Introduction

Vitamin D is an important nutrient for maintaining good health. It is especially important for good bone health and calcium metabolism. Many studies and articles have been published in scientific journals and in lay magazines about the benefits of vitamin D. Despite all of this interest, there is very little data about optimal levels of vitamin D, and most published studies are of low quality. The endocrine society and public health experts strongly recommend against measuring vitamin D levels in healthy individuals. Vitamin D is found in some foods, has been added to other foods (cereals and milk), and is increased with exposure to the sun. The U.S. National Institutes of Health (NIH) has recommended vitamin D supplementation for Americans based on age (600 IU per day for ages 1 to 70 years of age). Testing for vitamin D levels is covered when a person has signs or symptoms of vitamin D deficiency or risk factors for vitamin D deficiency.

Claims for vitamin D tests are reviewed after submission based on the diagnosis listed. The diagnoses considered medically necessary and that are covered are listed in this medical policy.

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.
### Testing Condition | Medical Necessity
---|---
**Asymptomatic** | **Testing vitamin D levels is considered medically necessary for asymptomatic patients when:**
- The patient has risk factors for vitamin D deficiency:
  - Chronic kidney disease, stage $\geq 3$
  - Cirrhosis/chronic liver disease
  - Malabsorption states
  - Osteomalacia
  - Osteoporosis
  - Rickets
  - Hypo- or hyper-calcemia
  - Granulomatous diseases
  - Vitamin D deficiency, on replacement
  - Obstructive jaundice/biliary tract disease
  - Osteogenesis imperfecta
  - Osteosclerosis/osteopetrosis
  - Chronic use of anticonvulsant medication or corticosteroids
  - Parathyroid disorders
  - Osteopenia
- The patient is institutionalized (see [Definition of Terms](#))

Testing vitamin D levels is considered not medically necessary for asymptomatic patients when criteria in this policy are not met.

### Testing Condition | Medical Necessity
---|---
**Symptomatic = Vitamin D Deficiency** | **Testing vitamin D levels may be considered medically necessary when the patient presents with signs and symptoms of vitamin D deficiency.**
- Signs and symptoms of vitamin D deficiency are largely manifested by changes in bone health and biochemical markers associated with bone production and resorption.
  - In most cases, a clinical diagnosis of an abnormality in bone health (eg, rickets, osteomalacia, osteoporosis) will lead to a
Testing Condition | Medical Necessity
--- | ---
 | decision to test vitamin D levels.
  | o Symptoms related to the clinical condition may be present, such as pain or low-impact fractures, but these symptoms are usually not indications for testing prior to a specific diagnosis.
  | o Some biochemical markers of bone health may indicate an increased risk for vitamin D deficiency, and testing of vitamin D levels may therefore be appropriate. These biochemical markers include unexplained abnormalities in serum calcium, phosphorous, alkaline phosphatase, and/or parathyroid hormone.
| Symptomatic = Vitamin D Toxicity (hypervitaminosis D) | Testing vitamin D levels may be considered medically necessary when the patient presents with signs and symptoms of vitamin D toxicity (hypervitaminosis D).  
  | • Signs and symptoms of vitamin D toxicity generally result from induced hypercalcemia.
  |   | o Acute intoxication can cause symptoms of confusion, anorexia, vomiting, weakness, polydipsia, and polyuria.
  |   | o Chronic intoxication can cause bone demineralization, kidney stones, and bone pain.
| Repeat testing | The need for repeat testing may vary by condition. A single test may be indicated for diagnostic purposes; a repeat test may be appropriate to determine whether supplementation has been successful in restoring normal serum levels.  
  | • More than 1 repeat test is rarely necessary, however, it may be indicated in cases where supplementation has not been successful in restoring levels, continued or recurrent signs and symptoms may indicate ongoing deficiency, and/or inadequate absorption or noncompliance with replacement therapy is suspected.

