-5210; 14 VAC 5-30-10 et seq., Rules Governing Life Insurance and Annuity Replacements; 14 VAC 5-70-10 et seq., Rules Governing Accelerated Benefits Provisions; 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine whether John Hancock's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with John Hancock's guidelines, and whether correct premiums were being charged.

UNDERWRITING REVIEW

Life Insurance

A sample of 100 from a population of 921 individual policies underwritten and issued during the examination time frame was selected for review.

Subsection 1 of § 38.2-508 of the Code states that no person shall unfairly discriminate between individuals of the same class and equal expectation of life (i) in the rates charged for any life insurance policy or annuity contract, or (ii) in the dividends or

other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract.

The review revealed 3 violations of this section, as discussed in Review Sheet UN12-JA. The examiners initially observed that, in situations where the accelerated benefit rider to the life policy was not listed as desired coverage on the application, John Hancock had issued the rider to some of the applicants and had not issued it to others. In addition, one applicant was not issued the rider despite listing it as desired coverage on the application. John Hancock disagreed and, in regard to the individuals who had not applied for the rider, stated:

> …while the accelerated benefit rider was not "checked off" on the application, the required "Summary and Disclosure Statement for Accelerated Benefit" form necessary to issue the policy with this rider was signed by the applicant and sent in at the time of application. Normally, if a client does not elect this rider on the application, but sends in the disclosure form, we will not inconvenience the client by asking them to correct the application as we have what we need to issue with the disclosure… all the client's [*sic*] were given the same opportunity to elect the coverage. We do not add the coverage unless it was elected, either on the application or the disclosure….

John Hancock also responded that, for the individual who was not issued the rider despite having applied for it, the rider was inadvertently not included due to a processing error and that the Company is taking corrective actions to have the rider added as part of a corrected policy. Upon further review, the examiners responded that, for the individuals who had not initially applied for the rider, 2 of the applicants had completed the "Summary and Disclosure Statement for Accelerated Benefit" form as described in the Company response and were still not issued the rider. The examiners also acknowledged the corrective action taken in regard to the individual who had initially applied for and was not issued the rider; however, the examiners maintained that John Hancock unfairly discriminated in the terms and conditions of the contract due to the failure to issue the

Accelerated Benefit Rider as applied for in a total of 3 instances. Finally, the examiners cautioned John Hancock that the "Summary and Disclosure Statement for Accelerated Benefit" form does not include language indicating that its completion constitutes application for the rider and that the Company needs to establish procedures for consistency in the application process for this rider.

Long-Term Care Insurance

A sample of 53 from a population of 274 individual policies underwritten and issued during the examination time frame was selected for review.

The review revealed no evidence of unfair discrimination.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that John Hancock was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that John Hancock had calculated its premiums in accordance with its filed rates and its established guidelines.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

Section 38.2-604 B 4 of the Code states that a NIP form shall include a description of the rights established under §§ 38.2-608 and 38.2-609 of the Code and the manner in which those rights may be exercised.

The review revealed that John Hancock failed to include a complete description of these rights and the manner exercised in 6 of its NIP forms, placing the Company in violation of § 38.2-604 B 4 of the Code in 6 instances. An example is discussed in Review Sheet UN01-JA, where the NIP form failed to describe the requirement to furnish corrected, amended, or deleted information or a filed statement by the individual to the insurance-support organizations, as required by §§ 38.2-609 B 2 and 38.2-609 D 3 of the Code. John Hancock disagreed with the examiners' observations by providing the Company's procedure for the handling of disputed information. The examiners responded that although John Hancock appears to satisfy the requirement in practice, the NIP form fails to disclose this practice.

NOTICE OF FINANCIAL INFORMATION PRACTICES

Section 38.2-604.1 of the Code sets forth the requirements for a notice of financial information collection and disclosure practices, either long form or short form, to be provided to all applicants that are individually underwritten.

The review revealed that the forms provided to applicants for coverage complied with the requirements of this section.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The examiners reviewed the disclosure authorization forms used during the underwriting process and found them to be in substantial compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 A of the Code requires that in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

Administrative Letter 2015-07 provides life and health insurers with a prototype AUD notice. An AUD notice containing wording substantially similar to the wording in the prototype notice is deemed to be approved for use in Virginia.

Life Insurance

The examiners reviewed a sample of 50 from a population of 359 applications that were declined during the examination time frame. In addition, the 100 issued policies were reviewed for situations where an AUD notice was required to have been provided to an applicant for coverage.

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that in the event of

an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The review revealed 22 violations of § 38.2-610 A 1 of the Code and 32 violations of § 38.2-610 A 2 of the Code. An example of each of these sections is discussed in Review Sheet UN13-JA, where John Hancock failed to send an AUD notice to applicants that initially applied for or were quoted coverage as Super Preferred but were issued policies as Preferred. John Hancock disagreed, stating:

> Based on the John Hancock underwriting review and process, a final assessment of Standard or better, when in conflict with the originally submitted illustration, would not be considered an adverse underwriting decision. In our perspective, not every applicant qualifies to be a Super Preferred risk, since each individual has his/her own "baseline" based upon multiple criteria (i.e. BRAVE calculator), such as height/weight. Therefore if someone's medical parameters only qualify them for Preferred as a best case scenario, that would not be considered an adverse decision since not everyone is entitled to qualify at Super Preferred.

The examiners responded that subsection 1 e of § 38.2-602 of the Code of Virginia defines an adverse underwriting decision as an offer to insure at higher rates, or with limitations, exceptions or benefits other than those applied for and that page 3 of Administrative Letter 2015-07 lists an example of an action triggering an AUD notice as life insurance offered at a rate higher than that requested or offered at a lower benefit level than that requested. As the applicants applied for Super Preferred rates but received Preferred rates, an AUD notice was required in these instances but was not provided.

Long-Term Care Insurance

The examiners reviewed a sample of 50 from a population of 203 individual applications that were declined during the examination time frame. The examiners also

reviewed the issued policies where AUD notices were required. In addition, the 53 issued policies were reviewed for situations where an AUD notice was required to have been provided to an applicant for coverage.

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The review revealed 4 violations of § 38.2-610 A 1 of the Code of Virginia and 10 violations of § 38.2-610 A 2 of the Code of Virginia. An example of each of these sections is discussed in Review Sheet UN06-JA, where John Hancock failed to provide an AUD notice to an applicant whose file was closed. John Hancock disagreed, stating:

> BOI 14 was approved at the rate that the applicant applied (applied for Select rates and approved at Select rates). After this approval, the proposed insured failed to send in the necessary requirements to proceed with issuance of a policy (required Beneficiary form), and the case was closed out as Incomplete. The Incomplete letter was sent to the client (included in original files). Again, no adverse underwriting decision was made.

The examiners responded that, as described on Page 3 of Administrative Letter 2015-07, when an application is closed/denied because the applicant, his physician, or some other person fails to furnish required information, this is a declination of coverage and triggers an AUD notice. John Hancock provided a letter to the applicant requiring outstanding

information to be submitted within 30 days, and the file was subsequently closed due to the requested information not being received, but no AUD notice was provided.

Section 38.2-610 B 3 of the Code states that upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one business days from the date of receipt of the written request the names and addresses of the institutional sources that supplied the specific items of personal and privileged information that support the reason or reasons for the adverse underwriting decision.

The review revealed 4 violations of this section. Examples are discussed in Review Sheet UN05-JA, where John Hancock received written requests for additional information regarding an adverse underwriting decision as set forth in § 38.2-610 B of the Code, but the Company's response letters failed to disclose the address of the institutional source as required by § 38.2 610 B 3 of the Code. John Hancock disagreed with the examiner's observations, stating:

> …In the event the Company receives such a written request from the applicant, a second letter is sent, which details the source of the information relied upon for the decision to decline the applicant for long-term care insurance. Please refer to second paragraph in the "Decline with Reason" letter, which includes the medical reason for declination and source. While the address of the source of the personal information is not disclosed in this particular sample, we believe our process meets the requirements of regulation **§ 38.2 610 B**.
>
> John Hancock's adverse underwriting process does not currently include providing the source address back to the customer when the decision was based on information provided by the applicant (i.e. on the application or during the medical exam or by one of their attending physicians). John Hancock does however provide the address in the Decline with Reason

> letter when the source of the information is a third party that John Hancock contracts to collect additional information….

The examiners responded that, for the files in question, information contributed from a physician not listed on the application was cited as the source of the reason for the declination. There was also no indication in the sample files that this physician information was provided by the applicant during the other stages of the application process. As an address for these physicians was not provided, John Hancock's response letters failed to comply with § 38.2-610 B 3 of the Code of Virginia.

LONG-TERM CARE DISCLOSURES

A review was conducted to determine if John Hancock was in compliance with the disclosure requirements of 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance, and Chapter 52 of the Code.

DISCLOSURE OF RATING PRACTICES

14 VAC 5-200-75 sets forth the requirements for disclosure of rating practices to the consumer. 14 VAC 5-200-75 A 2 states that an explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision, shall be provided to the applicant at the time of application. 14 VAC 5-200-75 C states that an insurer shall use Forms B and F to comply with the requirements of subsection A.

The review revealed 1 violation each of 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C. As discussed in Review Sheet UN19-JA, John Hancock's "Long-Term Care Insurance Potential Rate Increase Disclosure Form" failed to disclose to the consumer the percentage increases at ages 66, 67, 68, 79, 80, and 81 and

therefore failed to be substantially similar to Form F. John Hancock responded by stating that there had been an error due to an oversight during the drafting of the form, but that the complete grid is provided to the customer at issue of the policy. John Hancock's response was acknowledged; however, the regulation states that the information needs to be provided to the applicant at the time of application or enrollment.

OUTLINE OF COVERAGE

Section 38.2-5207 of the Code sets forth the requirements for fair disclosure in the sale of long-term care insurance policies. It requires that an outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. 14 VAC 5-200-200 interprets and makes specific the provisions of § 38.2-5207 of the Code of Virginia in prescribing a standard format and content of an outline of coverage.

The review revealed that John Hancock was in substantial compliance.

SHOPPER'S GUIDE

14 VAC 5-200-201 requires that a long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commission, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

The review revealed that John Hancock was in substantial compliance.

PARTNERSHIP PROGRAM AND DISCLOSURE NOTICES

14 VAC 5-200-205 C 1 states that an insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Form 200-A), outlining the

requirements and benefits of a partnership policy. The Partnership Program Notice shall be provided with the required Outline of Coverage. 14 VAC 5-200-205 C 2 states that a partnership policy issued or issued for delivery in the Commonwealth of Virginia shall include a Partnership Disclosure Notice (Form 200-B) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified state long-term care insurance partnership policy.

The review revealed that John Hancock was in substantial compliance with each of these sections.

POLICY SUMMARY

Section 38.2-5207.1 of the Code sets forth that whenever an individual life insurance policy which provides long-term care benefits within the policy or by rider is delivered, it shall be accompanied by a policy summary. The summary shall provide an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits; an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person; and any exclusions, reductions, and limitations on benefits of long-term care. If applicable to the policy type, the summary shall also include (i) a disclosure of the effects of exercising other rights under the policy, (ii) a disclosure of guarantees related to long-term care costs of insurance charges, and (iii) current and projected maximum lifetime benefits.

The review revealed that John Hancock was in substantial compliance.

ACCELERATED BENEFITS PROVISIONS

A review was conducted to determine if John Hancock was in compliance with 14 VAC 5-70-10 et seq., Rules Governing Accelerated Benefits Provisions.

ACCELERATED BENEFITS DISCLOSURE

14 VAC 5-70-80 requires that a written disclosure, including a brief description of the provisions of an Accelerated Benefit Rider, be given to each applicant and an acknowledgment of the disclosure shall be signed by the applicant and agent.

The review revealed that John Hancock was in substantial compliance.

INSURANCE REPLACEMENT

A review was conducted to determine if John Hancock was in compliance with the requirements of 14 VAC 5-30-10 et seq., Rules Governing Life Insurance and Annuity Replacements, and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

A sample of 31 individual life insurance replacements and the total population of 3 individual long-term care insurance replacements, in addition to the new business files where existing insurance was indicated, were reviewed for compliance.

The review revealed that John Hancock was in substantial compliance with these sections.

SUITABILITY

A review was conducted to determine if John Hancock was in compliance with the requirements of 14 VAC 5-200-175 of Rules Governing Long-Term Care Insurance.

LONG-TERM CARE INSURANCE

14 VAC 5-200-175 C 1 states that, to determine whether the applicant meets the suitability standards developed by the issuer, the issuer shall develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

The review revealed that John Hancock had developed suitability standards and trained its agents in the use of such standards during the examination time frame.

14 VAC 5-200-175 C 2 states that the issuer shall make reasonable efforts to obtain the information set out in subdivision 1 of this subsection. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." A copy of the issuer's personal worksheet shall be filed with the Commission for approval as required for a policy pursuant to § 38.2-316 of the Code.

The review revealed that John Hancock was in substantial compliance.

14 VAC 5-200-175 F states that at the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” shall be provided.

The review revealed that John Hancock was in substantial compliance.

ADMINISTRATIVE LETTER 2014-05

The purpose of this Administrative Letter was to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the

policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association,* was approved effective November 1, 2010. Beginning January 1, 2015, insurers were required to attach a revised notice to include the new address of the Virginia Life, Accident and Sickness Insurance Guaranty Association, and the new Bureau of Insurance web address.

The review revealed that John Hancock was in substantial compliance.

VIII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST

The examiners reviewed John Hancock's procedures and practices for processing premium notices, reinstatements, and policy loans.

PREMIUM NOTICES

LIFE INSURANCE

John Hancock's procedures state that for universal life and variable universal life products, a Premium Notice is mailed 10 to 28 days prior to the due date.

The review of cancellations, discussed in a subsequent section of the Report, revealed 2 instances of non-compliance with John Hancock's established procedures. An example is discussed in CN01-BB, where the sample file failed to include documentation that the Premium Notice was sent. John Hancock disagreed but failed to provide documentation of the notice or the date that it was mailed.

LONG-TERM CARE INSURANCE

John Hancock's procedures state that for long-term care billing, the Company sends out regular premium requests (bills) 30 days prior to due date. If no payment is received after 10 days, a Premium Reminder Notice is sent; if no payment is received after 30 days from due date, a Lapse Pending Notice is sent; and if payment is not received after 65 days from the due date, a Lapse/Termination Notice is sent.

While John Hancock was able to provide sample/template copies of its notices and document the mailing dates to indicate substantial compliance with its established procedures, the Company failed to maintain copies of the actual Lapse Pending Notices

sent in each sample file. This is discussed in more detail in the Cancellations/Nonrenewals section of the Report.

REINSTATEMENTS

LIFE INSURANCE

John Hancock's life reinstatement procedures require the policyholder to submit a series of forms, including a reinstatement application and a health questionnaire. Underwriting then determines whether the policy is suitable for reinstatement.

The examiners reviewed a sample of 18 from a population of 42 individual life reinstatement requests received during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

LONG-TERM CARE INSURANCE

John Hancock's long-term care reinstatement procedures require a policyholder to submit a reinstatement application within 5 months of the lapse. Reinstatement requests are subject to approval from the underwriting department. John Hancock may also reinstate a policy if the policy was deemed to have lapsed in error.

The examiners reviewed a sample of 20 from a population of 45 individual long-term care reinstatement requests received during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

POLICY LOANS AND LOAN INTEREST

The examiners reviewed a sample of 100 individual policy loan transactions from a total population of 2,350 life insurance policies with loan activity during the examination time frame.

The review revealed that policy loans and loan interest were calculated in accordance with established procedures and the policy provisions.

IX. CANCELLATIONS/NONRENEWALS

The examination included a review of John Hancock's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; the requirements of § 38.2-3303 of the Code covering the grace period; and the requirements of 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance

LIFE INSURANCE

Cash Surrenders

John Hancock's procedures state that in order to initiate a policy surrender, the policyholder must complete and submit a surrender request form. A written request from the policyholder is also accepted, if the policyholder has no taxable gain. Surrenders for term life, whole life, or universal life policies are processed within 15 calendar days.

The examiners reviewed a sample of 40 from a population of 686 individual cash surrenders processed during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

Reduced Paid-Up and Extended Term Insurance

The examiners reviewed a sample of 2 individual lapses to reduced paid-up from a population of 10 and 8 individual lapses to extended term from a population of 51 processed during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

Cancellations

The examiners reviewed a sample of 50 from a population of 208 individual life policies cancelled during the examination time frame.

John Hancock's procedures state that for universal life and variable universal life products, a Lapse Warning Notice is mailed when there is insufficient cash value to cover the cost of insurance and a Lapse Warning Reminder is mailed if a payment has not been made during the first 31 days of lapse pending/warning status.

The review revealed 2 instances of non-compliance with each of these established procedures. An example is discussed in Review Sheet CN01-BB, where the sample file failed to include documentation that the Lapse Warning Notice and Lapse Warning Reminder were sent. John Hancock disagreed and provided documentation of the last payment made on the policy, the policy's lapse pending status, and compliance with the grace period. The examiners responded that the Company failed to provide documentation of the Lapse Warning Notice and Lapse Warning Reminder.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy.

The review revealed 2 violations of this section. An example is discussed in Review Sheet CN01-BB, where John Hancock sent a Final Lapse Notice to the policyholder stating that "As of August 3, 2016 your policy has been terminated without value because the required monthly charge due on August 1, 2016 exceeded the policy value and the required minimum premium was not received within the time specified in

the ‘Grace Period’ provision of the policy,” indicating that the Company had only allowed a grace period from August 1, 2016 to August 3, 2016. John Hancock disagreed and stated that “The insured was provided 61 days grace period to make a payment and change the policy status to Inforce.” John Hancock also provided documentation outlining payments and payment dates reflecting that the policy had actually fallen into lapse pending status on June 1, 2016. The examiners maintain that the lapse notice incorrectly indicated that the required monthly charge was due on August 1, 2016, when the policy actually fell into lapse pending status in June of 2016. While John Hancock allowed the required grace period in the termination of the policy, the Final Lapse Notice sent to the policyholder lists an incorrect premium due date and therefore provides inaccurate information regarding the grace period, resulting in John Hancock issuing a statement that misrepresents the terms of the policy.

LONG-TERM CARE INSURANCE

The examiners reviewed a sample of 50 from a population of 858 individual long-term care policies cancelled during the examination time frame.

John Hancock’s established procedures state that a policy may be cancelled upon notification of the death of the insured or when a lapse in premium occurs. The review revealed that John Hancock was in substantial compliance with its established procedures.

14 VAC 5-200-65 A 3 states that no individual long-term care policy or certificate shall 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 any additional person designated by the applicant, at the address provided by the

insured for purposes of receiving notice of lapse or termination. Notification shall also be provided to the agent of record, if any, within 72 hours after the notice has been mailed to the insured and any additional person, and the insurer shall retain any and all evidence of mailing the notice, including the list of recipients, as applicable, and a copy of the notice, for at least three years following the date of notice. The review revealed 18 violations of this section. As discussed in review sheet CN04-JM, John Hancock failed to maintain copies of the required lapse notices. John Hancock agreed with the examiners' observations and indicated that it had begun technical work in 2018 to ensure that copies of the required lapse notices are maintained.

X. COMPLAINTS

John Hancock's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 20 from a total population of 34 written complaints received during the examination time frame was reviewed. The review revealed that John Hancock was in substantial compliance with this section.

XI. CLAIM PRACTICES

The examination included a review of John Hancock's claim practices for compliance with §§ 38.2-510, 38.2-3115, and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of individual life and individual and group long-term care claims.

PAID CLAIM REVIEW

Life Insurance

A sample of 50 was selected from a total population of 795 life claims paid during the examination time frame. The review revealed that claims were processed in accordance with the contract provisions with the exception of 1 claim, which is discussed later in this section.

Long-Term Care Insurance

A sample of 481 was selected from a total population of 18,831 long-term care claims paid during the examination time frame.

Section 38.2-514 B of the Code sets forth the requirement that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 180 violations of this section. An example is discussed

in Review Sheet CL15-JB, where the EOB failed to specify which benefit category in the policy the claim was being paid under. John Hancock disagreed and stated:

> …In accordance with Section 38.2-3407.4 B & Section 38.2-514 B of the Virginia Code, the EOB does clearly and accurately disclose the benefit payable under the contract, the method of benefit calculation and actual amount which has been paid. The EOBs for all payment samples in ***BOI Item #32*** clearly provides [*sic*] the service type, date of service, total charge, amount not covered under the policy, the total payment amount as well as a 'Code' column which eliminates the potential for consumer confusion. The purpose of this last column is to provide the claimant with the reason why a charge amount is not covered, for example *Code A - "Exceeds Maximum Daily Benefit"*. Based on this information, a claimant can clearly identify what policy benefit is paid, how much of the benefit is being reimbursed and what amount is not reimbursed. As such, again, both the method of the benefit calculation and the benefits payable under the contract are clearly and accurately disclosed pursuant to Section 38.2-3407.4 B & Section 38.2-514 B of the Virginia Code.

The examiners maintain that the policy schedule page shows a Nursing Home daily benefit rate that differs from the Assisted Care Living Facility daily benefit rate and that the claimant would be unable to determine which of these daily benefit rates applies when the only description of service type provided on the EOB is "Room & Board."

Section 38.2-3407.4 B of the Code sets forth the requirement that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of this section. As discussed in Review Sheet CL46-HW, in the payment of 4 invoices involving similar services for the same facility stay, 2 of the EOBs showed the services being paid under the Nursing Home benefit, and 2 of the EOBs showed the services being paid under the Alternate Care Facility benefit.

