

**Maine Bureau of Insurance**  
**Form Filing Requirements Checklist**  
**Individual Hospital Confinement Indemnity (H14I)**  
**Plans Issued on or after January 1, 2015**  
**(Amended 1/9/2015)**

Confirm compliance and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING in the last column. N/A:  
Check this box if a contract does not have to meet this requirement and EXPLAIN WHY in the last column.

State Benefit/Provision and/or ACA Requirement	State Law/ Rule and/or Federal Law	State Description of Requirement and/or ACA Description of Requirement	N/A →	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING MUST EXPLAIN WHY REQUIREMENT IS NOT APPLICABLE
<b>GENERAL REQUIREMENTS</b>				
Electronic (SERFF) Submission Requirements	<a href="#">24-A M.R.S.A. §2412 (2) Bulletin 360</a>	All filings must be filed electronically, using the <u>NAIC</u> System for Electronic Rate and Form Filing (SERFF). See <a href="http://www.serff.com">http://www.serff.com</a> .	<input type="checkbox"/>	
FILING FEES	<a href="#">24-A M.R.S.A. §601(17)</a>	\$20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report.	<input type="checkbox"/>	
Grounds for disapproval	<a href="#">24-A M.R.S.A. §2413</a>	Seven categories of the grounds for disapproving a filing.	<input type="checkbox"/>	
Readability	<a href="#">24-A M.R.S.A. §2441</a>	Minimum of 50. Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF.	<input type="checkbox"/>	

Variability of Language	<a href="#">24-A M.R.S.A. §2412</a>  <a href="#">§2413</a>	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations.	<input type="checkbox"/>	
<b>EXCEPTED BENEFIT REQUIREMENTS</b>				
Required Disclosures	79 FR 30240, 42 CFR §148.220(b)(4) (v)  <a href="#">Bulletin 396</a>  <a href="#">Appendices A and B</a>	The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016.  This applies to all insurers writing hospital indemnity policies or other fixed indemnity policies sold in the individual market in Maine, including association coverage and other coverage that is issued through non-employer groups.  All policies and certificates with effective dates on or after January 1, 2015, are subject to the Final Rule. In addition, the notice requirement applies to renewals for all policy years beginning on or after January 1, 2015.	<input type="checkbox"/>	
New Sales Application Materials Notice	42 CFR § 148.220(b)(4) (iv)	A notice is displayed prominently in the application materials in at least 14 point type that has the following language:  “THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”  This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate.	<input type="checkbox"/>	

<p>Renewal Notice</p>	<p>42 CFR § 148.220(b)(4)(iv)</p> <p><a href="#">Bulletin 396</a></p>	<p>A notice is displayed prominently in the application materials in at least 14 point type that has the following language:</p> <p><b>“THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”</b></p> <p>This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate.</p> <p>If no application for renewal is required because the policy or certificate renews automatically upon continued payment of premiums, then no later than October 1, 2016, the carrier shall send notice to each insured who was not given notice at the point of sale. The Bureau suggests that carriers use language substantially similar to the following notice:</p> <p><b>“THIS INSURANCE POLICY DOES NOT MEET THE AFFORDABLE CARE ACT'S REQUIREMENT THAT YOU MAINTAIN MINIMUM ESSENTIAL COVERAGE, ALSO KNOWN AS MAJOR MEDICAL INSURANCE. FAIL URE TO MAINTAIN MINIMUM ESSENTIAL HEAL TH COVERAGE MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE COVERAGE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS.”</b></p> <p>The attestation requirement applies to all renewal applications for coverage effective on or after October 1, 2016.</p>	<input type="checkbox"/>	
<p>Attestations</p>	<p>42 CFR § 148.220(b)(4)(i)</p>	<p>Benefits are provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B)</p>	<input type="checkbox"/>	

