MEDICAL POLICY – 2.04.123
Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases

BCBSA Ref. Policy: 2.04.123
Effective Date: Sept. 1, 2017
Last Revised: Aug. 22, 2017
Replaces: N/A

RELATED MEDICAL POLICIES:
None

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Connective tissue holds the body together as it surrounds and supports other tissues and organs. Tendons, ligaments, skin, blood vessels, and cartilage are examples of connective tissue, and connective tissue is also found in many organs such as the heart and lungs. Connective tissue is made up of two main proteins, elastin and collagen. If the connective tissue becomes inflamed, the inflammation can damage the elastin and collagen and it can affect the body parts they are associated with. There are many different connective tissue diseases, and their symptoms can overlap. Tests that look at several different substances in the blood at one time have been developed to help identify specific connective tissue disorders. These tests are unproven. More studies are needed to see if they bring more health benefits than the standard ways of diagnosing these disorders.

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

Testing

<table>
<thead>
<tr>
<th>Serum biomarker panel testing</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Serum biomarker panel testing with proprietary algorithms and/or index scores for the diagnosis of systemic lupus erythematosus (SLE) and other connective tissue diseases is considered investigational.</td>
</tr>
</tbody>
</table>

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>81599</td>
<td>Unlisted multianalyte assay with algorithmic analysis</td>
</tr>
<tr>
<td>84999</td>
<td>Unlisted chemistry procedure</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

Serum Biomarker Panel Tests

Tests offered by Exagen Diagnostics laboratory (see Description and Regulatory Status) include:

- Avise SLE + Connective Tissue 2.0
- Avise SLE 2.0
- Avise SLE Prognostic
Description

Systemic lupus erythematosus (SLE) and other connective tissue diseases can be difficult to diagnose because patients often present with diverse, nonspecific symptoms, and commonly used laboratory tests are not highly accurate. Currently, diagnosis depends on a combination of clinical signs and symptoms and individual laboratory tests. More accurate laboratory tests for SLE and other connective tissue diseases could facilitate diagnosis of the disease in many patients. Recently, laboratory-developed, diagnostic panel tests with proprietary algorithms and/or index scores for the diagnosis of SLE and other connective tissue diseases have become commercially available.

Background

Connective Tissue Diseases

Systemic Lupus Erythematosus

Systemic lupus erythematosus (SLE) is an autoimmune connective tissue disease (CTD) that affects approximately 1.5 million individuals in the United States.\(^1\) SLE is one of several types of lupus, the others being cutaneous and drug-induced lupus. About 90% of lupus patients are women between the ages of 15 and 45 years. SLE causes inflammation and can affect any part of the body, most commonly the skin, heart, joints, lungs, blood vessels, liver, kidneys, and nervous system. Although generally not fatal, SLE can increase mortality, most commonly from cardiovascular disease due to accelerated atherosclerosis. SLE can also lead to kidney failure, which may reduce survival. The survival rate in the United States is approximately 95% at 5 years and 78% at 20 years.\(^2\) The morbidity associated with SLE is substantial. Symptoms such as joint and muscle pain can impact quality of life and functional status. SLE also increases patients’ risk of infection, cancer, avascular necrosis (bone death), and pregnancy complications (eg, preeclampsia, preterm birth). The course of the disease is variable, and patients generally experience periods of mild-to-severe illness (called flares) and remission.
Other Connective Tissue Diseases

Several other CTDs (eg, rheumatoid arthritis, Sjögren syndrome, antiphospholipid syndrome, and polymyositis) have symptoms that can overlap with those seen in SLE and are often included in SLE’s differential diagnosis.