The review revelated 5 instances of non-compliance with the policy. An example is discussed in Review sheet CL02-JB, where the claim was paid at a higher daily benefit

maximum than had accrued with the 5% simple interest annual increases specified in the inflation rider.

Interest – Life Insurance

Section 38.2-3115 B of the Code sets forth the requirement that interest upon the principal sum shall be computed daily at an annual rate of 2.5% or at the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater. The review revealed 1 violation of this section where interest was underpaid, as discussed in Review Sheet CL47-JB.

The review also revealed 1 instance of non-compliance with the policy where interest was underpaid. As discussed in Review Sheet CL50-JB, John Hancock failed to pay interest on claim proceeds at an annual rate of 3.5%, as specified in the policy.

Interest – Long-Term Care Insurance

Section 38.2-3407.1 B of the Code sets forth the requirement that if no action is brought, interest upon the claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment. The review revealed 6 violations of this section. An example is discussed in Review Sheet CL11-JB, where interest was underpaid.

DENIED CLAIM REVIEW

Long-Term Care Insurance

A sample of 164 was selected from a total population of 1,243 long-term care claims denied during the examination time frame, including invoices submitted for payment and eligibility denials.

Section 38.2-514 B of the Code sets forth the requirement that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 32 violations of this section. An example is discussed in Review Sheet CL62-HW, where services billed on the invoice that were excluded under the terms of the policy were omitted from the EOB. John Hancock disagreed and stated:

> …In accordance with Section 38.2-514 B of the Virginia Code, the EOB does clearly and accurately disclose the benefit payable under the contract, the method of benefit calculation and actual amount which has been paid. The EOBs for all payment samples in ***BOI Item #28*** clearly provides [*sic*] the service type, date of service, total charge, amount not covered under the policy, the total payment amount as well as a 'Code' column which eliminates the potential for consumer confusion. The purpose of this last column is to provide the claimant with the reason why a charge amount is not covered, for example *Code A - "Exceeds Maximum Daily Benefit"*. Based on this information, a claimant can clearly identify what policy benefit is paid, how much of the benefit is being reimbursed and what amount is not reimbursed. As such, again, both the method of the benefit calculation and the benefits payable under the contract are clearly and accurately disclosed pursuant to Section 38.2-514 B of the Virginia Code.

The examiners responded that when the non-covered services are omitted from the EOB altogether, the method of benefit calculation is unclear to the claimant due to the fact that the total charges displayed on the EOB will be inconsistent with the total charges actually billed on the invoice.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

Life Insurance

The sample of 50 paid claims was reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The

review was conducted using the date the check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time. The review revealed 7 instances of non-compliance with this section. 14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer. The review revealed 13 instances of non-compliance with this section. An example of each is discussed in Review Sheet CL101-HW. Notification and proof of loss for the claim were received on April 15, 2016, and no other correspondence was sent to the claimant until the check was mailed on May 31, 2016, 31 working days later. John Hancock disagreed with the examiners' observations, stating:

> …In reference to 14 VAC 5-400-50 A and 14 VAC 5-400-60 A of the Code of Virginia, John Hancock's business practice is to pay all death claims within 10 business days and the Company strives to meet that 10 day payment schedule. However, during the time period of December 2015 to May 2016 the Company was in the process of system updates which caused a temporary disruption of our payment process. This is the case for BOI#1, where the letter of notification nor the claim payment was sent to the claimant in a timely manner. After the system disruption John Hancock had a high percentage rate of meeting the 10 claim payment process thus in most cases there is no need for a notification letter.

The examiners responded that a disruption caused by system updates does not exempt the Company from the requirements to acknowledge the receipt of the claim within 10 working days and affirm a claim within 15 working days.

John Hancock's failure to comply with 14 VAC 5-400-50 A and 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice, placing John Hancock in violation of these sections.

Long-Term Care Insurance

The sample of 645 paid and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The review was conducted using the date the check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer. The review revealed 15 instances of non-compliance with this section. An example is discussed in Review Sheet CL01-HW. Proof of loss for the claim was received on October 25, 2016, and the EOB was not mailed until December 1, 2016, 26 working days later. John Hancock disagreed with the examiners' observations, stating:

> …Section 14 VAC 5-400-50 & Section 14 VAC 5-400-60: This section refers to an initiation of an insured's claim to determine eligibility for the payments of benefits. Otherwise, this regulation would not refer to an acknowledgement unless a payment is made. It is for this reason the regulation is not applicable to invoice payment processing.

The examiners maintain the position that 14 VAC 5-400 60 A applies to the invoice/payment processing portion of a claim and that John Hancock failed to affirm the claim within 15 working days.

14 VAC 5-400-70 D states that in any case where there is no dispute as to coverage or liability, every insurer must offer to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim, provided the amount so offered is within policy limits and

in accordance with policy provisions. The review revealed 4 instances of non-compliance with this section. As discussed in Review Sheet CL46-HW, John Hancock failed to provide reimbursement for the monthly monitoring charge that was within the available plan maximums and was not included in the Limitations and Exclusions section of the policy.

THREATENED LITIGATION

John Hancock informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

DISCLOSURES FOR RETAINED ASSET ACCOUNTS

Section 38.2-3117.4 of the Code sets forth the requirements for the insurer to provide written disclosures to the beneficiary of a policy before the retained asset account is selected, if optional, or established, if not optional. The examiners reviewed the flyer, which included a supplemental contract, used by John Hancock to provide these disclosures to beneficiaries in connection with its life claims.

Subsection 4 of § 38.2-3117.4 of the Code states that the insurer shall provide a written disclosure including a statement identifying the account as either a checking account or a draft account and an explanation of how the account works. The review revealed 1 violation of the section. As discussed in Review Sheet CL43-JB, John Hancock's flyer described the account as both "an interest-bearing account accessible via drafts" and "an interest bearing checking account" and therefore failed to identify the account specifically as either a checking account or a draft account. John Hancock disagreed with the examiners' observations and stated:

> On the claim form and the Supplemental Contract John Hancock discloses that the Safe Access Account is not a checking account and only makes

> reference to checking accounts to make it easier for the customer to better understand the SAA option, as required by the code. Therefore, we do not feel we are in violation of subsection 4 of § 38.2-3117.4 of the Virginia code.

The examiners maintained their findings. While the flyer includes one sentence stating that the account "…is an interest-bearing account accessible via drafts" and includes language stating that "We sometimes refer to our Safe Access Account drafts as 'checks'…," the document repeatedly references checks and also identifies the account in another section as "an interest-bearing checking account." As these conflicting references are potentially misleading to the beneficiary, John Hancock has failed to identify the account as either a checking account or a draft account, in violation of subsection 4 of § 38.2-3117.4 of the Code of Virginia.

Subsection 8 of § 38.2-3117.4 of the Code states that the insurer shall provide a written disclosure of the minimum interest rate to be credited to the account and how the actual interest rate will be determined. The review revealed 1 violation of this section. As discussed in Review Sheet CL43-JB, while John Hancock's flyer included the language "Current interest rate 1.25%," the flyer failed to disclose whether or not this was the minimum interest rate and how the rate was determined. John Hancock disagreed with the examiners' observations and stated:

> Regarding subsection 8 of § 38.2-3117.4, In the Terms and Conditions of the Supplemental Contract John Hancock discloses that the rate is "determined by John Hancock". The 1.25% current rate is a flat rate and not subject to market conditions. Therefore, John Hancock does not feel it is in violation of subsection 8 of § 38.2-3117.4 of the Virginia code.

The examiners responded that descriptions in the flyer such as "current interest rate," "variable interest," "reflects economic factors and trends," and "rate is subject to change" appear to contradict the Company's response that it is a flat interest rate and not subject

to market conditions. John Hancock has failed to disclose the minimum interest rate to be credited to the account and how the actual interest rate will be determined.

XII. CORRECTIVE ACTION PLAN

Based on the findings in this Report, John Hancock shall:

1. Review and strengthen its procedures to ensure that life advertisements comply with 14 VAC 5-41-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
2. Revise its life advertisements, including the removal or revision of any broad and sweeping statements without parameters regarding the benefits of the products being advertised, so as to ensure that the advertisements are truthful and not misleading in fact or by implication, as required by 14 VAC 5-41-30 B;
3. Revise its life advertisements to ensure that if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, these terms shall be accompanied by a further disclosure of equal prominence and juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application, as required by 14 VAC 5-41-40 B;
4. Revise its life advertisements to ensure that the phrases "affordable," "low premiums," or any other terms similar to "inexpensive" or "low cost" are not used unless that fact is capable of being demonstrated to the satisfaction of the Commission, as required by 14 VAC 5-41-80 B;
5. Revise its life advertisements to ensure that terms similar to "financial planner," "investment advisor," "financial consultant," and "financial counseling," including the terms "financial representative" and "financial advisor," are not used in a way that implies that the person who is engaged in the business of insurance, is

generally engaged in an advisory business in which compensated is unrelated to sales unless that is actually a fact, as required by 14 VAC 5-41-90 J;

6. Review and strengthen its procedures to ensure that a copy of any long-term care advertisement intended for use in this Commonwealth is provided to the Commission for review and approval, as required by 14 VAC 5-200-160 A;

7. Review and strengthen its procedures to ensure all life policy, rider/endorsement, and application forms are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code;

8. Immediately review all life policy forms currently in force and currently being marketed in Virginia and identify any policy forms, including those referenced during the course of this examination, that were not previously filed with the Commission as required by §§ 38.2 316 A, 38.2-316 B, and 38.2-316 C 1 of the Code. Prior to taking any action, submit a remediation plan to the Forms section of the Life and Health Market Regulation division. It is requested that the Company clearly indicate in the letter(s) of transmittal that the submission is a result of John Hancock's efforts to comply with this examination's corrective action plan;

9. Identify and file for approval all long-term care EOB forms currently in use that have not yet been filed with the Commission, as required by §38.2-3407.4 A of the Code;

10. Establish and maintain procedures to ensure that its EOB forms are filed with and approved by the Commission, as required by §38.2-3407.4 A of the Code;

11. Review and strengthen its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;

12. Review and strengthen its procedures for notifying agents and agencies within 5 calendar days and the Commission within 30 calendar days of appointment termination, as required by § 38.2-1834 D of the Code;

13. Review and strengthen its procedures to ensure all agents receive the required initial training and ongoing training every 24 months thereafter before being permitted to sell, solicit or negotiate a long-term care partnership policy, as required by 14 VAC 5-200-205 E and 14 VAC 5-200-205 F;

14. Review and strengthen its procedures for the application and issuance of the accelerated benefit rider to prevent individuals of the same class and equal expectation of life from being unfairly discriminated against in the terms and conditions of the contract, as required by subsection 1 of § 38.2-508 of the Code;

15. Review and strengthen its procedures to ensure that NIP forms given to applicants and policyholders comply with all requirements set forth in § 38.2-604 of the Code;

16. Review and strengthen its procedures to ensure that the AUD notice required by §§ 38.2-610 A 1 and 38.2-610 A 2 of the Code is provided in accordance with the guidelines established by Administrative Letter 2015-07 in the case of declined/closed life and long-term care applications and in the case of offers to insure at higher rates or with limitations, exceptions or benefits other than those applied for;

17. Review and strengthen its procedures to ensure that an explanation of potential long-term care future premium rate revisions is provided to the applicant at the time of application and that Form F is used, as required by 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C;

18. Implement and maintain appropriate controls to ensure that Premium Notices, Lapse Warning Notices, and Lapse Warning Reminders for universal life and variable universal life products are sent in accordance with its established procedures and that documentation of sending the notices is maintained;

19. Revise its Final Lapse Notice for universal life and variable universal life products to provide clear and accurate information about the terms and conditions of the policy and the grace period, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

20. Establish and maintain procedures to ensure that it retains any and all evidence of mailing the lapse notice required by 14 VAC 5-200-65 A 3, including the list of recipients, as applicable, and a copy of the notice, for at least 3 years following the date of the notice;

21. Revise its long-term care EOBs to clearly identify which benefit category in the policy claims are being made under in order to clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid, as required by § 38.2-514 B of the Code;

22. Revise its long-term care EOBs to include all service charges listed on the submitted invoices in order to clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid, as required by § 38.2-514 B of the Code;

23. Review and strengthen its procedures to ensure that long-term care claims are processed under the correct benefit category in the policy and that this information is displayed correctly on the EOB, in order to ensure that the benefits payable

under the contract are clearly and accurately set forth, as required by § 38.2-3407.4 B of the Code;

24. Review and strengthen its procedures to ensure that long-term care claim benefits are paid in accordance with policy provisions;

25. Review and reconsider for re-adjudication the life claims discussed in Review Sheets CL47-JB and CL50-JB, and make interest payments, as required by § 38.2-3115 B of the Code and the terms of the policy. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

26. Review and strengthen its procedures for the payment of interest on life claim proceeds, as required by § 38.2-3115 B of the Code and the terms of the policy;

27. Review and consider for re-adjudication the long-term care claims discussed in Review Sheets CL09-JB, CL11-JB, CL02-HW, CL38-HW, and CL40-HW, and make interest payments, as required by § 38.2-3407.1 B of the Code. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

28. Review and strengthen its procedures for the payment of interest on long-term care claim proceeds, as required by § 38.2-3407.1 B of the Code;

29. Review and strengthen its procedures to ensure that life claims are processed in accordance with the requirements of 14 VAC 5-400-50 A and 14 VAC 5-400-60 A;

30. Review and strengthen its procedures to ensure that long-term care claims are processed in accordance with the requirements of 14 VAC 5-400-100 B and 14 VAC 5-400-70 D;

31. Revise its retained asset account disclosure to clearly provide a written statement identifying the account as either a checking account or draft account, as required by subsection 4 of § 38.2-3117.4 of the Code;

32. Revise its retained asset account disclosure to provide a written explanation of the minimum interest rate to be credited to the account and how the actual interest rate will be determined, as required by subsection 8 of § 38.2-3117.4 of the Code; and

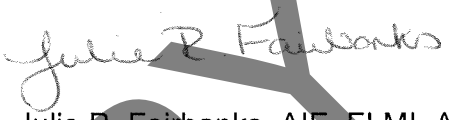
33. Within 90 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XIII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by John Hancock's officers and employees during the course of this examination is gratefully acknowledged.

Brant Lyons, MCM, Julie Atkins, MCM, Bernard Brown, Janay Brown, MCM, Jarod Mentzer, MCM, Heather Webb, MCM, and Laura Wilson, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,



Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XIV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

ADVERTISING
14 VAC 5-41-30 B, 10 violations, AD02-JA, AD05-JA, AD06-JA, AD11-JA, AD02-LW, AD03-LW, AD04-LW, AD05-LW, AD06-LW, AD08-LW
14 VAC 5-41-40 B, 2 violations, AD01-LW, AD05-LW
14 VAC 5-41-80 B, 2 violations, AD04-JA, AD11-JA
14 VAC 5-41-90 J, 5 violations, AD12-JA, AD13-JA, AD14-JA, AD04-LW, AD05-LW
14 VAC 5-200-160 A, 3 violations, AD05-JA, AD16-JA (2)
POLICY AND OTHER FORMS
§ 38.2-316 A, 4 violations, PF01-BB, PF03-JA, PF04-JA (2)
§ 38.2-316 B, 10 violations, PF03-JA (5), PF05-JA (3), PF06-JA (2)
§ 38.2-316 C 1, 14 violations, PF01-BB, PF03-JA (6), PF04-JA (2), PF05-JA (3), PF06-JA (2)
§ 38.2-3407.4 A, 4 violations, PF01-BL
AGENTS
§ 38.2-1812 A, 1 violation, AG01-JA
§ 38.2-1833 A 1, 2 violations, AG01-JA, AG02-JA
§ 38.2-1834 D, 3 violations, AG01-HW, AG02-HW, AG03-HW
14 VAC 5-200-205 E, 1 violation, AG05-JA
14 VAC 5-200-205 F, 1 violation, AG05-JA

UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT/INSURANCE REPLACEMENT AND SUITABILITY
Subsection 1 of § 38.2-508, 3 violations, UN12-JA
§ 38.2-604 B 4, 6 violations, UN01-JA, UN02-JA (2), UN10-JA (2), UN11-JA
§ 38.2-610 A 1, 26 violations, UN06-JA (4), UN09-JA (2), UN13-JA (5), UN16-JA, UN17-JA (14)
§ 38.2-610 A 2, 42 violations, UN06-JA (4), UN07-JA (6), UN08-JA (6), UN09-JA (6), UN13-JA (5), UN16-JA, UN17-JA (14)
§ 38.2-610 B 3, 4 violations, UN05-JA
14 VAC 5-200-75 A 2, 1 violation, UN19-JA
14 VAC 5-200-75 C, 1 violation, UN19-JA
CANCELLATIONS/NONRENEWALS/RESCISSIONS/CONVERSIONS
14 VAC 5-200-65 A 3, 18 violations, CN04-JM
Subsection 1 of § 38.2-502, 2 violations, CN01-BB
LIFE CLAIMS PRACTICES
§ 38.2-3115 B, 1 violation, CL47-JB
14 VAC 5-400-50 A, 7 violations, CL45-JB, CL54-JB, CL101-HW, CL105-HW, CL111-HW, CL112-HW, CL113-HW
14 VAC 5-400-60 A, 13 violations, CL44-JB, CL45-JB, CL46-JB, CL51-JB, CL54-JB, CL101-HW, CL102-HW, CL104-HW, CL105-HW, CL108-HW, CL109-HW, CL111-HW, CL112-HW
Subsection 4 of § 38.2-3117.4, 1 violation, CL43-JB

Subsection 8 of § 38.2-3117.4, 1 violation, CL43-JB
LONG-TERM CARE CLAIMS PRACTICES
§ 38.2-514 B, 212 violations, CL01-JB, CL02-JB (3), CL04-JB (3), CL05-JB (3), CL06-JB, CL10-JB (4), CL12-JB (3), CL13-JB (5), CL15-JB (4), CL18-JB (4), CL19-JB (5), CL25-JB (5), CL32-JB (3), CL33-JB (2), CL08-HW (4), CL09-HW (3), CL11-HW (3), CL14-HW (2), CL17-HW, CL18-HW (4), CL20-HW (4), CL22-HW (4), CL24-HW, CL25-HW (5), CL26-HW (3), CL30-HW (4), CL32-HW (3), CL33-HW (3), CL35-HW (3), CL36-HW (5), CL37-HW (5), CL40-HW, CL41-HW (4), CL42-HW (3), CL43-HW (3), CL44-HW (3), CL45-HW (4), CL46-HW, CL52-HW, CL53-HW (5), CL54-HW, CL55-HW (5), CL56-HW (6), CL57-HW (4), CL61-HW (2), CL62-HW, CL63-HW, CL64-HW, CL65-HW, CL67-HW (5), CL68-HW, CL69-HW, CL70-HW (3), CL71-HW (2), CL72-HW (2), CL75-HW, CL77-HW (3), CL78-HW, CL79-HW (3), CL80-HW (7), CL81-HW (7), CL82-HW (3), CL83-HW, CL84-HW (6), CL85-HW, CL86-HW (6), CL87-HW (2), CL95-HW, CL96-HW (3), CL98-HW (2), CL100-HW
§ 38.2-3407.1 B, 6 violations, CL09-JB (2), CL11-JB, CL02-HW, CL38-HW, CL40-HW
§ 38.2-3407.4 B, 1 violation, CL46-HW
14 VAC 5-400-60 A, 15 instances of non-compliance, CL09-JB (2), CL11-JB, CL01-HW, CL02-HW, CL33-HW, CL38-HW, CL40-HW, CL49-HW, CL60-HW, CL61-HW, CL66-HW, CL71-HW, CL74-HW, CL97-HW
14 VAC 5-400-70 D, 4 instances of non-compliance, CL46-HW

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

October 8, 2019

Sent Via E-Mail

Michele Jordan
Senior Compliance Consultant
John Hancock Life Insurance Company
197 Clarendon Street
Boston, MA 02116

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Jordan:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of John Hancock Life Insurance Company (U.S.A.) for the period of January 1, 2016 through December 31, 2016. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of John Hancock Life Insurance Company (U.S.A.), I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. John Hancock Life Insurance Company (U.S.A.) response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks

Julie Fairbanks, FLMI, AIE, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Julie Blauvelt

John Hancock Financial Services

Litigation, Alternative Dispute Resolution and Bankruptcy

U. S. Law Division

197 Clarendon Street – C-05-31
Boston, Massachusetts 02116
(617) 572-9184
Fax: (617) 572-5659
E-mail: wgottlieb@jhancock.com

William A. Gottlieb
Assistant Vice President & Associate General Counsel

December 5, 2019

VIA ELECTRONIC MAIL & FEDERAL EXPRESS

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
Manager
Commonwealth of Virginia
Bureau of Insurance
Market Conduct Section
Life and Health Division
P.O. Box 1157
1300 E. Main Street
Richmond, Virginia 23219

Re: Target Market Conduct Examination

Dear Ms. Fairbanks:

Pursuant to § 38.2-1320.1 of the Code of Virginia, John Hancock Life Insurance Company, (U.S.A.) (hereinafter alternatively referred to as "John Hancock" or the "Company"), hereby submits this response to the draft "Report on Target Market Conduct Examination of John Hancock Life Insurance Company (U.S.A.) as of December 31, 2016" ("Report"), prepared by the Bureau of Insurance ("Bureau"). On behalf of the Company, I have attempted to address the portions of the Report that contain what I believe to be factual inaccuracies, and allegations and/or commentary to which exception is taken. For ease of reference, all suggested modifications to the Report have been marked in "redline" form and the Company's supporting commentary has been set off against a light gray background. In this regard, the Company utilized the draft of the Report that it received electronically from the Bureau.

