Student Extended Network Program

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 materials 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's ID card will contain the First Health logo. You can access ID cards and the First Health network by signing into your secure member portal at 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. 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.

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Student Extended Network Program Verification

Primary Subscriber/Plan Participant Name: _____

Primary Subscriber/Plan Participant 11-Digit Member Number:

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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 reapplying 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

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