**Coding**

The following codes are specific to vitamin D testing and related to medically necessary diagnoses:
<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>82306</td>
<td>Vitamin D; 25 hydroxy, includes fraction(s), if performed</td>
</tr>
<tr>
<td>82652</td>
<td>Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed</td>
</tr>
<tr>
<td>ICD-10 Diagnosis Codes - Covered</td>
<td></td>
</tr>
<tr>
<td>D71</td>
<td>Functional disorders of polymorphonuclear neutrophils</td>
</tr>
<tr>
<td>D86.0 – D86.9</td>
<td>Sarcoïdosis</td>
</tr>
<tr>
<td>E20.0 – E20.9</td>
<td>Hypoparathyroidism, code range</td>
</tr>
<tr>
<td>E21.0 – E21.5</td>
<td>Hyperparathyroidism and other disorders of parathyroid gland</td>
</tr>
<tr>
<td>E41</td>
<td>Nutritional marasmus</td>
</tr>
<tr>
<td>E43</td>
<td>Unspecified severe protein-calorie malnutrition</td>
</tr>
<tr>
<td>E55.0; E55.9</td>
<td>Vitamin D deficiency codes</td>
</tr>
<tr>
<td>E67.3</td>
<td>Hypervitaminosis D</td>
</tr>
<tr>
<td>E72.0 – E72.09</td>
<td>Disorders of amino-acid transport, unspecified</td>
</tr>
<tr>
<td>E74.21</td>
<td>Galactosemia</td>
</tr>
<tr>
<td>E83.30 – E83.39</td>
<td>Disorder of phosphorus metabolism</td>
</tr>
<tr>
<td>E83.50 – E83.59</td>
<td>Disorder of calcium metabolism</td>
</tr>
<tr>
<td>E89.2</td>
<td>Postprocedural hypoparathyroidism</td>
</tr>
<tr>
<td>K70.0 – K77</td>
<td>Disorders of the liver, code range</td>
</tr>
<tr>
<td>K83.1 – K83.9</td>
<td>Other diseases of biliary tract</td>
</tr>
<tr>
<td>K90.0 – K90.9</td>
<td>Intestinal malabsorption, code range</td>
</tr>
<tr>
<td>K91.2</td>
<td>Postsurgical malabsorption, not elsewhere classified</td>
</tr>
<tr>
<td>M80.00 – M81.8</td>
<td>Osteoporosis, code range</td>
</tr>
<tr>
<td>M83.0 – M83.9</td>
<td>Osteomalacia, code range</td>
</tr>
<tr>
<td>M85.80 – M85.9</td>
<td>Other specified disorders of bone density and structure</td>
</tr>
<tr>
<td>N18.1 – N18.9</td>
<td>Chronic kidney disease (CKD), code range</td>
</tr>
<tr>
<td>N20.0 – N20.9</td>
<td>Calculus of kidney and ureter</td>
</tr>
<tr>
<td>N22</td>
<td>Calculus of urinary tract in diseases classified elsewhere</td>
</tr>
</tbody>
</table>
## Code | Descriptor
--- | ---
N25.81 | Secondary hyperparathyroidism of renal origin
P71.0 – P71.9 | Transitory neonatal disorders of calcium and magnesium metabolism
Q78.0 | Osteogenesis imperfecta
Q78.2 | Osteopetrosis
R17 | Unspecified jaundice
Z79.52 | Long term (current) use of systemic steroids
Z79.899 | Other long term (current) drug therapy

### Related Information

#### Definition of Terms

**Institutionalized**: For the purposes of this policy, “institutionalized” refers to patients who live in long-term care facilities where some degree of medical care is provided. Examples include long-term care hospitals, nursing homes, assisted living facilities, and similar environments.

#### Benefit Application

Consistent with federal mandates, vitamin D supplements are covered as preventive care for individuals age 65 and older (without cost sharing) when the member’s contract is subject to those mandates. A written prescription is needed for coverage.

