MEDICAL POLICY – 7.01.526
Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors

BCBSA Ref. Policy: 7.01.92
Effective Date: Oct. 1, 2018
Last Revised: Sept. 20, 2018
Replaces: 7.01.92

RELATED MEDICAL POLICIES:
7.01.95 Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Select a hyperlink below to be directed to that section.

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

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Introduction

Cryosurgical ablation uses extreme cold to destroy certain types of tumors. A probe is inserted into the tumor and an extremely cold liquid is circulated through the probe. An icy ball forms around the probe to freeze part or all of the tumor. The probe can be positioned in such a way as to maximize harm to the tumor while sparing nearby health tissue. The frozen area thaws, allowing the body to absorb the treated tissue. The policy discusses when this technique is considered medically necessary for specific breast and kidney tumors. It’s also been tried for other kinds of tumors. Because larger and longer medical studies are needed, this technique is considered investigational (unproven) for other types of tumors.

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
<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cryosurgical ablation of benign breast fibroadenomas</strong></td>
<td>Cryosurgical ablation of benign breast fibroadenomas may be considered medically necessary when ALL of the following criteria are met:</td>
</tr>
<tr>
<td></td>
<td>• The lesion must be sonographically visible AND • The diagnosis of fibroadenoma is confirmed histologically AND • The lesion(s) is less than 3 cm in largest diameter AND • There are none of the following contraindications in existence:</td>
</tr>
<tr>
<td></td>
<td>o Large core biopsy diagnosis suggestive of cystosarcoma phyllodes tumor or other malignancy</td>
</tr>
<tr>
<td></td>
<td>o Poor visualization of lesion by ultrasound</td>
</tr>
<tr>
<td></td>
<td>o Large core biopsy diagnosis of fibroadenoma where diagnosis is thought to be non-concordant with findings on imaging or physical examination</td>
</tr>
<tr>
<td><strong>Cryosurgical ablation, localized renal cell carcinoma</strong></td>
<td>Cryosurgical ablation may be considered medically necessary to treat localized renal cell carcinoma that is no more than 4 cm in size when either of the following criteria is met:</td>
</tr>
<tr>
<td></td>
<td>• Preservation of kidney function is necessary (ie, the patient has one kidney or renal insufficiency defined by a glomerular filtration rate [GFR] of less than 60 mL/min per m$^2$) and standard surgical approach (ie, resection of renal tissue) is likely to substantially worsen kidney function OR • Patient is not considered a surgical candidate</td>
</tr>
<tr>
<td><strong>Lung cancer</strong></td>
<td>Cryosurgical ablation may be considered medically necessary to treat lung cancer when either of the following criteria is met:</td>
</tr>
<tr>
<td></td>
<td>• The patient has early-stage non-small cell lung cancer and is a poor surgical candidate OR • The patient requires palliation for a central airway obstructing lesion.</td>
</tr>
<tr>
<td>Service</td>
<td>Investigational</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cryosurgical ablation, malignant tumors</td>
<td>Cryosurgical ablation is considered investigational to treat individuals with ANY of the following:</td>
</tr>
<tr>
<td></td>
<td>• Bone cancer</td>
</tr>
<tr>
<td></td>
<td>• Lung cancer (other than defined above)</td>
</tr>
<tr>
<td></td>
<td>• Malignant tumors of the breast</td>
</tr>
<tr>
<td></td>
<td>• Other solid tumors or metastases outside the liver and prostate</td>
</tr>
<tr>
<td></td>
<td>• Pancreatic cancers</td>
</tr>
<tr>
<td></td>
<td>• Renal cell carcinomas in patients who are surgical candidates</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:

- For cryosurgical ablation of benign breast fibroadenomas, clinical documentation that includes:
  - Lesion that is visible on an ultrasound
  - Histological result confirming the diagnosis of fibroadenoma
  - Size of the lesion
  - And none of the following contraindications:
    - Large core biopsy diagnosis that is suggestive of cystosarcoma phyllodes tumor or other malignancy
    - Poor visualization of lesion by ultrasound
    - Large core biopsy diagnosis of fibroadenoma where diagnosis is thought to be inconsistent with findings on imaging or physical examination