Alleged violations or references in the Report which have not been specifically addressed in this response are not necessarily accepted nor adopted as accurate. Further, John Hancock reserves the right to supplement its response in the future as may be necessary. John Hancock specifically reserves all rights afforded to it by Virginia law. As noted, I have also forwarded this document to you electronically to facilitate whatever editing the Bureau might

wish to undertake. Obviously, depending on the changes that are made, the page numbers in the Table of Contents and throughout the Report will have to be adjusted accordingly. Similarly, based on the changes the Bureau elects to make, the "Area Violations Summary by Review Sheet" section may also have to be revised to reflect the specific violations alleged and the number of violations asserted.

Respectfully, the Company is troubled that the Bureau appears to have uniformly dismissed the Company's detailed and reasoned written opposition to certain violations of Virginia law alleged during the course of the Examination and has nevertheless elected to include them in the Report. It appears that to date, the Bureau has unnecessarily included nearly every possible alleged violation of law. The Company believes this is inconsistent with the principles and standards set forth in the NAIC's Market Regulation Handbook. John Hancock is hopeful that appropriate legal and other senior personnel at the Bureau will now give due consideration to the Company's responsive comments and modify the Report accordingly. The Company looks forward to the opportunity to discuss these issues with the Bureau and to resolve this matter in an expeditious and amicable manner.

Thank you for your attention to this matter.

Very truly yours,

William A. Gottlieb

WAG/ash
Attachments

cc: Michele Jordan

REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

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

AS OF DECEMBER 31, 2016

Conducted from September 13, 2017

through

July 25, 2019

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 01-0233346
NAIC: 65838

TABLE OF CONTENTS

Section		Page
I.	SCOPE OF EXAMINATION	12
II.	EXECUTIVE SUMMARY	32
III.	COMPANY HISTORY	62
IV.	ADVERTISING	82
	LIFE INSURANCE ADVERTISING	92
V.	POLICY AND OTHER FORMS	232
	POLICIES	232
	APPLICATIONS/ENDORSEMENTS	252
	ACCIDENT AND SICKNESS RATE FILING	262
	EXPLANATION OF BENEFITS (EOB)	262
VI.	AGENTS	292
	LICENSED AGENT REVIEW	292
	APPOINTED AGENT REVIEW	292
	COMMISSIONS	302
	TERMINATED AGENT APPOINTMENT REVIEW	312
	LONG-TERM CARE PARTNERSHIP AGENT TRAINING REVIEW	322
VII.	UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT	342
	UNDERWRITING REVIEW	342
	UNDERWRITING PRACTICES – AIDS	372
	MECHANICAL RATING REVIEW	372
	NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)	382
	NOTICE OF FINANCIAL INFORMATION PRACTICES	382
	DISCLOSURE AUTHORIZATION FORMS	392
	ADVERSE UNDERWRITING DECISIONS (AUD)	392
	DISCLOSURE OF RATING PRACTICES	432

OUTLINE OF COVERAGE 442
SHOPPER'S GUIDE 452
PARTNERSHIP PROGRAM AND DISCLOSURE NOTICES 452
POLICY SUMMARY 462
LONG-TERM CARE INSURANCE 482

VIII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST 502

PREMIUM NOTICES 502
REINSTATEMENTS 512
POLICY LOANS AND LOAN INTEREST 522

IX. CANCELLATIONS/NONRENEWALS 532

LIFE INSURANCE 532
LONG-TERM CARE INSURANCE 562

X. COMPLAINTS 582

XI. CLAIM PRACTICES 592

GENERAL HANDLING STUDY 592
PAID CLAIM REVIEW 592
LIFE INSURANCE 592
LONG-TERM CARE INSURANCE 592
INTEREST – LONG-TERM CARE INSURANCE 662
DENIED CLAIM REVIEW 672
UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW 702
LONG-TERM CARE INSURANCE 712
THREATENED LITIGATION 752
DISCLOSURES FOR RETAINED ASSET ACCOUNTS 752

XII. CORRECTIVE ACTION PLAN 802

XIII. ACKNOWLEDGMENT 872

XIV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET 882

I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of John Hancock Life Insurance Company (U.S.A.) (hereinafter referred to as "John Hancock" or "the Company") was conducted under the authority of § 38.2-1317 of the Code of Virginia (hereinafter referred to as "the Code"). The examination included a detailed review of John Hancock's individual life and group and individual long-term care insurance coverage for the period beginning January 1, 2016 through December 31, 2016. The examination was conducted at the office of the State Corporation Commission's Bureau of Insurance (hereinafter referred to as the "Bureau") from September 13, 2017 through July 25, 2019.

The purpose of the examination was to determine whether John Hancock was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC" or "regulations").

~~A previous market conduct examination of Time Insurance Company (Time) covering the period of July 1, 2012 through June 30, 2013, where John Hancock was the administrator of long-term care coverage ceded by Time under a 100% reinsurance agreement, was concluded on December 8, 2014. As a result of this examination, John Hancock agreed to revise its practices to comply with Virginia's statutes under Case No. INS-2014-00222.~~

Comment on Time Insurance Company

Please refer to the Company's comment on Section 38.2-3407.4 A and Time Insurance Company in the body of the Report.

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. Failure to identify, comment on, or criticize

specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to John Hancock during the course of the examination.

II. EXECUTIVE SUMMARY

During the course of the examination, the examiners reviewed advertisements, policy forms, agents, underwriting, premium notices, reinstatements, policy loans, cancellations, nonrenewals, rescissions, conversions, complaints, and claim practices, to determine compliance with the Code, the applicable regulations, the terms of John Hancock's insurance contracts, and the Company's policies and procedures.

~~The current examination revealed that John Hancock failed to file for approval its explanation of benefits (EOB) forms, as required by § 38.2-3407.4 A of the Code. As this issue was also present during the prior examination of Time, this violation could be construed as knowing.~~

Comment on Section 38.2–3407.4 A and Time Insurance Company

Please refer to the Company's comment on Section 38.2–3407.4 A and Time Insurance Company in the body of the Report.

There are ~~629~~ violations and instances of non-compliance noted in this Report. ~~The review of advertisements revealed that the Company's life advertisements included broad and sweeping statements without parameters regarding the benefits of the products being advertised. John Hancock also used the terms "financial representative" and "financial advisor" to refer to its agents in life advertisements in a manner considered to be misleading.~~

Comment on the Number of Violations and Life Advertisements

The final number of violations will have to be calculated by the Bureau once the draft Report has been edited and finalized. Also, please refer to the Company's comment on life advertisments in the body of the report.

The policy forms review revealed that, while a few violations resulted from the failure to file life forms for approval, the majority of violations were the result of life forms that received approval initially and were subsequently modified by John Hancock outside of the permitted variability.

The underwriting review revealed that some of the Company's life and long-term care adverse underwriting decision (AUD) notices were not substantially similar to the prototype notice specified in the Bureau's administrative letter; the Company failed to provide AUD notices in the case of certain closed files; and the Company failed to provide AUD notices in the case of certain files where a rider to the base policy was declined or coverage was issued at a lower benefit level or higher rate than applied for.

The cancellations review revealed that John Hancock failed to maintain copies of its lapse notices as required by the long-term care regulation. The Company has, however, taken action subsequent to the examination time frame to begin implementation of a process ensuring these notices are maintained.

There were ~~464~~ violations and instances of non-compliance noted during the Claims review, with ~~441~~ involving long-term care claims and ~~23~~ involving life claims. ~~The long-term care claims review revealed that charges submitted on invoices for services that were excluded/non-covered under the policy were omitted altogether from the EOBs, which resulted in the Company failing to provide a denial in writing to the claimant, as~~

~~required by 14 VAC 5-400-70 A, and the failure of the EOB to clearly and accurately disclose the method of benefit calculation, as required by § 38.2-514 B of the Code. The long-term care claims review also revealed that several EOBs failed to clearly describe which benefit category in the policy claims were being paid under, resulting in additional violations of § 38.2-514 B of the Code.~~ The life claims review revealed instances where John Hancock failed to acknowledge the receipt of notification of claims within 10 working days, as required by 14 VAC 5-400-50 A, and failed to advise claimants of acceptance of claims within 15 working days, as required by 14 VAC 5-400-60 A. The Company attributed several of these instances to a temporary disruption of its payment process caused by system updates.

Comment on Long-Term Care Insurance EOBs

The final number of violations will have to be calculated by the Bureau once the draft Report has been edited and finalized. Also, please refer to the Company's comments on Long-Term Care Insurance EOBs in the body of the Report.

While John Hancock exited the stand alone long-term care market in December of 2016 and is not currently issuing new policies under this line of business, the Company is still responsible for compliance with Virginia's statutes and regulations, as well as applicable contract provisions, in transactions involving in force business. The Company also continues to offer long-term care riders attached to its life policies.

A corrective action plan (CAP) that must be implemented by John Hancock was established to address these issues and others discussed in the Report.

III. COMPANY HISTORY

John Hancock was incorporated on August 20, 1955 in the state of Maine as the Maine Fidelity Life Insurance Company and commenced writing business on January 31, 1956. On December 30, 1982, the Company became a wholly owned subsidiary of The Manufacturers Life Insurance Company ("MLI") when MLI acquired all of the then-issued and outstanding shares of the Company. The Company subsequently changed its name to The Manufacturers Life Insurance Company (U.S.A.) on July 31, 1990 and redomesticated to Michigan as of December 30, 1992.

On January 1, 2002, the Company merged with its immediate parent, Manulife Reinsurance Corporation (U.S.A.), a Michigan insurer, and its wholly owned subsidiary, The Manufacturers Life Insurance Company of North America, a Delaware insurer, with the Company surviving.

Also, on January 1, 2002, by way of assumption reinsurance, the Company assumed all of the insurance business, including all assets and liabilities, of its wholly owned subsidiary, The Manufacturers Life Insurance Company of America, which was subsequently merged with and into the Company on December 5, 2005.

Following the April 28, 2004 merger between Manulife Financial Corporation ("MFC") and John Hancock Financial Services, Inc., the Company changed its name to John Hancock Life Insurance Company (U.S.A.), effective January 1, 2005.

On December 31, 2009, the Company merged with its affiliates, John Hancock Life Insurance Company and John Hancock Variable Life Insurance Company, both Massachusetts insurers, with the Company surviving.

Net admitted assets as of December 31, 2016 totaled $229,892,290,373. As of December 31, 2016, total life insurance premiums in Virginia were $103,158,250, and total long-term care insurance premiums in Virginia were $84,592,302.

IV. ADVERTISING

A review was conducted of John Hancock's advertisements to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-41-10 et seq., Rules Governing Advertisement of Life Insurance and Annuities, 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-41-30 B and 14 VAC 5-90-50)

14 VAC 5-41-150 C and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed that John Hancock was in substantial compliance.

A sample of 50 life and 20 long-term care advertisements was originally selected from a population of 740 life and 41 long-term care advertisements distributed in Virginia during the examination time frame. As 1 life advertisement distributed in Virginia in 2017

was added to the review based on a referral, a total sample of 71 advertisements was reviewed.

~~The review revealed that 15 of the advertisements contained violations. In the aggregate, there were 21 violations, which are discussed in the following paragraphs.~~

LIFE INSURANCE ADVERTISING

14 VAC 5-41-30 B states that an advertisement shall be truthful and not misleading in fact or by implication. The form and content of an advertisement shall be sufficiently accurate, complete, and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. The review revealed that John Hancock was in substantial compliance with this section. ~~The review revealed 10 violations of this section. An example is discussed in Review Sheet AD02-LW, where the advertisement included the statement "Life insurance that protects you and your family no matter what life brings." John Hancock disagreed, stating that:~~

> ~~This statement, and the communication it was contained in, does not violate 14 VAC 5-41-30 B or the 'overall impression' standard noted within. In addition, this language is not an overstatement in the context of the entire presentation, and does not have the capacity to mislead or deceive any reader as to "the extent of the protection provided by the policy."~~
>
> ~~Advertisements must be read in their totality and under 14 VAC 5-41-30 B, when reviewing advertisements, one must look at the entirety of their content to determine balance, completeness, clarity, and whether an average reader would understand the messaging, content, and tone. To do otherwise, and selectively or exclusively focus on the phrasing in a single bullet leads to overbroad conclusions being drawn. In addition, looking to the manner in which a communication may be distributed, as well as the underlying audience for that communication, can help with determining compliance with states' advertising laws.~~
>
> ~~For this item in question, your office was provided a fifty-four (54) page PDF of a supplemental illustration (pages 1-3) and illustration report (pages 4-54). Policy illustrations are only provided to potential customers by licensed agents, appointed with John Hancock, whose licensing status has been~~

verified, for purposes of even providing them access to our illustration reports in the first instance. Invariably, when a personalized illustration is run for a customer, it is at that point in an agent's solicitation process when he / she has already had preceding discussions with the customer about insurance products (and the product the illustration correlates to). Pages 1-3 are a supplemental report that if used, would accompany the underlying new business illustration for the policy (here, our Protection Survivorship Indexed Universal Life policy), which is seen on pages 4-54 of this sample (template). Note that this three (3) page supplemental report can *only* be provided to a potential customer if and when a producer runs a policy illustration to provide to an individual. In no other instance would a producer be able to access this supplemental report. The new business illustration will always be provided to our customer as the basis for any sale, as this is a requirement under state law and with our company policy for reviewing applications and making underwriting determinations (and a decision whether to issue a policy or not).

You are referencing a five (5) word phrase on the first page of the entire illustration report, which states "no matter what life brings," and suggesting that this is an overstatement that is misleading or deceptive as to the entire illustration report and the extensive content within, so that a customer at this point in a solicitation process, would not know "the extent of the protection provided by the policy." First, this bullet statement is qualified by language immediately preceding it, which states "Protection SIUL with Vitality offers:" Second, based on an additional read of the optional report (pages 1-3), and the basic illustration (template pages 4-54), it is certainly not the case that this statement is misleading as to the extent of protection provided by the policy. New business illustrations are subject to state law requirements regarding content, and as is the case with the illustration in this example, the following (among other things) are listed on a personalized report for any customer:

- Death benefit / face amount of the policy
- On the actual illustration (ledger) pages, for any given policy year - a summary of premiums due, policy values, net surrender value, net death benefit, etc.
- A clear statement that '[t]he life insurance provided in this illustration reflects a Total Initial Death Benefit of $1,000,000
- Type / Category / name of product
- features / benefits of the policy (including the Healthy Engagement Rider and Vitality)
- Illustration assumptions, including illustrated rate(s) and charges
- Important Reminders
- Descriptions of how varying things like charges, loans, withdrawals, can impact a policy
- The customer's name, age, state the customer lives in

~~Regarding the first three pages of the supplemental report, they also provide context, balance, and a summary on the extent of protection provided by the illustrated policy. The values on this report are pulled from the basic illustration. The 2nd page lists:~~

- ~~the prospective customer's illustrated coverage amount (being applied for)~~
- ~~guaranteed death benefit durations~~
- ~~underwriting assumptions and potential premium amounts (to pay)~~
- ~~and the applicants' sex and age....~~

~~The examiners responded that the language in question is a broad and sweeping statement with no parameters or qualifiers and that the extent and impact of "no matter what life brings," as well as the extent and impact of the benefits provided by the product being advertised, is dependent upon many factors. The examiners maintain that the advertisement has the capacity to mislead or deceive the reader.~~

Comment on 14 VAC 5-41-30 B

The Company maintains and reiterates that its prior response fully refutes the assertion that 14 VAC 5-41-30 B was violated. Respectfully, the Bureau's position is both unduly rigid and unreasonable. The advertisements at issue have been approved for use throughout the United States. No other state department of insurance has made the objection to them now advanced by the Bureau. There have been no complaints from consumers in Virginia or elsewhere raising the issue being pressed by the Bureau. The Bureau's position is unfair to John Hancock, a company doing business in good faith in Virginia. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue. The Company respectfully requests that appropriate personnel in the Office of the Bureau's General Counsel review the issue.

14 VAC 5-41-40 B states that if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, these terms shall be accompanied by a further disclosure of equal prominence and juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application. The review revealed that John Hancock was in substantial compliance with this section. ~~2 violations of this section. An example is discussed in Review Sheet AD01-LW, where the advertisement stated "No medical exam required." It further stated "No medical exams," "No lengthy forms," and "Just a few simple questions and an answer in 3-5 days." A disclosure on the back of the form advised that "Policy issuance is not guaranteed..." and that "John Hancock will obtain additional information, including but not limited to medical records,..." However, the initial statements include no footnote directing the reader to the disclosure on the next page, and the disclosure is not juxtaposition (side by side/adjacent) to the statements to which it is applicable. John Hancock disagreed with the examiners' observations, stating that:~~

> ~~This letter is compliant with Virginia law as it does not make untrue, deceptive or misleading statements under Section 38.2-502 of the Code of Virginia, and its content and formatting is not misleading, deceptive, or untrue. In addition, it is compliant with the content and prominence standards seen in 14 VAC 5-41-40 B. Regarding 14 VAC 5-41-40 B, the intent of this code section is to ensure that advertisements aren't creating the impression that a guaranteed issue product is being promoted, when in fact, that is not the case.~~
>
> ~~As information on how this letter was generated and used, it was not put into use until December 2016. This letter was a high-level invitation to inquire - sent by a firm to prospective customers. This letter's offer was structured to apply to any John Hancock single life policies available for sale (including our "Vitality" products), which we would then employ a streamlined underwriting process to and review for eligibility to issue (only up to a maximum face amount of $500,000, as noted in the letter). You will see that no specific product type or product category was mentioned in this letter, and in fact we stated that "[w]e offer many life insurance options and will help you find the right product for your needs." As part of this~~

streamlined underwriting process we offered, no medical exam was required of the audience that this letter was sent to. In the letter we purposely stated there were "no medical exams" for those individuals to take - because this was a true statement based on the process we would employ.

Given this fact, not only was the language we used throughout the body of the letter purposeful, it clearly met the intent behind 14 VAC 5-41-40B (preventing against a customer believing they are being offered a "guaranteed issue" product). Specifically, preceding the body of the letter, we clearly state the individual is (merely) *invited to apply* for up to $500,000 in coverage, as opposed to saying something like "you will receive up to $500,000 in coverage." In addition, looking to the body of the letter, we never used the words or phrasing "guaranteed issue," "guaranteed acceptance," "instant issue," "automatic acceptance," and did not imply or state anything else in that vein. Additionally, we use language in the letter (1st page) that states we can provide "an ***answer*** in 3-5 days" (not an issued policy in 3-5 days, not an acceptance in 3-5 days), and that customers could call the agency to "discuss the solutions that ***could*** help" with their possible insurance needs" (emphasis on the word 'could' - where again – we never state or imply any policy issuance is guaranteed).

In addition, looking to the language we used on page 2 of the letter, that also met the intent behind 14 VAC 5-41-40B. The *first thing* a customer reads on that (back) page of the letter, is that for any policy a customer may inquire about, the policy has a description of coverage, varying exclusions and limitations, and that customers should contact an agent or John Hancock for more information and complete details on coverage (in fact, we state that *again*, at the bottom of page 2). This language does not state or imply a policy is guaranteed issue / acceptance, and as your Observation notes, this section of our letter further states the exact opposite ("Policy issuance is not guaranteed ….").

Regarding your observations, and more specifically the prominence standard in 14 VAC 5-41-40 B, this code section does not state that there is a requirement to use footnotes on any given piece. For this 1 sheet letter (front & back page), the following points show how our disclosure was of greater or equal prominence to the statement regarding no medical exams. Specifically:

- The first thing the reader sees on the 2nd page is a block disclosure
- This block disclosure is in a prominent 12 point font
- This disclosure references, two times, an application and medical review process (underwriting & obtaining additional information)
- This disclosure specifically states that policy issuance is not guaranteed

Looking at what 14 VAC 5-41-40B actually says, the following:

if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, ***these terms shall be accompanied by a further disclosure of*** *equal prominence and* ***juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application.*** (emphasis of bolded text, added).

The language we used in the disclosure section on page two (2) of the letter, counter-balances the page one (1) phrasing of 'no medical exams.' The meaning of the "juxtaposition to the effect that" language highlighted in bold text immediately above - refers to the substance and content of any contrast and comparison language that one must use to address phrasing like 'no medical exams.' The VAC section, however, does *not* state that any disclosure must be in "close proximity" as your Observation implies, and 14 VAC 5-41-40B does not use the terms "close proximity" or "minimized", or any similar phrasing, at all. Our letter's language, contrasting and comparing to the 'no medical exam' phrasing, is compliant as to its substance and placement, as we state to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application – where we reference an application and the review of medical information, two times:

- "any life insurance purchase is subject to completion of an application and underwriting approval"
- "John Hancock will obtain additional information, including but not limited to medical records, to evaluate your application ... and ... identify any misrepresentation in the application."

The examiners maintained their findings. In the version of the advertisement provided with John Hancock's response, the disclosure is not only on the back of the referenced statements, but it is in a smaller font and in regular type, while the referenced statements are in bold type. Further, the reader must read through half of the untitled, unreferenced disclosure paragraph before reaching information stating that "Policy issuance is not guaranteed as any life insurance purchase is subject to completion of an application and underwriting approval." The disclosure is neither of equal prominence nor juxtaposition to the statements to which it is applicable.