The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. (Grade B recommendation)

**Note**: The USPSTF does not recommend routine testing of vitamin D levels as a preventive strategy. (See Practice Guidelines and Position Statements).

### Evidence Review
Description

Vitamin D, also known as calciferol, is a fat-soluble vitamin that has a variety of physiologic effects, most prominently in calcium homeostasis and bone metabolism. In addition to the role it plays in bone metabolism, other physiologic effects include inhibition of smooth muscle proliferation, regulation of the renin-angiotensin system, decrease in coagulation, and decrease in inflammatory markers.¹

Background

Vitamin D Levels

Vitamin D deficiency is best assessed by measuring serum levels of 25-hydroxyvitamin D (25(OH)D). However, there is no consensus on the minimum vitamin D level or on the optimal serum level for overall health. A 2011 Institute of Medicine (IOM) report concluded that a serum level of 20 ng/mL is sufficient for most healthy adults.² Some experts, such as the National Osteoporosis Foundation and the American Geriatrics Society, recommend a higher level (30 ng/mL).²

Vitamin D deficiency, as defined by suboptimal serum levels, is common in the United States. In the National Health and Nutrition Examination Survey covering the period of 2000-2004, 30% of individuals over the age of 12 had 25(OH)D levels less than 20 ng/mL.³ Vitamin D deficiency occurs most commonly as a result of inadequate dietary intake coupled with inadequate sun exposure. Evidence from the National Nutrition Monitoring System and the National Health and Nutrition Examination Survey has indicated that the average dietary consumption is below recommended levels of intake. Yetley (2008) estimated that average daily intake for U.S. adults ranged from 228 to 335 IU/d, depending on gender and ethnicity.³ This is below the average daily requirement, estimated by IOM to be 400 IU/d for healthy adults, and well below IOM’s required daily allowance (estimated to be 600 IU for nonelderly adults and 800 IU for elderly adults).

Vitamin D deficiency may occur less commonly for other reasons. Kidney or liver disease can cause deficiency as a result of impaired conversion of inactive vitamin D to its active products. In rare situations, there is vitamin D resistance at the tissue level, which causes a functional vitamin D deficiency despite “adequate” serum levels.
The safe upper level for serum vitamin D is also not standardized. The IOM report concluded that there is potential harm associated with levels greater than 50 ng/mL and recommended that serum levels be maintained in the 20 to 40 ng/mL range. However, conclusions on this point have differed. A 2011 Agency for Healthcare Research and Quality (AHRQ) systematic review on vitamin D and bone health concluded that “There is little evidence from existing trials that vitamin D above current reference intakes is harmful.” The Women’s Health Initiative (WHI) concluded that hypercalcemia and hypercalciuria in patients receiving calcium and vitamin D were not associated with adverse clinical events. The WHI did find a small increase in kidney stones for women aged 50 to 79 years who received vitamin D and calcium.

Associations of vitamin D levels with various aspects of health have been noted over the last several decades, and these findings have led to the question of whether supplementation improves health outcomes. For example, a relationship between vitamin D levels and overall mortality has been reported in most observational studies that examined this association. Mortality is lowest at vitamin D levels in the 25 to 40 nmol/L range. At lower levels of serum vitamin D, mortality increases steeply, and overall mortality in the lowest quintile was more than 3 times that in the middle quintiles. Theodoratou et al identified 107 systematic reviews of observational studies examining the association between vitamin D levels and more than 100 different outcomes.

**Vitamin D Replacement**

The IOM has recommended reference values for intake of vitamin D and serum levels, based on available literature and expert consensus. Recommended daily allowances are 600 IU/d for individuals between 1 and 70 years of age and 800 IU/d for individuals older than 70 years.

