Out-of-Area Coverage for Students

Health Alliance™ gives your family access to top-notch doctors and hospitals. That doesn’t have to change when your student seeks education outside of our service area.

Through our Student Extended Network Program, dependent students on your plan who leave our service area—which extends across most of Illinois and parts of Iowa (see your plan material for details)—to attend an academic institution including (but not limited to) a college, university, technical school or vocational school can get access to the national First Health® network while in school.

Your student will receive a special ID card and can search the First Health® network through hally.com.

All other family members on the plan will keep their current ID cards and will use the standard provider network.

When your student gets care in the extended network, it’s their responsibility to make sure prior authorization is received when necessary. They can call Customer Service to check whether prior authorization is needed, and if so, should ask their doctor to request it.

It’s easy to sign your student up for extended coverage at no extra cost.

1. Fill out the attached form and return it to Health Alliance.
2. Give your student the new ID card we send you.
3. Turn in a new form each year that your student is in school (you’ll get a reminder when it’s time).

If you have questions, call the Customer Service number on the back of your ID card.
Student Extended Network Program Verification

Primary Subscriber/Plan Participant Name: ____________________________________________________________

Primary Subscriber/Plan Participant 11 Digit Member Number: ____________________________

Student Name: __________________________________________________

Student 11 Digit Member Number: ____________________________________________

Student SSN: ____________________________

Student Birth Date (MM/DD/YYYY): ______________

Student Address at Academic Institution (Address/City/State/Zip): ____________________________________________

☐ Please update my Student’s address to reflect this as their mailing address

Academic Institution Name: ____________________________

Academic Institution Address (Address/City/State/Zip): ____________________________________________

Start Date of Classes (MM/YYYY): ____________________________

End Date of Classes (MM/YYYY): ____________________________

I hereby verify that my above-mentioned student is considered a full-time student by the academic institution he/she attends and is eligible for student coverage under my Health Alliance-administered plan. I further agree to provide evidence of this fact as may be requested by Health Alliance. I understand that such a request may be made at any time while coverage is in effect under this plan. I understand that benefits available to the above-mentioned student are subject to all other plan provisions and limitations. I further understand there is a 90-day minimum (consecutive days) out-of-area requirement to qualify for extended network coverage.

I further understand I am responsible for re-applying for this extended network coverage annually.

Primary Subscriber/Plan Participant Signature: ____________________________________________ Date: ______________

Please send the completed form to
Mail: Health Alliance Medical Plans • Attn: Enrollment •
3310 Fields South Dr. • Champaign, IL 61822
Email: Membership@HealthAlliance.org
Fax: (217) 902-9755

benefit choice Health Alliance™