Diagnosis

Patients with SLE often present with nonspecific symptoms such as fever, fatigue, joint pain, and rash, which can make the disease difficult to diagnosis. In some patients, the diagnosis of SLE can be made with certainty. For example, when there are typical symptoms of rash and joint symptoms, and laboratory testing shows a high-titer abnormal antinuclear antibody (ANA) in a pattern specific for SLE. However, in many other patients, the symptom patterns of SLE are less clear, and ANA testing is equivocal. In addition, doing ANA testing alone can result in false positives due to low specificity. As a result, cascade testing with additional serologic tests may be ordered.

Classifications

The diagnosis of SLE has been based on a combination of clinical symptoms and laboratory results. In 1997 the American College of Rheumatology (ACR) updated 1982 criteria for the classification of SLE.\(^3\)\(^4\)

The ACR classification criteria are as follows:

1. Malar rash
2. Discoid rash
3. Photosensitivity
4. Mouth or nose ulcers (usually painless)
5. Arthritis (nonerosive) in two or more peripheral joints, along with tenderness, swelling, or effusion
6. Serositis: Pleuritis or pericarditis
7. Renal disorder: excessive protein in the urine, or cellular casts in the urine
8. Neurologic disorder: seizures and/or psychosis, in the absence of offending drugs or known metabolic derangements

9. Hematologic disorders: hemolytic anemia, leukopenia, lymphopenia or thrombocytopenia

10. Immunologic disorder: antibodies to double stranded DNA (anti-dsDNA), antibodies to Smith nuclear antigen (anti-Sm), positive antiphospholipid antibody or false positive serologic test for syphilis known to be positive for at least 6 months

11. Abnormal antinuclear antibody (ANA) test in the absence of drugs known to induce it

These criteria were originally developed for research, but they have been widely adopted in clinical care. Individuals who meet 4 or more of the 11 criteria are diagnosed with SLE. If a patient meets fewer than four of the criteria, lupus can still be diagnosed by clinical judgment and it is recommended that a rheumatologist confirm the diagnosis.\(^5\) ANA testing is usually performed for patients who present with signs and symptoms involving two or more organ systems, and individuals who test positive are recommended for additional laboratory testing.\(^6\) Assessments of ACR’s 1982 criteria have reported sensitivities ranging from 78% to 95% and specificities ranging from 89% to 100%, with lower accuracy in patients with mild disease.\(^6\)

In 2012, the Systemic Lupus International Collaborating Clinics (SLICC), an international group of researchers, developed revised criteria for diagnosing SLE.\(^7\) These criteria include more laboratory tests than the earlier ACR criteria, including elements of the complement system. Patients are classified as having SLE if they satisfy 4 or more of the 18 criteria below, including at least 1 clinical criterion and 1 immunologic criterion, or they have biopsy-confirmed nephritis compatible with SLE and with ANA or anti-dsDNA antibodies. In a sample of 690 patients, the SLICC criteria had a sensitivity of 97% and a specificity of 84% for diagnosing SLE, whereas the ACR criteria applied to the same sample had a sensitivity of 83% and a specificity of 96%. It is not clear how well accepted the SLICC recommendations are in the practice setting. The SLICC criteria are outlined in Table 1 below.

**Table 1. Clinical and Immunological Criteria**

<table>
<thead>
<tr>
<th>Clinical and Immunologic Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong></td>
</tr>
<tr>
<td>Acute cutaneous lupus (including but not limited to lupus malar rash)</td>
</tr>
<tr>
<td>Chronic cutaneous lupus (including but not limited to discoid rash)</td>
</tr>
<tr>
<td>Oral ulcers</td>
</tr>
</tbody>
</table>
### Clinical and Immunologic Criteria

<table>
<thead>
<tr>
<th>Clinical and Immunologic Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonscarring alopecia in the absence of other causes</td>
</tr>
<tr>
<td>Synovitis involving ≥2 joints, characterized by swelling or effusion or and ≥30 min of morning stiffness</td>
</tr>
<tr>
<td>Serositis</td>
</tr>
<tr>
<td>Renal: excessive protein in the urine or cellular casts in the urine</td>
</tr>
<tr>
<td>Neurologic disorder: seizures, psychosis, mononeuritis complex, or peripheral, or cranial neuropathy</td>
</tr>
<tr>
<td>Seizures</td>
</tr>
<tr>
<td>Hemolytic anemia</td>
</tr>
<tr>
<td>Leukopenia or lymphopenia</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
</tr>
</tbody>
</table>

