MEDICAL POLICY – 8.01.11

Transcatheter Arterial Chemoembolization (TACE) as a Treatment for Primary or Metastatic Liver Malignancies

BCBSA Ref. Policy: 8.01.11
Related Medical Policies:
- 7.01.95 Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- 7.01.133 Microwave Tumor Ablation
- 8.01.521 Radioembolization for Primary and Metastatic Tumors of the Liver

Effective Date: June 10, 2020
Last Revised: June 9, 2020
Replaces: 8.01.505

Introduction

Embolization is a procedure to block blood flow. When the material used to block the blood flow contains chemotherapy agents as well, it is a way to treat liver cancer in some situations. This treatment is usually known as TACE. In this procedure a catheter (a long, thin, hollow tube) is inserted in an artery near the groin. It’s threaded to the tumor’s blood supply. Chemotherapy and tiny particles are then sent directly into the tumor. The particles block off — embolize — the artery feeding the tumor, causing it to shrink. The chemotherapy works to kill the cancer cells. This treatment can be used in the liver because it has two sources of blood: the portal vein and the hepatic artery. The portal vein supplies most of the blood to the liver. The hepatic artery supplies a lesser amount, and tumors that grow in the liver usually get their blood supply from the hepatic artery. As a result, TACE can be used to starve the blood supply of the tumor usually without affecting the blood supply to the rest of the liver. This policy describes when TACE may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
### Policy Coverage Criteria

#### Treatment

<table>
<thead>
<tr>
<th>Transcatheter hepatic arterial chemoembolization</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transcatheter hepatic arterial chemoembolization may be considered medically necessary for the following situations:</strong></td>
<td><strong>Transcatheter hepatic arterial chemoembolization is considered investigational in all of the following situations:</strong></td>
</tr>
<tr>
<td>• Hepatocellular cancer that is unresectable but confined to the liver and not associated with portal vein thrombosis and liver function is not characterized as Child-Pugh class C*</td>
<td>• As neoadjuvant or adjuvant therapy in hepatocellular cancer that is considered resectable</td>
</tr>
<tr>
<td>• As a bridge to transplant in patients with hepatocellular cancer where the intent is to prevent further tumor growth and to maintain a patient’s candidacy for liver transplant, and the following is true:</td>
<td>• When used with radiofrequency ablation (RFA) to treat resectable or unresectable hepatocellular carcinoma</td>
</tr>
<tr>
<td>o A single tumor less than 5 cm or no more than 3 tumors each less than 3 cm in size</td>
<td></td>
</tr>
<tr>
<td>o Absence of extrahepatic disease or vascular invasion</td>
<td></td>
</tr>
<tr>
<td>o Child-Pugh score of either A or B*</td>
<td></td>
</tr>
<tr>
<td>• Treat liver metastasis in symptomatic patients with metastatic neuroendocrine tumor with both of the following:</td>
<td></td>
</tr>
<tr>
<td>o Symptoms persist despite systemic therapy AND</td>
<td></td>
</tr>
<tr>
<td>o Patients are not candidates for surgical resection</td>
<td></td>
</tr>
<tr>
<td>• To treat liver metastasis in patients with liver-dominant metastatic uveal melanoma</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* See Related Information for Child-Pugh Classification
### Treatment

<table>
<thead>
<tr>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To treat unresectable cholangiocarcinoma</td>
</tr>
<tr>
<td>• To treat liver metastases from any other tumors or to treat hepatocellular cancer that does not meet the criteria noted above, including recurrent hepatocellular carcinoma</td>
</tr>
<tr>
<td>• To treat hepatocellular tumors prior to liver transplantation except as noted above</td>
</tr>
</tbody>
</table>

### Documentation Requirements

The patient’s medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the relevant history and physical of ANY these situations:
  - Patient has primary liver cancer that cannot be surgically removed, located only in the liver and does not involve clot or narrowing of the portal vein
  - As a short-term treatment for patient with primary liver cancer waiting for a liver transplant, and the following are true
    - A single tumor less than 5 cm or no more than 3 tumors each less than 3 cm in size
    - Absence of extrahepatic disease or vascular invasion
    - Child-Pugh score of either A or B
  - Patient has tumors from neuroendocrine cancer that have spread to the liver when the tumors can’t be removed surgically and have not responded to other therapy
  - Patient has tumors in the liver that have spread from liver-dominant metastatic uveal melanoma

### Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
</tr>
<tr>
<td>75894</td>
<td>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</td>
</tr>
</tbody>
</table>

