MEDICAL POLICY – 8.01.24
Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults

BCBSA Ref. Policy: 8.01.24

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>May 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Revised:</td>
<td>April 3, 2018</td>
</tr>
<tr>
<td>Replaces:</td>
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</table>

RELATED MEDICAL POLICIES:
- 7.01.50 Placental and Umbilical Cord Blood as a Source of Stem Cells
- 7.01.95 Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- 7.01.526 Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- 8.01.21 Allogeneic Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms
- 8.01.22 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias
- 8.01.25 Hematopoietic Cell Transplantation for Autoimmune Diseases
- 8.01.26 Hematopoietic Cell Transplantation for Acute Myeloid Leukemia
- 8.01.29 Hematopoietic Cell Transplantation for Hodgkin Lymphoma
- 8.01.511 Hematopoietic Cell Transplantation for Solid Tumors of Childhood
- 8.01.529 Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas
- 8.01.530 Hematopoietic Cell Transplantation for Primary Amyloidosis
- 8.01.532 Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors

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

Hematopoietic stem cells are cells that form within the bone marrow and can become many different types of blood cells. In a hematopoietic stem cell transplant, stem cells can be taken from a donor’s bone marrow, peripheral blood, or from a newborn baby’s umbilical cord blood or placenta shortly after the baby was delivered. The stem cells can also be harvested from the patient himself before he is given any high dose chemotherapy. If the hematopoietic stem cells are harvested from another person, it is called an allogeneic transplant. If the cells come from
the patient himself before his high dose chemotherapy is given, it is called an autologous stem cell transplant.

Hematopoietic stem cell transplants are sometimes given to patients who have cancers that are solid tumors. These transplants are considered investigational when used to treat solid tumors. This policy explains why it is considered to be investigational.

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>Transplant</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autologous or allogeneic hematopoietic cell transplant</td>
<td>Autologous or allogeneic hematopoietic cell transplant is considered investigational for the following malignancies in adults:</td>
</tr>
<tr>
<td></td>
<td>• Cancer of the bile duct</td>
</tr>
<tr>
<td></td>
<td>• Cancer of the fallopian tubes</td>
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<tr>
<td></td>
<td>• Cervical cancer</td>
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<td></td>
<td>• Colon cancer</td>
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<td></td>
<td>• Esophageal cancer</td>
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<td></td>
<td>• Gall bladder cancer</td>
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<td></td>
<td>• Lung cancer, any histology</td>
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<tr>
<td></td>
<td>• Malignant melanoma</td>
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<tr>
<td></td>
<td>• Nasopharyngeal cancer</td>
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<tr>
<td></td>
<td>• Neuroendocrine tumors</td>
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<tr>
<td></td>
<td>• Pancreatic cancer</td>
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<td></td>
<td>• Paranasal sinus cancer</td>
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<tr>
<td></td>
<td>• Prostate cancer</td>
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<tr>
<td></td>
<td>• Rectal cancer</td>
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<tr>
<td></td>
<td>• Renal cell cancer</td>
</tr>
<tr>
<td></td>
<td>• Soft tissue sarcomas</td>
</tr>
<tr>
<td></td>
<td>• Stomach cancer</td>
</tr>
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### Transplant

<table>
<thead>
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<th>Investigational</th>
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</thead>
<tbody>
<tr>
<td>• Thyroid tumors</td>
</tr>
<tr>
<td>• Tumors of the thymus</td>
</tr>
<tr>
<td>• Tumors of unknown primary origin</td>
</tr>
<tr>
<td>• Uterine cancer</td>
</tr>
</tbody>
</table>

### Coding

#### Code | Description
--- | ---
**CPT**
38232 | Bone marrow harvesting for transplantation; autologous
38240 | Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241 | Hematopoietic progenitor cell (HPC); autologous transplantation
38242 | Allogeneic lymphocyte infusions

#### HCPCS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>S2140</td>
<td>Cord blood harvesting for transplantation, allogeneic</td>
</tr>
<tr>
<td>S2142</td>
<td>Cord blood-derived stem-cell transplantation, allogeneic</td>
</tr>
<tr>
<td>S2150</td>
<td>Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre and post transplant care in the global definition</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

### Benefit Application

The following considerations may supersede this policy:
State mandates requiring coverage for autologous bone marrow transplantation offered as part of clinical trials of autologous bone marrow transplantation approved by the National Institutes of Health (NIH).

Some plans may participate in voluntary programs offering coverage for patients participating in NIH-approved clinical trials of cancer chemotherapies, including autologous bone marrow transplantation.

Some contracts or certificates of coverage may include specific conditions in which autologous bone marrow transplantation would be considered eligible for coverage.

