Introduction

Cardiac rehabilitation — also called cardiac rehab — is a program to improve heart health. It’s done after an event like a heart attack or heart surgery, or for heart failure. The goals are to help a person regain strength and also reduce the risk of future heart events. Cardiac rehab is supervised by medical professionals and usually has three areas of focus:

- **Evaluation:** This involves assessing physical abilities, limitations, and risk factors in order to create a program tailored to the individual.

- **Exercise:** This can take many forms such as walking, riding an exercise cycle, or even jogging. Lifting weights or other strength training activities may also be recommended.

- **Education and stress reduction:** Guidance is given about nutrition, lifestyle choices, and stress management.

This policy discusses when cardiac rehabilitation is covered.

**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>
</table>
| **Outpatient cardiac rehabilitation programs** | Outpatient cardiac rehabilitation programs are considered medically necessary for patients with a history of the following conditions and procedures:  
- Acute myocardial infarction (MI) (heart attack) within the preceding 12 months  
- Compensated heart failure  
- Coronary artery bypass graft (CABG) surgery  
- Current stable angina pectoris  
- Heart valve surgery  
- Heart or heart-lung transplantation  
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting  

**ALL of the following components must be included in cardiac rehabilitation programs:**  
- Physician-prescribed exercise each day cardiac rehabilitation services are provided  
  AND  
- Cardiac risk factor modification  
  AND  
- Psychosocial assessment  
  AND  
- Outcomes assessment  
  AND  
- Individualized treatment plan detailing how each of the above components are utilized  

**Note:**  
A cardiac rehabilitation exercise program is eligible for coverage for 3 sessions per week up to a 12-week period (36 sessions). Programs should start within 90 days of the cardiac event and be completed within 6 months of the cardiac event.  

A comprehensive evaluation may be performed before initiation of cardiac rehabilitation to evaluate the patient and determine an appropriate exercise program. In addition to a medical examination, an
### Service | Medical Necessity
---|---
| | Electrocardiogram stress test may be performed. An additional stress test may be performed at the completion of the program. Physical and/or occupational therapy are considered not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

### Service | Investigational
---|---
Repeat participation | Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.
Intensive cardiac rehabilitation | Intensive cardiac rehabilitation with the Ornish Program for Reversing Heart Disease or Pritikin Program is considered investigational.

### Documentation Requirements
The medical records submitted for review should document that medical necessity criteria are met. The record should include detailed history and physical supporting any of the following conditions or procedures:
- Acute myocardial infarction (MI) (heart attack) within the preceding 12 months
- Compensated heart failure
- Coronary artery bypass graft (CABG) surgery
- Current stable angina pectoris
- Heart valve surgery
- Heart or heart-lung transplantation
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting

In addition, documentation that ALL of following components are included in the cardiac rehabilitation programs:
- Physician-prescribed exercise each day cardiac rehabilitation services are provided
- Cardiac risk factor modification
- Psychosocial assessment
- Outcomes assessment
- Individualized treatment plan detailing how each of the above components are utilized
### Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT</strong></td>
<td></td>
</tr>
<tr>
<td>93797</td>
<td>Physician services for outpatient cardiac rehab; without continuous ECG monitoring (per session)</td>
</tr>
<tr>
<td>93798</td>
<td>Physician services for outpatient cardiac rehab; with continuous ECG monitoring (per session)</td>
</tr>
<tr>
<td><strong>HCPCS</strong></td>
<td></td>
</tr>
<tr>
<td>G0422</td>
<td>Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session</td>
</tr>
<tr>
<td>G0423</td>
<td>Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per hour, per session</td>
</tr>
<tr>
<td>S9472</td>
<td>Cardiac rehabilitation program, non-physician provider, per diem</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**

Cardiac rehabilitation is an outpatient service. Therefore, this policy only addresses cardiac rehabilitation in the outpatient setting.

Cardiac rehabilitation must be performed in a facility approved by the Plan.