Estimates of vitamin D requirements are complicated by the many other factors that affect serum levels. Sun exposure is the most prominent factor that affects serum levels, and this is because individuals can meet their vitamin D needs entirely through adequate sun exposure. Other factors such as age, skin pigmentation, obesity, physical activity, and nutritional status also affect vitamin D levels and can result in variable dietary intake requirements to maintain adequate serum levels.

Excessive intake of vitamin D can have toxic effects. Toxic effects are usually due to hypercalcemia and may include confusion, weakness, polyuria, polydipsia, anorexia, and vomiting. In addition, high levels of vitamin D may promote calcium deposition and has the potential to exacerbate conditions such as calcium kidney stones and atherosclerotic vascular disease.
The IOM defined 3 parameters of nutritional needs for vitamin D, on the assumption of minimal sun exposure. They were the estimated average requirement, defined as the minimum intake required to maintain adequate levels; the recommended daily allowance, defined as the optimal dose for replacement therapy; and the upper-level intake, defined as the maximum daily dose to avoid toxicity. These recommendations are summarized in Table 1.

Table 1. Institute of Medicine Recommendations for Vitamin D Dietary Intake

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Estimated Average Requirement, IU/d</th>
<th>Recommended Daily Allowance, IU/d</th>
<th>Upper Limit Intake, IU/d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 years old</td>
<td>400</td>
<td>600</td>
<td>2500</td>
</tr>
<tr>
<td>4-8 years old</td>
<td>400</td>
<td>600</td>
<td>3000</td>
</tr>
<tr>
<td>9-70 years old</td>
<td>400</td>
<td>600</td>
<td>4000</td>
</tr>
<tr>
<td>&gt;70 years old</td>
<td>400</td>
<td>800</td>
<td>4000</td>
</tr>
</tbody>
</table>

Adapted from Institute of Medicine (2011).²

Analytic Framework

Figure 1 summarizes the approach to this evidence review. The diagram demonstrates the framework for how vitamin D testing affects outcomes. Using this framework, the main question is whether testing individuals for vitamin D deficiency improves outcomes.
Based on this analytic framework, the most relevant studies are those trials that test vitamin D levels and enroll only patients who are vitamin D deficient. Many of the existing RCTs, including the largest trial (Women’s Health Initiative [WHI]), did not test vitamin D levels prior to treatment. Rather, they treated all patients who were enrolled regardless of vitamin D levels. Results of some of the main systematic reviews that take this approach will be reviewed, but this evidence is indirect and must be extrapolated from treatment of all patients to treatment of patients who are vitamin D deficient.

Summary of Evidence

For individuals who are asymptomatic and without conditions or risk factors for which vitamin D treatment is recommended who receive testing of vitamin D levels, the evidence includes no randomized controlled trials (RCTs) of clinical utility (ie, evidence that patient care including testing vitamin D levels vs care without testing vitamin D levels improves outcomes). Indirect evidence of potential utility of testing includes many RCTs and systematic reviews of vitamin D supplementation. Relevant outcomes are overall survival, disease-specific survival, test accuracy and validity, symptoms, morbid events, and treatment-related morbidity. There is a lack of standardized vitamin D testing strategies and cutoffs for vitamin D deficiency are not
standardized or evidence-based. In addition, despite the large quantity of evidence, considerable uncertainty remains about the beneficial health effects of vitamin D supplementation. Many RCTs have included participants who were not vitamin D deficient at baseline and did not stratify results by baseline 25(OH)D level. Nonwhite race/ethnic groups are underrepresented in RCTs but have increased risk of vitamin D deficiency. For skeletal health, there may be a small effect of vitamin D supplementation on falls, but there does not appear to be an impact on reducing fractures for the general population. The effect on fracture reduction may be significant in elderly women, and with higher doses of vitamin D. For patients with asthma, there may be a reduction in severe exacerbations with vitamin D supplementation, but there does not appear to be an effect on other asthma outcomes. For overall mortality, there is also no benefit for the general population. RCTs evaluating extraskeletal, cancer, cardiovascular, and multiple sclerosis outcomes have not reported a statistically significant benefit for vitamin D supplementation. Although vitamin D toxicity and adverse events appear to be rare, few data on risks have been reported. 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 2.

