



PLAN OVERVIEW

AccessWV is a health plan created by West Virginia law to provide health insurance to West Virginians who have difficulty obtaining coverage in the private, individual market because of a medical condition. It is part of the Offices of the Insurance Commissioner.

Who Can Join

Health coverage through AccessWV is available to legal residents of West Virginia who are:

- "Medically eligible persons" unable to find health insurance in the individual market due to medical conditions or who have one or more of the Presumptive Health Conditions that make a person uninsurable. *See next page for Presumptive Health Conditions.*
- Persons with guaranteed access to health coverage through the federal Health Insurance Portability and Accountability Act (HIPAA).
- Persons eligible for the federal Health Coverage Tax Credit (HCTC).

Applicants must be residents for at least 30 days. (Does not apply to HIPAA or HCTC eligibles.)

Persons Not Eligible for AccessWV

AccessWV is not available to persons who:

- Are eligible for a government health insurance program (Medicare, Medicaid or WVCHIP.)
- Have access to employer-sponsored coverage.
- Reside in a state or federal correctional facility or hospital.
- Have terminated coverage in AccessWV during the previous 12 months.

Premiums

AccessWV members participate in the cost of their coverage by paying premiums and out-of-pocket amounts when they receive services. Premiums are charged based on geographic region, age, gender and kind of coverage (single or family). See **Monthly Premiums** chart.

Available Plans

AccessWV offers a choice of four Plans—A, B, C, and D. All cover the same broad range of services but differ in their premiums, deductibles and out-of-pocket maximums. All plans have a separate medical and pharmacy deductible and a separate medical and pharmacy out-of-pocket maximum. The annual medical benefit maximum is \$200,000 per member on all plans. The annual pharmacy benefit maximum is \$25,000 per member. The maximum combined lifetime benefit for medical and pharmacy is \$1 million.

Medical Services		Plan A	Plan B	Plan C	Plan D
Annual deductible*	Single	\$400	\$800	\$2,000	\$4,000
	Family	\$800	\$1,600	\$4,000	\$5,000
Annual out-of-pocket maximum* (after the deductible)	Single	\$2,000	\$2,500	\$3,000	\$5,000
	Family	\$4,000	\$5,000	\$6,000	\$10,000
* In-network services; amounts shown double for out-of-network.					
Pharmaceuticals		Plan A	Plan B	Plan C	Plan D
Annual deductible	Single	\$200	\$400	\$1,000	\$2,000
	Family	\$400	\$800	\$2,000	\$4,000
Annual out-of-pocket maximum (after the deductible)	Single	\$2,000			
	Family	\$4,000			

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Covered Services

All four plans—A, B, C and D—cover the following:

- Physician services
- Inpatient facility services
- Hospital outpatient services
- Diagnostic x-ray and lab
- Outpatient therapies
- Mental health & chemical dependency benefits
- Other medical services
- Prescription drugs

Once the medical deductible is met, coinsurance applies to most services. Copayments apply to certain services. Benefit limits may apply. For more information, see the **Summary of Benefits**.

Waiting Period for Pre-Existing Conditions

In general, persons joining AccessWV must meet a 6-month waiting period for pre-existing conditions. This means that AccessWV will not provide benefits for services related to these conditions, including prescriptions, for 6 months after coverage is effective. It will pay for services related to newly experienced injury or illness. A pre-existing condition is any condition for which medical advice, care or treatment was recommended or received during the 6-month period immediately preceding the effective date of coverage. This waiting period applies to persons who join AccessWV in the "medically eligible" category. It does not apply to persons who are HIPAA eligible and to certain persons eligible for the HCTC.

Provider Network

AccessWV uses Public Employee Insurance Agency (PEIA) reimbursement rates, and any WV provider who accepts these rates is considered a "participating" provider. Almost every provider in the State accepts PEIA reimbursement and thus is a member of the AccessWV network. Network providers are prohibited from balance billing AccessWV members. AccessWV strongly encourages members to use WV providers, and members experience higher out-of-pocket costs for out-of-state services. **Prior authorization is required for out-of-state services or a penalty also applies.**

Presumptive Health Conditions

Cardiovascular Aneurysm Angioplasty Bypass Surgery Congestive Heart Failure Coronary Artery Disease Heart Attack Heart Valve Replacement Pacemaker Implant Thrombophlebitis Valvular Disease	Kidney Dialysis Renal Failure Musculoskeletal Herniated/Degenerative Disc Joint Replacement Marfan's Syndrome Muscular Dystrophy Spina Bifida Occua Spinal Disorders	Pulmonary COPD Cystic Fibrosis Emphysema Other Hemophilia Infertility Treated with Medications Infertility: In Vitro or GIFT Pregnancy All cancerous conditions within the first five years except Basal Cell (skin) Cancer Applicant has been advised to have surgery that has not yet been performed.
Endocrine/Exocrine System Diabetes	Neurological Alzheimer's Disease Cerebral Palsy Down's Syndrome Parkinson's Disease Stroke Myasthenia Gravis Multiple Sclerosis Paralysis	
Gastrointestinal Cirrhosis of the Liver Crohn's Disease Ulcerative Colitis Hepatitis C	Psychiatric Psychosis Attempted Suicide	
Immunological AIDS AIDS Related Complex HIV Positive Status Rheumatoid Arthritis Systemic Lupus		