

## Centers of Excellence For Bargaining Unit Employees

### FREQUENTLY ASKED QUESTIONS

1. **What is a Center of Excellence ("COE")?** A COE is a healthcare provider that (1) has gained professional recognition through specialized clinical expertise and equipment acquisitions, and (2) is able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region. (3) You may research the current COE providers by going to <http://health.usnews.com/best-hospitals/rankings> - you are eligible to use Midwest providers.
2. **How do I request COE Reimbursement?** To obtain reimbursement for care provided at a COE, you must submit a COE application prior to your departure:
  - a. Complete a Center of Excellence Initial Request for Travel /Lodging Reimbursement form. **(Attachment#1)**
  - b. Submit a completed COE request form. For the timeliest response, please submit this material directly to either Benefit and Leave Specialist Miranda Laessig (475-3659) or USW Contract Coordinator Chad Korpi (475-6930) who will then forward it to Corporate for review. You should submit your paperwork as far in advance of your scheduled visit as possible, but at least two weeks in advance if you want approval prior to your trip.
  - c. After returning from your appointment, you must submit a completed Travel/Lodging Reimbursement Request form to either Miranda Laessig or Chad Korpi who will then forward it to Corporate for processing. Reimbursement is normally mailed within six to eight weeks.
3. **What does this benefit provide?** If your request for COE reimbursement is approved, you will be reimbursed for your travel expenses. Ordinarily, this will be in the form of a mileage reimbursement (at the applicable I.R.S. standard mileage rate for medical purposes) for the total mileage. If an overnight stay is required, you will also be reimbursed for the reasonable cost of a hotel room for lodging for you and/or a family member. This benefit does not include the cost of meals associated with your trip.
4. **How will I receive reimbursement?** You will receive a reimbursement check from Anthem Blue Cross and Blue Shield approximately six to eight weeks after you have sent in your Reimbursement Request Form. **(Attachment #2)** The reimbursement check will be sent to you attached to an Explanation of Benefits (EOB). The service date will coincide with your medical appointments and the description of service will be "other med services", the amount charged will coincide with the rate of your hotel, mileage etc. In the description of the claim it will state "*services were rendered by a non-participating provider. The attached check is to reimburse for the covered services rendered. You are responsible to pay the provider.*" This is the only way that Anthem can process these claims and because services such as hotels, mileage and parking are not in-network they would all be considered out of network providers. **This is your reimbursement check. (Attachment #3)**
5. **Do I have to fill out the same paperwork for a follow-up visit?** No, if you have previously requested COE coverage and it was approved, you do not need to re-submit a new initial request if you are going to the same COE for the same condition that was previously approved for coverage. Instead, there is a shorter follow-up form that you will need to complete. **(Attachment #4)**



Attachment #1

**2024 CENTER OF EXCELLENCE  
INITIAL REQUEST FOR TRAVEL/LODGING REIMBURSEMENT**

**NOTE: PRIOR APPROVAL IS REQUIRED FOR THIS TRAVEL/LODGING BENEFIT TO ENSURE REIMBURSEMENT.**

**Please complete this form and return to:**

Cleveland-Cliffs Inc.  
200 Public Square, Suite 3300  
Cleveland, Ohio 44114  
ATTN: Benefits Department  
Phone Number in event of questions 1-800-964-0153  
Secure Fax Number (216) 649-0752  
Email: [cliffsbenefits@clevelandcliffs.com](mailto:cliffsbenefits@clevelandcliffs.com)

**Section A: Employee Information**

Name: Robert Smith  
Address: 183 Amy Place St.  
City, State & Zip: Marquette, MI 49855  
Phone Number(s): 906-000-0000  
E-Mail Address: email@email.com

Date-of-Birth (MM/DD/YYYY): 01/01/1967  
Social Security Number: 000-00-0000  
Group Number (on ID Card): 3322222  
Identification Number (on ID card – include all letters & numbers): CFYAN 0000000

Check here if you would like the Determination Letter emailed to the above. Use email of the person in which the benefit is being used. In the case of a dependent child, please use the employee's email (please print clearly).