	<a href="#">Bulletin 396</a>	<p>The Bureau suggests that carriers issuing hospital or fixed indemnity coverage in the individual market (meaning all such coverage that is not offered as an employee benefit) use the following attestation language, immediately following the notice:</p> <p><b>"I hereby attest that I have Medicare or major medical health insurance that meets the requirement of 'minimum essential coverage' as defined by the Affordable Care Act."</b></p> <p>The attestation requirement also applies to all renewal applications for coverage effective on or after October 1, 2016.</p>		
Coordination of Benefits	42 CFR § 148.220(b)(4)(ii)	There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.	<input type="checkbox"/>	
Payment of Benefits	42 CFR § 148.220(b)(4)(iii)	The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, \$100/day or \$50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage.	<input type="checkbox"/>	
<b>GENERAL POLICY PROVISIONS</b>				
Classification of Coverage, Disclosure, and Minimum Standards	<a href="#">24-A M.R.S.A. §2694</a>  <a href="#">Rule 755</a>	<p>These rules establish minimum standards for benefits under individual and group health insurance. These rules clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules also set minimum standards for benefits for hospital confinement indemnity coverage.</p> <p>The following minimum standards for benefits are prescribed for hospital confinement indemnity coverage noted in the following subsections. An individual health insurance policy or group health insurance policy or certificate hospital confinement indemnity coverage shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for hospital confinement indemnity coverage or the Superintendent finds that the policies or certificates are approvable as supplemental health insurance and the outline of coverage complies with the outline of coverage in</p>	<input type="checkbox"/>	

Section 7(M) of this rule.

The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. § 2694 that the form is intended to be in.

This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in 24-A M.R.S.A. § 2694.

The requirements set forth in this section are in addition to any other applicable requirements as specified in Section 3(D).

Must comply with all applicable provisions of Rule 755 for Major Medical coverage including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G).

Must comply with all applicable provisions of Rule 755 for hospital confinement indemnity coverage including, but not limited to, Sections 4, 5, 6(A), 6(E), 7(A), 7(B), and 7(B)(F), specifically:

**Sec. 4.** Policy Definitions.

**Sec. 5.** Prohibited Policy Provisions

**Sec. 6(A).** General Rules.

**Sec. 6 (E)(1)** “Hospital confinement indemnity coverage” is a policy of health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$50 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

**(2)** Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(3) Except as permitted under 24-A M.R.S.A. § 2723, benefits shall be paid regardless of other coverage.

**Sec. 7 (A)(1)** Application disclosure: All applications for coverages specified in Sections 6B, C, D, E, G, I, J, K and L shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows:

**“The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully.”**

**Sec. 7(A)(4)** Each policy of individual health insurance and group health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

**Sec. 7(A)(8)** If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Preexisting Condition Limitations.”

**Sec. 7(A)(10)** All individual policies, except nonrenewable accident policies, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within ten days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificateholder is not satisfied for any reason. Ten days is a minimum; longer periods are permitted.

**Sec. 7(A)13(a)** Outlines of coverage delivered in connection with

	<p>policies defined in this rule as hospital confinement indemnity (Section 6E), specified disease (Section 6J), or supplemental health coverages (Section 6L) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections F and J, the following language, which shall be printed on or attached to the first page of the outline of coverage:</p> <p><b>“This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.”</b></p> <p>(b) An insurer shall deliver to persons eligible for Medicare any notice required under Bureau of Insurance Rule Chapter 275(17)(D).</p> <p><b>Sec. 7(A)(16)</b> All hospital confinement indemnity policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:</p> <p><b>“Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.”</b></p> <p><b>Sec. 7(B)</b> Outline of Coverage Requirements</p> <p>(1) An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual health insurance, group health insurance, dental plans, and vision plans as required in 24-A M.R.S.A. § 2695. This requirement shall not apply to group major medical policies and certificates issued to employer groups as described in 24-A M.R.S.A. § 2804 and labor union groups as described in 24-A M.R.S.A. § 2805. Except as provided in Section 10, all outlines of coverage used in this state require the approval of the Superintendent.</p> <p>(2) If an outline of coverage was delivered at the time of application or</p>	
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enrollment and the policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:

**“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued.”**

**(3)** In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the Superintendent for prior approval.

**(4)** An outline of coverage may take the form of an advertisement provided that it satisfies the standards specified for outlines of coverage in 24-A M.R.S.A. § 2695(8) as well as this rule.

