authorizing an automatic bank draft or making quarterly payments in advance. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check. The check must be sent in with the Payment Selection Form. The draft or quarterly payment will begin with the third month after the month of approval.

For those individuals who choose to pay through monthly bank drafts, the TEFRA Premium Unit will draft the account for the third month after approval and the following months. Each draft will be made on the first day of the covered month. The TEFRA Premium Unit will send monthly invoices that the bank account has been drafted.

For those who choose quarterly payments, the individual must initially pay for the month after the month of approval and the following month in advance by check, after which the TEFRA Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter.

If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the family will be reimbursed for the partial month.

Failure to provide the Payment Selection Form or make the two month initial payment will cause the child to be ineligible, and the case will be closed after proper advance notice. For ongoing cases, if the premium is not paid for three months, advance notice will be sent and the case will be closed. The TEFRA Premium Unit will notify the county office if the Payment Selection Form is not received.

Monthly aged reports will be sent to each county showing the cases with overdue premiums and the number of monthly payments in arrears. The caseworker will send a 10-day advance notice to each case showing three months of non-payment, advising that the case will be closed if payment is not made. At the end of the notice period, if payment of the premiums has not been made, the case will be closed. (Refer to C-231 for re-application when TEFRA case is closed due to non-payment of premiums.)

F-180 Other Health Insurance Coverage

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For most eligibility groups, an individual may be covered by other health insurance without affecting his or her eligibility for Medicaid. There are two exceptions to this which are described below.

MEDICAL SERVICES POLICY MANUAL, SECTION F

Adult Expansion Group

An individual who is eligible for or enrolled in Medicare is not eligible for the Adult Expansion Group.

ARKids B

Children who have health insurance or who have been covered by health insurance other than Medicaid in the 90 days preceding the date of application will not be eligible for ARKids B unless one of the following conditions is met:

a. The health insurance is a non-group or non-employer sponsored plan.

b. The health insurance was lost through termination of employment for any reason.

c. The health insurance was lost through no fault of the applicant. For example, health insurance is lost through no fault of the applicant if the employer ceases to provide employer-sponsored health insurance.

d. The health insurance is/was not primary comprehensive. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

e. Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out of state and covers the child on his or her HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the caseworker based on information provided by the applicant.

If a parent or guardian voluntarily terminates insurance within the 90 days preceding application for a reason other than those listed above, the children will **not** be eligible for ARKids B.

The applicant's declaration regarding the child's health insurance coverage will be accepted.

This is a special requirement for ARKids B only and does not apply to ARKids A or other Medicaid categories.