WEST VIRGINIA CODE: §33-16F-4

§33-16F-4. Required plan provisions; grounds for disapproval; alternative plans.

(a) To be approved, plan entities must assure that each proposed plan will provide cost containment through the use of plan design features such as limits on the number of services, caps on benefit payments or copayments for services.

(b) To provide consumer choice, plan entities must develop and submit two alternative benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage. Plans providing catastrophic coverage must, at a minimum, provide coverage for preventive health services and inpatient hospital stays and may also include coverage of one or more of the following: Hospital emergency care services and outpatient facility services; outpatient surgery; or outpatient diagnostic services.

(c) All plans must offer prescription drug benefit coverage.

(d) Plan enrollment materials must provide information in plain language on policy benefit coverage, benefit limits, cost-sharing requirements, exclusions and a clear representation of what is not covered in the plan. The enrollment materials must include a standard disclosure form developed by the commissioner that must be reviewed and executed by all consumers purchasing West Virginia affordable health care plan coverage.

(e) The commissioner shall disapprove any plan that:

(1) Contains any ambiguous, inconsistent or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

(2) Provides benefits that are unreasonable in relation to the premium charged; or

(3) Contains provisions that are unfair or inequitable, contrary to the public policy of this state, encourage misrepresentation or result in unfair discrimination in sales practices.