**Sec. 7(B)(F) Hospital Confinement Indemnity Coverage (Outline of Coverage)**

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 6(E) of this rule. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

**HOSPITAL CONFINEMENT INDEMNITY COVERAGE**

**THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS**

**BENEFITS PROVIDED ARE SUPPLEMENTAL  
AND ARE NOT INTENDED TO COVER ALL  
MEDICAL EXPENSES**

		<p style="text-align: center;"><b>OUTLINE OF COVERAGE</b></p> <p><b>(1) Read Your [Policy][Certificate] Carefully</b>—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you <b>READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!</b></p> <p><b>(2) Hospital confinement indemnity coverage</b> is designed to provide coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.</p> <p><b>(3) [A brief specific description of the benefits in the following order:</b></p> <p>(a) Daily benefit payable during hospital confinement; and  (b) Duration of benefit described in (a).</p> <p>The description of benefits shall be stated clearly and concisely.]</p> <p><b>(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or, in any other manner, operate to qualify payment of the benefit, described in Paragraph (3) above.]</b></p> <p><b>(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]</b></p> <p><b>(6) [Any benefits provided in addition to the daily hospital benefit.]</b></p>		
Definition Of Emergency Services & Medical Condition	<a href="#">Rule 850, Sec. 5(O) &amp; 5(P)</a>	Acute symptoms that if not medically attended to could result in placing the health, physical or mental, of the individual (or unborn child) in serious jeopardy; serious impairment of bodily functions; serious dysfunction of bodily organ or part; for pregnant women if having contractions and there is inadequate time to transfer to another	<input type="checkbox"/>	

		hospital or there is a safety issue involved. Includes prudent layperson language		
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	<a href="#">24-A M.R.S.A. §2413</a>	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	<input type="checkbox"/>	
Extension of Benefits	<a href="#">24-A M.R.S.A. §2849-A</a>	Must provide an extension of benefits of at least 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.	<input type="checkbox"/>	
Free look period	<a href="#">24-A M.R.S.A. §2717</a>	There shall be a provision in the policy or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason.	<input type="checkbox"/>	
General format	<a href="#">24-A M.R.S.A. §2703</a>	Readability, term of policy described, cost disclosed, form number in bottom left corner.	<input type="checkbox"/>	
Grace Period	<a href="#">24-A M.R.S.A. §2707</a>	There shall be a provision that a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.	<input type="checkbox"/>	
Legal actions	<a href="#">24-A M.R.S.A. §2715</a>	No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	<input type="checkbox"/>	
Notice of Policy Changes and Modifications	<a href="#">24-A M.R.S.A. §2850(B)(3)(I)</a>	A carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product.	<input type="checkbox"/>	
Notice of Rate Increase	<a href="#">24-A M.R.S.A. §2735-A</a>	Requires that insurers provide a minimum of 60 days written notice to affected policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. It specifies the	<input type="checkbox"/>	