- For cryosurgical ablation of localized renal cell carcinoma, documentation of:
  - The need to preserve the kidney because:
    - Patient has one kidney
    - Patient has renal insufficiency as defined by a glomerular filtration rate (GFR) of less than or equal to 60 mL/min/m², and standard surgical approach (ie, resection of renal tissue) is likely to substantially worsen kidney function
    - Patient is considered not a surgical candidate

- For lung cancer, documentation of:
  - Patient has early-stage non-small cell lung cancer and is a poor surgical candidate
**Documentation Requirements**

- The patient requires palliation for a central airway obstructing lesion

**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT</strong></td>
<td>Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance (code terminated 1/1/18, replaced by 32994)</td>
</tr>
<tr>
<td>0340T</td>
<td>Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma</td>
</tr>
<tr>
<td>19105</td>
<td>Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation</td>
</tr>
<tr>
<td>20983</td>
<td>Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation (new code effective 1/1/18)</td>
</tr>
<tr>
<td>32994</td>
<td>Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed</td>
</tr>
<tr>
<td>50250</td>
<td>Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed</td>
</tr>
<tr>
<td>50593</td>
<td>Ablation, renal tumor(s), unilateral, percutaneous, cryoablation</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
Description

Cryosurgical ablation (hereafter referred to as cryosurgery or cryoablation) involves freezing of target tissues; this is most often performed by inserting a coolant-carrying probe into the tumor. Cryosurgery may be performed as an open surgical technique or as a closed procedure under laparoscopic or ultrasound guidance.

Background

Breast Tumors

Early-stage primary breast tumors are treated surgically. The selection of lumpectomy, modified radical mastectomy, or another approach is balanced against the patient’s desire for breast conservation, the need for tumor-free margins in resected tissue, and the patient’s age, hormone receptor status, and other factors. Adjuvant radiation therapy decreases local recurrences, particularly for those who select lumpectomy. Adjuvant hormonal therapy and/or chemotherapy are added, depending on presence and number of involved nodes, hormone receptor status, and other factors. Treatment of metastatic disease includes surgery to remove the primary lesion and combination chemotherapy.

Fibroadenomas are common, benign tumors of the breast that can either present as a palpable mass or a mammographic abnormality. These benign tumors have been frequently surgically excised to rule out a malignancy.

Lung Tumors

Early-stage lung tumors are typically treated surgically. Patients with early-stage lung cancer who are not surgical candidates may be candidates for radiotherapy with curative intent. Cryoablation is being investigated in patients who are medically inoperable, with small primary lung cancers or lung metastases. Patients with more advanced local disease or metastatic disease may undergo chemotherapy with radiation following resection. Treatment is rarely curative: rather, it seeks to retard tumor growth or palliate symptoms.
Pancreatic Cancer

Pancreatic cancer is a relatively rare solid tumor that occurs almost exclusively in adults, and it is largely considered incurable. Surgical resection of tumors contained entirely within the pancreas is currently the only potentially curative treatment. However, the nature of the cancer is such that few tumors are found at such an early and potentially curable stage. Patients with more advanced local disease or metastatic disease may undergo chemotherapy with radiation following resection. Treatment focuses on slowing tumor growth and palliation of symptoms.

Renal Cell Carcinoma (RCC)

Localized renal cell carcinoma is treated with radical nephrectomy or nephron-sparing surgery. Prognosis drops precipitously if the tumor extends outside the kidney because chemotherapy is relatively ineffective against metastatic renal cell carcinoma.

Cryosurgical Treatment

Cryosurgical treatment of various tumors including malignant and benign breast disease, lung cancer, pancreatic cancer, and renal cell carcinoma has been reported in the literature. The hypothesized advantages of cryosurgery include improved local control and benefits common to any minimally invasive procedure (eg, preserving normal organ tissue, decreasing morbidity, decreasing length of hospitalization).