Table 2. 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><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01169259</td>
<td>Vitamin D and Omega-3 Trial (VITAL)</td>
<td>25,871</td>
<td>Jun 2018</td>
</tr>
<tr>
<td>NCT01490502</td>
<td>A Randomized Controlled Trial of Vitamin D Supplementation in Multiple Sclerosis (VIDAMS)</td>
<td>172</td>
<td>Mar 2019</td>
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<tr>
<td>NCT00920621</td>
<td>Randomized Trial: Maternal Vitamin D Supplementation to Prevent Childhood Asthma (VDAART)</td>
<td>876</td>
<td>Jun 2019</td>
</tr>
<tr>
<td>NCT02166333</td>
<td>Vitamin D Supplements to Prevent Falls in Older Adults: A Dose-Response Trial (STURDY)</td>
<td>1200</td>
<td>Dec 2019</td>
</tr>
<tr>
<td><strong>Unpublished</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01153568</td>
<td>Vitamin D and Osteoporosis Prevention in Elderly African American Women: A 4-year Randomized, Double-blind,</td>
<td>260</td>
<td>Oct 2016 (completed)</td>
</tr>
</tbody>
</table>

Page | 10 of 16
<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo-controlled Study to Investigate the Effect of Vitamin D Status in Elderly African American Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02424552</td>
<td>EVITA Trial: Effect of Vitamin D as add-on Therapy for Vitamin D Insufficient Patients With Severe Asthma: a Randomized, Double-blind, Placebo-controlled Trial</td>
<td>54</td>
<td>Feb 2017 (terminated)</td>
</tr>
<tr>
<td>NCT02750293</td>
<td>The Effect of Vitamin D Supplementation on Cardiovascular Risk Factors in Subjects With Low Serum 25-hydroxyvitamin D Levels (D-COR)</td>
<td>411</td>
<td>Sep 2017 (completed)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial

Practice Guidelines and Position Statements

*Endocrine Society*

In 2011, the Endocrine Society published clinical practice guidelines on the evaluation, treatment and prevention of vitamin D deficiency. The following recommendations were made regarding testing vitamin D levels:

- 25(OH)D [25-hydroxyvitamin D] serum level testing is recommended “to evaluate vitamin D status only in patients who are at risk of deficiency.” The guideline did not recommend screening of individuals not at risk of vitamin D deficiency.

- 1,25(OH)2D [1,25-dihydroxyvitamin D] testing is not recommended to evaluate vitamin D status. However, the guideline did recommend monitoring calcitriol levels in certain conditions.

*American College of Obstetrics and Gynecology*

The American College of Obstetrics and Gynecology issued a committee opinion (2011) on the testing of vitamin D levels and vitamin D supplementation in pregnant women. The following recommendation was made concerning testing vitamin D levels:

- At this time there is insufficient evidence to support a recommendation for screening all pregnant women for vitamin D deficiency. For pregnant women thought to be at increased risk of vitamin D deficiency, maternal serum 25-hydroxyvitamin D levels can be considered
and should be interpreted in the context of the individual clinical circumstance. When vitamin D deficiency is identified during pregnancy, most experts agree that 1,000-2,000 international units per day of vitamin D is safe.

**American Academy of Family Physicians**

In 2014, the American Academy of Family Physicians concluded that the current evidence was insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency.59

**U.S. Preventive Services Task Force Recommendations**

The U.S. Preventive Services Task Force (USPSTF) published a recommendation in 201460 and associated guidelines in 201561 on vitamin D screening. USPSTF concluded that the current evidence was insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic individuals (grade I [insufficient evidence]).

