MEDICAL POLICY – 7.01.567
Surgical Treatments for Lymphedema and Lipedema

BCBSA Ref. Policy: 7.01.162
Effective Date: May 1, 2020
Last Revised: April 14, 2020
Replaces: 7.01.162

RELATED MEDICAL POLICIES:
10.01.514  Cosmetic and Reconstructive Services

Select a hyperlink below to be directed to that section.

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

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

Introduction

Lymphatic fluid is a clear fluid that travels throughout the body. Its job is to remove wastes and bacteria from tissue. Lymphedema is swelling when too much lymphatic fluid accumulates in any part of the body. Lymphedema can be a result of certain surgeries or other procedures that remove or affect lymph node drainage. Lymphedema occurs because there are fewer natural channels for the fluid to move through. Typical treatment calls for raising the affected arm, massaging the area, or using pumps that apply light pressure. Certain surgeries are now being studied. These surgeries call for rerouting the flow of lymphatic fluid by connecting lymph vessels to veins, lymph nodes and veins, or lymph vessels to other lymph vessels. Other surgeries try to reduce swelling by moving other tissue into the surgical area or using suction to remove excess fat and proteins. All of these surgeries are investigational (unproven). More studies are needed to see how well they work over the long term.

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

Policy Coverage Criteria
### Treatment | Medically Necessary
--- | ---
**Lipectomy or liposuction for the treatment of lymphedema or lipedema** | Lipectomy or liposuction for the treatment of lymphedema or lipedema may be considered medically necessary when the following criteria are met:
- There is documentation of significant physical functional impairment (e.g., difficulty ambulating or performing activities of daily living); and
- The individual has not responded to at least 3 consecutive months of optimal medical management (such as conservative treatment with compression garments and manual lymph drainage); and
- The plan of care postoperatively is to continue to wear compression garments as instructed to maintain the benefits of treatment; and
- For the diagnosis of lipedema, the individual has all of the following clinical exam findings: (see Table 1)
  - Bilateral symmetric adiposity in the extremities;
  - Non-pitting edema;
  - Tissue in affected areas is soft to palpation;
  - Tissue in affected areas is tender to palpation
- Submission of photographs document the affected extremities requested for treatment

### Treatment | Investigational
--- | ---
**Surgical treatments** | The following surgical treatments for lymphedema (e.g., upper or lower extremities or genitalia) are considered investigational:
- Lymphatic physiologic microsurgery
- Lymphatico-lymphatic bypass
- Lymphovenous bypass
- Lymphaticovenous anastomosis
- Autologous lymph node transplantation
- Vascularized lymph node transfer
- Tissue transfer (e.g., omental or mesenteric flap)
- Reductive/ablative techniques
- Direct excision
## Treatment

<table>
<thead>
<tr>
<th>Preventive surgical treatment</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphatic physiologic microsurgery performed during nodal dissection or breast reconstruction to prevent lymphedema (including, but not limited to, the Lymphatic Microsurgical Preventing Healing Approach) in individuals who are being treated for breast cancer is considered investigational.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reverse lymphatic mapping</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reverse lymphatic mapping used during lymphatic surgical or liposuction procedures is considered investigational.</td>
<td></td>
</tr>
</tbody>
</table>

## Documentation Requirements

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

- Office visit notes that contain the relevant history and physical (with the specific surgical procedure requested, any physical functional impairment noted, medical management tried, post-op plan of care for use of compression garments)
- If request is for the treatment of lipedema all of the following clinical exam findings are documented: bilateral symmetric adiposity in the extremities, non-pitting edema, tissue in affected areas is soft to palpation, and tissue in affected areas is tender to palpation
- Photographs document the affected extremities requested for treatment

## Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
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<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
</tr>
<tr>
<td>15833</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</td>
</tr>
<tr>
<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</td>
</tr>
<tr>
<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
</tr>
<tr>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
</tr>
<tr>
<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
</tr>
<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
</tr>
</tbody>
</table>
### Table 1. Comparison of Findings in Lipedema, Lymphedema, and Lifestyle-induced Obesity