Summary of Evidence

For individuals who have solid tumors (located in areas of the breast, lung, pancreas, kidney, or bone) who receive cryosurgical ablation, the evidence includes nonrandomized comparative studies, case series, and systematic reviews of these nonrandomized studies. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related morbidity. There is a lack of randomized controlled trials and high-quality comparative studies to determine the efficacy and comparative effectiveness of cryoablation. The largest amount of evidence assesses renal cell carcinoma in select patients (ie, those with small tumors who are not surgical candidates, or those who have baseline renal insufficiency of such severity that standard
surgical procedures would impair their kidney function). Cryoablation results in short-term tumor control and less morbidity than surgical resection, but long-term outcomes may be inferior to surgery. For other indications, there is less evidence, with single-arm series reporting high rates of local control. Due to the lack of prospective controlled trials, it is difficult to conclude that cryoablation improves outcomes for any indication better than alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes. However, based on clinical input, cryosurgical ablation of benign breast fibroadenomas is considered medically necessary when criteria are met.

**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><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01957787</td>
<td>Study of Cryoablation for Metastatic Lung Tumors (SOLSTICE)</td>
<td>134</td>
<td>Sep 2018</td>
</tr>
<tr>
<td>NCT02399124-a</td>
<td>ICE-SECRET PROSENSE™ Cryotherapy for Renal Cell Carcinoma Trial</td>
<td>100</td>
<td>Jan 2022</td>
</tr>
<tr>
<td>NCT03390413</td>
<td>Robot-assisted Surgical Resection vs. Cryoablation of Localised Renal Cancer - a Randomised Trial of Functional, Oncological and Financial Aspects</td>
<td>190</td>
<td>Mar 2028</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

*a* Denotes industry-sponsored or cosponsored trial.

**Clinical Input 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.
2017 Input

In response to requests, clinical input on use of cryosurgical ablation to manage individuals with localized renal cell cancer, use of cryosurgical ablation to manage individuals with lung cancer, and use of cryosurgical ablation to manage individuals with breast, pancreatic, or bone cancers was received from 9 respondents, including 2 specialty society-level responses, 3 physician-level responses identified by specialty societies, and 4 physicians identified by 1 health system, while this policy was under review in 2017.

Based on the evidence and independent clinical input, the clinical input supports that the following indications provide a clinically meaningful improvement in the net health outcome and are consistent with generally accepted medical practice.

- Use of cryosurgical ablation to manage individuals with localized renal cell cancer when either of the following criteria is met:
  - No more than 4 cm in size when preservation of kidney function is necessary (ie, the patient has 1 kidney or renal insufficiency defined by a glomerular filtration rate <60 mL/min/m²), and standard surgical approach (ie, resection of renal tissue) is likely to worsen kidney function substantially; or
  - When the patient is not considered a surgical candidate.

- Use of cryosurgical ablation to manage individuals with lung cancer when either of the following criteria is met:
  - Poor surgical candidates with early-stage non-small-cell lung cancer; or
  - Palliation of a central airway obstructing lesion

Based on the evidence and independent clinical input, the clinical input does not support whether the following indication provides a clinically meaningful improvement in the net health outcome or is consistent with generally accepted medical practice.

- Use of cryosurgical ablation to manage individuals with:
  - Malignant or benign tumors of the breast;
  - Pancreatic cancer; or
  - Bone cancer
2009 Input

In response to requests, input was received from 2 physician specialty societies (5 reviews) and from 2 academic medical centers (3 reviews) while this policy was under review in 2009. There was strong support for the use of cryoablation in the treatment of select patients with renal tumors. There also was support for its use in the treatment of benign breast disease. Reviewers generally agreed cryoablation was investigational in the treatment of pancreatic cancer.

Practice Guidelines and Position Statements

The American Society of Breast Surgeons

The American Society of Breast Surgeons 2008 consensus statement on management of fibroadenomas of the breast indicated cryoablation is appropriate for histologically confirmed fibroadenoma lesions that are less than 4 cm in largest diameter and sonographically visible. Cryoablation of fibroadenoma of the breast is contraindicated when ultrasound visualization is poor or core biopsy suggests a diagnosis of cystosarcoma phyllodes tumor or other malignancy or if physical examination or imaging is discordant with a biopsy diagnosis of fibroadenoma.