Services that are educational in nature (eg, lectures or counseling), which are performed as part of the cardiac rehabilitation program, are not eligible for coverage, even when occurring on a different date of service, unless specified in the contract or certificate of coverage.

Psychological testing and psychotherapy are not a usual component of cardiac rehabilitation. Such services for patients who have a psychiatric diagnosis must be considered under the Mental Health benefits of the contract.
The ongoing maintenance program that follows the 12-week rehabilitation program is not eligible for coverage.

Some contracts have an exclusion for cardiac rehabilitation, because this is considered “self-care” or “self-help” training. In these cases, any related diagnostic testing must also be excluded.

Evidence Review

Description

Cardiac rehabilitation refers to comprehensive medically supervised outpatient programs that aim to improve the function of patients with heart disease and prevent future cardiac events. National organizations have specified core components to be included in cardiac rehabilitation programs.

Background

Cardiac Rehabilitation

In 1995, the U.S. Public Health Service (USPHS) defined cardiac rehabilitation services as, in part, “comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. ... [These programs are] designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.” This USPHS guideline recommended cardiac rehabilitation services for patients with coronary heart disease and with heart failure, including those awaiting or following cardiac transplantation. A 2010 definition of cardiac rehabilitation by the European Association of Cardiovascular Prevention and Rehabilitation stated: “Cardiac rehabilitation can be viewed as the clinical application of preventive care by means of a professional multi-disciplinary integrated approach for comprehensive risk reduction and global long-term care of cardiac patients.” Since release of the USPHS guidelines, other societies, including the American Heart Association (2005) and the Heart Failure Society of America (2010) have developed guidelines on the role of cardiac rehabilitation in patient care.
Summary of Evidence

For individuals who have diagnosed heart disease who receive outpatient cardiac rehabilitation, the evidence includes multiple randomized controlled trials (RTCs) and systematic reviews of these trials. The relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. Meta-analyses of the available trials have found that cardiac rehabilitation improves health outcomes for selected patients, particularly those with coronary heart disease, heart failure, and who have had cardiac surgical interventions. The available evidence has limitations, including lack of blinded outcome assessment, but, for the survival-related outcomes of interest, this limitation is less critical. The evidence is sufficient to determine that the technology results in meaningful improvement in the net health outcome.

For individuals who have diagnosed heart disease without a second event who receive repeat outpatient cardiac rehabilitation, the evidence includes no trials. The relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have diagnosed heart disease who receive intensive cardiac rehabilitation with the Ornish Program for Reversing Heart Disease, the evidence includes an RCT and uncontrolled studies. The relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. No RCTs have compared the Ornish Program with a “standard” cardiac rehabilitation program; an RCT compared it with usual care. The trial included patients with coronary artery disease and no recent cardiac events and had mixed findings at 1 and 5 years. The trial had a small sample size for a cardiac trial (N=48), and only 35 patients were available for the 5-year follow-up. The Ornish Program is considered by the Centers for Medicare & Medicaid Services as an intensive cardiac rehabilitation program, but the program described in the RCT could meet criteria for standard cardiac rehabilitation. No studies were identified comparing the Ornish Program with any other cardiac rehabilitation program. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have diagnosed heart disease who receive intensive cardiac rehabilitation with the Pritikin Program, the evidence includes a case series. The relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. Studies are needed that compare the impact of intensive cardiac rehabilitation using the Pritikin Program with standard outpatient cardiac rehabilitation programs. The evidence is insufficient to determine the effects of the technology on health outcomes.
Ongoing and Unpublished Clinical Trials