<table>
<thead>
<tr>
<th></th>
<th>Lipedema</th>
<th>Lymphedema</th>
<th>Lifestyle-induced Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Women</td>
<td>Women and men</td>
<td>Women and men</td>
</tr>
<tr>
<td><strong>Adiposity</strong></td>
<td>Bilateral extremities Symmetric</td>
<td>Unilateral or bilateral extremities Asymmetric</td>
<td>Whole body, proportionate Symmetric</td>
</tr>
<tr>
<td><strong>Edema</strong></td>
<td>Nonpitting Minimal change with elevation; minimal change with compression</td>
<td>Pitting Reduced by elevation; reduced with compression</td>
<td>None No change with elevation or compression</td>
</tr>
<tr>
<td></td>
<td>Lipedema</td>
<td>Lymphedema</td>
<td>Lifestyle-induced Obesity</td>
</tr>
<tr>
<td>-------------------</td>
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<td>------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Tissue turgor</strong></td>
<td>Soft</td>
<td>Firm</td>
<td>Soft</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>Tender to palpation</td>
<td>Usually nontender</td>
<td>None</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td>Rare</td>
<td>Common</td>
<td>Rare</td>
</tr>
</tbody>
</table>

Source: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5055019/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5055019/) Accessed April 2020

### Evidence Review

#### Description

Surgery and radiotherapy for breast cancer can lead to lymphedema and is one of the most common causes of secondary lymphedema. There is no cure for lymphedema. However, physiologic microsurgical techniques such as lymphaticovenular anastomosis or vascularized lymph node transfer have been developed that may improve lymphatic circulation, thereby decreasing symptoms and risk of infection.

#### Background

**Lymphedema**

Lymphedema is an accumulation of fluid due to disruption of lymphatic drainage. Lymphedema can be caused by congenital or inherited abnormalities in the lymphatic system (primary lymphedema) but is most often caused by acquired damage to the lymphatic system (secondary lymphedema).

#### Diagnosis and Staging

A diagnosis of secondary lymphedema is based on history (eg, cancer treatment, trauma) and physical examination (localized, progressive edema and asymmetric limb measurements) when other causes of edema can be excluded. Imaging, such as magnetic resonance imaging, computed tomography, ultrasound, or lymphoscintigraphy, may be used to differentiate lymphedema from other causes of edema in diagnostically challenging cases.
Table 2 lists International Society of Lymphology guidance for staging lymphedema based on "softness" or "firmness" of the limb and the changes with an elevation of the limb.¹

**Table 2. Recommendations for Staging Lymphedema**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0 (subclinical)</td>
<td>Swelling is not evident and most patients are asymptomatic despite impaired lymphatic transport</td>
</tr>
<tr>
<td>Stage I (mild)</td>
<td>Accumulation of fluid that subsides (usually within 24 hours) with limb elevation; soft edema that may pit, without evidence of dermal fibrosis</td>
</tr>
<tr>
<td>Stage II (moderate)</td>
<td>Does not resolve with limb elevation alone; limb may no longer pit on examination</td>
</tr>
<tr>
<td>Stage III (severe)</td>
<td>Lymphostatic elephantiasis; pitting can be absent; skin has trophic changes</td>
</tr>
</tbody>
</table>

**Breast Cancer–Related Lymphedema**

Breast cancer treatment is one of the most common causes of secondary lymphedema. Both the surgical removal of lymph nodes and radiotherapy are associated with development of lymphedema in patients with breast cancer.

In a systematic review of 72 studies (N=29,612 women), DiSipio et al (2013) reported that approximately 1 in 5 women who survive breast cancer will develop arm lymphedema.² Reviewers reported that risk factors for development of lymphedema that had a strong level of evidence were extensive surgery (ie, axillary-lymph-node dissection, greater number of lymph nodes dissected, mastectomy) and being overweight or obese.