		requirements for the notice. See these sections for more details		
Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies	<a href="#">Rule 275, Sec. 17(D)</a>	There must be a notice predominantly displayed on the first page of the policy that states:  <b>"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."</b>	<input type="checkbox"/>	
Preexisting Conditions	<a href="#">Rule 755(8)</a>	If a policy or certificate contains any limitations with respect to preexisting conditions, the limitation shall appear as a separate paragraph of the policy or certificate and be labeled as <b>"PREEXISTING CONDITION LIMITATION."</b>	<input type="checkbox"/>	
Prohibited practices	<a href="#">24-A M.R.S.A. §2736-C(3)(A)</a>	An enrollee may not be cancelled or denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage.	<input type="checkbox"/>	
Rate Filing	<a href="#">24-A M.R.S.A. §2736</a>	1. Filing of rate information. Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701.  2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing.	<input type="checkbox"/>	
Reinstatement	<a href="#">24-A M.R.S.A. §2708</a>	There shall be a provision that if any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy.	<input type="checkbox"/>	
Renewal provision	<a href="#">24-A M.R.S.A. §2738</a>	Policy must contain the terms under which the policy can or cannot be renewed prominently on first page of policy or certificate.	<input type="checkbox"/>	
Representations on Applications	<a href="#">24-A M.R.S.A. §2411</a>	There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties.	<input type="checkbox"/>	

Third Party Notice of Cancellation	<a href="#">24-A M.R.S.A. §2707-A,</a>  <a href="#">Rule 580</a>	Third party 10 day prior notice of cancellation and reinstatement for cognitive impairment or functional incapacity.	<input type="checkbox"/>	
Time limit on certain defenses	<a href="#">24-A M.R.S.A. §2706</a>	There shall be a provision that from the date of issue of a policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such 3-year period.	<input type="checkbox"/>	
<b>ELIGIBILITY/ENROLLMENT</b>				
Children of Unmarried Women	<a href="#">24-A M.R.S.A. §2741</a>	Coverage of children must be made available to unmarried women on the same basis as married women.	<input type="checkbox"/>	
Definition of Dependent	<a href="#">24-A M.R.S.A. §2742</a>	Children (including stepchildren, adopted children or children placed for adoption) under the age of 19. Cannot use financial dependency as a requirement for eligibility. Adopted, or placed for adoption children are to be provided the same benefits as natural dependent children and stepchildren.	<input type="checkbox"/>	
Dependent Children Up to Age 25	<a href="#">24-A M.R.S.A. §2742-B</a>	An individual health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age. The child must be unmarried, have no dependent of their own, be a resident of Maine or be enrolled as a full-time student, and not have coverage under any other health policy/contract or federal or state government program.	<input type="checkbox"/>	
Dependent children with mental or physical illness	<a href="#">24-A M.R.S.A. §2742-A</a>	Requires health insurance policies to continue coverage for dependent children who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility.	<input type="checkbox"/>	
<b>CLAIMS &amp; UTILIZATION REVIEW</b>				
Claim forms	<a href="#">24-A M.R.S.A. §2710</a>	There shall be a provision that the insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss	<input type="checkbox"/>	

		upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.		
Examination, autopsy	<a href="#">24-A M.R.S.A. §2714</a>	There shall be a provision that the insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not prohibited by law.	<input type="checkbox"/>	
Limits on priority liens/subrogation	<a href="#">24-A M.R.S.A. §2729-A</a>	Does this policy have subrogation provisions? If yes, see provisions below:  Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien.	<input type="checkbox"/>	Yes <input type="checkbox"/> Please provide citation for section in policy <hr/> No <input type="checkbox"/>
Notice of Claim	<a href="#">24-A M.R.S.A. §2709</a>	There shall be a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.	<input type="checkbox"/>	
Payment of Claims	<a href="#">24-A M.R.S.A. §2436</a>	A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer.	<input type="checkbox"/>	
Penalty for failure to notify of hospitalization	<a href="#">24-A M.R.S.A. §2749-B</a>	No penalty for hospitalization for emergency treatment.	<input type="checkbox"/>	
<b>GRIEVANCES &amp; APPEALS</b>				
Grievance and Appeal Procedures	<a href="#">24-A M.R.S.A. §2747</a>	The policy must contain the procedure to follow if an insured wishes to file a grievance regarding policy provisions or denial of benefits.	<input type="checkbox"/>	