Comment on 14 VAC 5-41-40 B

The Company maintains and reiterates that its prior response fully refutes the assertion that 14 VAC 5-41-40 B was violated. Respectfully, the Bureau's position is both unduly rigid and unreasonable. The advertisements at issue have been approved for use throughout the United States. No other state department of insurance has made the objection to them now advanced by the Bureau. There have been no complaints from consumers in Virginia or elsewhere raising the issue being pressed by the Bureau. The Bureau's position is unfair to John Hancock, a company doing business in good faith in Virginia. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue. The Company respectfully requests that appropriate personnel in the Office of the Bureau's General Counsel review the issue.

14 VAC 5-41-80 B states that an advertisement of a particular policy shall not use the phrase "inexpensive," "low cost" or any similar term unless that fact is capable of being demonstrated to the satisfaction of the commission. The review revealed that John Hancock was in substantial compliance with this section. ~~2 violations of this section. An example is discussed in Review Sheet AD04-JA, where the terms "affordable" and "low premiums" were not substantiated or demonstrated to be true in the advertisement. The terms are used to generally describe the policy's rates; therefore, the examiners requested evidence to support the claim that the coverage advertised was affordable to the target audience and requiring low premiums based on financial data, demographic studies, or other documentation. John Hancock disagreed, stating:~~

> ~~This advertisement does not violate 14 VAC 5-41-30 B or the 'overall impression' standard noted therein. We believe the phrasing in this piece is balanced and can demonstrate, along with the additional documentation requested in your observation, that this piece is compliant under Virginia state law. We disagree with the assertion that the 1x use of the term 'low~~

premiums,' and the referenced use of the term 'affordable,' need to be based on the recipient of the advertisement's ability to pay (for insurance and this particular policy).

In looking at this piece in its entirety, and contextually reviewing all of its content relative to all statements made within it, this piece is balanced and sufficiently clear and complete so as not to be misleading or deceptive. Regarding the use of the referenced term 'affordable,' it is used in this immediate sentence:
"John Hancock Term offers you an affordable way to help prevent financial hardship in the event of your untimely death." (PDF page 4 of 8).

This statement, intended to pique any reader's interest in insurance or this particular product, is postioned [*sic*] to have the reader consider whether or not insurance is affordable relative to the hypothetical questions presented to the reader on the prior page (PDF page 3 of 8). More specifically, whether the reader could otherwise – without insurance coverage – afford to: replace lost income, make tuition payments, pay toward one's mortgage, continue a business, etc.

In addition, the phrasing in the sentence itself, refers to the manner in which insurance could be affordable, and clearly does not state that this product is affordable for every reader. The statement says: "John Hancock Term ***offers*** you an ***affordable way to help prevent*** financial hardship," and then this piece immediately and subsequently refers to how the premium obligation for this policy (type) is for a fixed amount, and for a fixed duration. For term insurance, a fixed premium for the referenced 10, 15, 20 year duration – is for a shorter timeframe than a premium obligation on a permanent policy whose premiums are typically in the marketplace, at least to life expectancy of the insured or even lifetime (commonly known as being over age 100 or even to age 121). Use of the word affordable in this context is not deceptive.

As part of an analysis to determine an advertisement's compliance with state law, and here, both 14 VAC 5-41-30 B and 14 VAC 5-41-80 B, one has to have an understanding of how term products are positioned in the marketplace. Industrywide, term products are often positioned as low-cost and affordable. Our company could readily produce multiple examples from either 2016 or even today, which show our competitors positioning term insurance in the way John Hancock did within this guide in question, and where they also use terms like "affordable," "the most affordable option," or "lowest initial price." For our term product and this guide in question, it did offer low and affordable premiums – and as seen in the provided quote and illustration (see PDFs provided) – this 20 year Term 2016 product for a 35 year old preferred male would have been $612 in annual premium; whereas our Protection UL 16' permanent product for 20 years on the same insured would have been $2,571 annually....

~~The examiners maintained their findings and stated that without substantiation of the affordability of the rates or the "low premiums," the advertisement is considered to have the capacity or tendency to mislead or deceive.~~

Comment on 14 VAC 5-41-80 B

The Company maintains and reiterates that its prior response fully refutes the assertion that 14 VAC 5-41-80 B was violated. Respectfully, the Bureau's position is both unduly rigid and unreasonable. The advertisements at issue have been approved for use throughout the United States. No other state department of insurance has made the objection to them now advanced by the Bureau. There have been no complaints from consumers in Virginia or elsewhere raising the issue being pressed by the Bureau. The Bureau's position is unfair to John Hancock, a company doing business in good faith in Virginia. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue. The Company respectfully requests that appropriate personnel in the Office of the Bureau's General Counsel review the issue.

14 VAC 5-41-90 J states that an insurer or agent shall not use the terms "financial planner," "investment advisor," "financial consultant," "financial counseling" or other similar terms in a way that implies that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales unless that is actually a fact. No person engaged in the business of insurance shall hold himself out, directly or indirectly, to the public as a "financial planner," "investment advisor," "financial consultant," "financial counselor" or any other specialist engaged in the business of giving complete financial planning advice relating to investments, insurance, real estate, tax matters, and trust and estate matters unless that person in fact is engaged in that business and renders those services. The review

revealed that John Hancock was in substantial compliance with this section. ~~5 violations of this section. An example is discussed in Review Sheet AD04-LW, where the disclosures section of the advertisement instructed the reader to "Please consult your financial representative as to how premium savings may affect the policy you purchase" and to "Please consult your financial representative as to product availability." Five lines down, the advertisement stated "Please contact a licensed agent or John Hancock for more information, costs, and complete details on coverage," thus giving the impression that the "financial representative" and the "licensed agent" were different individuals with different functions. Use of the term "financial representative" in referring to the licensed agent implies that the "financial representative" is generally engaged in an advisory business with compensation unrelated to sales. John Hancock disagreed, stating, in part:~~

> ~~Your observation states: "The use of such terms in referring to an agent implies that the agent is generally engaged in an advisory business with compensation unrelated to sales." This assertion is untrue and a close examination of it reveals it has circular logic, it is an argument that assumes its own conclusion. Specifically, you are stating that when a term like financial representative is used, its mere use always means (and automatically implies) "that an agent is generally engaged in an advisory business." This is not true under 14 VAC 5-41-90.J. Here is what this VAC section actually says:~~
>
> ~~*an insurer or agent shall not use the terms "financial planner," "investment advisor," "financial consultant," "financial counseling" or other similar terms* ***in a way that implies*** *that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales unless that is actually a fact.* [emphasis added].~~
>
> ~~Unquestionably, 14 VAC 5-41-90.J does not have an absolute prohibition against use of the term in question (or for that matter, terms like "financial planner" listed in the code), and had the Virginia Department of Insurance wished to state otherwise in the VAC (i.e. – that use of such terms or similar terms in all instances would imply a person engaged in the insurance business is also generally engaged in an advisory business), it could have easily done so by different ways of phrasing this section.~~

Looking beyond the observation's misinterpretation of the VAC, as a factual matter we reject the idea that the term "financial representative" has the same meaning as the specifically noted examples in the VAC, "financial planner," "investment advisor," "financial counseling," or "financial consultant." Regardless, even looking at the use of the term in question here ("financial representative"), there is no way within either the context of the piece itself, or the sentences you have referenced and extracted, that this term per se and even how it is used in any sentence in the piece, is used "in a way that implies [a person] who is engaged in the business of insurance, is generally engaged in an advisory business ...." As noted earlier in our response, this (or any piece) must be read in its totality and in context, relative to among other things, its primary / secondary / overall messaging, and its tone. This is an educational piece, an FAQ document written about the John Hancock Vitality program for John Hancock life insurance policies, and it was written for potential customers. That is the extent of the content of the piece – there is no content in it to suggest that a 'financial representative' is engaged in an advisory business. Also, while this piece was written by John Hancock, it was not (is not) distributed directly to customers by John Hancock. It is generic in nature in that the only way customers could receive it, is if it was given to them by a licensed and appointed representative who sells our products, and who has been granted access to this piece through a verified account with John Hancock. This piece, like the majority of our print pieces, is created for any 'accountholder' agent to access and distribute – but it is not personalized to any individual, nor is it formatted so it could be personalized by anyone (as it's a locked PDF), so it cannot imply any status or title so that an individual agent could be perceived as holding himself out in a manner that is prohibited by the VAC.

Looking at the three (3) examples where you noted how the phrase "financial representative" is used, in those sentences themselves there is no messaging that conveys or implies an individual is "generally engaged in an advisory business in which compensation is unrelated to sales." Here are the sentences, two of which are in a *disclosure section* on our piece, and what they (and their intent) communicates:

1) Text in flyer: "Please consult your financial representative to determine if the program is available on your existing policy." Translation: inquire for more information on whether Vitality is available with the life insurance products listed in the "Additional Information" FAQ # 16.

2) Disclosure in flyer (FN marker #1): "Please consult your financial representative as to how premium savings may affect the policy you purchase." Translation: inquire as to how lowering your premiums and any savings realized, could affect your policy.

3) Disclosure in flyer (FN marker # 5): "Please consult your financial representative as to product availability." Translation: this disclosure is used to meet varying states' disclosure requirements, we are asking current or potential customers to confirm whether or not a policy manufactured by John Hancock would even be available for them to purchase, before further inquiring on that product....

The examiners responded that it is their position that the term "financial representative" is substantially similar to the terms referenced in 14 VAC 5-41-90 J such as "financial planner" and "financial consultant." Further, 2 disclosures instructing the reader to **consult** [emphasis added] his or her "financial representative" immediately followed by an instruction to **contact** [emphasis added] "a licensed agent or John Hancock" implies that the "financial representative" is a different individual and provides a different service and function than the "licensed agent." While mere use of the terms referenced in the regulation is not prohibited, the regulation does prohibit using them in a way that implies that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensation is unrelated to sales. The examiners maintain that the manner in which the term "financial representative" is used in this advertisement is in non-compliance with the requirements of 14 VAC 5-41-90 J.

Comment on 14 VAC 5-41-90 J

The Company maintains and reiterates that its prior response fully refutes the assertion that 14 VAC 5-41-90 J was violated. Respectfully, the Bureau's position is both unduly rigid and unreasonable. The advertisements at issue have been approved for use throughout the United States. No other state department of insurance has made the objection to them now advanced by the Bureau. There have been no complaints from consumers in Virginia or elsewhere raising the issue being pressed by the Bureau. The Bureau's position is unfair to John Hancock, a company doing business in good faith in Virginia. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at

issue. The Company respectfully requests that appropriate personnel in the Office of the Bureau's General Counsel review the issue.

SUMMARY

~~John Hancock violated 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, and 14 VAC 5-41-90 J, placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.~~

Comment on Summary

Please refer to the Company's prior comments on each referenced provision of Virginia law.

Filing Requirements for Long-Term Care Insurance Advertising

14 VAC 5-200-160 A states that every insurer providing long-term care insurance or benefits in this Commonwealth shall provide a copy of any long-term care insurance advertisement, as defined in 14 VAC 5-90-30, intended for use in this Commonwealth whether through written, radio or television or other electronic medium to the Commission. To the extent that it may be required or permitted under the laws of this Commonwealth, the Commission may review or review for approval all such advertisements. The review revealed that 3 advertisements were not filed with the Commission, in violation of this section in 3 instances. An example is discussed in Review Sheet AD16-JA, where John Hancock altered the filed version of an advertisement by inserting additional language. John Hancock disagreed and stated:

> ...this language was inserted because it was thought to be allowed-for under a statement of variability, and the language was an educational fact that provided objective information which was neither a marketing point nor

a "material change" relative to any possible marketing content in these pieces.

The examiners responded that the standards regarding variability of information specified by the Insurance Product Regulation Commission state that any change in content other than that described in the statement of variability requires prior approval. This change was not approved and does not appear in the statement of variability.

V. POLICY AND OTHER FORMS

A review was conducted to determine if John Hancock complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms. Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia. 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the applicable filing and approval requirements for long-term care policies. 14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued.

POLICIES

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of policy forms prior to use.

Life Insurance

The examiners reviewed a sample of 100 from a population of 921 individual life policies issued during the examination time frame. The examiners also reviewed the policy forms used in the individual term life conversions sample files and the policy forms used as part of the 1035 exchanges included in the individual life surrenders sample files.

The review revealed 4 violations of §§ 38.2-316 A and 38.2-316 C 1 of the Code where John Hancock issued the 4 policy forms listed in the table below that were not filed with and approved by the Commission as required.

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATIONS	REVIEW SHEET
ICC10_09ACCUL	Flexible Premium Adjustable Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF04-JA
ICC08_08MAJVULX	Flexible Premium Variable Adjustable Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF04-JA
ICC12 12PROVUL	Flexible Premium Variable Universal Life Insurance Policy	38.2-316 A 38.2-316 C 1	PF01-BB
S0682va	Survivorship Term Life Policy	38.2-316 A 38.2-316 C 1	PF03-JA

An example is discussed in Review Sheet PF04-JA, where John Hancock altered the approved version of the policy to remove text referencing time periods under the "RIGHT TO RETURN" provision of the policy. John Hancock disagreed and stated:

> ... Unfortunately, we did not identify MVULX as a policy that required update, and recognize that this was an oversight on our part. It is our understanding that the forms are compliant with ICC standards, as well as VA's free look standards, it is our position that we are in compliance. The language that was removed is redundant language, and we respectfully request that this observation be removed as immaterial.

The examiners responded that a form must be submitted in its final form, and the policy had been modified from the filed and approved format that did not allow for such variability.

Long-Term Care Insurance

The examiners reviewed a sample of 53 from a population of 274 individual long-term care policies issued during the examination time frame.

The review revealed that the policy forms used by John Hancock were filed with and approved by the Commission.

APPLICATIONS/ENDORSEMENTS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and endorsement forms prior to use.

Life Insurance

The review revealed 10 violations of each of these sections where John Hancock used the 10 application/endorsement forms listed in the table below that were not filed with and approved by the Commission as required.

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	REVIEW SHEET
NB5171US (04/2011)	Medical Exam Continuation Page	38.2-316 B 38.2-316 C 1	PF03-JA
NB5136VA (12/2013) Version 05/2015	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
NB5136VA (12/2013) Version 05/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
ICC16 NB6016 (03/2016) Version 05/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
ICC16 NB6016 (03/2016) Version 10/2016	Variable Life - Fund Allocation	38.2-316 B 38.2-316 C 1	PF03-JA
None listed	Application Supplement	38.2-316 B 38.2-316 C 1	PF05-JA
None listed	Changes Not Otherwise Ratified Provision	38.2-316 B 38.2-316 C 1	PF05-JA
None listed	Endorsement	38.2-316 B 38.2-316 C 1	PF05-JA
S432-9VA	Supplementary Benefit Four Year Term	38.2-316 B 38.2-316 C 1	PF06-JA
S134-1VA	Supplementary Benefit Accelerated Benefit Rider	38.2-316 B 38.2-316 C 1	PF06-JA

Examples are discussed in Review Sheet PF05-JA, where John Hancock used the "Application Supplement," "Changes Not Otherwise Ratified Provision," and "Endorsement" forms but failed to file them for approval. John Hancock agreed with the examiners' observations.

Long-Term Care Insurance

The review revealed that the application/endorsement forms used by John Hancock were filed with and approved by the Commission.

~~**ACCIDENT AND SICKNESS RATE FILING**~~

~~Sections 38.2-316 A and 38.2-316 C of the Code set forth the requirements for the filing of rates and rate changes.~~ 14 VAC 5-200-77 and 14 VAC 5-200-153 set forth the filing of rate and rate changes for long-term care insurance policies.

The review revealed that John Hancock was in substantial compliance.

~~**EXPLANATION OF BENEFITS (EOB)**~~

~~Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval by the Commission.~~

~~The examiners' review of the sample long-term care claims revealed that the EOB forms issued had not been filed with and approved by the Commission. These violations are discussed in Review Sheet PF01-BL. John Hancock's use of an EOB that had not been filed with and approved by the Commission placed the Company in violation of § 38.2-3407.4 A of the Code in 4 instances. John Hancock agreed with the examiners' observations and noted that 3 of the 4 EOBs had been subsequently filed with and~~

~~approved by the Commission on May 23, 2018 and that the Company is in the process of filing the other EOB for approval.~~

~~Due to the fact that the prior Report of Time, where John Hancock was the administrator of long-term care coverage, included violations of § 38.2-3407.4 A of the Code, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.~~

Comment on Section 38.2–3407.4 A and Time Insurance Company

As a preliminary matter, Section 38.2–3407.4 A is entitled "Explanation of Benefits". On its face, this provision relates exclusively to "accident and sickness insurance" policies. Section 38.2–109 defines accident and sickness insurance to mean "insurance against loss from sickness, or from bodily injury or death by accident or accidential means, or from a combination of any or all of these perils." This definition does not include long-term care ("LTC") insurance. If LTC insurance was meant to be included, it would have been specifically referenced. It was not.

In Virginia, accident and sickness insurance does not relate to LTC insurance. Section 38.2–3431 is entitled, "Application of article; definitions". Section 38.2–3431 states, "Benefits not subject to requirements of this article if offered separately" include "Benefits for long-term care..." Thus, beyond the absence of the affirmative inclusion of LTC insurance in the definition of accident and sickness insurance, LTC insurance was specifically excluded.

LTC insurance is governed by a separate section of the Code of Virginia. In this regard, Chapter 52 is entitled "Long-Term Care Insruance (38.2-5200 thru 38.2-5210)" Section 38.2-5205 is entitled, "Promulgation of regulations; standards for policy provision". Section 38.2-5202 C 4 states that, "Regulations issued by the Commission shall... 4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies..." Thus, Virginia law overtly

acknowledges the difference and distinctions between LTC insurance policies and accident and sickness insurance policies. The definition of LTC insurance in Section 38.2-5200 make no reference whatsoever to "accident and sickness" insurance. The only reference to accident and sickness insurance is to say that LTC insurance "may be issued by... accident and sickness insurers" and that "accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance." It is crystal clear that LTC and accident and sickness insurance are two distinctly different types of insurance.

John Hancock first started selling LTC insurance in 1987. From 1987 until 2016, when the Company exited that business, the Company has never been required by any other state to submit its LTC insurance Explanation of Benefits forms for approval. Similarly, John Hancock is not aware of another company selling LTC insurance being requested to do so by any state other than Virginia. It appears that only the Commonwealth of Virginia has attempted to impose this obligation.

The Bureau might subjectively believe that Section 38.2-3407.4 A governs LTC insurance and may have acted accordingly for some period of time. Nevertheless, merely asserting that this is the law, does not necessarily make it so. It is the Company's view is that the Bureau is in error and if this issue was properly presented to an appropriate court of law, the Bureau's position would not be upheld. Since Section 38.2-3407.4 A does not apply to LTC insurance Explanation of Benefits forms, no violation of the cited law has occurred and this language should be deleted from the Report.

Notwithstanding the foregoing, the market conduct examination of Time Insurance Company ("Time") was an examination of Time not John Hancock. LTC insurance was only a minor piece of the Time examination. As such, even if there were a well-founded violation of Section 38.2-3407.4 A in the Time examination and/or here, which is not the case, it would be inequitable for the Bureau to extrapolate John Hancock's experience during the Time examination to a knowing violation of Section 38.2-3407.4 A.

VI. AGENTS

The purpose of this review was to determine compliance with various Sections of Title 38.2, Chapter 18 of the Code and the applicable agent training requirements included in 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

A sample of 10 from a population of 828 agent and agency appointments in effect during the examination time frame was selected for review. The writing agents or agencies designated in the 100 life and 53 long-term care sample new business files were also reviewed, as well as those designated in the term life conversions sample files and the 1035 exchanges included in the life surrenders sample files.

LICENSED AGENT REVIEW

Section 38.2-1822 A of the Code prohibits a person from acting as an agent prior to obtaining a license to transact the business of insurance in the Commonwealth.

The review revealed that John Hancock was in substantial compliance with this section.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

~~The review revealed 2 violations of this section. An example is discussed in Review Sheet AG02-JA, where an individual who had executed an application on behalf of an agent had not been appointed by John Hancock. John Hancock disagreed, stating that the individual had been allowed to sign on behalf of the agent that was paid a commission on the sale as a manager-approved accommodation. The examiners~~

~~responded that although the individual in question had not been paid a commission on the sale, he was acting as an agent in the solicitation of an application/policy and had not been appointed by John Hancock.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Appointed Agent Review

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures.

Where no violations of law were asserted, the Bureau has noted that the Company was in "substantial compliance" with the provisions of law at issue. Throughout the report, if no violation of law was advanced, the Bureau should not qualify the finding. Instead, it should be noted that the review revealed the Company to be "fully in compliance" or simply "in compliance".

Here the sample size was too small to draw any valid conclusions and it is inappropriate and inconsistent with the error tolerance ratios set forth in the Market Regulation Handbook to cite two violations of Section 38.2-1833 A 1. That is particularly the case where the two violations at issue here were previously contested on the merits by the Company. Given the totality of circumstances, it would be more equitable for the the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that was not appointed or licensed at the time of the transaction.

The review revealed that John Hancock was in substantial compliance with this Section.

~~The review revealed 1 violation of this section. As discussed in Review Sheet AG01-JA, an agency that did not have an active appointment at the time of the transaction was paid a commission. John Hancock disagreed, stating that the agency "...was licensed and appointed at the time the policy was underwritten and issued." The examiners responded that the agency's appointment was administratively terminated on October 7, 2015, but the agency received a commission for an application executed on June 2, 2016.~~

Formatted: Indent: First line: 0.5"

Comment on Commissions

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective

policies and procedures. That is particularly the case where the single violation at issue here was contested on the merits by the Company. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment.