### Immunologic

<table>
<thead>
<tr>
<th>Immunologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antinuclear antibody above laboratory reference range</td>
</tr>
<tr>
<td>Antibodies to double-stranded DNA above laboratory reference range</td>
</tr>
<tr>
<td>Antibodies to Smith nuclear antigen</td>
</tr>
<tr>
<td>Antiphospholipid antibody</td>
</tr>
<tr>
<td>Low complement (low C3, low C4, or low CH150)</td>
</tr>
<tr>
<td>Direct Coombs tests in the absence of hemolytic anemia</td>
</tr>
</tbody>
</table>

As previously noted, the SLICC classification system includes a wider range of laboratory tests than the ACR criteria. To date, the most common laboratory tests performed in the diagnosis of SLE are serum ANA, and if this is positive, tests for anti-dsDNA and anti-Sm antibody. ANA tests are highly sensitive (ie, with a high negative predictive value) but have low specificity and relatively low positive predictive value, particularly when the ANA is positive at a low level. Specificity of testing can be increased by testing for specific antibodies against individual nuclear antigens (extractable nuclear antigens, called ENAs) to examine the “pattern” of ANA positivity. These include antigens against single and double-stranded DNA, histones, Sm, Ro, La, and RNP. The presence of anti-dsDNA or anti-Sm is highly specific for SLE because few patients without SLE test positive; however, neither of these tests have high sensitivity. The presence of other antibody patterns may indicate the likelihood of alternate diagnoses. For example, the presence of Ro and La antibodies suggests Sjögren syndrome, while the presence of antihistone antibodies suggests drug-induced lupus.

Better diagnostic tests for SLE and other CTDs would be useful in clinical practice. A variety of biomarkers, including markers associated with the complement system, are being explored to
aid in the diagnosis of lupus. The complement system is part of the immune system and consists of 20 to 30 protein molecules that circulate in the blood in an inactive form until activated by a trigger (eg, an infection). When the protein molecules are activated, a sequence of events known as the complement cascade is initiated. This cascade involves the proteolysis of a complement protein into a smaller protein and a peptide. The smaller protein is able to bind to the complex at the surface of the invading microorganism, and the peptide diffuses away. For example, in the first step, complement protein C3 is cleaved into C3b and C3a. C3b binds to the surface of the microorganism and activates the next step in the cascade, the proteolysis of C5, and the small peptide, C3a diffuses away. The precursors C3 and C4 and the complement activation products (eg, C3a, C5a, C4d) have been considered as SLE biomarkers. More recently, cell-bound complement activation products, which live longer than circulating complement activation products, have been investigated as biomarkers of SLE.

In addition to exploration of individual biomarkers with higher accuracy than accepted markers (eg, ANA, anti-dsDNA), there is interest in identifying a panel of tests with high sensitivity and specificity for SLE diagnosis. At least 1 multibiomarker test to aid the diagnosis of SLE and other CTDs is commercially available. This panel contains two separate panels (the 10-marker Avise Lupus test and the Avise CTD test for a total of 22 different tests). Avise CTD includes nuclear antigen antibodies markers to help distinguish specific CTDs, a rheumatoid arthritis panel to rule-in or rule-out rheumatoid arthritis, an antiphospholipid syndrome panel to assess risk for thrombosis and cardiovascular events, and a thyroid panel to help rule-in or rule-out Graves disease and Hashimoto disease. Specific biomarkers in the panel are listed below in Table 2.