Evidence Review

Description

Hematopoietic cell transplantation (HCT) is an established treatment for certain hematologic malignancies and has been investigated for a variety of adult solid tumors. Interest continues in exploring nonmyeloablative allogeneic HCT (allo-HCT) for a graft-versus-tumor effect of donor-derived T cells in metastatic solid tumors.

Background

Hematopoietic Cell Transplantation

HCT refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of cytotoxic drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or from a donor (allogeneic HCT). They can be harvested from bone marrow, peripheral blood, or from umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease (GVHD). Cord blood is discussed in greater detail in a separate medical policy (see Related Policies).

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. However, immunologic compatibility between donor and patient is a
critical factor for achieving a good outcome of allogeneic HCT. Compatibility is established by
typing of human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. HLA
refers to the tissue type expressed at the Class I and Class II loci on chromosome 6. Depending
on the disease being treated, an acceptable donor will match the patient at all or most of the
HLA loci (with the exception of umbilical cord blood).

**Conditioning for HCT**

**Conventional Conditioning**

The conventional (“classical”) practice of allogeneic HCT involves administration of cytotoxic
agents (eg, cyclophosphamide, busulfan) with or without total body irradiation at doses
sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial
treatment effect in this procedure results from a combination of initial eradication of malignant
cells and subsequent graft-versus-malignancy (GVM) effect. This GVM effect is mediated by
non-self-immunologic effector cells that develop after engraftment of allogeneic stem cells
within the patient’s bone marrow space. While the slower GVM effect is considered to be the
potentially curative component, it may be overwhelmed by extant disease without the use of
pre-transplant conditioning. However, intense conditioning regimens are limited to patients who
are medically able to tolerate substantial adverse effects that include pre-engraftment
opportunistic infections secondary to loss of endogenous bone marrow function and organ
damage and failure caused by the cytotoxic drugs. Furthermore, in any allogeneic HCT, immune
suppressant drugs are required to minimize graft rejection and GVHD, which also increases
susceptibility of the patient to opportunistic infections. The immune reactivity between donor T
cells and malignant cells that is responsible for the GVM effect also leads to acute and chronic
GVHD.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or
without radiation to eradicate cancerous cells from the blood and bone marrow. This permits
subsequent engraftment and repopulation of bone marrow space with presumably normal
hematopoietic stem cells obtained from the patient before undergoing bone marrow ablation.
As a consequence, autologous HCT is typically performed as consolidation therapy when the
patient’s disease is in CR. Patients who undergo autologous HCT are susceptible to
chemotherapy-related toxicities and opportunistic infections before engraftment, but not GVHD.
**Reduced-Intensity Conditioning for Allo-HCT**

Reduced-intensity conditioning (RIC) refers to the pre-transplant use of lower doses or less intense regimens of cytotoxic drugs or radiation than are used in traditional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden but also to minimize as much as possible associated treatment-related morbidity and non-relapse mortality (NRM) in the period during which the beneficial GVM effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary with numerous versions employed, all seek to balance the competing effects of NRM and relapse due to residual disease. RIC regimens can be viewed as a continuum, from being nearly totally myeloablative, to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and the patient’s condition. Patients who undergo RIC with allogeneic HCT initially demonstrate donor cell engraftment and bone marrow mixed chimerism. Most will subsequently convert to full-donor chimerism, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells. For the purposes of this policy, RIC will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

**HCT in Solid Tumors in Adults**

HCT is an established treatment for certain hematologic malignancies. Its use in solid tumors is less well established, although it has been investigated for a variety of solid tumors. With the advent of nonmyeloablative allogeneic transplant, interest has shifted to exploring the generation of alloreactivity to metastatic solid tumors via a graft-versus-tumor effect of donor-derived T cells.¹

HCT as a treatment of breast cancer, ovarian cancer, germ cell tumors, ependymoma, or malignant glioma is addressed in separate policies (see Related Policies). This policy collectively addresses other solid tumors of adults for which HCT has been investigated, including lung cancer; malignant melanoma; tumors of the gastrointestinal tract (affecting the colon, rectum, pancreas, stomach, esophagus, gallbladder, or bile duct); male and female genitourinary systems (eg, renal cell carcinoma, prostate cancer, cervical cancer, uterine cancer, fallopian tube cancer); tumors of the head and neck; soft tissue sarcoma; thyroid tumors; tumors of the thymus; and tumors of unknown primary origin.
Summary of Evidence