A sample of 25 from a population of 2,330 agent and agency terminations processed during the examination time frame was selected for review.

The review revealed 3 violations of this section. An example is discussed in Review Sheet AG01-HW, where the agent's appointment was terminated on February 10, 2016, but the only notification sent to the agent was prior to the termination on December 9, 2015. John Hancock agreed with the examiners' observations.

LONG-TERM CARE PARTNERSHIP AGENT TRAINING REVIEW

14 VAC 5-200-205 E requires that an individual may not sell, solicit or negotiate a partnership policy unless the individual is a licensed and appointed insurance agent in accordance with provisions of Chapter 18 (§ 38.2-1800 et seq.) of Title 38.2 of the Code of Virginia and has completed an initial training component and ongoing training every 24 months thereafter. 14 VAC 5-200-205 F requires that insurers offering a partnership policy shall obtain verification that an agent has received the training required by subsection E of this section before the agent is permitted to sell, solicit or negotiate the insurer's partnership policy.

~~The review revealed 1 violation of each of these sections. As discussed in Review Sheet AG05-JA, an agent sold a partnership policy without completing the required training, placing John Hancock in violation of 14 VAC 5-200-205 E and 14 VAC 5-200-205 F. John Hancock disagreed, stating that the agent had completed the training prior to the application being submitted. The examiners responded that while the agent did complete the initial training, more than 24 months had passed since the agent's last refresher course at the time the application was accepted.~~

The review revealed that John Hancock was in substantial compliance with these sections.

Comment on Long-Term Care Partnership Agent Training Review

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, notwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. That is particularly the case where the single violation at issue here was previously contested on the merits by the Company. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provisions of law at issue.

VII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of John Hancock's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; Long-Term Care Insurance, §§ 38.2-5200 through 38.2-5210; 14 VAC 5-30-10 et seq., Rules Governing Life Insurance and Annuity Replacements; 14 VAC 5-70-10 et seq., Rules Governing Accelerated Benefits Provisions; 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine whether John Hancock's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with John Hancock's guidelines, and whether correct premiums were being charged.

UNDERWRITING REVIEW

Life Insurance

A sample of 100 from a population of 921 individual policies underwritten and issued during the examination time frame was selected for review.

Subsection 1 of § 38.2-508 of the Code states that no person shall unfairly discriminate between individuals of the same class and equal expectation of life (i) in the

rates charged for any life insurance policy or annuity contract, or (ii) in the dividends or other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract.

The review revealed 3 violations of this section, as discussed in Review Sheet UN12-JA. The examiners initially observed that, in situations where the accelerated benefit rider to the life policy was not listed as desired coverage on the application, John Hancock had issued the rider to some of the applicants and had not issued it to others. In addition, one applicant was not issued the rider despite listing it as desired coverage on the application. John Hancock disagreed and, in regard to the individuals who had not applied for the rider, stated:

> ...while the accelerated benefit rider was not "checked off" on the application, the required "Summary and Disclosure Statement for Accelerated Benefit" form necessary to issue the policy with this rider was signed by the applicant and sent in at the time of application. Normally, if a client does not elect this rider on the application, but sends in the disclosure form, we will not inconvenience the client by asking them to correct the application as we have what we need to issue with the disclosure... all the client's [*sic*] were given the same opportunity to elect the coverage. We do not add the coverage unless it was elected, either on the application or the disclosure....

John Hancock also responded that, for the individual who was not issued the rider despite having applied for it, the rider was inadvertently not included due to a processing error and that the Company is taking corrective actions to have the rider added as part of a corrected policy. Upon further review, the examiners responded that, for the individuals who had not initially applied for the rider, 2 of the applicants had completed the "Summary and Disclosure Statement for Accelerated Benefit" form as described in the Company response and were still not issued the rider. The examiners also acknowledged the corrective action taken in regard to the individual who had initially applied for and was not

~~issued the rider; however, the examiners maintained that John Hancock unfairly discriminated in the terms and conditions of the contract due to the failure to issue the Accelerated Benefit Rider as applied for in a total of 3 instances. Finally, the examiners cautioned John Hancock that the "Summary and Disclosure Statement for Accelerated Benefit" form does not include language indicating that its completion constitutes application for the rider and that the Company needs to establish procedures for consistency in the application process for this rider.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Underwriting Review – Life Insurance

The Company maintains and reinterates that its prior response to each of the three alleged violations of law fully refutes the assertion that Subsection 1 of Section 38.2-508 was violated. To label this as "discrimination" and to extrapolate this fact pattern into an alleged violation of the "Unfair Trade Practices Act" is both unfounded and unreasonable.

Also, Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate…" Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for a one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. This is particularly troubling given the fact that the Company had previously contested the allegations on the merits. Here, the error tolerance ratio of 3% is inconsistent with the standards set forth in the Market Regulation Handbook. Given the

totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of the law at issue.

Long-Term Care Insurance

A sample of 53 from a population of 274 individual policies underwritten and issued during the examination time frame was selected for review.

The review revealed no evidence of unfair discrimination.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that John Hancock was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that John Hancock had calculated its premiums in accordance with its filed rates and its established guidelines.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

Section 38.2-604 B 4 of the Code states that a NIP form shall include a description of the rights established under §§ 38.2-608 and 38.2-609 of the Code and the manner in which those rights may be exercised.

The review revealed that John Hancock failed to include a complete description of these rights and the manner exercised in 6 of its NIP forms, placing the Company in violation of § 38.2-604 B 4 of the Code in 6 instances. An example is discussed in Review Sheet UN01-JA, where the NIP form failed to describe the requirement to furnish corrected, amended, or deleted information or a filed statement by the individual to the insurance-support organizations, as required by §§ 38.2-609 B 2 and 38.2-609 D 3 of the Code. John Hancock disagreed with the examiners' observations by providing the Company's procedure for the handling of disputed information. The examiners responded that although John Hancock appears to satisfy the requirement in practice, the NIP form fails to disclose this practice.

NOTICE OF FINANCIAL INFORMATION PRACTICES

Section 38.2-604.1 of the Code sets forth the requirements for a notice of financial information collection and disclosure practices, either long form or short form, to be provided to all applicants that are individually underwritten.

The review revealed that the forms provided to applicants for coverage complied with the requirements of this section.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The examiners reviewed the disclosure authorization forms used during the underwriting process and found them to be in substantial compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 A of the Code requires that in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

Administrative Letter 2015-07 provides life and health insurers with a prototype AUD notice. An AUD notice containing wording substantially similar to the wording in the prototype notice is deemed to be approved for use in Virginia.

Life Insurance

The examiners reviewed a sample of 50 from a population of 359 applications that were declined during the examination time frame. In addition, the 100 issued policies were reviewed for situations where an AUD notice was required to have been provided to an applicant for coverage.

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The review revealed 22 violations of § 38.2-610 A 1 of the Code and 32 violations of § 38.2-610 A 2 of the Code. An example of each of these sections is discussed in Review Sheet UN13-JA, where John Hancock failed to send an AUD notice to applicants that initially applied for or were quoted coverage as Super Preferred but were issued policies as Preferred. John Hancock disagreed, stating:

> Based on the John Hancock underwriting review and process, a final assessment of Standard or better, when in conflict with the originally submitted illustration, would not be considered an adverse underwriting decision. In our perspective, not every applicant qualifies to be a Super Preferred risk, since each individual has his/her own "baseline" based upon multiple criteria (i.e. BRAVE calculator), such as height/weight. Therefore if someone's medical parameters only qualify them for Preferred as a best case scenario, that would not be considered an adverse decision since not everyone is entitled to qualify at Super Preferred.

The examiners responded that subsection 1 e of § 38.2-602 of the Code of Virginia defines an adverse underwriting decision as an offer to insure at higher rates, or with limitations, exceptions or benefits other than those applied for and that page 3 of Administrative Letter 2015-07 lists an example of an action triggering an AUD notice as life insurance offered at a rate higher than that requested or offered at a lower benefit

level than that requested. As the applicants applied for Super Preferred rates but received Preferred rates, an AUD notice was required in these instances but was not provided.

Long-Term Care Insurance

The examiners reviewed a sample of 50 from a population of 203 individual applications that were declined during the examination time frame. The examiners also reviewed the issued policies where AUD notices were required. In addition, the 53 issued policies were reviewed for situations where an AUD notice was required to have been provided to an applicant for coverage.

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The review revealed 4 violations of § 38.2-610 A 1 of the Code of Virginia and 10 violations of § 38.2-610 A 2 of the Code of Virginia. An example of each of these sections is discussed in Review Sheet UN06-JA, where John Hancock failed to provide an AUD notice to an applicant whose file was closed. John Hancock disagreed, stating:

> BOI 14 was approved at the rate that the applicant applied (applied for Select rates and approved at Select rates). After this approval, the proposed insured failed to send in the necessary requirements to proceed with issuance of a policy (required Beneficiary form), and the case was

> closed out as Incomplete. The Incomplete letter was sent to the client (included in original files). Again, no adverse underwriting decision was made.

The examiners responded that, as described on Page 3 of Administrative Letter 2015-07, when an application is closed/denied because the applicant, his physician, or some other person fails to furnish required information, this is a declination of coverage and triggers an AUD notice. John Hancock provided a letter to the applicant requiring outstanding information to be submitted within 30 days, and the file was subsequently closed due to the requested information not being received, but no AUD notice was provided.

Section 38.2-610 B 3 of the Code states that upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one business days from the date of receipt of the written request the names and addresses of the institutional sources that supplied the specific items of personal and privileged information that support the reason or reasons for the adverse underwriting decision.

The review revealed 4 violations of this section. Examples are discussed in Review Sheet UN05-JA, where John Hancock received written requests for additional information regarding an adverse underwriting decision as set forth in § 38.2-610 B of the Code, but the Company's response letters failed to disclose the address of the institutional source as required by § 38.2 610 B 3 of the Code. John Hancock disagreed with the examiner's observations, stating:

> ...In the event the Company receives such a written request from the applicant, a second letter is sent, which details the source of the information

relied upon for the decision to decline the applicant for long-term care insurance. Please refer to second paragraph in the "Decline with Reason" letter, which includes the medical reason for declination and source. While the address of the source of the personal information is not disclosed in this particular sample, we believe our process meets the requirements of regulation **§ 38.2 610 B**.

John Hancock's adverse underwriting process does not currently include providing the source address back to the customer when the decision was based on information provided by the applicant (i.e. on the application or during the medical exam or by one of their attending physicians). John Hancock does however provide the address in the Decline with Reason letter when the source of the information is a third party that John Hancock contracts to collect additional information....

The examiners responded that, for the files in question, information contributed from a physician not listed on the application was cited as the source of the reason for the declination. There was also no indication in the sample files that this physician information was provided by the applicant during the other stages of the application process. As an address for these physicians was not provided, John Hancock's response letters failed to comply with § 38.2-610 B 3 of the Code of Virginia.

LONG-TERM CARE DISCLOSURES

A review was conducted to determine if John Hancock was in compliance with the disclosure requirements of 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance, and Chapter 52 of the Code.

DISCLOSURE OF RATING PRACTICES

14 VAC 5-200-75 sets forth the requirements for disclosure of rating practices to the consumer. 14 VAC 5-200-75 A 2 states that an explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of

a premium rate revision, shall be provided to the applicant at the time of application. 14 VAC 5-200-75 C states that an insurer shall use Forms B and F to comply with the requirements of subsection A.

The review revealed that John Hancock was in substantial compliance with these provisions. ~~1 violation each of 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C. As discussed in Review Sheet UN19-JA, John Hancock's "Long-Term Care Insurance Potential Rate Increase Disclosure Form" failed to disclose to the consumer the percentage increases at ages 66, 67, 68, 79, 80, and 81 and therefore failed to be substantially similar to Form F. John Hancock responded by stating that there had been an error due to an oversight during the drafting of the form, but that the complete grid is provided to the customer at issue of the policy. John Hancock's response was acknowledged; however, the regulation states that the information needs to be provided to the applicant at the time of application or enrollment.~~

Comment on 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate…" Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. That is particularly the case where the single violation at issue

here was provision contested on the merits by the Company. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

OUTLINE OF COVERAGE

Section 38.2-5207 of the Code sets forth the requirements for fair disclosure in the sale of long-term care insurance policies. It requires that an outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. 14 VAC 5-200-200 interprets and makes specific the provisions of § 38.2-5207 of the Code of Virginia in prescribing a standard format and content of an outline of coverage.

The review revealed that John Hancock was in substantial compliance.

SHOPPER'S GUIDE

14 VAC 5-200-201 requires that a long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commission, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

The review revealed that John Hancock was in substantial compliance.

PARTNERSHIP PROGRAM AND DISCLOSURE NOTICES

14 VAC 5-200-205 C 1 states that an insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Form 200-A), outlining the

requirements and benefits of a partnership policy. The Partnership Program Notice shall be provided with the required Outline of Coverage. 14 VAC 5-200-205 C 2 states that a partnership policy issued or issued for delivery in the Commonwealth of Virginia shall include a Partnership Disclosure Notice (Form 200-B) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified state long-term care insurance partnership policy.

The review revealed that John Hancock was in substantial compliance with each of these sections.

POLICY SUMMARY

Section 38.2-5207.1 of the Code sets forth that whenever an individual life insurance policy which provides long-term care benefits within the policy or by rider is delivered, it shall be accompanied by a policy summary. The summary shall provide an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits; an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person; and any exclusions, reductions, and limitations on benefits of long-term care. If applicable to the policy type, the summary shall also include (i) a disclosure of the effects of exercising other rights under the policy, (ii) a disclosure of guarantees related to long-term care costs of insurance charges, and (iii) current and projected maximum lifetime benefits.

The review revealed that John Hancock was in substantial compliance.

ACCELERATED BENEFITS PROVISIONS

A review was conducted to determine if John Hancock was in compliance with 14 VAC 5-70-10 et seq., Rules Governing Accelerated Benefits Provisions.

ACCELERATED BENEFITS DISCLOSURE

14 VAC 5-70-80 requires that a written disclosure, including a brief description of the provisions of an Accelerated Benefit Rider, be given to each applicant and an acknowledgment of the disclosure shall be signed by the applicant and agent.

The review revealed that John Hancock was in substantial compliance.

INSURANCE REPLACEMENT

A review was conducted to determine if John Hancock was in compliance with the requirements of 14 VAC 5-30-10 et seq., Rules Governing Life Insurance and Annuity Replacements, and 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance.

A sample of 31 individual life insurance replacements and the total population of 3 individual long-term care insurance replacements, in addition to the new business files where existing insurance was indicated, were reviewed for compliance.

The review revealed that John Hancock was in substantial compliance with these sections.

SUITABILITY

A review was conducted to determine if John Hancock was in compliance with the requirements of 14 VAC 5-200-175 of Rules Governing Long-Term Care Insurance.

LONG-TERM CARE INSURANCE

14 VAC 5-200-175 C 1 states that, to determine whether the applicant meets the suitability standards developed by the issuer, the issuer shall develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

The review revealed that John Hancock had developed suitability standards and trained its agents in the use of such standards during the examination time frame.

14 VAC 5-200-175 C 2 states that the issuer shall make reasonable efforts to obtain the information set out in subdivision 1 of this subsection. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." A copy of the issuer's personal worksheet shall be filed with the Commission for approval as required for a policy pursuant to § 38.2-316 of the Code.

The review revealed that John Hancock was in substantial compliance.

14 VAC 5-200-175 F states that at the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided.

The review revealed that John Hancock was in substantial compliance.

ADMINISTRATIVE LETTER 2014-05

The purpose of this Administrative Letter was to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association,* was approved effective November 1, 2010. Beginning January 1, 2015, insurers were required to attach a revised notice to include the new address of the Virginia Life, Accident and Sickness Insurance Guaranty Association, and the new Bureau of Insurance web address.

The review revealed that John Hancock was in substantial compliance.

VIII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST

The examiners reviewed John Hancock's procedures and practices for processing premium notices, reinstatements, and policy loans.

PREMIUM NOTICES

LIFE INSURANCE

John Hancock's procedures state that for universal life and variable universal life products, a Premium Notice is mailed 10 to 28 days prior to the due date.

~~The review of cancellations, discussed in a subsequent section of the Report, revealed 2 instances of non-compliance with John Hancock's established procedures. An example is discussed in CN01-BB, where the sample file failed to include documentation that the Premium Notice was sent. John Hancock disagreed but failed to provide documentation of the notice or the date that it was mailed.~~

Comment on Life Insuance Premium Notices

Please refer to the Company's comment on Life Insurance Cancellations.

LONG-TERM CARE INSURANCE

John Hancock's procedures state that for long-term care billing, the Company sends out regular premium requests (bills) 30 days prior to due date. If no payment is received after 10 days, a Premium Reminder Notice is sent; if no payment is received

after 30 days from due date, a Lapse Pending Notice is sent; and if payment is not received after 65 days from the due date, a Lapse/Termination Notice is sent.

While John Hancock was able to provide sample/template copies of its notices and document the mailing dates to indicate substantial compliance with its established procedures, the Company failed to maintain copies of the actual Lapse Pending Notices sent in each sample file. This is discussed in more detail in the Cancellations/Nonrenewals section of the Report.

REINSTATEMENTS

LIFE INSURANCE

John Hancock's life reinstatement procedures require the policyholder to submit a series of forms, including a reinstatement application and a health questionnaire. Underwriting then determines whether the policy is suitable for reinstatement.

The examiners reviewed a sample of 18 from a population of 42 individual life reinstatement requests received during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

LONG-TERM CARE INSURANCE

John Hancock's long-term care reinstatement procedures require a policyholder to submit a reinstatement application within 5 months of the lapse. Reinstatement requests are subject to approval from the underwriting department. John Hancock may also reinstate a policy if the policy was deemed to have lapsed in error.

The examiners reviewed a sample of 20 from a population of 45 individual long-term care reinstatement requests received during the examination time frame. The

review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

POLICY LOANS AND LOAN INTEREST

The examiners reviewed a sample of 100 individual policy loan transactions from a total population of 2,350 life insurance policies with loan activity during the examination time frame.

The review revealed that policy loans and loan interest were calculated in accordance with established procedures and the policy provisions.

IX. CANCELLATIONS/NONRENEWALS

The examination included a review of John Hancock's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; the requirements of § 38.2-3303 of the Code covering the grace period; and the requirements of 14 VAC 5-200-10 et seq., Rules Governing Long-Term Care Insurance

LIFE INSURANCE

Cash Surrenders

John Hancock's procedures state that in order to initiate a policy surrender, the policyholder must complete and submit a surrender request form. A written request from the policyholder is also accepted, if the policyholder has no taxable gain. Surrenders for term life, whole life, or universal life policies are processed within 15 calendar days.

The examiners reviewed a sample of 40 from a population of 686 individual cash surrenders processed during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

Reduced Paid-Up and Extended Term Insurance

The examiners reviewed a sample of 2 individual lapses to reduced paid-up from a population of 10 and 8 individual lapses to extended term from a population of 51 processed during the examination time frame. The review revealed that John Hancock was in substantial compliance with its established procedures and policy provisions.

Cancellations

The examiners reviewed a sample of 50 from a population of 208 individual life policies cancelled during the examination time frame.

John Hancock's procedures state that for universal life and variable universal life products, a Lapse Warning Notice is mailed when there is insufficient cash value to cover the cost of insurance and a Lapse Warning Reminder is mailed if a payment has not been made during the first 31 days of lapse pending/warning status.

~~The review revealed 2 instances of non-compliance with each of these established procedures. An example is discussed in Review Sheet CN01-BB, where the sample file failed to include documentation that the Lapse Warning Notice and Lapse Warning Reminder were sent. John Hancock disagreed and provided documentation of the last payment made on the policy, the policy's lapse pending status, and compliance with the grace period. The examiners responded that the Company failed to provide documentation of the Lapse Warning Notice and Lapse Warning Reminder.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Life Cancellations

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Conduct Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and

procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy.

~~The review revealed 2 violations of this section. An example is discussed in Review Sheet CN01-BB, where John Hancock sent a Final Lapse Notice to the policyholder stating that "As of August 3, 2016 your policy has been terminated without value because the required monthly charge due on August 1, 2016 exceeded the policy value and the required minimum premium was not received within the time specified in the 'Grace Period' provision of the policy," indicating that the Company had only allowed a grace period from August 1, 2016 to August 3, 2016. John Hancock disagreed and stated that "The insured was provided 61 days grace period to make a payment and change the policy status to Inforce." John Hancock also provided documentation outlining payments and payment dates reflecting that the policy had actually fallen into lapse pending status on June 1, 2016. The examiners maintain that the lapse notice incorrectly indicated that the required monthly charge was due on August 1, 2016, when the policy actually fell into lapse pending status in June of 2016. While John Hancock allowed the required grace period in the termination of the policy, the Final Lapse Notice sent to the~~

~~policyholder lists an incorrect premium due date and therefore provides inaccurate information regarding the grace period, resulting in John Hancock issuing a statement that misrepresents the terms of the policy.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Cancellations: Subsection 1 of § 38.2-502

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for a one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

LONG-TERM CARE INSURANCE

The examiners reviewed a sample of 50 from a population of 858 individual long-term care policies cancelled during the examination time frame.

John Hancock's established procedures state that a policy may be cancelled upon notification of the death of the insured or when a lapse in premium occurs. The review

revealed that John Hancock was in substantial compliance with its established procedures.