American College of Radiology

The 2009 American College of Radiology Appropriateness Criteria for renal cell carcinoma, updated most recently in 2014, indicated that “As an alternative to partial nephrectomy, energy-ablative therapies, such as cryoablation... are being used to treat small renal cell carcinomas. These therapies have been shown to be effective and safe.” These recommendations are based on review of the data and consensus.

American Urological Association (AUA)

The American Urological Association (2017) updated its guidelines on evaluation and management of clinically localized sporadic renal masses suspicious for renal cell carcinoma. The guideline statements on thermal ablation (radiofrequency ablation, cryoablation) are listed in Table 2.
Table 2. Guidelines on Localized Masses Suspicious for Renal Cell Carcinoma

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>LOR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guideline statement 24</strong></td>
<td></td>
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<tr>
<td>Physicians should consider thermal ablation (TA) as an alternate approach for the management of cT1a renal masses &lt; 3 cm in size. For patients who elect TA, a percutaneous technique is preferred over a surgical approach whenever feasible to minimize morbidity.</td>
<td>Conditional</td>
<td>C</td>
</tr>
<tr>
<td><strong>Guideline statement 25</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both radiofrequency ablation and cryoablation are options for patients who elect thermal ablation</td>
<td>Conditional</td>
<td>C</td>
</tr>
<tr>
<td><strong>Guideline statement 27</strong></td>
<td></td>
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</tr>
<tr>
<td>Counseling about thermal ablation should include information regarding an increased likelihood of tumor persistence or local recurrence after primary thermal ablation relative to surgical extirpation, which may be addressed with repeat ablation if further intervention is elected</td>
<td>Strong</td>
<td>B</td>
</tr>
</tbody>
</table>

LOE: level of evidence; LOR: level of recommendation.

**National Comprehensive Cancer Network**

National Comprehensive Cancer Network (NCCN) guidelines on kidney cancer (v.4.2018) state that based on lower level evidence and uniform NCCN consensus, cryosurgery: “can be considered for patients with clinical stage T1 renal lesions who are not surgical candidates. Biopsy of small lesions may be considered to obtain or confirm a diagnosis of malignancy and guide surveillance, cryosurgery ... [and] ablation strategies.”52 NCCN guidelines also note that “Randomized phase III comparison with surgical resection (ie, radical or partial nephrectomy by open or laparoscopic techniques) has not been done” and “ablative techniques are associated with a higher local recurrence rate than conventional surgery.”

NCCN guidelines for non-small cell lung cancer (v.4.2108) indicate surgical “resection is the preferred local treatment modality” and “other modalities include ... cryotherapy.”53
Medicare National Coverage

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

Regulatory Status

Several cryoablation devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for use in open, minimally invasive or endoscopic surgical procedures in the areas of general surgery, urology, gynecology, oncology, neurology, dermatology, proctology, thoracic surgery and ear, nose, and throat. Examples include:

- Cryocare® Surgical System (Endocare)
- CryoGen Cryosurgical System (Cryosurgical)
- CryoHit® (Galil Medical) for the treatment of breast fibroadenoma
- SeedNet™ System (Galil Medical)
- Visica® System (Sanarus Medical)