**Medicare National Coverage**

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

**Regulatory Status**

The U.S. Food and Drug Administration has cleared a number of immunoassay in vitro diagnostic devices for the quantitative measurement of total 25(OH)D through the 510(k) process.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests (LDTs) must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Laboratories that offer LDTs must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.
13. Theodoratou E, Tzoulaki I, Zagaza L, et al. Vitamin D and multiple health outcomes: umbrella review of systematic reviews and meta-analyses of observational studies and randomised trials. BMJ. Apr 01 2014;348:g2035. PMID 24690624
22. Sanders KM, Stuart AL, Williamson EJ, et al. Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial. JAMA. May 12 2010;303(18):1815-1822. PMID 20460620


**History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>01/12/16</td>
<td>New policy, add to Pathology/Laboratory testing section. Replaces 2.04.507; testing of vitamin D serum levels may be considered medically necessary when criteria are met.</td>
</tr>
<tr>
<td>02/04/16</td>
<td>Coding update. Added ICD10 diagnosis code E74.21.</td>
</tr>
<tr>
<td>02/19/16</td>
<td>Coding update. Minor clarifications to osteomalacia code range and correction to code K70.0.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Interim Update, approved July 12, 2016. Policy published in new template with introduction added. Clarified institutional information. Intent remains the same.</td>
</tr>
<tr>
<td>03/01/17</td>
<td>Annual review, approved February 14, 2017. Policy updated literature review through October 10, 2016; references 14-16, 29, 31-36, 43, and 45 added. Policy statements unchanged.</td>
</tr>
<tr>
<td>08/15/17</td>
<td>Minor formatting updates.</td>
</tr>
<tr>
<td>03/01/18</td>
<td>Annual Review, approved February 6, 2018. Policy updated with literature review through October 2017; references 32-34 and 36-48 added; notes 15 and 62 updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>10/01/18</td>
<td>Coding update. Updated diagnosis code range for “other diseases of biliary tract” from K83.0 – 8.39 to K83.1 – K83.9.</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.

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Toll free 855-332-4535, Fax 425-918-5592. TTY 800-842-5357
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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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Avis sila a gen Enfòmasyon Enpòtan Ilayann. Avis sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravé Premera Blue Cross. Kapab genyen dat ki enpòtan nan a avis sila a. Ou ka gen pou pou nan kòk akson avan séten dat limit pou ka kònete kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewa enfòmasyon sa a ak asisans nan lang ou pale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):
Tsab ntawv tshal xo no muaj cov ntsiab lus tseem ceeb. Tej zaum tsab ntawv tshal xo no muaj cov ntsiab lus tseem ceeb tsoog koj dain twaw thov keb pov los yoj koj chov keb pov cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnb tseem ceeb cuam rau hauv daim ntawm no. Tej zaum koj kuj yuvau taa ua qee yam uaspek koj uas tsip pub dhou cov caj nyong uas teev tseg rau hauv daim ntawm no mas koj kuj yuvau tbaais keb pov cuam rau hauv daim ntawm po mab kori kuo koj kuj yuvau taa laodi keb pov cuam rau hauv daim ntawm po mab kori kuo koj kuj yuvau taa laodi keb pov cuam rau hauv daim ntawm.

Ilokano (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalbin nga adda ket naglaon iti napateg nga impormasion maingapengg iti aplikasyonwo nyo coverag babaen iti Premera Blue Cross. Daytoy ket mabalbin dagiti importante a pesla iti daytoy a pakdaar. Mabalbin nga adda rumbeng nga aramidenyo nga addang sakkay dagiti partikular a naiutding nga adda tawap tapo napagatinlaydo nga daytoy ti salun-atyo nga tungol kadagit gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tungol iti bukodyo a pagasasa nga awan ti bayadanyo. Tumawag ti numero nga os wa 800-722-1471 (TTY: 800-842-5357).

Oromoo (Cushite):
Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) ti bilbilaa.