14 VAC 5-200-65 A 3 states that no individual long-term care policy or certificate shall 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 any additional person designated by the applicant, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notification shall also be provided to the agent of record, if any, within 72 hours after the notice has been mailed to the insured and any additional person, and the insurer shall retain any and all evidence of mailing the notice, including the list of recipients, as applicable, and a copy of the notice, for at least three years following the date of notice. The review revealed 18 violations of this section. As discussed in review sheet CN04-JM, John Hancock failed to maintain copies of the required lapse notices. John Hancock agreed with the examiners' observations and indicated that it had begun technical work in 2018 to ensure that copies of the required lapse notices are maintained.

X. COMPLAINTS

John Hancock's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 20 from a total population of 34 written complaints received during the examination time frame was reviewed. The review revealed that John Hancock was in substantial compliance with this section.

XI. CLAIM PRACTICES

The examination included a review of John Hancock's claim practices for compliance with §§ 38.2-510, 38.2-3115, and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of individual life and individual and group long-term care claims.

PAID CLAIM REVIEW

Life Insurance

A sample of 50 was selected from a total population of 795 life claims paid during the examination time frame. The review revealed that ~~claims were processed in accordance with the contract provisions with the exception of 1 claim, which is discussed later in this section~~ John Hancock was in substantial compliance.

Comment on Paid Claim Review: Life Insurance

Please refer to the Company's comment on Interest-Life Insurance.

Long-Term Care Insurance

A sample of 481 was selected from a total population of 18,831 long-term care claims paid during the examination time frame.

Subsection 1 of § 38.2-502 of the Code sets forth the requirement that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison

that misrepresents the benefits, advantages, conditions or terms of any insurance policy. ~~The review revealed 3 violations of this section. As discussed in Review Sheet CL40-HW, John Hancock issued 3 EOBs with a statement indicating an available Nursing Home benefit of $262,800 when the schedule page of the policy stated that the Nursing Home benefit policy limit was only $236,729.62.~~ The review revealed that John Hancock was in substantial compliance.

Comment on Section 38.2-502 1

There was no reference to these facts or this allegation in the original "Observations" submitted to the Company by the Examiners during the course of the examination. As a result, the issue was not addressed in the "Company Response". The issue first arose in the "Examiner's Response" to the "Company Response". It appears that the Company was not given a meaningful opportunity to respond to this new allegation. Notwithstanding the foregoing, the reason that the available coverage noted on the Explaination of Benefits form is higher than the original level of coverage when the policy issued in 1992, is because the isured had selected the inflation coverage option that operates to increase the level of coverage by 5% each year.

This allegation has no merit whatsoever. No violation of Section 38.2-502 1, which is entitled "Misrepresentations and false advertising of insurance," occurred. As such, this language should be stricken from the Report.

~~Section 38.2-514 B of the Code sets forth the requirement that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 180 violations of this section. An example is discussed~~

~~in Review Sheet CL15-JB, where the EOB failed to specify which benefit category in the policy the claim was being paid under. John Hancock disagreed and stated:~~

> ~~...In accordance with Section 38.2-3407.4 B & Section 38.2-514 B of the Virginia Code, the EOB does clearly and accurately disclose the benefit payable under the contract, the method of benefit calculation and actual amount which has been paid. The EOBs for all payment samples in **BOI Item #32** clearly provides [*sic*] the service type, date of service, total charge, amount not covered under the policy, the total payment amount as well as a 'Code' column which eliminates the potential for consumer confusion. The purpose of this last column is to provide the claimant with the reason why a charge amount is not covered, for example *Code A - "Exceeds Maximum Daily Benefit"*. Based on this information, a claimant can clearly identify what policy benefit is paid, how much of the benefit is being reimbursed and what amount is not reimbursed. As such, again, both the method of the benefit calculation and the benefits payable under the contract are clearly and accurately disclosed pursuant to Section 38.2-3407.4 B & Section 38.2-514 B of the Virginia Code.~~

~~The examiners maintain that the policy schedule page shows a Nursing Home daily benefit rate that differs from the Assisted Care Living Facility daily benefit rate and that the claimant would be unable to determine which of these daily benefit rates applies when the only description of service type provided on the EOB is "Room & Board."~~

Comment on Section 38.2-514 B

As a preliminary matter, Section 38.2–3407.4 A is entitled "Explanation of Benefits". On its face, this provision relates exclusively to "accident and sickness insurance" policies. Section 38.2–109 defines accident and sickness insurance to mean "insurance against loss from sickness, or from bodily injury or death by accident or accidential means, or from a combination of any or all of these perils." This definition does not include long-term care ("LTC") insurance. If LTC insurance was meant to be included, it would have been specifically referenced. It was not.

In Virginia, accident and sickness insurance does not relate to LTC insurance. Section 38.2–3431 is entitled, "Application of article; definitions". Section 38.2–3431

states, "Benefits not subject to requirements of this article if offered separately" include "Benefits for long-term care..." Thus, beyond the absence of the affirmative inclusion of LTC insurance in the definition of accident and sickness insurance, LTC insurance was specifically excluded.

LTC insurance is governed by a separate section of the Code of Virginia. In this regard, Chapter 52 is entitled "Long-Term Care Insruance (38.2-5200 thru 38.2-5210)" Section 38.2-5205 is entitled, "Promulgation of regulations; standards for policy provision". Section 38.2-5202 C 4 states that, "Regulations issued by the Commission shall... 4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies..." Thus, Virginia law overtly acknowledges the difference and distinctions between LTC insurance policies and accident and sickness insurance policies. The definition of LTC insurance in Section 38.2-5200 make no reference whatsoever to "accident and sickness" insurance. The only reference to accident and sickness insurance is to say that LTC insurance "may be issued by... accident and sickness insurers" and that "accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance." It is crystal clear that LTC and accident and sickness insurance are two distinctly different types of insurance.

John Hancock first started selling LTC insurance in 1987. From 1987 until 2016, when the Company exited that business, the Company has never been required by any other state to submit its LTC insurance Explanation of Benefits forms for approval. Similarly, John Hancock is not aware of another company selling LTC insurance being requested to do so by any state other than Virginia. It appears that only the Commonwealth of Virginia has attempted to impose this obligation.

The Bureau might subjectively believe that Section 38.2-3407.4 A governs LTC insurance and may have acted accordingly for some period of time. Nevertheless, merely asserting that this is the law, does not necessarily make it so. It is the Company's view that the Bureau is in error and if this issue was properly presented to an appropriate court of law, the Bureau's position would not be upheld. Since Section 38.2-3407.4 A does not apply to LTC insurance Explanation of Benefits forms, no violation of the cited law has occurred and this language should be deleted from the Report. Further, Section 38.2-514,

which is entitled, "Failure to make disclosure," specifically relates only to annuities, life insurance and accident and sickness insurance. In this regard, it does not govern LTC insurance.

~~Section 38.2-3407.4 B of the Code sets forth the requirement that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of this section. As discussed in Review Sheet CL46-HW, in the payment of 4 invoices involving similar services for the same facility stay, 2 of the EOBs showed the services being paid under the Nursing Home benefit, and 2 of the EOBs showed the services being paid under the Alternate Care Facility benefit.~~

~~The review revelated 5 instances of non-compliance with the policy. An example is discussed in Review sheet CL02-JB, where the claim was paid at a higher daily benefit maximum than had accrued with the 5% simple interest annual increases specified in the inflation rider.~~

Comment on Section 38.2-3407.4 B

As a preliminary matter, Section 38.2–3407.4 A is entitled "Explanation of Benefits". On its face, this provision relates exclusively to "accident and sickness insurance" policies. Section 38.2–109 defines accident and sickness insurance to mean "insurance against loss from sickness, or from bodily injury or death by accident or accidential means, or from a combination of any or all of these perils." This definition does not include long-term care ("LTC") insurance. If LTC insurance was meant to be included, it would have been specifically referenced. It was not.

In Virginia, accident and sickness insurance does not relate to LTC insurance. Section 38.2–3431 is entitled, "Application of article; definitions". Section 38.2–3431 states, "Benefits not subject to requirements of this article if offered separately" include "Benefits for long-term care..." Thus, beyond the absence of the affirmative inclusion of

LTC insurance in the definition of accident and sickness insurance, LTC insurance was specifically excluded.

LTC insurance is governed by a separate section of the Code of Virginia. In this regard, Chapter 52 is entitled "Long-Term Care Insruance (38.2-5200 thru 38.2-5210)" Section 38.2-5205 is entitled, "Promulgation of regulations; standards for policy provision". Section 38.2-5202 C 4 states that, "Regulations issued by the Commission shall... 4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies..." Thus, Virginia law overtly acknowledges the difference and distinctions between LTC insurance policies and accident and sickness insurance policies. The definition of LTC care insurance in Section 38.2-5200 make no reference whatsoever to "accident and sickness" insurance. The only reference to accident and sickness insurance is to say that LTC insurance "may be issued by... accident and sickness insurers" and that "accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance." It is crystal clear that LTC and accident and sickness insurance are two distinctly different types of insurance.

John Hancock first started selling LTC insurance in 1987. From 1987 until 2016, when the Company exited that business, the Company has never been required by any other state to submit its LTC insurance Explanation of Benefits forms for approval. Similarly, John Hancock is not aware of another company selling LTC insurance being requested to do so by any state other than Virginia. It appears that only the Commonwealth of Virginia has attempted to impose this obligation.

The Bureau might subjectively believe that Section 38.2-3407.4 A governs LTC insurance and may have acted accordingly for some period of time. Nevertheless, merely asserting that this is the law, does not necessarily make it so. It is the Company's view that the Bureau is in error and if this issue was properly presented to an appropriate court of law, the Bureau's position would not be upheld. Since Section 38.2-3407.4 A and Section 38.2-3407.4 B do not apply to LTC insurance Explanation of Benefits forms, no violation of the cited law has occurred and this language should be deleted from the Report.

Interest – Life Insurance

Section 38.2-3115 B of the Code sets forth the requirement that interest upon the principal sum shall be computed daily at an annual rate of 2.5% or at the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater. ~~The review revealed 1 violation of this section where interest was underpaid, as discussed in Review Sheet CL47-JB.~~

~~The review also revealed 1 instance of non-compliance with the policy where interest was underpaid. As discussed in Review Sheet CL50-JB, John Hancock failed to pay interest on claim proceeds at an annual rate of 3.5%, as specified in the policy~~.

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Interest – Life Insurance

Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate…" Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for a one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

Interest – Long-Term Care Insurance

~~Section 38.2-3407.1 B of the Code sets forth the requirement that if no action is brought, interest upon the claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment. The review revealed 6 violations of this section. An example is discussed in Review Sheet CL11-JB, where interest was underpaid.~~

Comment on Interest – Long-Term Care Insurance

As a preliminary matter, Section 38.2–3407.4 A is entitled "Explanation of Benefits". On its face, this provision relates exclusively to "accident and sickness insurance" policies. Section 38.2–109 defines accident and sickness insurance to mean "insurance against loss from sickness, or from bodily injury or death by accident or accidential means, or from a combination of any or all of these perils." This definition does not include long-term care ("LTC") insurance. If LTC insurance was meant to be included, it would have been specifically referenced. It was not.

In Virginia, accident and sickness insurance does not relate to LTC insurance. Section 38.2–3431 is entitled, "Application of article; definitions". Section 38.2–3431 states, "Benefits not subject to requirements of this article if offered separately" include "Benefits for long-term care…" Thus, beyond the absence of the affirmative inclusion of LTC insurance in the definition of accident and sickness insurance, LTC insurance was specifically excluded.

LTC insurance is governed by a separate section of the Code of Virginia. In this regard, Chapter 52 is entitled "Long-Term Care Insruance (38.2-5200 thru 38.2-5210)" Section 38.2-5205 is entitled, "Promulgation of regulations; standards for policy provision". Section 38.2-5202 C 4 states that, "Regulations issued by the Commission shall… 4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies…" Thus, Virginia law overtly acknowledges the difference and distinctions between LTC insurance policies and accident and sickness insurance policies. The definition of LTC insurance in Section 38.2-

5200 make no reference whatsoever to "accident and sickness" insurance. The only reference to accident and sickness insurance is to say that LTC insurance "may be issued by... accident and sickness insurers" and that "accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance." It is crystal clear that LTC and accident and sickness insurance are two distinctly different types of insurance.

John Hancock first started selling LTC insurance in 1987. From 1987 until 2016, when the Company exited that business, the Company has never been required by any other state to submit its LTC insurance Explanation of Benefits forms for approval. Similarly, John Hancock is not aware of another company selling LTC insurance being requested to do so by any state other than Virginia. It appears that only the Commonwealth of Virginia has attempted to impose this obligation.

The Bureau might subjectively believe that Section 38.2-3407.4 A governs LTC insurance and may have acted accordingly for some period of time. Nevertheless, merely asserting that this is the law, does not necessarily make it so. It is the Company's view that the Bureau is in error and if this issue was properly presented to an appropriate court of law, the Bureau's position would not be upheld. Since Section 38.2-3407.4 A does not apply to LTC insurance Explanation of Benefits forms, no violation of the cited law has occurred and this language should be deleted from the Report.

Section 38.2-3407.1 is entitled "Interest on Accident and Sickness Claim proceeds". On its face, it relates only to accident and sickness insurance. It does not govern LTC insurance.

DENIED CLAIM REVIEW

Long-Term Care Insurance

A sample of 164 was selected from a total population of 1,243 long-term care claims denied during the examination time frame, including invoices submitted for payment and eligibility denials.

Section 38.2-514 B of the Code sets forth the requirement that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 32 violations of this section. An example is discussed in Review Sheet CL62-HW, where services billed on the invoice that were excluded under the terms of the policy were omitted from the EOB. John Hancock disagreed and stated:

> ...In accordance with Section 38.2-514 B of the Virginia Code, the EOB does clearly and accurately disclose the benefit payable under the contract, the method of benefit calculation and actual amount which has been paid. The EOBs for all payment samples in ***BOI Item #28*** clearly provides [*sic*] the service type, date of service, total charge, amount not covered under the policy, the total payment amount as well as a 'Code' column which eliminates the potential for consumer confusion. The purpose of this last column is to provide the claimant with the reason why a charge amount is not covered, for example *Code A - "Exceeds Maximum Daily Benefit"*. Based on this information, a claimant can clearly identify what policy benefit is paid, how much of the benefit is being reimbursed and what amount is not reimbursed. As such, again, both the method of the benefit calculation and the benefits payable under the contract are clearly and accurately disclosed pursuant to Section 38.2-514 B of the Virginia Code.

The examiners responded that when the non-covered services are omitted from the EOB altogether, the method of benefit calculation is unclear to the claimant due to the fact that the total charges displayed on the EOB will be inconsistent with the total charges actually billed on the invoice.

Comment on Section 38.2-514 B

As a preliminary matter, Section 38.2–3407.4 A is entitled "Explanation of Benefits". On its face, this provision relates exclusively to "accident and sickness insurance" policies. Section 38.2–109 defines accident and sickness insurance to mean "insurance against loss from sickness, or from bodily injury or death by accident or accidential means, or from a combination of any or all of these perils." This definition does

not include long-term care ("LTC") insurance. If LTC insurance was meant to be included, it would have been specifically referenced. It was not.

In Virginia, accident and sickness insurance does not relate to LTC insurance. Section 38.2–3431 is entitled, "Application of article; definitions". Section 38.2–3431 states, "Benefits not subject to requirements of this article if offered separately" include "Benefits for long-term care..." Thus, beyond the absence of the affirmative inclusion of LTC insurance in the definition of accident and sickness insurance, LTC insurance was specifically excluded.

LTC insurance is governed by a separate section of the Code of Virginia. In this regard, Chapter 52 is entitled "Long-Term Care Insruance (38.2-5200 thru 38.2-5210)" Section 38.2-5205 is entitled, "Promulgation of regulations; standards for policy provision". Section 38.2-5202 C 4 states that, "Regulations issued by the Commission shall... 4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies..." Thus, Virginia law overtly acknowledges the difference and distinctions between LTC insurance policies and accident and sickness insurance policies. The definition of LTC insurance in Section 38.2-5200 make no reference whatsoever to "accident and sickness" insurance. The only reference to accident and sickness insurance is to say that LTC insurance "may be issued by... accident and sickness insurers" and that "accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance." It is crystal clear that LTC and accident and sickness insurance are two distinctly different types of insurance.

John Hancock first started selling LTC insurance in 1987. From 1987 until 2016, when the Company exited that business, the Company has never been required by any other state to submit its LTC insurance Explanation of Benefits forms for approval. Similarly, John Hancock is not aware of another company selling LTC insurance being requested to do so by any state other than Virginia. It appears that only the Commonwealth of Virginia has attempted to impose this obligation.

The Bureau might subjectively believe that Section 38.2-3407.4 A governs LTC insurance and may have acted accordingly for some period of time. Nevertheless, merely

asserting that this is the law, does not necessarily not make it so. It is the Company's view that the Bureau is in error and if this issue was properly presented to an appropriate court of law, the Bureau's position would not be upheld. Since Section 38.2-3407.4 A does not apply to LTC insurance Explanation of Benefits forms, no violation of the cited law has occurred and this language should be deleted from the Report.

Section 38.2-514 is entitled, "Failure to make disclosure". On its face, it relates only to annuities, life insurance and accident and sickness insurance. It does not govern LTC insurance.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

Life Insurance

The sample of 50 paid claims was reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The review was conducted using the date the check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time. The review revealed 7 instances of non-compliance with this section. 14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer. The review revealed 13 instances of non-compliance with this section. An example of each is discussed in Review Sheet CL101-HW. Notification and proof of loss for the claim were received on April 15, 2016, and no other correspondence was sent to the claimant until

the check was mailed on May 31, 2016, 31 working days later. John Hancock disagreed with the examiners' observations, stating:

> ... In reference to 14 VAC 5-400-50 A and 14 VAC 5-400-60 A of the Code of Virginia, John Hancock's business practice is to pay all death claims within 10 business days and the Company strives to meet that 10 day payment schedule. However, during the time period of December 2015 to May 2016 the Company was in the process of system updates which caused a temporary disruption of our payment process. This is the case for BOI#1, where the letter of notification nor the claim payment was sent to the claimant in a timely manner. After the system disruption John Hancock had a high percentage rate of meeting the 10 claim payment process thus in most cases there is no need for a notification letter.

The examiners responded that a disruption caused by system updates does not exempt the Company from the requirements to acknowledge the receipt of the claim within 10 working days and affirm a claim within 15 working days.

~~John Hancock's failure to comply with 14 VAC 5-400-50 A and 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice, placing John Hancock in violation of these sections.~~

Comment on General Business Practice

The problem at issue was an inadvertent systems error. It was not intentional. In any event, the number of violations does not rise to the level of a general business practice.

Long-Term Care Insurance

The sample of 645 paid and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The review was conducted using the date the check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

~~14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer. The review revealed 15 instances of non-compliance with this section. An example is discussed in Review Sheet CL01-HW. Proof of loss for the claim was received on October 25, 2016, and the EOB was not mailed until December 1, 2016, 26 working days later. John Hancock disagreed with the examiners' observations, stating:~~

> ~~...Section 14 VAC 5-400-50 & Section 14 VAC 5-400-60: This section refers to an initiation of an insured's claim to determine eligibility for the payments of benefits. Otherwise, this regulation would not refer to an acknowledgement unless a payment is made. It is for this reason the regulation is not applicable to invoice payment processing.~~

~~The examiners maintain the position that 14 VAC 5-400-60 A applies to the invoice/payment processing portion of a claim and that John Hancock failed to affirm the claim within 15 working days.~~

Comment on 14 VAC-5 400-60 A

14 VAC 5-400-60 is entitled "Standards for Prompt Investigation of Claims". It reads in pertinent part, "within 15 calendar days after receipt by the insurer of any required property executed proof of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the insured." It is important to note that this provision of law is not entitled "standards for prompt **payment** of claims" (emphasis added). The provision of law cited is simply inapplicable and does not stand for the proposition asserted by the Bureau. As the Company previously indicated in response to Review Sheet CL01-HW, this provision "refers to an intiation of an insured's claim to determine eligibility for payment of benefits." The cited law is not applicable to invoice payment process associated with long-term care insurance. As such, the language in question should be deleted from the Report.

14 VAC 5-400-70 A states that any denial of a claim must be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial. ~~The review revealed 200 instances of non-compliance with this section. An example is discussed in Review Sheet CL05-JB, where a denial explanation was not included on the EOB for the monthly haircut/shampoo & set service billed on the facility invoice. John Hancock disagreed with the examiners' observations and stated:~~

> ~~...Section 14 VAC 5-400-70: Primarily, long term care policies cover care services only. Please refer to policy form LTC 96 VA 9/96, LIMITATIONS ON OR CONDITIONS FOR ELIGIBILITY FOR BENEFITS section, 2.12 page 9, of the policy. As per the policy excerpt below, charges such as supplies, haircut/shampoo, etc, are not covered.~~

2.12	**Charges Not Covered**	**We** will not pay for any of the following: **Physician's** charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; durable medical equipment; transportation; and items and services furnished at **Your** request for beautification, comfort, convenience or entertainment.

[The section above should also be deleted.]