Some ongoing and unpublished trials that might influence this policy 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>NCT03385837</td>
<td>Activity Level and Barriers to Participate of Cardiac Rehabilitation in Advanced Heart Failure Patients</td>
<td>50</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>NCT02762825</td>
<td>Novel Cardiac Rehabilitation in Patients Heart Failure and Preserved Ejection Fraction</td>
<td>66</td>
<td>Sept 2020</td>
</tr>
<tr>
<td>NCT02984449</td>
<td>Preventive Heart Rehabilitation in Patients Undergoing Elective Open Heart Surgery to Prevent Complications and to Improve Quality of Life (Heart-ROCQ) - A Prospective Randomized Open Controlled Trial, Blinded End-point (PROBE)</td>
<td>350</td>
<td>Aug 2025</td>
</tr>
<tr>
<td><strong>Unpublished</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01822769</td>
<td>Cardiopulmonary Rehabilitation for Adolescents and Adults With Congenital Heart Disease</td>
<td>28</td>
<td>Dec 2017 (last updated 01/25/18)</td>
</tr>
<tr>
<td>NCT03385837</td>
<td>Activity Level and Barriers to Participate of Cardiac Rehabilitation in Advanced Heart Failure Patients</td>
<td>50</td>
<td>Dec 2018 (unknown; last updated 12/12/17)</td>
</tr>
<tr>
<td>NCT02619422</td>
<td>Multicenter, prospective, randomized, open, blinded for the end point evaluator to compare compliance to secondary prevention measures after acute coronary syndrome and intensive cardiac rehabilitation program vs standard program</td>
<td>509</td>
<td>Feb 2018 (last updated 06/06/18)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial
Practice Guidelines and Position Statements

American College of Cardiology Foundation et al

In 2013, the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) updated their joint guidelines on the management of heart failure. These guidelines included the following class IIA recommendation related on cardiac rehabilitation (level of evidence B):

Cardiac rehabilitation can be useful in clinically stable patients with HF [heart failure] to improve functional capacity, exercise duration, health-related quality of life, and mortality.

The 2017 focused update of the guideline did not include additional information on cardiac rehabilitation.21

American College of Physicians

In 2012, the American College of Physicians and 6 other cardiology associations published joint guidelines on management of stable ischemic heart disease.22 The guidelines included the following statement on cardiac rehabilitation:

Medically supervised exercise programs, (cardiac rehabilitation) and physician-directed home-based programs are recommended for at-risk patients at first diagnosis.

The 2014 update to the guideline did not include additional information on cardiac rehabilitation.23

American Heart Association et al

In 2007, the American Heart Association and the American Association of Cardiovascular and Pulmonary Rehabilitation issued a consensus statement on the core components of cardiac rehabilitation programs.5 The core components included patient assessment before beginning the program, nutritional counseling, weight management, blood pressure management, lipid management, diabetes management, tobacco cessation, psychosocial management, physical activity counseling, and exercise training. Programs that only offered supervised exercise training were not considered to be cardiac rehabilitation. The guidelines specified the assessment, interventions, and expected outcomes for each of the core components. For example, symptom-
limited exercise testing before exercise training was strongly recommended. The guidelines do not specify the optimal overall length of programs or number or duration of sessions.

In 2019, the American Heart Association, with the American Association of Cardiovascular and Pulmonary Rehabilitation and the American College of Cardiology, released a scientific statement on home-based cardiac rehabilitation. They make the following suggestions for healthcare providers:

- Recommend center-based cardiac rehabilitation (CBCR) to all eligible patients.
- As an alternative, recommend home-based cardiac rehabilitation (HBCR) to clinically stable low- and moderate-risk patients who cannot attend CBCR.
- Design and test HBCR “using effective processes of care for CVD secondary prevention.”
- For healthcare organizations, develop and support the following:
  - Maximization of CR referrals
  - High-quality CBCR and HBCR programs “using evidence-based standards and guidelines, strategies to maximize patient adherence both in the shorter and longer-term, and outcome tracking methods to help promote continuous quality improvement.”
  - “Testing and implementation of evidence-based hybrid approached to CR” that are optimized for each patient and that “promote long-term adherence and favorable behavior change.”
- For CR professionals, “work with other healthcare professionals and policymakers to implement additional research and...expand the evidence base for HBCR.”