<table>
<thead>
<tr>
<th>Systemic Lupus Erythematosus Tests</th>
<th>10-marker Avise Lupus test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-antibodies: ANA, anti-dsDNA, antimutated citrullinated vimentin, C4d erythrocyte-bound complement fragment, C4d lymphocyte-bound complement, anti-Sm, Jo-1, Sci-70, CENP, SS-B/La</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Avise CTD Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-antibodies: U1RNP, RNP70, SS-A/Ro</td>
</tr>
<tr>
<td>Rheumatoid arthritis auto-antibodies: rheumatoid factor IgM, rheumatoid factor IgA, anticyclic citrullinated peptide IgG</td>
</tr>
<tr>
<td>Anti-phospholipid syndrome auto-antibodies: cardiolipin IgM, cardiolipin IgG, β2-glycoprotein 1 IgG, β2-glycoprotein 1 IgM</td>
</tr>
<tr>
<td>Thyroid auto-antibodies: thyroglobulin IgG, thyroid peroxidase IgG</td>
</tr>
</tbody>
</table>
ANA: antinuclear antibody; anti-dsDNA: Antibodies to double-stranded DNA; anti-Sm: antibodies to Smith nuclear antigen; Ig: immunoglobulin.

The index score, calculated using a proprietary algorithm, rates how suggestive test results are of SLE. Although there is information on cutoffs used to indicate positivity for individual markers, information is not available on how precisely the index score is calculated. The score can range from -5 (highly nonsuggestive of SLE) to 5 (highly suggestive of SLE) and a score of -0.1 to 0.1 is considered indeterminate.

Exagen also offers the Avise SLE Prognostic test, a 10-marker panel that can be ordered with the Avise SLE 2.0/Avise SLE + Connective Tissue 2.0 panels. The prognostic test focuses on patients’ risk of lupus nephritis, neuropsychiatric SLE, thrombosis, and cardiovascular events. The test includes anti-C1q, anti-ribosomal P, anti-phosphatidylserine/prothrombin immunoglobulin (Ig) M and IgG, anti-cardiolipin IgM, IgG, and IgA and anti-β2-glycoprotein 1 IgM, IgG, and IgA. Four of the 10 markers are included in both panel tests.

**Treatment**

Treatments for SLE can ameliorate symptoms, reduce disease activity, and slow progression of organ damage; however, there is no cure for SLE. Muscle and joint pain, fatigue, and rashes are generally treated initially with nonsteroidal anti-inflammatory drugs. Antimalarial drugs such as hydroxychloroquine can relieve some symptoms of SLE including fatigue, rashes, and joint pain. Patients with more severe symptoms (eg, heart, lung, or kidney involvement) can be treated with corticosteroids or immune suppressants. There are also biologic treatments (eg, rituximab) approved by the U.S. Food and Drug Administration for treatment of rheumatoid arthritis and are being evaluated for SLE.

**Summary of Evidence**

For individuals with signs and/or symptoms of systemic lupus erythematosus (SLE) or connective tissue disease other than SLE who receive serum biomarker panel testing, the evidence includes several diagnostic accuracy studies. Relevant outcomes are test accuracy, symptoms, and quality of life. One study evaluated a panel similar to a commercially available test. It found that the panel test had somewhat higher specificity and lower sensitivity than the most common currently used biomarkers. The clinical significance of this degree of difference in diagnostic accuracy is unclear. One case-control study found a high sensitivity and specificity for a
commercially available test for diagnosing SLE, but this retrospective analysis has several limitations, and prospective studies are therefore needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in June 2017 did not identify any ongoing or unpublished trials that would likely influence this review.