Food and Drug Administration product code: GEH

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/30/04</td>
<td>Add to Surgery Section - New Policy</td>
</tr>
<tr>
<td>10/11/05</td>
<td>Replace Policy BC.7.01.92 - Policy statement revised to indicate that benign breast fibroadenomas may be considered medically necessary if certain criteria are met. References added regarding cryoablation of breast cancer, benign fibroadenomas and renal tumors.</td>
</tr>
<tr>
<td>02/06/06</td>
<td>Codes updated - No other changes.</td>
</tr>
<tr>
<td>06/06/09</td>
<td>Disclaimer and Scope update - No other changes.</td>
</tr>
<tr>
<td>10/10/06</td>
<td>Replace Policy - Policy updated with literature search; reference added. No change to policy statement</td>
</tr>
<tr>
<td>04/10/07</td>
<td>Replace Policy - Policy updated with literature review; no change in policy statement. Policy reviewed and recommended by OAP on February 22, 2007. Codes updated.</td>
</tr>
<tr>
<td>03/11/08</td>
<td>Replace Policy - Policy updated with literature search; no change to policy statement. References added.</td>
</tr>
<tr>
<td>10/14/08</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>03/10/09</td>
<td>Replace Policy - Policy updated with literature review; no change in policy statement. References added. OAP reviewed on February 19, 2009 and recommended that BCBSA statement of medical necessity for renal cell carcinoma not be adopted.</td>
</tr>
<tr>
<td>08/11/09</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>03/09/10</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
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<td>------------</td>
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<tr>
<td>09/14/10</td>
<td>Replace Policy - Policy updated with literature review. Policy statement changed: Renal cell carcinoma, previously considered investigational, may now be considered medically necessary when criteria are met.</td>
</tr>
<tr>
<td>08/09/11</td>
<td>Replace Policy – Policy updated with literature search; no change in policy statement. References added.</td>
</tr>
<tr>
<td>02/27/12</td>
<td>Related Policies updated; 7.01.133 added.</td>
</tr>
<tr>
<td>03/23/12</td>
<td>Replace Policy – Policy updated with literature search; no change in policy statement. References added. Reviewed and recommended by OAP on February 16, 2012.</td>
</tr>
<tr>
<td>09/27/12</td>
<td>Update Related Policy – 8.01.516 as it was archived.</td>
</tr>
<tr>
<td>12/20/12</td>
<td>Update Related Policies; policy number 7.01.540 was replaced with 7.01.95.</td>
</tr>
<tr>
<td>09/27/13</td>
<td>Replace policy. Description section, policy guidelines, and rationale section updated. No change to policy statement. References added.</td>
</tr>
<tr>
<td>12/03/13</td>
<td>Coding Update. Add ICD-10 codes.</td>
</tr>
<tr>
<td>01/12/15</td>
<td>Coding update. New CPT codes 20983 and 47383, effective 1/1/15, added to the policy.</td>
</tr>
<tr>
<td>09/08/15</td>
<td>Annual Review. Minor edits for readability. Policy updated with literature review through June 7, 2015; reference 24 added. Removed CPT codes 47383 and 0304T (replaced with 0340T, the correct code) as not related to this policy. CPT code 50542 in the policy guidelines added to coding table at end of policy. Policy statements unchanged.</td>
</tr>
<tr>
<td>09/01/16</td>
<td>Interim Review, approved August 9, 2016. Update Related Policies. Remove 8.01.27 as it was archived. Removed coding table at end of policy.</td>
</tr>
<tr>
<td>11/01/16</td>
<td>Annual Review, approved October 11, 2016. No changes made to the Policy Statement.</td>
</tr>
<tr>
<td>01/01/18</td>
<td>Annual Review, approved December 12, 2017. Coverage has been increased by addition of lung cancer as medically necessary indication; harmonized with prostate and liver local therapy policies. References and Clinical Trials section updated. Added CPT code 32994 (new code effective 1/1/18).</td>
</tr>
<tr>
<td>10/01/18</td>
<td>Annual Review, approved September 20, 2018. Policy updated with literature review through May 2018; references 52-54 updated. Policy statement changed to include bone cancer and other solid tumors or metastases outside the prostate as investigational.</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
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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
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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)

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Français (French):

Kreyòl ayisyen (Creole):

Deutsche (German):

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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 claras 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. Liame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring magaawa lamang ng mga tulong sa kalusugan o tulong na maayos at mahusay. Kung minsan, maaaring maging mahalagang imbang ang bukod sa impormasyon na ito.

Polskie (Polish):

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde e ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):

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 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).

ไทย (Thai):
ประกาศนี้อาจมีข้อมูลที่สําคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และการมีสิทธิ์ในการเข้ารับการช่วยเหลือในภาษามInstalled language. หากคุณต้องการข้อมูลเพิ่มเติมเกี่ยวกับภาษาที่คุณต้องการที่มีอยู่ในประกาศนี้โปรดติดต่อที่ 800-722-1471 (TTY: 800-842-5357).

Українська (Ukrainian):
Це повідомлення містить важливу інформацію. Ця повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у 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 за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):