**Medicare National Coverage**

**Cardiac Rehabilitation**

Since 1989, Medicare has had a national coverage determination for cardiac rehabilitation. In 2010, there was a change in Medicare coverage for cardiac rehabilitation. Indications for coverage remain the same; namely, patients who have experienced at least one of the following:

- Acute myocardial infarction within the preceding 12 months
- Coronary artery bypass surgery
• Current stable angina pectoris
• Heart valve repair or replacement
• Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
• Heart or heart-lung transplant

As of February 2014, patient eligibility criteria were expanded for cardiac rehabilitation to patients with the following:

Stable, chronic heart failure, defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (≤ 6 weeks) or planned (≤ 6 months) major cardiovascular hospitalizations or procedures.26

The 2010 criteria specify the required components of cardiac rehabilitation programs. Programs must include ALL of the following25:

• Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished
• Cardiac risk factor modification, including education, counseling and behavioral intervention at least once during the program, tailored to patients’ individual needs
• Psychosocial assessment
• Outcomes assessment
• Individualized treatment plan detailing how components are utilized for each patient.

In January 2010, the criteria on the frequency and duration of cardiac rehabilitation services were updated25.

Cardiac rehabilitation items and services must be furnished in a physician’s office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program....

...[C]ardiac rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option of an additional 36 sessions over an extended period of time if approved by the Medicare contractor.
**Intensive Cardiac Rehabilitation**

In January 2010, Medicare added intensive cardiac rehabilitation as a benefit. Intensive cardiac rehabilitation programs must be approved by Medicare on an individual basis.\(^{25}\)

The national coverage determination described intensive cardiac rehabilitation in the following manner:

Intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. As required by §1861(eee)(4)(A) of the Social Security Act (the Act), an ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients: (1) positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; and, (3) reduced the need for percutaneous coronary interventions. The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services: (1) low density lipoprotein; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and, (6) the need for cholesterol, blood pressure, and diabetes medications. Individual ICR programs must be approved through the national coverage determination process to ensure that they demonstrate these accomplishments.

In 2010, Center for Medicare & Medicaid Services also issued 2 decision memos on specific programs. One stated that the Ornish Program for Reversing Heart Disease met the intensive cardiac rehabilitation program requirements and was included on the list of approved intensive cardiac rehabilitation programs.\(^{27}\) It provided the following description of the Ornish Program: “The Ornish Program for Reversing Heart Disease (also known as the Multisite Cardiac Lifestyle Intervention Program, Multicenter Cardiac Lifestyle Intervention Program and the Lifestyle Heart Trial program) ... incorporates comprehensive lifestyle modifications including exercise, a low-fat diet, smoking cessation, stress management training, and group support sessions. Over the years, the Ornish program has been refined but continues to focus on these specific risk factors.”

The other stated that the Pritikin Program met program requirements and was included on the list of approved intensive cardiac rehabilitation programs.\(^{27}\) As described in the decision memo: “The Pritikin program (also known as the Pritikin Longevity Program) evolved into a comprehensive program that is provided in a physician’s office and incorporates a specific diet
(10%–15% of calories from fat, 15%–20% from protein, 65%–75% from complex carbohydrates), exercise and counseling lasting 21-26 days. An optional residential component is also available for participants.”