Practice Guidelines and Position Statements

In 2014, an international group including participants in the European autoimmunity standardization initiative and the International Union of Immunologic Societies published recommendations on the assessment of autoantibodies to cellular antigens.\textsuperscript{16} The recommendations included the following statements relevant to the diagnosis of SLE:

- The diagnosis of systemic autoimmune rheumatic diseases (SARD) requires a panel of specific laboratory tests (ie, ANA [antinuclear antibodies], anti-dsDNA [double stranded DNA], anti-ENA [extractable nuclear antigen] antibodies)
- The detection of ANA is the first-level test for laboratory diagnosis of SARD
- If the ANA test is positive, testing for anti-dsDNA antibodies is advised when there is clinical suspicion of SLE
- If the ANA test is positive, testing for anti-ENA antibodies is recommended

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

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 (CLIA). The Avise® tests (Exagen Diagnostics, Vista, CA) are available under the auspices of CLIA. CLIA must license laboratories that offer laboratory-developed tests for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/13/14</td>
<td>New policy, add to Pathology/Laboratory section. Policy created with literature review through July 23, 2014. Serum biomarker panel tests for systemic lupus erythematosus with proprietary algorithms and/or index scores are considered investigational.</td>
</tr>
<tr>
<td>09/01/16</td>
<td>Annual Review, approved August 9, 2016. Policy updated with literature review through April 29, 2016; no references added. Policy statement unchanged.</td>
</tr>
<tr>
<td>09/01/17</td>
<td>Annual Review, approved August 22, 2017. Policy updated with literature review through April 25, 2017; references 10 and 15 added. The phrase “and other connective tissue diseases” added to policy statement and title.</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 customer 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). ©2017 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 Office for Civil Rights Complaint Portal, available at: https://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).

阿拉伯 (Arabic):
يحيى هذا الإشعار معلومات هامة. قد يحيى هذا الإشعار معلومات متعلقة ببعض الآليات التي تPECT دفع الحصول عليها من خلال Premera Blue Cross. في هذا الإشعار، يمكن أن تكون محتوا الإشارة إلى ترتيبات تبرير البحث في الموقع الإلكتروني لمزيد من المعلومات و taille la conscience d’être inclus dans le groupe. تصل إلى 800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):
通知有重要的信息。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。您有权利免费以您的母语得到本讯息和帮助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):

Deutsche (German):

Italiano (Italian):
Japanese (Japanese):
この通じには重要な情報が含まれています。この通じには、Premera Blue Crossの申請または補償範囲に関する重要な情報が含まれている場合があります。この通じには記載されている情報が重要である場合を含んでいただくため、健康保険や保険サービスを維持するには、特定の部門までに行動を起こすことができます。健康保険や保険サービスが用いられる場合には、定期的なリポートをチェックするようにお願いします。この通じは、保険サービスが提供されるかどうかを確認するためのツールです。

한국어 (Korean):
본 통지를 보는 중요한 정보가 있습니다. 즉 이용자는 추가 칭호를 통해 Premera Blue Cross 를 통해 커버하기 위해 관련 정보를 제공하고 있습니다. 본 통지를 보는 데는 필요 없거나 불필요할 수 있습니다. 이용자는 추가 커버하기 위해 필요한 만큼 정보를 취해视 할 필요가 있을 수 있습니다. 이용자는 추가 정보를 이용자의 언어에 따라 비용 부담없이 얻을 수 있습니다. 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)로 전화하시오.


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, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Espanol (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud de 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 al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):

ไทย (Thai):
ประกาศนี้มีข้อมูลสําคัญเกี่ยวกับการขอและการรับการช่วยเหลือของ Premera Blue Cross และมีข้อมูลเกี่ยวกับการรับช่วยเหลือของ Premera Blue Cross ที่มีรายละเอียดเกี่ยวกับสิทธิของคุณในการขอและการรับช่วยเหลือของ Premera Blue Cross ซึ่งมีรายละเอียดเกี่ยวกับสิทธิของคุณในการขอและการรับช่วยเหลือของ Premera Blue Cross 800-722-1471 (TTY: 800-842-5357).

Український (Ukrainiian):
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 вказані в цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки 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 на номер телефону 800-722-1471 (TTY: 800-842-5357).