WEST VIRGINIA CODE: §33-48-8

§33-48-8. Benefits.

(a) The plan shall offer health care coverage consistent with comprehensive coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and subject to the approval of the commissioner.

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles and coinsurance factors annually according to the medical component of the consumer price index.

(d) Preexisting conditions. --

(1) Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual. The board may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to propose any other additional class of eligible individuals to which the preexisting condition exclusion may not apply.

(2) Subject to subdivision (1) of this subsection, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated: Provided, That:

(A) Application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated; and

(B) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

(e) Nonduplication of benefits. --

(1) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be

reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this subdivision.