Health Alliance™

Student Extended Network

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, dependent children 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 PHCS and MultiPlan networks while in school.

Your dependent student will receive a special ID card and can search the PHCS and MultiPlan networks through **YourHealthAlliance.org.**

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

When your child gets care in the extended network, it's their responsibility to make sure preauthorization is received when necessary. They can call Customer Service to check whether preauthorization 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 child the new ID card we send you.
3. Turn in a new form each year that your child 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:

9	4								–		

Dependent Name: _____

Dependent 11 Digit Member Number:

9	4								–		

Dependent SSN:

			–			–				

Dependent Birth Date (MM/DD/YYYY): _____

Dependent Address at Academic Institution (Address/City/State/Zip):

_____

☐ Please update my dependent'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 dependent is considered a full-time student by the academic institution he/she attends and is eligible for dependent 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 dependent 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: _____

Fax: 217-902-9755
Email: Membership@HealthAlliance.org
Mail to: Health Alliance Medical Plans
Attn: Enrollment
3310 Fields South Drive
Champaign, IL 61822