**Autologous HCT**

For individuals who have adult soft tissue sarcomas who receive autologous HCT, the evidence includes 2 TEC Assessments, a randomized controlled trial, and a number of phase 2 single-arm studies, some of which have been summarized in a systematic review. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. The 1995 and 1999 TEC Assessments, focusing on autologous HCT as primary and salvage therapy for a variety of solid tumors, found that the available evidence did not permit conclusions about the effect of HCT on patient survival. Although a small phase 2 randomized controlled trial reported longer survival for patients treated with autologous HCT than with standard chemotherapy, this trial did not show a survival benefit with HCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have small cell lung cancer who receive autologous HCT, the evidence includes 2 TEC Assessments, several randomized controlled trials, and systematic reviews of these studies. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. The 1995 and 1999 TEC Assessments, focusing on autologous HCT as primary and salvage therapy for a variety of solid tumors, found that the available evidence did not permit conclusions about the effect of HCT on patient survival. Studies published since the TEC Assessments have not reported increased overall survival for patients with small cell lung cancer treated with autologous HCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Allo-HCT**

For individuals who have renal cell carcinoma, colorectal cancer, pancreatic cancer, or nasopharyngeal cancer who receive allo-HCT, the evidence includes a TEC Assessment and small single-arm series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. The 1995 and 1999 TEC Assessments, focusing on allo-HCT as primary and salvage therapy for a variety of solid tumors, found that the available evidence did not permit conclusions about the effect of allo-HCT on patient survival. Since the publication of the TEC Assessments, the evidence for allo-HCT to treat renal cell carcinoma, colorectal cancer, pancreatic cancer, and nasopharyngeal cancer has been limited to small case series. The evidence is insufficient to determine the effects of the technology on health outcomes.
Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. 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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<tr>
<td>Unpublished</td>
<td>Phase I Study of Nonmyeloablative Allogeneic Hematopoietic Stem Cell Transplantation in the Treatment of Pancreatic Cancer</td>
<td>30</td>
<td>April 2019</td>
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</table>

NCT: national clinical trial.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

Current National Comprehensive Cancer Network guidelines (2017-2018) on the tumors addressed in this policy do not discuss hematopoietic cell transplantation (HCT) as a treatment option.31

American Society for Blood and Marrow Transplantation

In 2015, the American Society for Blood and Marrow Transplantation issued guidelines related to indications for autologous and allogeneic hematopoietic cell transplantation.32 The tumors addressed herein for which ASBMT has provided recommendations are as follows:

- Ewing sarcoma, high risk: allogeneic HCT – N (“not generally recommended”); autologous HCT – C (“standard of care, clinical evidence available”)
U.S. Preventive Services Task Force Recommendations

Hematopoietic cell transplantation is not a preventive service.

Medicare National Coverage

The Centers for Medicare and Medicaid Services currently have the following national noncoverage decision on autologous stem cell transplantation [AuSCT]: “Insufficient data exist to establish definite conclusions regarding the efficacy of AuSCT for the following condition[s]: Solid tumors (other than neuroblastoma).”

Regulatory Status

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation (CFR) title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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</thead>
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<tr>
<td>02/01/00</td>
<td>Add to Therapy Section - New Policy — replaces 8.01.15, original master policy on high-dose chemotherapy for miscellaneous malignancies. However, policy statement is unchanged.</td>
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<td>03/11/03</td>
<td>Replace policy - Policy updated; new references; no change in policy statement.</td>
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<td>05/13/03</td>
<td>Replace policy - Update CPT codes only.</td>
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<td>08/12/03</td>
<td>Replace policy - Reviewed by OAP on 7/22/03. Recommended that investigational statement be more inclusive.</td>
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<td>Replace policy - Policy updated with literature review; no change to policy statement. Approved by OAP 10/29/04, no need to back to MPC.</td>
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<td>Disclaimer and Scope updates - No other changes.</td>
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<td>Update References - Policy reviewed and recommended by OAP on February 22, 2007.</td>
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<td>Replace policy - Policy updated with literature review; policy statement unchanged. References added.</td>
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<td>Replace policy - Policy updated with literature search; no change to the policy statement. Description and rationale updated. Title changed to delete “HDC” and added “Transplant” after “Stem Cell”. References and codes added. Policy reviewed and recommended by OAP on May 22, 2008.</td>
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<td>12/08/09</td>
<td>Replace policy - Policy updated with literature search; no change to the policy statement. References added. Policy reviewed and recommended by OAP on November 19, 2009.</td>
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<tr>
<td>02/09/10</td>
<td>Code Update - New 2010 codes added.</td>
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<td>Replace policy - Policy updated with literature review using MEDLINE through July 2010; reference number 22 added and number 23 updated. Policy statements remain unchanged. Reviewed and recommended by OAP in November 2010.</td>
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<td>Replace policy – Policy updated with literature review using MEDLINE through July 2011; reference numbers 9 and 22 added; reference 6 removed; references renumbered. Policy statements unchanged. ICD-10 codes added. Codes 38220 and 38221 removed from policy.</td>
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<tr>
<td>01/24/12</td>
<td>Code 38232 added.</td>
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<td>02/10/12</td>
<td>The CPT code 38204 was removed from the policy.</td>
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<td>06/20/12</td>
<td>Minor update: Related Policies updated; 8.01.17 replaced 8.01.507 effective June 12, 2012.</td>
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<td>07/31/12</td>
<td>Update Related Policy titles: 8.01.17, 8.01.21, 8.01.26, 8.01.27, 8.01.29, 8.01.30, 8.01.31, and 8.01.35. Removed Policy 8.01.507 as it was renamed to 8.01.17.</td>
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<td>10/18/13</td>
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<td>01/20/14</td>
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<td>04/18/14</td>
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<td>06/24/14</td>
<td>Update Related Policies. Remove 8.01.35 and 8.01.42, then add 8.01.530 and 8.01.532.</td>
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<td>12/17/14</td>
<td>Annual Review. Policy updated with literature review through September 30, 2014. References 9-10, 12, and 26 added. Policy statement unchanged. ICD-9 and ICD-10 diagnosis and procedure codes removed; these do not relate to policy adjudication.</td>
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<td>02/03/15</td>
<td>Update Related Policies. Remove 8.01.23, 8.01.28 and 8.01.30.</td>
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<td>12/08/15</td>
<td>Annual Review. Literature review performed; no change to policy statements.</td>
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<td>05/01/16</td>
<td>Annual Review, approved April 12, 2016. Policy updated with literature review through October 27, 2015; references 2, 6, 18, and 22 added. Policy statement unchanged.</td>
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<tr>
<td>09/01/16</td>
<td>Update Related Policies. Remove 8.01.27 as it was archived.</td>
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<td>11/04/16</td>
<td>Coding update. Removed codes that are transplant benefit related.</td>
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<td>08/01/17</td>
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<td>11/10/17</td>
<td>Policy moved to new format, no changes to policy statement.</td>
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</tbody>
</table>