References


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/02/99</td>
<td>Add to Therapy Section - New Policy</td>
</tr>
<tr>
<td>11/12/02</td>
<td>Replace Policy - Policy reviewed without literature review; new review date only</td>
</tr>
<tr>
<td>02/10/04</td>
<td>Replace Policy - Policy reviewed without literature review; new review date only. Title updated by dropping “Programs”</td>
</tr>
<tr>
<td>06/16/06</td>
<td>Replace Policy - Policy updated with new Medicare policy guidelines; reference added; no change in policy statement.</td>
</tr>
<tr>
<td>10/09/07</td>
<td>Replace Policy - Policy updated with literature review; no change in policy statement; policy status changed from AR to BC.</td>
</tr>
<tr>
<td>12/08/09</td>
<td>Replace Policy - Policy updated with literature review; no change to policy statement. Reference added.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Replace Policy - Policy updated with literature review through April 2010. Rationale rewritten; reference numbers 1-5 added. “In the outpatient setting” added to policy title; changes to existing medically necessary policy statement include the addition of the indications “heart-lung transplantation” and “coronary stenting,” and specification of components in cardiac rehabilitation programs; second policy statement that repeat programs are investigational has been added.</td>
</tr>
<tr>
<td>08/09/11</td>
<td>Replace Policy – Policy updated with literature review through April 2011. References 2, 5 and 8 added; no change to policy statements.</td>
</tr>
<tr>
<td>08/20/12</td>
<td>Replace policy. Policy updated with literature review through April 2012. References 3, 5, 6 and 7 added; other references renumbered or removed. No change to policy statements.</td>
</tr>
<tr>
<td>10/09/12</td>
<td>Update Coding Section – ICD-10 codes are now effective 10/01/2014.</td>
</tr>
<tr>
<td>08/16/13</td>
<td>Replace policy. Policy updated with literature review through May 13, 2013. References 3 and 9 added; other references renumbered or removed. No change to policy statements.</td>
</tr>
<tr>
<td>08/11/14</td>
<td>Annual Review. Policy updated with literature review through May 12, 2014. References 1-2, 5-6, 13, 15 added; others renumbered/removed. Policy statements unchanged. ICD-9 and ICD-10 diagnosis codes removed; they are not utilized in adjudication of the policy. ICD-9 procedure codes removed with the exception of 93.36 which is specific to this policy.</td>
</tr>
<tr>
<td>08/11/15</td>
<td>Annual Review. List of medically necessary conditions and procedures put in alpha-order format. Clinical trials list reformatted as a table. Policy updated with literature review through May 12, 2015; reference 18 added. Policy statements unchanged. CPT codes 93015, 93016 and 99215; these are not specific to the policy. ICD-9 procedure code 93.36 removed; informational only.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>08/01/17</td>
<td>Annual Review, approved July 18, 2017. Policy moved to new format. Policy updated with literature review through May 31, 2017; references 11, 14-16, and 22-23 added. Repeat participation is considered not medically necessary (previously considered investigational). Added statement that intensive cardiac rehabilitation with the Pritikin Program or the Ornish Program is considered investigational.</td>
</tr>
<tr>
<td>05/01/18</td>
<td>Annual Review, approved April 18, 2018. Policy updated with literature review through January 2018; references 13-14, and 16 added. Minor edit to the Policy section; policy statements otherwise unchanged.</td>
</tr>
<tr>
<td>06/01/19</td>
<td>Annual Review, approved May 7, 2019. Policy updated with literature review through January 2019; references added. Policy statements unchanged.</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). ©2020 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-537-7697 (TDD)
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 S09F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):

يوجد هذا الإشعار معلومات هامة. قد يوجد هذا الإشعار معلومات مهمة بخصوص تلك أو هذه المعلومات. قد تكون هناك تأثيرات مهمة في هذا الإشعار. قد تكون تأثيرات إضافية في تأثيرات أخرى على تأثيرات الصحة والإمكانية، بما في ذلك الكفاءة. قد تكون تأثيرات أخرى على هذه المعلومات، بما في ذلك الكفاءة، التي تتعلق بكيفية استخدام المعلومات. يرجى الرجوع إلى محتوى هذا الإشعار عند تقديم طلبك. يمكن الوصول إلى محتوى هذا الإشعار على الطرق المذكورة أعلاه، بما في ذلك الكفاءة، إذا كنت ترغب في ذلك.

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

中文 (Chinese):

本通知有重要的讯息。本通知可能有关於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。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).

Italiano (Italian):

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

Tagsalog (Tagalog):

Vietnamese (Vietnamese):