> ~~This regulation pertains to the denial of a claim based on an insured not meeting policy eligibility requirements, resulting in claim denial. Denial of eligibility of a claim is distinguished from services not covered.~~

~~The examiners maintain the position that services and fees not paid due to being non-covered charges under the policy are considered denials and are subject to the requirement of 14 VAC 5-400-70 A to provide a denial in writing to the claimant.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on 14 VAC 5-400-70 A

There appears to be confusion about what benefits the Company's long-term care ("LTC") insurance policies cover and how the LTC policies function. The Company's contracts make it crystal clear what charges and services the Company will reimburse for and what charges and services the Company will not pay. As all insurance companies that have sold LTC insurance know, nursing homes and other facilities almost invariably issue a single invoice to the insured. These invoices typically include charges to the insured that are not covered by their LTC policy. Thereafter, it is equally typical that the insured or the insured's relatives merely submit the invoice to the Company. For the benefit of its insureds, the Company does not reject such claims. The Company simply reimburses only for the services/charges that are covered.

As discussed in the Review Sheet CLO5-JB, the insured's relatives used a fax cover sheet which simply attached an invoice from the assisted living facility that had been directed to the insured. The fax cover sheet merely referenced the policy number and the claim number. No attempt was made by the insured's relatives or the facility to designate those charges that were thought to be covered by John Hancock's LTC policy and those that were not. As such, rather than reject the invoice, the Company did not address the "haircut" for $15 and the "shampoo and set" for $20. Consistent with the terms of the policy, the Company paid $127 per day on the $179 per day charge. The handling of the claim was as clear as can be and everyone involved understood what had happened. There were no complaints or questions associated with the Company's treatment of this claim or the other 199 at issue here.

The Company does LTC business in all fifty states and no other state insurance department has taken this position on LTC claims. It appears that the Bureau has failed or refused to acknowledge the difference between a denial of eligibility to be on claim and the obvious non-payment of services that are not covered while on claim. Respectuflly, all 200 of the allged violations should be deleted from the Report.

14 VAC 5-400-70 D states that in any case where there is no dispute as to coverage or liability, every insurer must offer to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim, provided the amount so offered is within policy limits and in accordance with policy provisions. The review revealed 4 instances of non-compliance with this section. As discussed in Review Sheet CL46-HW, John Hancock failed to provide reimbursement for the monthly monitoring charge that was within the available plan maximums and was not included in the Limitations and Exclusions section of the policy.

~~John Hancock's failure to comply with 14 VAC 5-400-70 A occurred with such frequency as to indicate a general business practice, placing John Hancock in violation of this section.~~

Comment on General Business Practice

Please see the Company's comment on 14 VAC 5-400-70 A. Since the underlying allegation is inapplicable, the assertion of a general business practice is unsubstantiated and should be deleted from the Report.

THREATENED LITIGATION

John Hancock informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

DISCLOSURES FOR RETAINED ASSET ACCOUNTS

Section 38.2-3117.4 of the Code sets forth the requirements for the insurer to provide written disclosures to the beneficiary of a policy before the retained asset account

is selected, if optional, or established, if not optional. The examiners reviewed the flyer, which included a supplemental contract, used by John Hancock to provide these disclosures to beneficiaries in connection with its life claims.

Subsection 4 of § 38.2-3117.4 of the Code states that the insurer shall provide a written disclosure including a statement identifying the account as either a checking account or a draft account and an explanation of how the account works. ~~The review revealed 1 violation of the section. As discussed in Review Sheet CL43-JB, John Hancock's flyer described the account as both "an interest-bearing account accessible via drafts" and "an interest bearing checking account" and therefore failed to identify the account specifically as either a checking account or a draft account. John Hancock disagreed with the examiners' observations and stated:~~

~~On the claim form and the Supplemental Contract John Hancock discloses that the Safe Access Account is not a checking account and only makes reference to checking accounts to make it easier for the customer to better understand the SAA option, as required by the code. Therefore, we do not feel we are in violation of subsection 4 of § 38.2-3117.4 of the Virginia code.~~

~~The examiners maintained their findings. While the flyer includes one sentence stating that the account "...is an interest-bearing account accessible via drafts" and includes language stating that "We sometimes refer to our Safe Access Account drafts as 'checks'...," the document repeatedly references checks and also identifies the account in another section as "an interest-bearing checking account." As these conflicting references are potentially misleading to the beneficiary, John Hancock has failed to~~

Formatted: Indent: Left: 0", Right: 0", Space After: 0 pt, Line spacing: Double, Tab stops: 6.5", Right,Leader: ... + Not at 6.38"

~~identify the account as either a checking account or a draft account, in violation of subsection 4 of § 38.2-3117.4 of the Code of Virginia.~~

The review revealed that John Hancock was in substantial compliance with this section.

Formatted: Right: 0", Space After: 0 pt, Tab stops: 6.5", Right,Leader: ... + Not at 6.38"

Comment on Subsection 404 § 38.2 – 3117.4

The flyer at issue is not "misleading". The flyer has been used throughout the United States. None of John Hancock's customers in Virginia or elsewhere have complained that it was confusing or misleading. No other state regulator has suggested, as the Bureau has, that it is "potentially misleading".

Also, Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate…" Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. This is particularly the case here, where the Company has contested the alleged violation on the merits. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

Subsection 8 of § 38.2-3117.4 of the Code states that the insurer shall provide a written disclosure of the minimum interest rate to be credited to the account and how the actual interest rate will be determined. ~~The review revealed 1 violation of this section. As discussed in Review Sheet CL43-JB, while John Hancock's flyer included~~

~~the language "Current interest rate 1.25%," the flyer failed to disclose whether or not this was the minimum interest rate and how the rate was determined. John Hancock disagreed with the examiners' observations and stated:~~

> ~~Regarding subsection 8 of § 38.2-3117.4, In the Terms and Conditions of the Supplemental Contract John Hancock discloses that the rate is "determined by John Hancock". The 1.25% current rate is a flat rate and not subject to market conditions. Therefore, John Hancock does not feel it is in violation of subsection 8 of § 38.2-3117.4 of the Virginia code.~~

~~The examiners responded that descriptions in the flyer such as "current interest rate," "variable interest," "reflects economic factors and trends," and "rate is subject to change" appear to contradict the Company's response that it is a flat interest rate and not subject to market conditions. John Hancock has failed to disclose the minimum interest rate to be credited to the account and how the actual interest rate will be determined.~~

The review revealed that John Hancock was in substantial compliance with this section.

Comment on Section 8 of § 38.2-3117.4

There is no violation of Section 38.2-3117.4. It is clear that there is no minimum interest rate and that the applicable interest rate is to be determined by the Company. It is also clear that the then current interest rate of 1.25% is the interest rate that would apply. This alleged violation of law should be deleted from the Report.

Also, Section 38.2-1318 of the Code of Virginia is entitled, "Examinations; how conducted" and requires that examiners "observe to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate..." Chapter 14 of the Market Regulation Handbook is entitled "Sampling" and sets forth sampling techniques and error tolerance ratios in

recognition of the fact that, nothwithstanding robust and efficacious policies and procedures, a random error may occur. It is seldom appropriate for one or two alleged violations to constitute a finding of non-compliance with a regulation or a statute or to justify recommendations to change or enhance the Company's otherwise effective policies and procedures. This is particularly the case here, where the Company has contested the alleged violation on the merits. Given the totality of circumstances, it would be more equitable for the Bureau to indicate that the Company was in substantial compliance with the provision of law at issue.

XII. CORRECTIVE ACTION PLAN

Based on the findings in this Report, John Hancock shall:

Comment on Corrective Action Plan

Please see the Company's comments in the body of the Report disputing certain underlying violations of law that relate to the corresponding aspects of the proffered Corrective Action Plan. The Company has contested the violations at issue. As such, from the Company's perspective, no corrective action is necessary. Depending on the changes the Bureau elects to make, the Corrective Action Plan particulars will have to be renumbered accordingly.

1. ~~Review and strengthen its procedures to ensure that life advertisements comply with 14 VAC 5-41-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;~~
2. ~~Revise its life advertisements, including the removal or revision of any broad and sweeping statements without parameters regarding the benefits of the products being advertised, so as to ensure that the advertisements are truthful and not misleading in fact or by implication, as required by 14 VAC 5-41-30 B;~~
3. ~~Revise its life advertisements to ensure that if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, these terms shall be accompanied by a further disclosure of equal prominence and juxtaposition to the effect that issuance of the policy may depend upon the answers to the health questions contained in the application, as required by 14 VAC 5-41-40 B;~~

4. ~~Revise its life advertisements to ensure that the phrases "affordable," "low premiums," or any other terms similar to "inexpensive" or "low cost" are not used unless that fact is capable of being demonstrated to the satisfaction of the Commission, as required by 14 VAC 5-41-80 B;~~

5. ~~Revise its life advertisements to ensure that terms similar to "financial planner," "investment advisor," "financial consultant," and "financial counseling," including the terms "financial representative" and "financial advisor," are not used in a way that implies that the person who is engaged in the business of insurance, is generally engaged in an advisory business in which compensated is unrelated to sales unless that is actually a fact, as required by 14 VAC 5-41-90 J;~~

6. Review and strengthen its procedures to ensure that a copy of any long-term care advertisement intended for use in this Commonwealth is provided to the Commission for review and approval, as required by 14 VAC 5-200-160 A;

7. Review and strengthen its procedures to ensure all life policy, rider/endorsement, and application forms are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code;

8. Immediately review all life policy forms currently in force and currently being marketed in Virginia and identify any policy forms, including those referenced during the course of this examination, that were not previously filed with the Commission as required by §§ 38.2 316 A, 38.2-316 B, and 38.2-316 C 1 of the Code. Prior to taking any action, submit a remediation plan to the Forms section of the Life and Health Market Regulation division. It is requested that the Company clearly indicate in the letter(s) of transmittal that the submission is a result of John Hancock's efforts to comply with this examination's corrective action plan;

9. ~~Identify and file for approval all long-term care EOB forms currently in use that have not yet been filed with the Commission, as required by §38.2-3407.4 A of the Code;~~

10. ~~Establish and maintain procedures to ensure that its EOB forms are filed with and approved by the Commission, as required by §38.2-3407.4 A of the Code;~~

11. ~~Review and strengthen its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;~~

12. Review and strengthen its procedures for notifying agents and agencies within 5 calendar days and the Commission within 30 calendar days of appointment termination, as required by § 38.2-1834 D of the Code;

13. ~~Review and strengthen its procedures to ensure all agents receive the required initial training and ongoing training every 24 months thereafter before being permitted to sell, solicit or negotiate a long-term care partnership policy, as required by 14 VAC 5-200-205 E and 14 VAC 5-200-205 F;~~

14. ~~Review and strengthen its procedures for the application and issuance of the accelerated benefit rider to prevent individuals of the same class and equal expectation of life from being unfairly discriminated against in the terms and conditions of the contract, as required by subsection 1 of § 38.2-508 of the Code;~~

15. Review and strengthen its procedures to ensure that NIP forms given to applicants and policyholders comply with all requirements set forth in § 38.2-604 of the Code;

16. Review and strengthen its procedures to ensure that the AUD notice required by §§ 38.2-610 A 1 and 38.2-610 A 2 of the Code is provided in accordance with the guidelines established by Administrative Letter 2015-07 in the case of

declined/closed life and long-term care applications and in the case of offers to insure at higher rates or with limitations, exceptions or benefits other than those applied for;

17. ~~Review and strengthen its procedures to ensure that an explanation of potential long-term care future premium rate revisions is provided to the applicant at the time of application and that Form F is used, as required by 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C;~~

18. Implement and maintain appropriate controls to ensure that Premium Notices, Lapse Warning Notices, and Lapse Warning Reminders for universal life and variable universal life products are sent in accordance with its established procedures and that documentation of sending the notices is maintained;

19. Revise its Final Lapse Notice for universal life and variable universal life products to provide clear and accurate information about the terms and conditions of the policy and the grace period, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

20. Establish and maintain procedures to ensure that it retains any and all evidence of mailing the lapse notice required by 14 VAC 5-200-65 A 3, including the list of recipients, as applicable, and a copy of the notice, for at least 3 years following the date of the notice;

21. ~~Implement and maintain appropriate controls to ensure that long-term care EOBs include the correct information regarding available benefits and policy limits, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;~~

22. ~~Revise its long-term care EOBs to clearly identify which benefit category in the policy claims are being made under in order to clearly and accurately disclose the~~

method of benefit calculation and the actual amount which has been or will be paid, as required by § 38.2-514 B of the Code;

23. Revise its long-term care EOBs to include all service charges listed on the submitted invoices in order to clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid, as required by § 38.2-514 B of the Code;

24. Review and strengthen its procedures to ensure that long-term care claims are processed under the correct benefit category in the policy and that this information is displayed correctly on the EOB, in order to ensure that the benefits payable under the contract are clearly and accurately set forth, as required by § 38.2-3407.4 B of the Code;

25. Review and strengthen its procedures to ensure that long-term care claim benefits are paid in accordance with policy provisions;

26. Review and reconsider for re-adjudication the life claims discussed in Review Sheets CL47-JB and CL50-JB, and make interest payments, as required by § 38.2-3115 B of the Code and the terms of the policy. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

27. Review and strengthen its procedures for the payment of interest on life claim proceeds, as required by § 38.2-3115 B of the Code and the terms of the policy;

28. Review and consider for re-adjudication the long-term care claims discussed in Review Sheets CL09-JB, CL11-JB, CL02-HW, CL38-HW, and CL40-HW, and

~~make interest payments, as required by § 38.2-3407.1 B of the Code. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;~~

29. ~~Review and strengthen its procedures for the payment of interest on long-term care claim proceeds, as required by § 38.2-3407.1 B of the Code;~~

30. Review and strengthen its procedures to ensure that life claims are processed in accordance with the requirements of 14 VAC 5-400-50 A and 14 VAC 5-400-60 A;

31. ~~Review and strengthen its procedures to ensure that long-term care claims are processed in accordance with the requirements of 14 VAC 5-400-100 B and 14 VAC 5-400-70 D;~~

32. ~~Establish and maintain procedures to ensure that a written denial is provided for excluded/non-covered charges submitted during the invoice/payment phase for long-term care claims, as required by 14 VAC 5-400-70 A;~~

33. ~~Revise its retained asset account (SAA) flyer and supplemental contract to clearly provide a written disclosure including a statement identifying the account as either a checking account or draft account, as required by subsection 4 of § 38.2-3117.4 of the Code;~~

34. ~~Revise its retained asset account (SAA) flyer and supplemental contract to provide a written disclosure of the minimum interest rate to be credited to the account and how the actual interest rate will be determined, as required by subsection 8 of § 38.2-3117.4 of the Code; and~~

35. Within 90 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XIII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by John Hancock's officers and employees during the course of this examination is gratefully acknowledged.

Brant Lyons, MCM, Julie Atkins, MCM, Bernard Brown, Janay Brown, MCM, Jarod Mentzer, MCM, Heather Webb, MCM, and Laura Wilson, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XIV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

Comment on Area Violations Summary by Review Sheet

Depending on the changes to the Report that the Bureau elects to make, this section of the Report will have to be edited accordingly.

ADVERTISING
14 VAC 5-41-30 B, 10 violations, AD02-JA, AD05-JA, AD06-JA, AD11-JA, AD02-LW, AD03-LW, AD04-LW, AD05-LW, AD06-LW, AD08-LW
14 VAC 5-41-40 B, 2 violations, AD01-LW, AD05-LW
14 VAC 5-41-80 B, 2 violations, AD04-JA, AD11-JA
14 VAC 5-41-90 J, 5 violations, AD12-JA, AD13-JA, AD14-JA, AD04-LW, AD05-LW
14 VAC 5-200-160 A, 3 violations, AD05-JA, AD16-JA (2)
POLICY AND OTHER FORMS
§ 38.2-316 A, 4 violations, PF01-BB, PF03-JA, PF04-JA (2)
§ 38.2-316 B, 10 violations, PF03-JA (5), PF05-JA (3), PF06-JA (2)
§ 38.2-316 C 1, 14 violations, PF01-BB, PF03-JA (6), PF04-JA (2), PF05-JA (3), PF06-JA (2)
§ 38.2-3407.4 A, 4 violations, PF01-BL
AGENTS
§ 38.2-1812 A, 1 violation, AG01-JA
§ 38.2-1833 A 1, 2 violations, AG01-JA, AG02-JA

§ 38.2-1834 D, 3 violations, AG01-HW, AG02-HW, AG03-HW
14 VAC 5-200-205 E, 1 violation, AG05-JA
14 VAC 5-200-205 F, 1 violation, AG05-JA
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT/INSURANCE REPLACEMENT AND SUITABILITY
Subsection 1 of § 38.2-508, 3 violations, UN12-JA
§ 38.2-604 B 4, 6 violations, UN01-JA, UN02-JA (2), UN10-JA (2), UN11-JA
§ 38.2-610 A 1, 26 violations, UN06-JA (4), UN09-JA (2), UN13-JA (5), UN16-JA, UN17-JA (14)
§ 38.2-610 A 2, 42 violations, UN06-JA (4), UN07-JA (6), UN08-JA (6), UN09-JA (6), UN13-JA (5), UN16-JA, UN17-JA (14)
§ 38.2-610 B 3, 4 violations, UN05-JA
14 VAC 5-200-75 A 2, 1 violation, UN19-JA
14 VAC 5-200-75 C, 1 violation, UN19-JA
CANCELLATIONS/NONRENEWALS/RESCISSIONS/CONVERSIONS
14 VAC 5-200-65 A 3, 18 violations, CN04-JM
Subsection 1 of § 38.2-502, 2 violations, CN01-BB
LIFE CLAIMS PRACTICES
§ 38.2-3115 B, 1 violation, CL47-JB
14 VAC 5-400-50 A, 7 violations, CL45-JB, CL54-JB, CL101-HW, CL105-HW, CL111-HW, CL112-HW, CL113-HW

14 VAC 5-400-60 A, 13 violations, CL44-JB, CL45-JB, CL46-JB, CL51-JB, CL54-JB, CL101-HW, CL102-HW, CL104-HW, CL105-HW, CL108-HW, CL109-HW, CL111-HW, CL112-HW
Subsection 4 of § 38.2-3117.4, 1 violation, CL43-JB
Subsection 8 of § 38.2-3117.4, 1 violation, CL43-JB
LONG-TERM CARE CLAIMS PRACTICES
Subsection 1 of § 38.2-502, 3 violations, CL40-HW
§ 38.2-514 B, 212 violations, CL01-JB, CL02-JB (3), CL04-JB (3), CL05-JB (3), CL06-JB, CL10-JB (4), CL12-JB (3), CL13-JB (5), CL15-JB (4), CL18-JB (4), CL19-JB (5), CL25-JB (5), CL32-JB (3), CL33-JB (2), CL08-HW (4), CL09-HW (3), CL11-HW (3), CL14-HW (2), CL17-HW, CL18-HW (4), CL20-HW (4), CL22-HW (4), CL24-HW, CL25-HW (5), CL26-HW (3), CL30-HW (4), CL32-HW (3), CL33-HW (3), CL35-HW (3), CL36-HW (5), CL37-HW (5), CL40-HW, CL41-HW (4), CL42-HW (3), CL43-HW (3), CL44-HW (3), CL45-HW (4), CL46-HW, CL52-HW, CL53-HW (5), CL54-HW, CL55-HW (5), CL56-HW (6), CL57-HW (4), CL61-HW (2), CL62-HW, CL63-HW, CL64-HW, CL65-HW, CL67-HW (5), CL68-HW, CL69-HW, CL70-HW (3), CL71-HW (2), CL72-HW (2), CL75-HW, CL77-HW (3), CL78-HW, CL79-HW (3), CL80-HW (7), CL81-HW (7), CL82-HW (3), CL83-HW, CL84-HW (6), CL85-HW, CL86-HW (6), CL87-HW (2), CL95-HW, CL96-HW (3), CL98-HW (2), CL100-HW
§ 38.2-3407.1 B, 6 violations, CL09-JB (2), CL11-JB, CL02-HW, CL38-HW, CL40-HW
§ 38.2-3407.4 B, 1 violation, CL46-HW
14 VAC 5-400-60 A, 15 instances of non-compliance, CL09-JB (2), CL11-JB, CL01-HW, CL02-HW, CL33-HW, CL38-HW, CL40-HW, CL49-HW, CL60-HW, CL61-HW, CL66-HW, CL71-HW, CL74-HW, CL97-HW

14 VAC 5-400-70 A, 200 violations, CL01-JB, CL02-JB (3), CL04-JB (3), CL05-JB (3), CL06-JB, CL10-JB (4), CL12-JB (3), CL13-JB (5), CL18-JB (4), CL19-JB (5), CL25- JB (5), CL08-HW (4), CL09-HW (3), CL11-HW (3), CL14-HW (2), CL17-HW, CL18-HW (4), CL20-HW (4), CL22-HW (4), CL24-HW, CL25-HW (5), CL26-HW (3), CL30-HW (4), CL32-HW (3), CL33-HW (3), CL35-HW (3), CL36-HW (5), CL37-HW (5), CL40-HW, CL41-HW (4), CL42-HW (3), CL43-HW (3), CL44-HW (3), CL45-HW, CL46-HW, CL52-HW, CL53-HW (5), CL54-HW, CL55-HW (5), CL56-HW (6), CL57-HW (4), CL61-HW (2), CL62-HW, CL63-HW, CL64-HW, CL65-HW, CL67-HW (5), CL68-HW, CL69-HW, CL70-HW (3), CL71-HW (2), CL72-HW (2), CL75-HW, CL77-HW (3) CL78-HW, CL79-HW (3), CL80-HW (7), CL81-HW (7), CL82-HW (3), CL83-HW, CL84-HW (6), CL85-HW, CL86-HW (6), CL87-HW (2), CL95-HW, CL96-HW (3), CL98-HW (2), CL100-HW
14 VAC 5-400-70 D, 4 instances of non-compliance, CL46-HW

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

February 11, 2020

VIA EMAIL

William Gottlieb
Assistant Vice President & Associate General Counsel
John Hancock Life Insurance Company (U.S.A.)
197 Clarendon Street – C-05-31
Boston, MA 02116

RE: Response to the Draft Examination Report
John Hancock Life Insurance Company (U.S.A.) (John Hancock)

Dear Mr. Gottlieb:

The examiners have received and reviewed John Hancock's response to the Draft Report dated December 5, 2019. This letter addresses John Hancock's concerns and proposed revisions to each area of review in the same order as presented in the Draft Report and company response.