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).
## Related Information

### Child-Pugh Classification of Liver Disease

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Points assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Ascites</td>
<td>None</td>
</tr>
<tr>
<td>Bilirubin</td>
<td>&lt; 34 µM</td>
</tr>
<tr>
<td>Albumin</td>
<td>&gt; 35 g/L</td>
</tr>
<tr>
<td>INR</td>
<td>&lt; 1.7</td>
</tr>
<tr>
<td>Encephalopathy</td>
<td>Grade 0</td>
</tr>
</tbody>
</table>

- Grade 0: normal cognition
- Grade 1: euphoria, fluctuation in level of consciousness, slurred/disoriented speech
- Grade 2: drowsiness, inappropriate behavior, loss of sphincteric control
- Grade 3: marked confusion, stupor, incoherent speech
- Grade 4: coma

### Evidence Review

#### Description

Transcatheter arterial chemoembolization (TACE) of the liver is a proposed alternative to conventional systemic or intra-arterial chemotherapy and to various nonsurgical ablative techniques, to treat resectable and nonresectable tumors. TACE combines the infusion of chemotherapeutic drugs with particle embolization. Tumor ischemia secondary to the embolization raises the drug concentration compared with infusion alone, extending the...
retention of the chemotherapeutic agent and decreasing systemic toxicity. The liver is especially amenable to such an approach, given its distinct lobular anatomy, the existence of two independent blood supplies, and the ability of healthy hepatic tissue to grow and thus compensate for tissue mass lost during chemoembolization.

Background

Transcatheter Arterial Chemoembolization

Transcatheter arterial chemoembolization (TACE) is a minimally invasive procedure performed by interventional radiologists who inject highly concentrated doses of chemotherapeutic agents into the tumor tissues and to restrict tumor blood supply. The embolic agent(s) causes ischemia and necrosis of the tumor and slows anticancer drug washout. The most common anticancer drugs used in published TACE studies for hepatocellular carcinoma (HCC) include doxorubicin (36%), followed by cisplatin (31%), epirubicin (12%), mitoxantrone (8%), and mitomycin C (8%).

The TACE procedure requires hospitalization for placement of a hepatic artery catheter and workup to establish eligibility for chemoembolization. Before the procedure, the patency of the portal vein must be demonstrated to ensure an adequate posttreatment hepatic blood supply. With the patient under local anesthesia and mild sedation, a superselective catheter is inserted via the femoral artery and threaded into the hepatic artery. Angiography is then performed to delineate the hepatic vasculature, followed by injection of the embolic chemotherapy mixture. Embolic material varies but may include a viscous collagen agent, polyvinyl alcohol particles, or ethiodized oil. Typically, only one lobe of the liver is treated during a single session, with subsequent embolization procedures scheduled five days to six weeks later. In addition, because the embolized vessel recanalizes, chemoembolization can be repeated as many times as necessary.

Adverse Events

TACE of the liver has been associated with potentially life-threatening toxicities and complications, including severe postembolization syndrome, hepatic insufficiency, abscess, or infarction. TACE has been investigated to treat resectable, unresectable, and recurrent hepatocellular carcinoma, cholangiocarcinoma, liver metastases, and in the liver transplant setting. Treatment alternatives include resection when possible, chemotherapy administered systemically or by hepatic artery infusion. Hepatic artery infusion involves the continuous
infusion of chemotherapy with an implanted pump, while TACE is administered episodically. Hepatic artery infusion does not involve the use of embolic material.

**Summary of Evidence**

**Unresectable and Resectable Hepatocellular Carcinoma**

For individuals who have unresectable hepatocellular carcinoma (HCC) confined to the liver and not associated with portal vein thrombosis who receive TACE, the evidence includes several randomized controlled trials (RCTs), large observational studies, and systematic reviews. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Evidence from a limited number of RCTs has suggested that TACE offers a survival advantage compared with no therapy and survival with TACE is at least as good as with systemic chemotherapy. One systematic review has highlighted possible biases associated with these studies. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have resectable HCC who receive neoadjuvant or adjuvant TACE, the evidence includes several RCTs and systematic reviews. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Studies have shown little to no difference in overall survival rates with neoadjuvant TACE compared with surgery alone. A meta-analysis found no significant improvements in survival or recurrence with preoperative TACE for resectable HCC. While both RCTs and the meta-analysis that evaluated TACE as adjuvant therapy to hepatic resection in HCC reported positive results, the quality of individual studies and the methodologic issues related to the meta-analysis preclude certainty when interpreting the results. Well-conducted multicentric trials from the United States or Europe representing relevant populations with adequate randomization procedures, blinded assessments, centralized oversight and publication in peer-reviewed journals are required. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have resectable HCC who receive TACE plus RFA, the evidence includes a single RCT. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. The RCT failed to show the superiority in survival benefit with combination TACE plus RFA treatment compared with surgery for HCC lesions 3 cm or smaller. Further, an ad hoc subgroup analysis showed a significant benefit for surgery in recurrence and overall survival in patients with lesions larger than 3 cm. It cannot be determined
from this trial whether TACE plus RFA is as effective as surgical resection for these small tumors. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have unresectable HCC who receive TACE plus RFA, the evidence includes multiple systematic reviews and RCTs. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Multiple meta-analyses and RCTs have shown a consistent benefit in survival and recurrence-free survival favoring combination TACE plus RFA over RFA alone. However, results of these meta-analyses are difficult to interpret because the pooled data included heterogeneous patient populations and, in a few cases, data from a study retracted due to questions about data veracity. A larger well-conducted RCT has reported a relative reduction in the hazard of death by 44% and a 14% difference in 4-year survival favoring combination therapy. The major limitations of this trial were its lack of a TACE-alone arm and the generalizability of its findings to patient populations that have unmet needs such as those with multiple lesions larger than 3 cm and Child-Pugh class B or C. Further, this single-center trial was conducted in China, and until these results have been reproduced in patient populations representative of pathophysiology and clinical stage more commonly found in the United States or Europe, the results may not be generalizable. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Bridge to Liver Transplant**

For individuals who have a single hepatocellular tumor less than 5 cm or no more than three tumors each less than 3 cm in size, absence of extrahepatic disease or vascular invasion, and Child-Pugh class A or B seeking to prevent further tumor growth and to maintain patient candidacy for liver transplant who receive pretransplant TACE, the evidence includes multiple small prospective studies. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of comparative trials on various locoregional treatments as a bridge therapy to liver transplantation. Multiple small prospective studies have demonstrated that TACE can prevent dropouts from the transplant list. TACE has become an accepted method to prevent tumor growth and progression while patients are on the liver transplant waiting list. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
**Unresectable Cholangiocarcinoma**

For individuals who have unresectable cholangiocarcinoma who receive TACE, the evidence includes several retrospective observational studies and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. RCTs evaluating the benefit of adding TACE to standard of care for patients with unresectable cholangiocarcinoma are lacking. Results of three retrospective studies have shown a survival benefit with TACE over standard of care. These studies lacked matched patient controls. Although the observational data are consistent, the lack of randomization limits definitive conclusions. The evidence is insufficient to determine the effects of the technology on health outcomes.

**TACE for Symptomatic Unresectable Neuroendocrine Tumors**

For individuals who have symptomatic metastatic neuroendocrine tumors despite systemic therapy and are not candidates for surgical resection who receive TACE, the evidence includes retrospective single-cohort studies. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence from RCTs assessing use of TACE. Uncontrolled trials have reported that TACE reduces symptoms and tumor burden, and improves hormone profiles. Generally, the response rates are over 50% including patients with massive hepatic tumor burden. While many studies have demonstrated symptom control, survival benefits are less clear. Despite the uncertain benefit on survival, the use of TACE to palliate the symptoms associated with hepatic neuroendocrine metastases can provide a clinically meaningful improvement in net health outcome. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Liver-Dominant Metastatic Uveal Melanoma**

For individuals who have liver-dominant metastatic uveal melanoma who receive TACE, the evidence includes observational studies and reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence from RCTs assessing use of TACE. Noncomparative prospective and retrospective studies have reported improvement in tumor response and survival compared with historical controls. Given the very limited treatment response from systemic therapy and the rarity of this condition, the existing evidence may support conclusions that TACE meaningfully
improves outcomes for patients with hepatic metastases from uveal melanoma. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Other Unresectable Hepatic Metastases

For individuals who have unresectable hepatic metastases from any other types of primary tumors (eg, colorectal or breast cancer) who receive TACE, the evidence includes multiple RCTs, observational studies, and systematic reviews. The relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Multiple RCTs and numerous nonrandomized studies have compared TACE with alternatives in patients who have colorectal cancer with metastases to the liver. Nonrandomized studies report that TACE can stabilize disease in 40% to 60% of treated patients but whether this translates into a prolonged survival benefit relative to systemic chemotherapy alone is uncertain. Two small RCTs have reported that TACE with drug-eluting beads has resulted in statistically significant improvements in response rate and progression-free survival. Whether this translates into a prolonged survival benefit relative to systemic chemotherapy alone is uncertain. For cancers other than colorectal, the evidence is extremely limited and no conclusions can be made. Studies have assessed small numbers of patients and the results have varied due to differences in patient selection criteria and treatment regimens used. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01004978</td>
<td>A Phase III Randomized, Double-Blind Trial of Chemoembolization With or Without Sorafenib in Unresectable Hepatocellular Carcinoma (HCC) in Patients With and Without Vascular Invasion</td>
<td>400</td>
<td>Jul 2019</td>
</tr>
<tr>
<td>NCT No.</td>
<td>Trial Name</td>
<td>Planned Enrollment</td>
<td>Completion Date</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>NCT02936388</td>
<td>Transarterial Radioembolisation in Comparison to Transarterial Chemoembolisation in Uveal Melanoma Liver Metastasis (SirTac)</td>
<td>108</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>NCT01906216</td>
<td>Sorafenib With or Without Transarterial Chemoembolization (TACE) in Advanced Hepatocellular Carcinoma: A Multicenter, Randomized, Controlled Trial</td>
<td>246</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>NCT01833286</td>
<td>Radiofrequency Ablation Combined With Transcatheter Arterial Chemoembolization Versus Re-resection for Recurrent Hepatocellular Carcinoma</td>
<td>200</td>
<td>Jul 2019</td>
</tr>
</tbody>
</table>

**Unpublished**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01676194</td>
<td>Efficacy of Transarterial Chemoembolization With DC-BeadsR Prior to Liver Transplantation for Hepatocellular Carcinoma on Patient Survival: A Prospective Multicentre and Randomized Study</td>
<td>140</td>
<td>Aug 2018 (unknown)</td>
</tr>
<tr>
<td>NCT01512407</td>
<td>Randomised Controlled Trial on Adjuvant Transarterial Chemoembolisation After Curative Hepatectomy for Hepatocellular Carcinoma</td>
<td>144</td>
<td>Jan 2018 (unknown)</td>
</tr>
<tr>
<td>NCT00908752*</td>
<td>A Randomized, Double-blind, Multicenter Phase III Study of Brivanib Versus Placebo as Adjuvant Therapy to Trans-Arterial Chemo-Embolization (TACE) in Patients With Unresectable Hepatocellular Carcinoma (The BRISK TA Study)</td>
<td>734</td>
<td>Jan 2018 (completed)</td>
</tr>
<tr>
<td>NCT01869088</td>
<td>Phase III Trial of Transcatheter Arterial Chemoembolization(TACE) Plus Recombinant Human Adenovirus Type 5 Injection for Unresectable Hepatocellular Carcinoma (HCC)</td>
<td>266</td>
<td>Jan 2018</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
a Denotes industry-sponsored or cosponsored trial.

**Clinical Input Received from Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.
In response to requests, input was received from one specialty medical society (two reviewers) and three academic medical centers while this policy was under review in 2012. There was general agreement that the use of TACE was medically necessary for indications in the policy; however, reviewers were split for its use as a bridge to transplant. There was general support for the investigational policy statement for the use of TACE as neoadjuvant or adjuvant therapy in resectable HCC. Reviewers were split over the investigational policy statement to treat other liver metastases or for recurrent HCC. Four reviewers provided input on the use of TACE in unresectable cholangiocarcinoma; two reviewers considered it investigational and two others considered it investigational but also medically necessary, the latter citing data showing a survival benefit of TACE compared with supportive therapy.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

Hepatocellular Carcinoma

National Comprehensive Cancer Network (NCCN) guidelines on hepatocellular carcinoma (v.2.2019) list transarterial chemoembolization as an option for patients not candidates for surgically curative treatments or as a part of a strategy to bridge patients for other curative therapies (category 2A). The guidelines also recommend that patients with tumors sized between 3 and 5 cm can be considered for combination therapy with ablation and arterial embolization and those with unresectable or inoperable tumors greater than 5 cm be treated using arterial embolic approaches or systemic therapies. Additionally, TACE in highly selected patients has been shown to be safe in the presence of limited tumor invasion of the portal vein.

Intrahepatic Cholangiocarcinoma

The NCCN guidelines on intrahepatic cholangiocarcinoma (v.3.2019) consider arterially directed therapies, including TACE, to be treatment options for unresectable and metastatic intrahepatic cholangiocarcinoma.
Neuroendocrine Tumors, Carcinoid, and Islet Cell Tumors

The NCCN guidelines on neuroendocrine tumors, carcinoid, and islet cell tumors (v.1.2019) consider chemoembolization as an effective approach for patients with hepatic-predominant metastatic disease (category 2A).\textsuperscript{78}

Uveal Cancer

No NCCN guidelines were identified for uveal malignancies as of May 2019.

Colon Cancer

An update discussion is in process to establish the NCCN guidelines on the use of TACE for colorectal liver metastases (v.2.2019). As of this guideline version, the NCCN can recommend TACE only for clinical trials.\textsuperscript{79}

Breast Cancer

The NCCN guidelines on breast cancer (v.2.2019) do not address TACE as a treatment option for breast cancer metastatic to the liver.\textsuperscript{80}

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Chemoembolization for hepatic tumors is a medical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration. However, the embolizing agents and drugs are subject to Food and Drug Administration approval.

2. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Transcatheter arterial chemoembolization of hepatic tumors. TEC Assessments. 2000;Volume 15;Tab 22.


## History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/19</td>
<td>New policy, approved September 5, 2019. This policy replaces policy 8.01.505 (originally effective June 1999) which is now deleted. Policy created with literature review through May 2019. Transcatheter hepatic arterial chemoembolization may be considered medically necessary when criteria are met; considered investigational when criteria are not met.</td>
</tr>
<tr>
<td>04/01/20</td>
<td>Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.</td>
</tr>
<tr>
<td>06/10/20</td>
<td>Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.</td>
</tr>
</tbody>
</table>

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Email AppealsDepartmentInquiries@Premera.com

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U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente.

Chiamà 800-722-1471 (TTY: 800-842-5357).
To og kluczowe daty, które mogą mieć znaczenie dla waszego planu zdrowotnego przez Premera Blue Cross. Prosimy zwrócić uwagę na daty, które mogą być potrzebne do kontroli zdrowotnej, wizytek, lekarstw, procedur, lub innych usług medycznych.

The information contained herein is provided by Premera Blue Cross and is designed to offer helpful health care information. Premera Blue Cross does not provide medical advice, diagnosis or treatment. Always seek the advice of a qualified health care provider with any questions you may have regarding a health care condition. If you have any questions regarding this notice please contact Premera Blue Cross at 800-722-1471 (TTY: 800-842-5357) or visit Premera.com.

English (English): This notice contains information about key dates that may affect your health care during a medical plan year through Premera Blue Cross. It is not a substitute for a medical consultation. Always seek the advice of a qualified health care provider with any questions you may have regarding a health care condition. If you have any questions regarding this notice please contact Premera Blue Cross at 800-722-1471 (TTY: 800-842-5357) or visit Premera.com.

日本語 (Japanese): この通知には重要な情報が含まれています。この通知には、Premera Blue Crossのプログラムの利用に影響を及ぼす可能性がある重要な日付が含まれています。常に医療専門家に相談することをお勧めします。この通知についての質問は、Premera Blue Crossに電話して800-722-1471 (TTY: 800-842-5357)でお問い合わせください。

한국어 (Korean): 본 통지서에는 중요한 정보가 들어 있습니다. 특히 본 통지서는 의료보험의 경우 환자에게 중요한 날짜들이 포함되어 있습니다. 이에 대해서는 의료진을 통해 확인하시기 바랍니다. 이에 대한 문의는 Premera Blue Cross에 800-722-1471 (TTY: 800-842-5357)으로 연락해 주세요.

Русский (Russian): Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам необходимо обратиться к специалистам, чтобы получить информацию о ключевых сроках для сохранения страховочного покрытия или помощи с расходами. Вы можете получить дополнительную информацию по телефону 800-722-1471 (TTY: 800-842-5357).

Español (Spanish): Este aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame ai 800-722-1471 (TTY: 800-842-5357).


ไทย (Thai): ประกาศนี้มีข้อมูลที่สำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการคำนวณระยะเวลาเอ็ดจูสเคปของสิทธิ์การคุ้มครองของคุ้มครองสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีการเปลี่ยนแปลงในอนาคต คุณควรตรวจสอบการเปลี่ยนแปลงที่เกี่ยวข้อง เพื่อให้ทราบว่าการเปลี่ยนแปลงใด ๆ ที่เกิดขึ้นอาจมีผลต่อสิทธิ์การคุ้มครองสุขภาพของคุณผ่าน Premera Blue Cross.


Український (Ukrainian): Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути відомі вам. Існує можливість того, що Вам треба буде звернутися до медичного департаменту в конкретній ситуації для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дозвоніться за номером телефону 800-722-1471 (TTY: 800-842-5357).