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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 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.
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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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Call 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):
Avis sila a gen Enfòmasyon Enpòtad ladan. Avis sila a kapab genyen enfòmasyon enpòtan konsënan aplikasyon w lwa osna konsënan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan ari sila a. Ou ka gen pou pron kèk akson avan sètèn dat limit pou ka kente kouvèti asirans sante w la osna pou yo ka ede w avèk depans yo. Se dwa w pou resewa enfòmasyon sa a ak asistans 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 ntawm tsaj xo no muaj cov ntsib w la osna acid sètèn ceej. Tjëj saum tsab ntawm tsaj xo no muaj cov ntsib w la osna acid ceej tsoj daim ntawm thov kev pab los yoj koj chov kev pab cuam los ntsawm Premera Blue Cross. Tjëj saum cov hnuv tsej ceej uos rau hauv daim ntawm no. Tjëj saum koj koy juav tuu uae yam nar ov sëd koj uos tis pub dhasu cov cajj nyong uos teev tsag rau hauv daim ntawm no mas koy koy juav tuu basia kev pab cuam koh mo los yoj kev pab cuam tej tsi qho kho mo mawtaw. Koy muaj cai kom laww muab cov ntsib w la osna tuu mawtaw sa uos koy hom lus pub dabow rau koy. Hu rau 800-722-1471 (TTY: 800-842-5357).

Ilokano (Ilocano):
Daytoy a Pakdaar ket naglao iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglao iti napateg nga impormasion maipanggip iti aplikasyonu wngw coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a pelsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidengu nga addang sakbay dagiti partikular a naituding nga adda alaw napo mapagtaliadengoy ti coverage ti salun-atyo wngw tulong kadagiti gastos. Adda karbenganoy a mangala iti daytoy nga impormasion ken tulong ti bukodyo a pagasasao nga awan ti bayadangy. Tumawig ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
From: Premera Blue Cross

Dear [Name],


[54x443] [54x465] [54x476] [54x487]

Premera Blue Cross

Termine limit

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This notification contains important information about your application or coverage through Premera Blue Cross. You may have to act by a specified date to maintain your coverage or to avoid paying additional costs. You can contact Premera Blue Cross at 800-722-1471 (TTY: 800-842-5357) for more information.

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Spanish (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 claves 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):

Ang Paunawa na ito ay naglalaman ng malagaling impormasyon. Ang paunawa na ito ay naglalaman ng malagaling impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring maga ingat sa kalakaran o tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang tulong na tayo sa unang

(Thai):

ที่นี้มีข้อมูลสําคัญที่จะส่งผลต่อกลางใจของคุณและคุณจะต้องปฏิบัติตามภายในวันที่ที่ระบุไว้ให้คุณสามารถรักษาการคลาสสิกของคุณได้ โปรดติดต่อกับ Premera Blue Cross ที่ 800-722-1471 (TTY: 800-842-5357) ถ้าคุณมีคำถาม.

Ukrainian (Ukrainian):

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 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).

Vietnamese (Vietnamese):