**Section B: Patient Information (if employee leave blank)**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
\*Group Number (on ID Card): \_\_\_\_\_

Date-of-Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
\*Identification Number (on ID card – include all letters & numbers): \_\_\_\_\_

**Section C: Purpose for the Travel (Please specify below.)**

Managed care participants may elect to utilize "Centers of Excellence" for medical services or procedures that are difficult, costly or specialized and where such treatment would be likely to reduce costs or improve the outcome. Centers of Excellence are health care institutions that have gained professional recognition through specialized clinical expertise and equipment acquisitions, and are able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region. Please contact the Benefits Helpline at 800-964-0153 to find out if your destination is a Center of Excellence.

Please briefly explain medical condition(s)  
Cancer treatment

Anticipated Follow-Up Visit(s): Yes  No  if Yes how many? ? (please inquire with physician)

**Note: You must attach a letter from Attending Physician outlining the reason for utilizing a Centers of Excellence, if applicable.**

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**PRIOR AUTHORIZATION IS REQUIRED IN ORDER TO RECEIVE THIS BENEFIT FOR EACH VISIT TO A CENTER OF EXCELLENCE, UNLESS OTHERWISE SET FORTH IN WRITING FROM THE COMPANY. FAILURE TO OBTAIN THIS PRIOR AUTHORIZATION BEFORE TRAVEL HAS COMMENCED MAY BE A FORFEIT OF THIS BENEFIT!**

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- a. Emergency travel will be processed expeditiously. Please allow a minimum of two weeks for authorization on non-emergency travel, provided all necessary paperwork is received and completed thoroughly.
  - b. When additional tests may be required, best efforts need to be made to be sure that scheduling is made to accommodate for those services to be performed on the same day.
  - c. Travel benefits if approved will be for the reasonable cost to get the member and their companion from the member's residence to the Center of Excellence and back to the member's residence.

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**Section H: Expiration Date:**

If not previously revoked, this authorization will terminate on the earliest of the following dates:

- (1) one year from the signature date below; or
- (2) upon the following date, event or condition: \_\_\_\_\_
- (3) the date the individual coverage ends (only if disclosure requested by the insurance company)

*The party identified in Section D must be notified in writing of the event/condition to cancel authorization.*

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**Section I: Signature:**

Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization. This authorization form applies only to travel/lodging reimbursement to a Center of Excellence.

A copy of this authorization is available to you, or to your personal representative, upon request and will serve as the original.

Signature: Robert Smith Date: 7/2/24

If this authorization is signed by a personal representative on behalf of the individual receiving care, complete the following and attach a copy of the representative's authority to sign this form (e.g. copy of Health Care Power of Attorney, Executor/Administrator of an estate):

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_



Attachment #1  
 00023 000253 00025A 000315 0003/0003 000273  
**Explanation of Benefit Payments**  
**THIS IS NOT A BILL**

CHECK REF. NO:  
 STATEMENT DATE: **9.21.2024**  
 ID#: **AN1123233**

000253 000315 000 01 0014

Robert Smith  
 123 Anyplace Street  
 NORT, MI 49855

Group #: **3322221**  
 This statement reports on claim(s) recently processed for you and/or your dependents. For more details log on to ANTHEM.COM. If you have any questions, please call or visit:  
**ANTHEM BLUE CROSS AND BLUE SHIELD**  
 P.O. BOX 108007  
 ATLANTA, GA 30346  
 1-800-603-6280

If you know of a situation that may involve health insurance fraud, please call toll-free 1-877-203-1624.

