

# College Extended Network Program

## Out-of-Area Coverage for College Students

**Health Alliance gives your family access to top-notch doctors and hospitals. That doesn't have to change when your student goes away to college.**

Through our College Extended Network Program, dependent children on your plan who leave our service area to attend a college, university, technical school or vocational school can get access to the national PHCS and MultiPlan networks while in school.

Your dependent college 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 turn it in to your human resources department.
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.**

This program may not be available to all members. Contact Customer Service to check your eligibility.



# College Extended Network Program Verification

Primary Subscriber/Plan Participant Name: \_\_\_\_\_

Primary Subscriber/Plan Participant 11 Digit Member Number:

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Dependent Name: \_\_\_\_\_

Dependent 11 Digit Member Number:

9	4									-		
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Dependent SSN:

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Dependent Birth Date (MM/DD/YYYY): \_\_\_\_\_

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

\_\_\_\_\_

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: \_\_\_\_\_

This program may not be available to all members. Contact Customer Service to check your eligibility.

HR Manager—Please submit this document to Health Alliance in one of the following ways:  
 Fax: 217-902-9755  
 Email: [Membership@HealthAlliance.org](mailto:Membership@HealthAlliance.org)  
 Mail to: Health Alliance Medical Plans  
 Attn: Enrollment  
 3310 Fields South Drive  
 Champaign, IL 61822