**Management and Treatment**

Early and ongoing treatment of lymphedema is necessary. Conservative therapy may consist of several features depending on the severity of the lymphedema. Patients are educated on the importance of self-care including hygiene practices to prevent infection, maintaining ideal body weight through diet and exercise, and limb elevation. Compression therapy consists of repeatedly applying padding and bandages or compression garments. Manual lymphatic drainage is a light pressure massage, performed by trained physical therapists or by patients, designed to move fluid from obstructed areas into functioning lymph vessels and lymph nodes. Complete decongestive therapy is a multiphase treatment program involving all of the previously mentioned conservative treatment components at different intensities. Pneumatic
compression pumps may also be considered as an adjunct to conservative therapy or as an alternative to self-manual lymphatic drainage in patients who have difficulty performing self-manual lymphatic drainage. In patients with more advanced lymphedema after fat deposition and tissue fibrosis has occurred, palliative surgery using reductive techniques such as liposuction may be performed.

### Table 3. Physiologic Microsurgical Interventions for Lymphedema

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Surgery</th>
<th>Description</th>
<th>Key Features</th>
</tr>
</thead>
</table>
| Bypass or reconstruct obstructed lymph vessels to improve drainage | Lymphatic-lymphatic bypass | Connects functioning lymphatic vessels directly to affected lymphatic vessels; healthy vessels come from donor site | • Lymphedema can develop in donor extremity  
• Scarring at donor site |
| | Lymphovenous bypass and lymphaticovenular anastomosis | Lymphatic vessels in an affected limb are connected to the venous system | • Outpatient procedure or usually discharged within a day  
• Quick return to daily activities |
| Transfer lymph tissue to reestablish lymphatic flow | Autologous lymph node transplantation and vascularized lymph node transfer | Healthy lymph nodes are transferred to the affected limb | • Inpatient procedure; requires 2-3 days of hospitalization  
• Lymphedema can develop in donor extremity |

### Reductive (Excisional or Ablative) Surgical Interventions

Reductive techniques remove fibrous, fatty tissue that has developed from sustained lymphatic fluid stasis. Reductive interventions include direct excision and liposuction procedures.

- **Direct excision**: There are several direct excision procedures for the treatment of extremity and genital lymphedema. Subcutaneous tissue is excised along with the skin and soft tissues to attempt to reduce the volume of the affected area. The resulting defects are then covered with tissue flaps or skin grafts. Wound healing complications and infections have been reported side effects of this type of intervention along with sexual dysfunction, decreased sensation and urethral injury when performed on the genitalia.35

- **Liposuction**: Fibrous, fatty issue is removed through multiple small incisions of the affected extremity via a cannula attached to a powered suction device. Compression garments are
worn postoperatively and may be required indefinitely to maintain the adipose tissue volume reduction obtained with this procedure. This technique is intended for patients with end-stage lymphedema who have not responded to conservative treatments. Minor complications such as occasional paresthesias and wound healing are reported with this technique.35

**Liposuction for the Treatment of Lipedema**

Lipedema is a rare disorder in which increased adipose (fat) tissue builds up under the skin causing non-pitting, symmetric, bilateral swelling of the lower extremities; the upper extremities can also be affected. Hands and feet characteristically do not swell. It primarily affects women. The cause of lipedema is unknown and there is currently no curative treatment for this condition. Signs and symptoms typically present at puberty, pregnancy, or menopause. Because of this it is theorized that there is a hormonal influence on the disorder. Hereditary factors are also thought to play a role in its etiology. Lipedema is often painful and may present with bruising along with sensitivity to touch. This condition gradually worsens over time and may progress to a lipo-lymphedema due to the lymphatic load exceeding the lymphatic transport capacity. Lipedema is often misdiagnosed as obesity or lymphedema but does not generally respond to weight loss, exercise, or elevation of the limbs as do those disorders.

**Types of Lipedema**

Type 1: Pelvis, buttocks and hips (saddle bag phenomenon)

Type 2: Buttocks to knees with formation of folds of fat around the inner side of the knee

Type 3: Buttocks to ankles

Type 4: Arms

Type 5: Isolated lower leg

**Stages of Lipedema**

Stage 1: Even and smooth skin surface with enlarged subcutaneous fat tissue

Stage 2: Uneven skin surface with nodular elevations and indentations of subcutaneous fat and lipomas

Stage 3: Large deforming growths of nodular fat or hanging flaps of the thighs and around the knees
Stage 4: Large overhangs of tissue, dysfunctional lymphatics with lipedema and lipolyphedema

Treatment is aimed at relieving the symptoms. Conservative care with combined decongestive therapy (manual lymphatic drainage and compression garments) is the mainstay treatment of choice. If there is an inadequate response to conservative or supportive measures, tumescent liposuction has been proposed as the next line of treatment. Tumescent liposuction is a technique whereby local anesthetic, such as diluted lidocaine and epinephrine, is injected into subcutaneous fat and a vibrating cannula associated with power-assisted liposuction removes the fat. Water-jet assisted liposuction is another method of liposuction that may be used to treat lipedema. This method uses a pressurized stream of saline to dislodge the fat and more gently loosen and remove the fat cells.