SERVICE DATE	DESCRIPTION	AMOUNT CHARGED	ALLOWABLE CHARGES	OTHER INSURANCE	YOUR LIABILITY					
					APPLIED TO DEDUCTIBLE	COPAY	COINSURANCE	OTHER AMOUNTS NOT COVERED	AMOUNT PAID	CODE
<b>PATIENT: SMITH, Robert</b>										
<b>PROVIDER: PROFESSIONAL</b>										
<b>CL: 0001 7817010320202</b>										
9.24	OTHER MED SERVICES	572.84	572.84	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	572.84
9.24	OTHER MED SERVICES	487.89	487.89	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	487.89
	OTHER MED SERVICES	0.00	0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00
<b>TOTAL:</b>		<b>1060.73</b>	<b>1060.73</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>1060.73</b>
<b>B-YOUR TOTAL RESPONSIBILITY ON THIS CLAIM IS \$0.00. (2031)</b>										
A-SERVICES WERE RENDERED BY A NON-PARTICIPATING PROVIDER. THE ATTACHED CHECK IS TO REIMBURSE FOR THE COVERED SERVICES RENDERED. YOU ARE RESPONSIBLE TO PAY THE PROVIDER. (7690)										
YOU HAVE MET \$0.00 OF YOUR 2018 INDIVIDUAL ANNUAL OUT OF NETWORK OUT-OF-POCKET. (Y021)										
YOU HAVE MET \$0.00 OF YOUR 2018 FAMILY ANNUAL OUT OF NETWORK OUT-OF-POCKET. (Y121)										

\*An Independent Licensee of the Blue Cross and Blue Shield Association  
 This statement provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

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\*An Independent Licensee of the Blue Cross and Blue Shield Association