While John Hancock presented the same argument in response to different violations discussed in various sections of the Report, the Bureau responded to each argument once and has noted the other findings where the same position applies. Since John Hancock's response will also be attached to the final Report, this response does not address those issues where John Hancock did not specifically indicate disagreement. John Hancock should note that upon finalization of this exam, John Hancock will be given approximately 90 days to document compliance with all the corrective actions in the Report.

John Hancock has expressed concerns throughout its response and accompanying letter requesting "due consideration" from "appropriate legal and other senior personnel at the Bureau." Please be advised that the findings identified and discussed in the Report and this letter have been reviewed by and are supported by appropriate management at the Bureau and general counsel.

SECTION IV. ADVERTISING

LIFE INSURANCE ADVERTISING

Regarding the violations of 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, and 14 VAC 5-41-90 J, John Hancock "maintains and reiterates that its prior response fully refutes" the findings noted in the Draft Report. The Company's prior responses have already been reviewed and responded to by the examiners, and it was previously communicated to John Hancock that its responses were not sufficient to prompt removal of the findings. It was also previously communicated to John Hancock that filing an advertisement with or receiving approval from regulators of other jurisdictions does not constitute compliance with or absolve the company of its obligation to comply with the advertising requirements of the Commonwealth of Virginia ("Commonwealth").

In response to John Hancock's claim that "There have been no complaints from consumers in Virginia or elsewhere raising the issue being pressed by the Bureau," the examiners would direct John Hancock to the second paragraph of the Advertising section of the Draft Report (page 7 of the Report), which states the following:

> **Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-41-30 B and 14 VAC 5-90-50)**

John Hancock has also argued throughout its response under other sections of the Report that there were no consumer complaints or concerns from other state regulators regarding the findings expressed in the Draft Report. Similar to the Bureau's response regarding advertising, please be advised that a complaint is not required for non-compliance to exist and that the requirements of other states are not applicable to the Commonwealth. No changes to the Report are necessary.

SECTION V. POLICY AND OTHER FORMS

EXPLANATION OF BENEFITS (EOB)

The examiners acknowledge John Hancock's objection to filing its long-term care EOB form as required by § 38.2-3407.4 A of the Code of Virginia. The Bureau disagrees with John Hancock's analysis and finds its claim that accident and sickness insurance and long-term care insurance are wholly distinct to be contrary to the way in which accident and sickness insurance and long-term care insurance have long been regulated in the Commonwealth.

Article 2 of Chapter 100 of Title 38.2 of the Code defines and lists the varying classes of insurance that are regulated by the Commonwealth. Long-term care insurance is not listed as a separate class of insurance in Article 2. Thus, it follows that long-term care insurance must fall within another class of insurance that is defined in Article 2 of Chapter 100 – namely, within accident and sickness insurance, as defined in § 38.2-109 of the Code.

Long-term care insurance has always been viewed as a subset of accident and sickness insurance. As an illustration, Chapter 140 of Title 14 of the Virginia Administrative Code, which sets forth the minimum standards for individual accident and sickness policies, provides that, "This chapter (14VAC5-140) shall apply to *all individual accident and sickness insurance* policies delivered or issued for delivery in this Commonwealth *except it shall not apply to* Medicare supplement, *long-term care,* and specified disease policies" (emphasis added). If long-term care insurance did not fall under the umbrella of accident and sickness insurance, there would be no need to except these policies out of the scope of Chapter 140.

John Hancock argues that the fact that long-term care insurance and accident and sickness insurance are governed by separate chapters of the Code and separate regulations means that they are distinct categories of insurance. However, this conclusion is incorrect. The existence of differing statutory and regulatory requirements does not necessarily mean that there is no overlap between accident and sickness insurance and long-term care insurance or that requirements that apply to accident and sickness insurance do not also apply to long-term care insurance. In fact, several other specific types of accident and sickness insurance, including specified disease policies and Medicare supplement, also fall under the umbrella of accident and sickness insurance even though they are governed by separate chapters of the Virginia Administrative Code.

It is also important to note that in the Commonwealth, carriers that are licensed to issue accident and sickness insurance are permitted to issue long-term care insurance to the extent that they are otherwise authorized to issue life insurance or accident and sickness insurance. *See, e.g.,* § 38.2-5200 of the Code. There is no license that is specific to the issuance of long-term care insurance; it falls under the accident and sickness license. This further supports the view that long-term care insurance is a type of accident and sickness insurance rather than a wholly distinct category of insurance.

Regarding the applicability of § 38.2-3407.4 A of the Code to long-term care insurance policies, § 38.2-5201 of the Code states that all long-term care policies and certificates, "shall comply with all the provisions of this title related to insurance policies and certificates generally, except Article 2 (§ 38.2-3408 *et seq.*) of Chapter 34 and Chapter 36 of this title. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling." Section 38.2-5201 of the Code clearly sweeps in the provisions of Chapter 34 of Title 38.2 of the Code, except for Article 2, pertaining to mandated benefits. Thus, since there is no direct conflict between § 38.2-3407.4 A of the Code and the provisions of Chapter 52, § 38.2-3407.4 A of the Code would apply to long-term care policies and certificates.

John Hancock argues that it has not been required to file its EOB forms in any state for long-term care insurance and it is not aware of any other carrier that is filing EOB forms for long-term care insurance in any other state. The Bureau has consistently required that all insurers issuing long-term care insurance in the Commonwealth file their EOB form as required by § 38.2-3407.4 A of the Code.

Furthermore, John Hancock's application of the long-term care exemption in § 38.2-3431 of the Code is incorrect. Sections 38.2-3431 through 38.2-3437 of the Code form the contents of "Article 5. Group Market Reforms and Individual Coverage Offered to Employees of Small Employers." The long-term care insurance exception referenced by John Hancock applies only to "requirements of *this article* (emphasis added) if offered separately," meaning long-term care insurance is only exempt from the requirements of §§ 38.2-3431 through 38.2-3437 of the Code. Please be advised that this language does not exempt long-term care insurance from any other requirements of Chapter 34 (for reference, the requirements of § 38.2-3407.4 A of the Code fall under "Article 1. General Provisions"). Similar to the rationale regarding Chapter 140 of Title 14 of the Virginia Administrative Code, the need for § 38.2-3431 of the Code to exclude long-term care insurance further supports the fact that all of the requirements of Chapter 34 are otherwise applicable to long-term care insurance unless specifically excluded.

Finally, while the examiners have removed specific references to the examination of Time Insurance Company (Time) in the Report, the examiners disagree with the Company's assertion that "it would be inequitable for the Bureau to extrapolate John Hancock's experience during the Time examination to a knowing violation of Section 38.2-3407.4 A" because "LTC insurance was only a minor piece of the Time examination."

During the time frame of the Time exam, John Hancock was the administrator of long-term care coverage ceded by Time under a 100 percent reinsurance agreement. John Hancock provided its own response, dated September 19, 2014, to the Time draft report asserting that long-term care insurance is not subject to § 38.2-3407.4 A of the Code and was informed in the Bureau's October 16, 2014 response that long-term care insurance does, in fact, fall within accident and sickness insurance in the Commonwealth and is therefore subject to Chapter 34. As part of the corrective action plan for the Time examination, the Bureau worked directly with John Hancock for several months to ensure that the Company's EOBs used in connection with Time's business were filed and approved. As such, John Hancock was aware of the applicability of § 38.2-3407.4 A of the Code to long-term care insurance prior to the current examination and knowingly failed to file for approval the long-term care EOBs used for its own business until 2017, which is after the forms had already been used during the exam time frame. No changes to the Report regarding the violations of § 38.2-3407.4 A of the Code are necessary.

Please be advised that the fact that long-term care insurance is accident and sickness insurance also addresses John Hancock's arguments throughout its response under other sections of the Report regarding the applicability of §§ 38.2-316 A, 38.2-316 C, 38.2-514 B, 38.2-3407.1 B and 38.2-3407.4 B of the Code.

SECTION VI. AGENTS

APPOINTED AGENT REVIEW

John Hancock has expressed concerns regarding sampling techniques and "error tolerance ratios" required in the Market Regulation Handbook ("Handbook"), and the Company has asserted that one or two "alleged violations" do not constitute a finding or justify recommendations to change or enhance procedures. The Company's use of the term "error tolerance ratio" appears to be a reference to the term "benchmark error rate," explained in the Handbook as a threshold used to establish the legal presumption of a general business practice. The Handbook sets forth standards for tolerance levels for statistical sampling purposes and as benchmarks for evaluating when violations of state's unfair claim and trade practices have occurred. However, the Handbook (on page 184 of the 2016 version) also states the following:

> ...many other state laws are not dependent upon the frequency of commission of an act in order to constitute a violation of the law – each instance of commission of the act constitutes a separate and distinct violation....

Please be advised that, except for Chapter 400 of Title 14 of the Virginia Administrative Code addressing Unfair Claim Settlement Practices, none of the violations cited in this Report are subject to a general business practice requirement. As each instance of non-compliance with the code section in question constitutes a separate and distinct violation, the benchmark error rate is not applicable to these findings and it is appropriate for each violation to be included in the Report as well as any necessary corrective actions requiring the Company to strengthen or establish procedures. Furthermore, if John Hancock believes that the sample sizes reviewed are not large enough, the Bureau would not object to reopening the examination and selecting additional sample files for review. However, any findings resulting from an additional review would be added to those already referenced in the Report.

The Company further asserts that the violations at issue "were previously contested on the merits by the Company." The company's previous responses were reviewed and responded to by the examiners during the examination and were not sufficient to prompt removal of the findings. No changes to the Report are necessary.

Please be advised that the Bureau's above position also addresses all the Company's arguments throughout its response under this and other sections of the Report regarding sample sizes and use of the Handbook.

SECTION VII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

UNDERWRITING REVIEW

Life Insurance

Subsection 1 of § 38.2-508 of the Code: In addition to the Company's sampling and Handbook concerns, which have been addressed in the previous section of this response, John Hancock has also argued that "its prior response to each of the three alleged violations of law fully refutes the assertion that Subsection 1 of Section 38.2-508 was violated." The company's prior responses were previously reviewed and responded to by the examiners and were not sufficient to prompt removal of the findings. No changes to the Report are necessary.

SECTION XI. CLAIM PRACTICES

PAID CLAIM REVIEW

Long-Term Care Insurance

Subsection 1 of § 38.2-502 of the Code: Upon further consideration, the examiners have removed the 3 violations of subsection 1 of § 38.2-502 of the Code associated with Review Sheet CL40-HW. The Report has been revised to reflect this change.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

Life Insurance

14 VAC 5-400-50 A and 14 VAC 5-400-60 A: John Hancock has indicated that these violations were an "inadvertent systems error" and that "the number of violations does not rise to the level of a general business practice." As already noted in the Draft Report, a disruption caused by system updates does not exempt the Company from the requirements to acknowledge the receipt of the claim within 10 working days and affirm a claim within 15 working days. Based on a sample of 50 paid claims, John Hancock was cited for 7 instances of non-compliance with 14 VAC 5-400-50 A and 13 instances of non-compliance with 14 VAC 5-400-60 A, which accounts for 14 percent and 26 percent of the sample, respectively, and rises to the level of a general business practice. No changes to the Report are necessary.

Long-Term Care Insurance

14 VAC 5-400-60 A: John Hancock has stated that "this provision of law is not entitled 'standards for prompt **payment** of claims' (emphasis added)," that the provision "refers to an initiation of an insured's claim to determine eligibility for payment of benefits," and that "The cited law is not applicable to invoice payment process associated with long-term care insurance." While insureds/claimants should also be notified of initial eligibility determinations in a timely manner, the examiners maintain that 14 VAC 5-400-60 A is

applicable to the invoice/payment processing portion of a long-term care claim. Though John Hancock has not provided any new information beyond that presented in its previous responses, the examiners are providing the following additional clarifications:

- 14 VAC 5-400-20 defines a claim as "a demand for payment by a claimant," which would include an invoice. 14 VAC 5-400-60 A requires the insurer to advise the claimant of acceptance or denial of the claim (i.e. invoice) within 15 working days of receipt of proof of loss. As John Hancock uses an EOB to notify the claimant of acceptance of the charges submitted on the invoice, this regulation therefore requires that an EOB be provided within 15 working days after receipt of proof of loss.

- Several of John Hancock's policies, such as Form Number LTC-02 VA, define proof of loss, in part, as "itemized bills for your care and services," and further state "After receiving the written proof of loss, the Company will pay monthly all benefits then due for Long-Term Care Services." This appears to be referring to invoice payment/processing with the invoice indicated as proof of loss under the policy.

- As of January 1, 2018, long-term care claims are subject to 14 VAC 5-400-100 B, which specifically requires an insurer to provide an EOB describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss. Please be advised that John Hancock should currently be complying with this regulation, which specifies the current number of days required for providing EOBs in a timely manner.

No changes to the Report are necessary.

14 VAC 5-400-70 A and § 38.2-514 B of the Code: The examiners acknowledge that John Hancock provides written explanations in cases of claim eligibility denials. However, John Hancock's practice of omitting the non-covered/excluded charges altogether from its EOBs continues to be problematic. As the billed amounts on the EOB do not match those of the invoice, this inhibits the claimant's ability to reconcile the charges and determine whether the correct daily benefit was paid. While the examiners have removed the 200 violations of 14 VAC 5-400-70 A, the 200 violations of § 38.2-514 B of the Code cited for John Hancock's failure to address non-covered/excluded charges on its EOBs will remain in the Report.

DISCLOSURES FOR RETAINED ASSET ACCOUNTS

Subsection 8 of § 38.2-3117.4 of the Code: In addition to the Company's sampling and Handbook concerns, which have been addressed in an earlier section of this response, John Hancock has argued that:

> ...It is clear that there is no minimum interest rate and that the applicable interest rate is to be determined by the Company. It is also clear that the then current interest rate of 1.25% is the interest rate that would apply....

John Hancock uses a flyer, which includes a supplemental contract, to provide disclosures to beneficiaries in connection with its life claims. The examiners maintain that the inclusion of the phrases "Current interest rate 1.25%" and "determined by John Hancock" do not satisfy the requirement to clearly disclose the minimum interest rate (or the Company's claim that there is no minimum interest rate) or how the interest rate will be determined. Furthermore, the other language included in the flyer such as "variable interest," "reflects economic factors and trends," and "rate is subject to change" adds ambiguity to the already minimal disclosures that are provided. While no changes to the Report regarding the findings are necessary, page 63 of the Report has been revised to refer to "disclosure" instead of "flyer/supplemental contract."

A copy of the entire Report with the revised pages noted is attached for your review, and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that John Hancock violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, subsection 1 of § 38.2-508, and § 38.2-514 B of the Code, in addition to 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, and 14 VAC 5-41-90 J of Rules Governing Advertisement of Life Insurance and Annuities and 14 VAC 5-400-50 A and 14 VAC 5-400-60 A of Rules Governing Unfair Claim Settlement Practices.

It also appears that John Hancock violated subsection 4 of § 38.2-3117.4, subsection 8 of § 38.2-3117.4, §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-604 B 4, 38.2-610 A 1, 38.2-610 A 2, 38.2-610 B 3, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3115 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B of the Code, in addition to 14 VAC 5-200-65 A 3, 14 VAC 5-200-75 A 2, 14 VAC 5-200-75 C, 14 VAC 5-200-160 A, 14 VAC 5-200-205 E, and 14 VAC 5-200-205 F of Rules Governing Long-Term Care Insurance.

Violations of the above sections of the Code can subject John Hancock to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

Considering the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

John Hancock Life Insurance Company (U.S.A.)

200 Berkeley Street – B-03-23
Boston, Massachusetts 02116
(617) 663-3797
E-mail: ateta@jhancock.com

Anthony M. Teta
Head of US Legacy Business

February 26, 2020

Ms. Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

RE: Alleged violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, subsection 1 of § 38.2-502, subsection 1 of § 38.2-508, 38.2-514 B, 38.2-604 B 4, 38.2-610 A 1, 38.2-610 A 2, 38.2-610 B 3, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3115 B, subsection 4 of § 38.2-3117.4, subsection 8 of § 38.2-3117.4, 38.2-3407.1 B, 38.2-3407.4 A, and 38.2-3407.4 B of the Code, in addition to, 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, 14 VAC 5-41-90 J, 14 VAC 5-200-65 A 3, 14 VAC 5-200-75 A 2, 14 VAC 5-200-75 C, 14 VAC 5-200-160 A, 14 VAC 5-200-205 E, 14 VAC 5-200-205 F, 14 VAC 5-400-50 A, and 14 VAC 5-400-60 A.
Case No. INS-2020-00027

Dear Ms. Blauvelt:

This will acknowledge receipt of the Bureau of Insurance's letter dated February 18, 2020, concerning the above-referenced matter. John Hancock wishes to make a settlement offer for the alleged violations cited above.

At your request, I have enclosed with this letter a certified check, payable to the Treasurer of Virginia in the amount of $60,600.

The Company agrees to comply with the corrective action plan set forth in the Target Market Conduct Examination Report as of December 31, 2016.

I acknowledge that John Hancock has right to a hearing before the State Corporation Commission in this matter and that the Company will waive that right if the State Corporation Commission accepts this offer of settlement.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Thank you for your attention to this matter.

Sincerely,

Anthony M. Teta

Attachment

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION 200320095

AT RICHMOND, MARCH 11, 2020

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2020-00027

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

SETTLEMENT ORDER

Based on a market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that John Hancock Life Insurance Company (U.S.A.) ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated §§ 38.2-316 A and 38.2-316 B of the Code of Virginia ("Code") by failing to comply with insurance application form filing requirements of the Commission; § 38.2-316 C (1) of the Code by failing to use insurance policies or forms on file and approved by the Commission as of the effective date requested by the Defendant; § 38.2-502 (1) of the Code by misrepresenting the benefits, advantages, conditions, or terms of an insurance policy; § 38.2-508 (1) of the Code by engaging in unfair discrimination; § 38.2-514 B of the Code by failing to make proper disclosures on the explanation of benefits; § 38.2-604 B (4) of the Code by failing to accurately provide the required notices to insureds; §§ 38.2-610 A (1) and 38.2-610 A (2) of the Code by failing to provide written notice of an adverse underwriting decision and by failing to provide a summary of rights in the form approved by the Commission; § 38.2-610 B (3) of the Code by failing to disclose the names and addresses of the institutional sources of information; § 38.2-1812 A of the Code by paying or

sharing commissions with an unlicensed agent; § 38.2-1833 A (1) of the Code by failing to file a notice of appointment of agents with the Commission; § 38.2-1834 D of the Code by failing to comply with the Commission's notification requirements of the termination of agent appointments; § 38.2-3115 B of the Code by failing to properly pay interest on life insurance and annuity contract proceeds; §§ 38.2-3117.4 (4) and 38.2-3117.4 (8) by failing to provide the required written disclosures to the beneficiary of a policy before a retained asset account is selected; § 38.2-3407.1 B of the Code by failing to comply with the requirement for the payment of interest on claim proceeds; § 38.2-3407.4 A of the Code by failing to file for approval by the Commission its explanation of benefits forms; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth the benefits payable under the contract in the explanation of benefits; 14 VAC 5-41-30 B, 14 VAC 5-41-40 B, 14 VAC 5-41-80 B, and 14 VAC 5-41-90 J of the Commission's Rules Governing Advertisement of Life Insurance and Annuities, 14 VAC 5-41-10 *et seq.*, by failing to comply with the requirements related to the advertisement of life insurance and annuities; 14 VAC 5-200-65 A 3 of the Commission's Rules Governing Long-Term Care Insurance, 14 VAC 5-200-10 *et seq.* ("Rules"), by failing to provide an insured the required notice of lapse or termination of a policy; 14 VAC 5-200-75 A 2 and 14 VAC 5-200-75 C of the Commission's Rules by failing to disclose the required rating practices to consumers; 14 VAC 5-200-160 A of the Commission's Rules by failing to comply with the requirements related to the advertisement of long-term care insurance; 14 VAC 5-200-205 E and F of the Commission's Rules by failing to comply with the insurance agent training requirements; as well as 14 VAC 5-400-50 A and 14 VAC 5-400-60 A of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to properly acknowledge

notification of a claim receipt and by failing to provide claimants timely notification of acceptance or denial of claims.

The Commission is authorized by §§ 38.2-218, 38.2-219 and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting nor denying any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan outlined in the examination report as of December 31, 2016; has tendered to the Treasurer of Virginia the sum of Sixty Thousand Six Hundred Dollars ($60,600); and has waived the right to a hearing.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: William Gottlieb, Assistant Vice President and Associate General Counsel, John Hancock Life Insurance Company (U.S.A.), 197 Clarendon Street, C-05-31, Boston, Massachusetts 02116; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission