Introduction

A tumor marker is a chemical in blood, urine, or tissue that is often made by cancer cells. But just because a tumor marker is found doesn’t necessarily mean a person has cancer. Normal cells often make tumor markers, too. But if cancer is present, much more of the tumor marker is made. There are difficulties in using tumor markers to try to screen for, diagnose, or monitor cancer. Conditions other than cancer can make the level of a tumor marker go up. And, not all cancers create high levels of tumor markers. For these reasons, just looking for high levels of tumor markers isn’t enough to diagnose cancer. This policy specifically discusses tumor markers for bladder cancer. Using tumor marker tests to look for bladder cancer is investigational (unproven). There’s not enough current medical evidence to show that using tumor marker tests compared to standard tests to look for bladder cancer leads to more health benefits. More medical studies are needed.

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

**Service**  
**Urinary tumor markers such as:**
- Alere NMP22®
- BladderChek®
- BTA stat® test
- BTA TRAK® test
- Cxbladder™
- PolypDx™
- uCyt+™ / ImmunoCyt™
- UroVysion®

**Investigational**

The use of urinary tumor markers is considered investigational in the screening, diagnosis of, and monitoring for bladder cancer, or screening for precancerous colonic polyps.

## Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>0012M</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma</td>
</tr>
<tr>
<td>0013M</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
</tr>
<tr>
<td>0002U</td>
<td>Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps</td>
</tr>
<tr>
<td>81479</td>
<td>Unlisted molecular pathology procedure</td>
</tr>
<tr>
<td>86294</td>
<td>Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)</td>
</tr>
<tr>
<td></td>
<td>- May be used to describe the BTA stat test when performed qualitatively in a physician office.</td>
</tr>
<tr>
<td>86316</td>
<td>Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each</td>
</tr>
</tbody>
</table>
### Code Description

- May be used to describe the BTA or NMP22 test when performed quantitatively in a clinical lab.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86386</td>
<td>Nuclear Matrix Protein 22 (NMP22), qualitative</td>
</tr>
<tr>
<td>88120</td>
<td>Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual</td>
</tr>
<tr>
<td>88121</td>
<td>Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology</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

N/A

### Evidence Review

#### Description

The diagnosis of bladder cancer is generally made by cystoscopy and biopsy. Bladder cancer has a very high frequency of recurrence and therefore follow-up cystoscopy, along with urine cytology, is done periodically to identify recurrence early. Urine biomarkers that might be used to supplement or supplant these tests have been actively investigated.

#### Background

*Urinary Bladder Cancer*

Urinary bladder cancer, a relatively common form of cancer in the United States, results in significant morbidity and mortality. Bladder cancer (urothelial carcinoma) typically presents as a tumor confined to the superficial mucosa of the bladder. The most frequent symptom of early...
bladder cancer is hematuria; however, urinary tract symptoms (ie, urinary frequency, urgency, dysuria) may also occur. Cigarette smoking is an important risk factor for urothelial carcinoma.

**Diagnosis**

The criterion standard for a confirmatory diagnosis of bladder cancer is cystoscopic examination with biopsy. At initial diagnosis, approximately 70% of patients have cancers confined to the epithelium or subepithelial connective tissue. Non-muscle-invasive disease is usually treated with transurethral resection, with or without intravesical therapy, depending on the depth of invasion and tumor grade. However, a 50% to 75% incidence of recurrence has been noted in these patients, with 10% to 15% progressing to muscle invasion over a 5-year period. Current follow-up protocols include flexible cystoscopy and urine cytology every 3 months for 1 to 3 years, every 6 months for an additional 2 to 3 years, and then annually thereafter, assuming no recurrence.

While urine cytology is a specific test (from 90% to 100%), its sensitivity is lower, ranging from 50% to 60% overall, and it is considered even lower for low-grade tumors. Therefore, interest has been reported in identifying tumor markers in voided urine that would provide a more sensitive and objective test for tumor recurrence.

Adjunctive testing to urine cytology has used a variety of nuclear and cytoplasmic targets, and a range of molecular pathology and traditional (eg, immunohistochemistry) methods.

Commercially available tests approved or cleared by the U.S. Food and Drug Administration (FDA) as well as laboratory-developed tests, are summarized in the Regulatory Status section.

**Summary of Evidence**

For individuals who have signs and/or symptoms of bladder cancer who receive urinary tumor marker tests in addition to cytology, the evidence includes a number of diagnostic accuracy studies and meta-analyses of these studies. Relevant outcomes are overall survival, disease-specific survival, test accuracy and validity, and resource utilization. A meta-analysis of diagnostic accuracy studies determined that urinary tumor marker tests have sensitivity ranging from 47% to 85% and specificity ranging from 53% to 95%. This analysis found that combining urinary tumor markers with cytology improves diagnostic accuracy, but about 10% of cancers would still be missed. The evidence is insufficient to determine the effects of the technology on health outcomes.
For individuals who have a history of bladder cancer who receive urinary tumor marker tests in addition to cytology, the evidence includes a number of diagnostic accuracy studies, meta-analyses, as well as a decision curve analysis and a retrospective study examining the clinical utility of urinary tumor marker tests. Relevant outcomes are overall survival, disease-specific survival, test accuracy and validity, and resource utilization. The diagnostic accuracy studies found that urinary tumor marker tests have pooled sensitivity ranging from 55% to 75% and pooled specificity ranging from 71% to 83%. The decision analysis found only a small clinical benefit for use of a urinary tumor marker test and the retrospective study found that a urinary tumor marker test was not significantly associated with findings of the subsequent surveillance cystoscopy. No studies using the preferred trial design to evaluate clinical utility were identified; i.e., controlled studies prospectively evaluating health outcomes in patients managed with and without the use of urinary tests or prospective studies comparing different cystoscopy protocols used in conjunction with urinary tumor markers. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are asymptomatic and at a population-level risk of bladder cancer who receive urinary tumor marker tests, the evidence includes a systematic review and several uncontrolled prospective and retrospective studies. Relevant outcomes are overall survival, disease-specific survival, and test accuracy and validity. A 2010 systematic review (conducted for the U.S. Preventive Services Task Force) did not identify any RCTs, the preferred trial design to evaluate the impact of population-based screening and found only 1 prospective study that the Task Force rated as poor quality. A more recent retrospective study, assessing a population-based screening program in the Netherlands, reported low diagnostic yield. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are asymptomatic and at a population-level risk of colon cancer who receive urinary tests for precancerous polyps, evidence includes a validation study. Relevant outcomes are overall survival, disease-specific survival, and test accuracy and validity. A urine metabolite assay for adenomatous polyps is at a very early stage of development, with a report of a training and validation set published in 2017. Current evidence does not support the diagnostic accuracy of urinary tumor markers to screen asymptomatic individuals for precancerous polyps. 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>
<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>NCT02969109a</td>
<td>Clinical Validation of a Urine-based Assay With Genomic and Epigenomic Markers for Predicting Recurrence During Surveillance for Non-muscle Invasive Bladder Cancer</td>
<td>380</td>
<td>Jul 2018</td>
</tr>
<tr>
<td>NCT02745301a</td>
<td>Urinary Biomarkers in the Detection of Urothelial Carcinoma of the Bladder</td>
<td>50</td>
<td>Sep 2020</td>
</tr>
<tr>
<td>NCT03413982</td>
<td>Bladder Cancer Longitudinal Biorepository for Development of Novel Therapeutics/Biomarkers</td>
<td>1000</td>
<td>Jan 2035</td>
</tr>
</tbody>
</table>

*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 through 2 physician specialty societies and 5 academic medical centers while the policy was under review in 2012. There was unanimous agreement that urinary tumor markers approved by the Food and Drug Administration may be considered medically necessary as an adjunctive test in the diagnosis and monitoring of bladder cancer in conjunction with standard diagnostic procedures. In contrast, there was mixed support, but no consensus, on the incremental value of urinary tumor markers compared with urinary cytology alone and for whether urinary tumor markers lead to changes in patient management. There was unanimous agreement that the use of urinary tumor markers is investigational to screen for bladder cancer in asymptomatic subjects.
Practice Guidelines and Position Statements

National Comprehensive Cancer Network

The National Comprehensive Cancer Network (v.4.2018) bladder cancer guidelines include consideration for urinary urothelial tumor markers every 3 months along with urine cytology for the first 2 years of follow-up for high-risk patients with non-muscle-invasive bladder cancer (category 2B recommendation).\(^\text{13}\)

American Urological Association et al

The 2016 guidelines from the American Urological Association and Society of Urologic Oncology addressed the diagnosis and treatment of non-muscle-invasive bladder cancer, based on a systematic review completed by the Agency for Health Care Research and Quality.\(^\text{14}\) Table 2 summarizes statements on the use of urine markers after the diagnosis of bladder cancer.

Table 2. Guidelines for Urine Tumor Markers After the Diagnosis of Bladder Cancer

<table>
<thead>
<tr>
<th>Guidance Statement</th>
<th>SOR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In surveillance of NMIBC, a clinician should not use urinary biomarkers in place of cystoscopic evaluation.&quot;</td>
<td>Strong</td>
<td>B</td>
</tr>
<tr>
<td>&quot;In a patient with a history of low-risk cancer and a normal cystoscopy, a clinician should not routinely use a urinary biomarker or cytology during surveillance.&quot;</td>
<td>Expert opinion</td>
<td></td>
</tr>
<tr>
<td>&quot;In a patient with NMIBC, a clinician may use biomarkers to assess response to intravesical BCG (UroVysion® FISH) and adjudicate equivocal cytology (UroVysion® FISH and ImmunoCyt™).&quot;</td>
<td>Expert opinion</td>
<td></td>
</tr>
</tbody>
</table>


The 2012 guidelines from the American Urological Association (reviewed and affirmed in 2016) on the evaluation of microscopic hematuria in adults recommended cystoscopic evaluation for the following individuals:\(^\text{15}\):

- Older than age 40 with microscopic hematuria; and
• Younger than age 40 with microscopic hematuria and risk factors for developing bladder cancer

U.S. Preventive Services Task Force Recommendations

The U.S. Preventive Services Task Force concluded (2011) concluded that there was insufficient evidence to assess the benefits and harms of screening for bladder cancer in asymptomatic adults. The recommendation was based on insufficient evidence (grade I).

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

Regulatory Status

Table 3 lists urinary tumor marker tests approved or cleared for marketing by FDA. The FDA-approved or cleared tests are indicated as adjuncts to standard procedures for use in the initial diagnosis of bladder cancer or surveillance of bladder cancer patients.

<table>
<thead>
<tr>
<th>Test</th>
<th>Manufacturer</th>
<th>Type</th>
<th>Detection</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>BTA stat®</td>
<td>Polymedco</td>
<td>Point of care immunoassay</td>
<td>Human complement factor H-related protein</td>
<td>Qualitative detection of bladder tumor-associated antigen in the urine of persons diagnosed with bladder cancer</td>
</tr>
<tr>
<td>BTA TRAK®</td>
<td>Polymedco</td>
<td>Reference laboratory immunoassay</td>
<td>Human complement factor H-related protein</td>
<td>Quantitative detection of bladder tumor-associated antigen in the urine of persons diagnosed with bladder cancer</td>
</tr>
<tr>
<td>Alere NMP22®</td>
<td>Alere</td>
<td>Immunoassay</td>
<td>NMP22 protein</td>
<td>In vitro quantitative determination of the nuclear mitotic apparatus protein (NuMA) in stabilized voided urine.</td>
</tr>
<tr>
<td>Test</td>
<td>Manufacturer</td>
<td>Type</td>
<td>Detection</td>
<td>Indication</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>-------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BladderChek®</td>
<td>Alere</td>
<td>Point of care immunoassay</td>
<td>NMP22 protein</td>
<td>Used as adjunct to cystoscopy</td>
</tr>
<tr>
<td>uCyt+/ImmunoCyt™</td>
<td>Scimedx</td>
<td>IHC</td>
<td>Cell-based mucin glycoprotein and an antigen</td>
<td>Adjunct to cystoscopy in patients at risk for bladder cancer</td>
</tr>
<tr>
<td>UroVysion®</td>
<td>Abbott Molecular</td>
<td>FISH^</td>
<td>Cell-based chromosomal abnormalities</td>
<td>Aid in the initial diagnosis of bladder cancer (P030052) and monitoring patients with previously diagnosed bladder cancer (K033982)</td>
</tr>
</tbody>
</table>

FISH: fluorescence in situ hybridization; IHC: immunohistochemistry; NMP: nuclear matrix protein
^ FISH is a molecular cytogenetic technology that can be used with either DNA or RNA probes to detect chromosomal abnormalities. DNA FISH probe technology involves the creation of short sequences of fluorescently labeled, single-strand DNA probes that match target sequences. The probes bind to complementary strands of DNA, allowing for identification of the location of the chromosomes targeted.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Urine-based tests are available under the auspices of the Clinical Laboratory Improvement Amendments. Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, FDA has chosen not to require any regulatory review of these tests. Laboratory-developed tests include:

- **Cxbladder Monitor** (Pacific Edge) measures the expression of 5 genes (*MDK, HOXA13, CDC2, IGFBP5, CXCR2*). Pacific Edge also has Cxbladder Detect and Cxbladder Triage tests.

- **PolypDx™** (Metabolomic Technologies) is a urine metabolite assay that uses liquid chromatography–mass spectrometry. An algorithm compares urine metabolite concentrations to determine the likelihood of colonic adenomatous polyps.

References


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/01/98</td>
<td>Replace Policy - Policy updated.</td>
</tr>
<tr>
<td>12/21/00</td>
<td>Replace Policy - New CPT coding information added.</td>
</tr>
<tr>
<td>12/11/01</td>
<td>Replace Policy - New information on NMP-22 added and title changed from Bladder Tumor Antigen.</td>
</tr>
<tr>
<td>08/12/03</td>
<td>Replace Policy - Policy updated; policy statement unchanged; references added.</td>
</tr>
<tr>
<td>08/09/05</td>
<td>Replace Policy - Policy updated with literature review; references added; policy statement revised to indicate the use of bladder cancer tumor markers involving immunoassay tests NMP-22 or BTA stat® as medically necessary as an adjunct in the diagnosis of bladder cancer. Information on fluorescence in situ hybridization (FISH) added; additional policy statement indicating FISH as medically necessary added. Finally, added investigational policy statements for use of these tests for screening in asymptomatic persons.</td>
</tr>
<tr>
<td>01/10/06</td>
<td>Replace Policy - Policy updated with the addition of ICD-9 code 599.7; no change to policy statement. Going to OAP 2/16/06.</td>
</tr>
<tr>
<td>03/28/06</td>
<td>Code Change - Coding updated only, no other changes</td>
</tr>
<tr>
<td>06/30/06</td>
<td>Update Scope and Disclaimer - No other changes.</td>
</tr>
<tr>
<td>11/14/06</td>
<td>Replace Policy - Literature review update completed and information added on ImmunoCyt along with policy statement of medically necessary for this indication in the monitoring of patients with bladder cancer, remaining investigational for all other uses. Comments added regarding other tumor markers currently under study, however, remaining investigational. References added. Code S3701 removed from policy. Policy reviewed and recommended by OAP on 2/16/06.</td>
</tr>
<tr>
<td>11/11/08</td>
<td>Replace Policy - Policy updated with literature search, no change to the policy statement. References added. Reviewed and recommended by OAP on 5/22/08.</td>
</tr>
<tr>
<td>03/10/09</td>
<td>Code Update - Code 88291 added.</td>
</tr>
<tr>
<td>07/14/09</td>
<td>Replace Policy - Policy updated with literature search. Policy statement has been reworded for clarification however; intent of policy statements remains unchanged. Statements have been modified to include FDA-approved uses. References and code added.</td>
</tr>
<tr>
<td>8/10/10</td>
<td>Replace Policy - Policy updated with literature review from April 2009 through March 2010. Policy statements unchanged. Rationale rewritten; new references 1, 4-5, 7-12, 14-15 added; other references have been renumbered or removed.</td>
</tr>
<tr>
<td>07/12/11</td>
<td>Replace Policy - Policy updated with literature search from March 2010 through March 2011. References 7, 13, 14, 17 and 22 added; other references renumbered and/or updated. Policy statements unchanged. ICD-10 codes added to policy. CPT coding for FISH testing also updated.</td>
</tr>
<tr>
<td>09/11/12</td>
<td>Replace policy. Policy updated with literature search through March 2012. Policy changed to investigational for diagnosing, monitoring and/or screening for bladder</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>05/28/13</td>
<td>Replace policy. Policy updated with literature search through January 31, 2013. Policy statement unchanged. References 3, 4, 8-10 and 14 added; other references renumbered or removed.</td>
</tr>
<tr>
<td>05/12/14</td>
<td>Annual Review. Policy updated with literature review through February 4, 2014. Policy statement unchanged. References 4, 23. and 25 added; other references renumbered or removed.</td>
</tr>
<tr>
<td>12/08/14</td>
<td>Update Related Policies. Remove 203.501 as it was archived.</td>
</tr>
<tr>
<td>05/12/15</td>
<td>Archive Policy. Policy updated with literature review through February 10, 2015. References 3, 5, 15 added. Policy statement unchanged. This service costs more to review than to allow.</td>
</tr>
<tr>
<td>02/09/16</td>
<td>Reinstitute policy. Claims volumes and cost have increased substantiating a need for the policy.</td>
</tr>
<tr>
<td>11/10/16</td>
<td>Minor formatting update. All coding information added to Policy Guidelines section.</td>
</tr>
<tr>
<td>09/01/18</td>
<td>Annual Review, approved August 14, 2018. Policy updated with literature review through April 2018; references 11-12 added; some references removed. Urinary screening for precancerous colonic polyps added to the investigational statement. Title changed from “Urinary Tumor Markers for Bladder Cancer” to “Urinary Biomarkers for Cancer Screening, Diagnosis, and Surveillance.” Added CPT code 0002U, removed CPT codes 88271, 88291, 88299, 88358, 88365, 88367, and 88368.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the OCRportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
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)
Complaint forms are available at

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):
يعني هذا الإشعار معلومات هامة. قد يعني هذا الإشعار معلومات مهمة بالنصوص عليها في إشارة Premera Blue Cross. لن تكون هناك إشارة Premera Blue Cross في هذا الإشعار. وقد تحتاج لإشارة إجراء إلى توضيح خطة للحصول على تبعية صحية والعناية إذا كنتijkstra قبل الحصول على هذه المعلومات والمعلومات الخاصة بذلك في اللغة الكتبية.سوف تكون إشارة Premera Blue Cross في اللغة الكتبية. سوف تكون إشارة Premera Blue Cross في اللغة الكتبية.

Chinese (Chinese):
本通知有重要的讯息。本通知可能有关於您透过 Premera Blue Cross 提交的申请或保险的重要讯息。本通知可能有关於重要日期。您可能需要在截止日期之前採取行动，以保留您的健康保险或费用补贴。您可免費以您的母语得到本讯息和帮助。请拨打电话 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):

Deutsche (German):

Hmoob (Hmong):

Iollo (Ilocano):
Daytoy a Pakdaa ket naglao iti Napateg nga Impormasion. Daytoy a pakdaa mabalina nga adda ket naglao iti napateg nga impormasion mainpaaggio iti aplikasyonu woy coverage babaen iti Premera Blue Cross. Daytoy ket mabalina dagiti importante a pelsa iti daytoy a pakdaa. Mabalina nga adda rumbenga a ngadimendi nga addang sakbayan dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salu-ayno woy tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodoy a pasagas nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
Este aviso contém informações importantes.

ció pode conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir dados importantes neste aviso.

Aviso importante sobre cobertura:

Premera Blue Cross.

Por favor, compare as informações neste aviso com as informações que usamos para cobrir a saúde. Se houver perguntas, por favor, entre em contato conosco.

Alguns exemplos de dados que podem ser importantes incluem:

- Data da aplicação ou cobertura
- Ano de cobertura
- Nome do prestador de saúde
- Data do nascimento
- Estado de saúde
- Dados pessoais

Se tiver alguma dúvida sobre os dados que estão incluídos, entre em contato conosco para obter mais informações.

Informações importantes:

Este aviso foi preparado em dinheiro por pessoas com experiência em saúde. Ele pode conter informações importantes e não deve ser usado como um substituto para aconselhamento médico.

Se tiver alguma dúvida sobre os dados que estão incluídos, entre em contato conosco para obter mais informações.

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Informações importantes:

Este aviso foi preparado em dinheiro por pessoas com experiência em saúde. Ele pode conter informações importantes e não deve ser usado como um substituto para aconselhamento médico.

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