Summary of Evidence

For individuals who have breast cancer–related secondary lymphedema who receive physiologic microsurgery to treat lymphedema along with continued conservative therapy, the evidence includes a randomized controlled trial (RCT), observational studies, and systematic reviews. Relevant outcomes are symptoms, morbid events, functional outcomes, health status measures, quality of life, resource utilization, and treatment-related morbidity. Several physiologic microsurgeries have been developed; examples include lymphaticovenular anastomosis and vascularized lymph node transfer. No RCTs of lymphaticovenular anastomosis or similar surgeries involving the venous system were identified. One RCT of vascularized lymph node transfer with 36 participants has been conducted. Systematic reviews have indicated that the preponderance of the available evidence comes from single-arm clinical series from individual institutions. Surgical technique, outcomes metrics, and follow-up time have varied across these studies. These types of studies might be used for preliminary estimates of the amount of volume reduction expected from surgery, the durability of the reduction in volume, and the rates of adverse events. However, these studies are not adequate for determining the comparative efficacy of physiologic microsurgery vs conservative treatment or decongestive therapy, or the comparative efficacy of different microsurgery techniques. RCTs are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are undergoing lymphadenectomy for breast cancer who receive physiologic microsurgery to prevent lymphedema, the evidence includes an RCT, observational studies, and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. Lymphatic Microsurgical Preventing Healing Approach is a preventive lymphaticovenular anastomosis performed during nodal dissection. One RCT including 46 patients has been conducted. The trial reported that
lymphedema developed in 4% of women in the Lymphatic Microsurgical Preventing Healing Approach group and 30% in the control group by 18 months of follow-up. Longer follow-up is needed to observe incident lymphedema occurring after 18 months and assess the durability of the procedure. The trial methods of randomization and allocation concealment were not described and there was no sham procedure or blinding, potentially introducing bias. The remaining evidence consists of 2 controlled observational studies with inadequate description of control selection and uncontrolled studies. The evidence is insufficient to determine the effects of the technology on health outcomes.

Randomized controlled trials are needed to prove the benefits of pedicled or laparoscopic free omental lymphatic flap for the management of lymphedema.

Reverse mapping using blue dye as a method for preserving the lymphatic drainage of the arm in breast cancer cases or indo-cyanine green as a technique to identify lymph node drainage patterns to localize lymph nodes in the surgical treatment of lymphedema are being investigated. Further studies are needed to determine the long-term outcomes of these techniques. The evidence is insufficient to determine the effects of the technology on health outcomes.

Results of the available studies provide limited evidence that suction-assisted protein lipectomy (SAPL) for the treatment of lymphedema that fails to respond to conservative therapy due to overgrowth of adipose tissue is a safe and effective technique. The best available evidence of efficacy was obtained in nonrandomized controlled studies. Liposuction combined with compression therapy reduced lymphedema volume versus compression therapy alone. Additional controlled studies are needed to confirm that liposuction for the treatment of lymphedema is a safe and effective therapy.

A 2019 Hayes Search and Summary on liposuction for the treatment of lipedema concludes that there is insufficient published evidence to assess the safety and health outcomes of liposuction for the treatment of lipedema.

Despite the lack of strong evidence, clinical guidelines recommend liposuction in patients with advanced lipedema and for chronic lymphedema as there is limited treatment available when conservative measures have failed.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 4.
Table 4. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02790021</td>
<td>Improving Quality of Survivorship for Breast Cancer-related Lymphedema by Lymphaticovenous Anastomosis: A Randomized Controlled Trial</td>
<td>60</td>
<td>Sep 2019</td>
</tr>
<tr>
<td>NCT03428581</td>
<td>Preventing Lymphedema in Patients Undergoing Axillary Lymph Node Dissection Via Axillary Reverse Mapping and Lympho-venous Bypass</td>
<td>264</td>
<td>Feb 2023</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

Practice Guidelines and Position Statements

**Austrian Academy of Cosmetic Surgery and Aesthetic Medicine and the International Society for Dermatologic Surgery**


**National Institute for Health and Care Excellence (NICE)**

The National Institute for Health and Care Excellence (NICE, 2017) states that “Current evidence on the safety and efficacy of liposuction for chronic lymphoedema is adequate to support the use of this procedure provided that standard arrangements are in place for clinical governance, consent and audit.”
National Lymphedema Network

The National Lymphedema Network published a position paper on the diagnosis and treatment of lymphedema in 2011.²² The paper stated the following on microsurgical procedures:

Microsurgical and supramicrosurgical (much smaller vessels) techniques have been developed to move lymph vessels to congested areas to try to improve lymphatic drainage. Surgeries involve connecting lymph vessels and veins, lymph nodes and veins, or lymph vessels to lymph vessels. Reductions in limb volume have been reported and a number of preliminary studies have been done, but there are no long-term studies of the effectiveness of these techniques.

International Society of Lymphology

International Society of Lymphology published a consensus document on the diagnosis and treatment of peripheral lymphedema in 2016.¹ The document stated the following on lymphaticovenous (or lymphovenous) anastomoses (LVA):

LVA are currently in use at multiple centers around the world. These procedures have undergone confirmation of long-term patency (in some cases more than 20 years) and some demonstration of improved lymphatic transport (by objective physiologic measurements of long-term efficacy).

U.S. Preventive Services Task Force Recommendations

No U.S. Preventive Services Task Force recommendations for lymphedema have been identified.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Physiologic microsurgery for lymphedema is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/18</td>
<td>New policy, approved September 11, 2018, effective January 4, 2019. Policy created with a literature review through May 2018. Lymphatic physiologic microsurgery to treat lymphedema in individuals who have been treated for breast cancer is considered investigational. Lymphatic physiologic microsurgery performed during nodal dissection or breast reconstruction to prevent lymphedema in individuals who are being treated for breast cancer is considered investigational.</td>
</tr>
<tr>
<td>12/01/18</td>
<td>Interim Review, approved November 13, 2018, effective January 4, 2019. Title changed from “Surgical Treatments for Breast Cancer Related Lymphedema” to “Surgical Treatments for Lymphedema”. Policy statements added: Excisional procedures (debulking, liposuction including SAPL), tissue transfers (eg, omental flap) and reverse lymphatic mapping are considered investigational. References 24-35 added. Policy renumbered from 7.01.162 to 7.01.567. Added CPT code 76499.</td>
</tr>
<tr>
<td>05/01/19</td>
<td>Annual Review, approved April 2, 2019. Policy updated with literature search through December 2018; References 36-37 added. Policy statements unchanged.</td>
</tr>
<tr>
<td>10/01/19</td>
<td>Interim Review, approved September 10, 2019. Policy updated with literature review through May 2019; References 42-56 added. Policy statement added indicating liposuction for the treatment of lipedema is investigational Title changed from “Surgical Treatments for Lymphedema” to “Surgical Treatments for Lymphedema and Lipedema”. Added CPT codes 15832, 15833, 15836, 15839, 15877, 15878, and 15879.</td>
</tr>
<tr>
<td>05/01/20</td>
<td>Interim Review, approved April 14, 2020. References added. Lipectomy or liposuction for the treatment of lymphedema or lipedema changed from investigational to may be considered medically necessary when criteria are met.</td>
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<td>07/27/20</td>
<td>Correct minor error in formatting with no impact on policy statements or intent.</td>
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</tbody>
</table>
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200 Independence Avenue SW, Room 509F, HHH Building
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U.S. Department of Health and Human Services
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Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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لا يمكن أن تكون هذه المعلومات محدودة من حيث اللغة أو ...

Chinese (Chinese):
本通知有重要的讯息。本通知可能有关於您透過 Premera Blue Cross 提交的申請或保障的重要訊息。本通知内可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).