Wells Fargo Bank, NA

CHECK NO. **057890888**

92-22  
 311

ANTHEM BLUE CROSS AND BLUE SHIELD\*  
 P.O. BOX 105557  
 ATLANTA, GA 30348

**VOID**

PAY TO THE ORDER

Robert E. Smith  
 123 Anyplace Street  
 NORT MI 49855

DATE	PAYEE NO.	CHECK REF.
9.21.24	AN1123233	

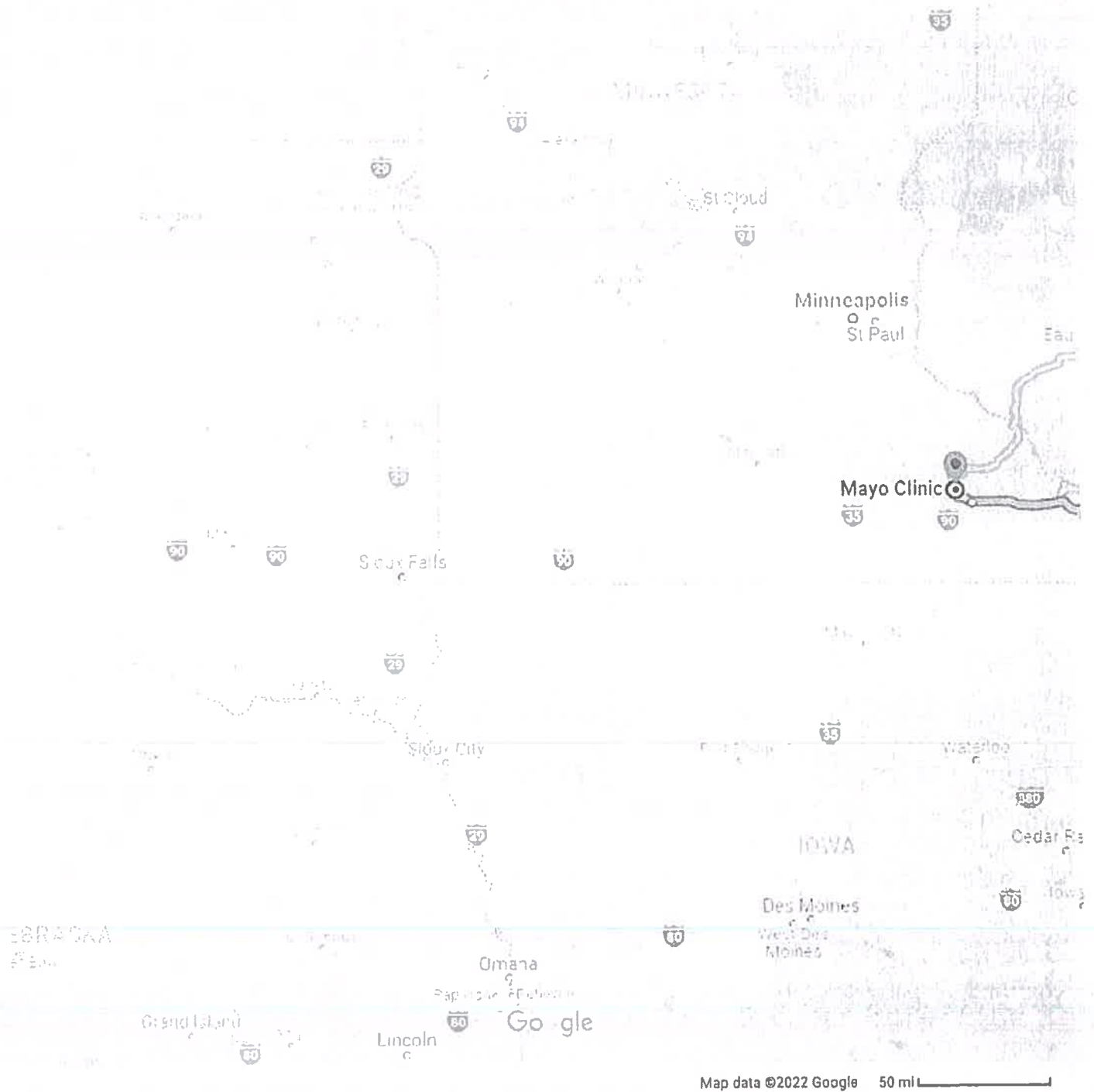
\*\*\* 1,060.73

*John LaLage*


AUTHORIZED SIGNATURE


THE SUM OF FIVE HUNDRED FORTY-EIGHT DOLLARS AND 00/100

DUPLICATE



Map data ©2022 Google 50 mi

 via WI-29 W/WI-29 Trunk W 7 hr 14 min  
Fastest route, the usual traffic 402 miles

 via I-90 W 7 hr 17 min



Attachment #4

2024 CENTERS OF EXCELLENCE REQUEST  
FOR FOLLOW UP APPOINTMENT  
TRAVEL/LODGING REIMBURSEMENT

NOTE: PRIOR APPROVAL IS REQUIRED FOR THIS TRAVEL/LODGING BENEFIT TO ENSURE REIMBURSEMENT.

Please complete this form and return to:

Cleveland-Cliffs Inc.  
200 Public Square, Suite 3300  
Cleveland, Ohio 44114  
ATTN: Benefits Department  
Phone Number in event of questions 1-800-964-0153  
Secure Fax Number (216) 649-0752  
Email: [Cliffsbenefits@clevelandcliffs.com](mailto:Cliffsbenefits@clevelandcliffs.com)

**Section A: Employee/Patient Information**

Employee Name: Robert Smith Phone Number: 906-000-0000  
Address: 123 Any Place St City Marquette State MI Zip 49855  
Patient Name: (if not employee): \_\_\_\_\_ Relationship to Employee: SELF  
E-Mail Address: email@email.com

Check here if you would like the Determination Letter emailed to the above. Use email of the person in which the benefit is being used. In the case of a dependent child, please use the employee's email (please print clearly).

**Section B: Purpose for the Travel (Please specify below.)**

Please provide a brief description of the original visit (date, purpose, physician(s) visited, etc.) and this follow up visit. Please make sure to note if there are any changes in physician, purpose, etc. for this follow up visit.

Cancer treatment

**Attending Physician(s): Please include any specialist(s) that have been seen regarding this medical condition(s).**

Name: Dr. Kim  
Specialty: oncology  
Address: 200 N. 2nd St.  
City, State & Zip: Rockville, MD 20850  
Phone Number: 507-000-0000

Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_