LifeWise
Health Plan of Washington

MEDICAL POLICY – 2.04.152

Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes

BCBSA Ref. Policy:	2.04.152	
Effective Date:	May 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	April 8, 2024	None
Replaces:	N/A	

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

Maternal serum biomarker tests use blood samples to look for health problems during pregnancy. These tests can use one or more variables to try to predict health problems. Preeclampsia is unexpected high blood pressure in pregnancy. This condition can cause organ damage to the mother. It can also slow the baby's normal growth. In severe situations, it can be life-threatening for the mother and baby. Spontaneous preterm birth is when the baby is born too early, between the 20th and 37th week of pregnancy. The standard way to check for pre-eclampsia and preterm birth is to identify and monitor known risk factors. The use of maternal serum biomarker tests to predict pre-eclampsia and spontaneous preterm birth is unproven (investigational). More studies are needed to see if this type of testing improves health outcomes.

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

Test	Investigational
Maternal serum biomarker tests	**The use of maternal serum biomarker tests with or without additional algorithmic analysis for prediction of pre-eclampsia is considered investigational.** **The use of maternal serum biomarker tests with or without additional algorithmic analysis for prediction of spontaneous preterm birth is considered investigational**

Coding

Code	Description
CPT	
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia (i.e., PGIF Preeclampsia Screen by PerkinElmer Genetics, Inc., Brahms sFlt-1/ PlGF KRYPTOR Test System)
0247U	Obstetrics (preterm birth), insulin-like growth factor-binding protein 4 (IBP4), sex hormone-binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth (i.e., PreTRM test by Sera Prognostics, Inc.)

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

Evidence Review

Description

Improved accuracy of the identification of pregnant individuals at risk of preeclampsia and spontaneous preterm birth has the potential to reduce maternal and perinatal morbidity and mortality. Assessment of historical risk and clinical factors represents the traditional approach to diagnosis and planning interventions. Maternal serum biomarker testing is proposed as an adjunct to standard screening to identify pregnant individuals at risk of pre-eclampsia and spontaneous preterm birth.

Background

Preeclampsia

Hypertensive disorders in pregnancy affected approximately 1 in 7 delivery hospitalizations between 2017 and 2019 in the US with a prevalence of approximately 1 in 5 delivery hospitalizations among Black pregnant individuals and 1 in 3 among pregnant individuals aged 45 to 55 years.[1,]Preeclampsia is defined as new onset maternal hypertension and proteinuria or new onset hypertension and significant end-organ dysfunction (with or without proteinuria) after the 20th week of gestation.[2]

Maternal complications of pre-eclampsia include progression to eclampsia, placental abruption, and a life-threatening complication known as hemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome. In the fetus, preeclampsia can lead to fetal growth restriction and intrauterine fetal death. Preeclampsia can develop in nulliparous pregnant individuals with no known risk factors.[3] Maternal factors associated with an increased risk of preeclampsia include advanced maternal age, presence of a chronic illness such as diabetes mellitus, chronic hypertension, chronic kidney disease, or systemic lupus erythematosus, obesity, multiple gestations, and a prior history of preeclampsia. Preeclampsia can also develop in the postpartum period. In pregnant individuals determined to be at increased risk of developing preeclampsia, the use of daily, low-dose aspirin beginning in the 12th week of gestation is associated with a reduction in risk and is recommended by the US Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG).[,4,5]

Despite decades of research, accurate identification of pregnant individuals at risk of preeclampsia, particularly prior to the 20th week of gestation, remains challenging.[3] Standard methods for preeclampsia risk-factor assessment are based on medical and obstetric history and clinical assessment, including routine maternal blood pressure measurement at each prenatal visit.[4] The use of maternal serum biomarker assays as an adjunct to standard preeclampsia risk assessment has been suggested as a mechanism that could improve accurate identification of at-risk individuals. More accurate identification of risk could create an opportunity for additional assessment, surveillance, and interventions that would ultimately reduce the maternal and fetal or newborn morbidity and mortality associated with preeclampsia. Individual maternal serum biomarkers, such as serum placental growth factor (PlGF), soluble Fms-like tyrosine kinase 1 (s-Flt 1), and pregnancy-associated plasma protein A (PAPP-A) have been investigated as predictors of preeclampsia.[6] Multivariable preeclampsia risk assessment tools have been developed that incorporate maternal serum biomarkers; several of these tools have been commercially produced (see **Regulatory Status**) but few have been externally validated.[7] Clinically useful risk assessment using maternal serum biomarker testing would need to show increased predictive value over standard assessment of preeclampsia risk without serum biomarker testing.

Spontaneous Preterm Birth

Preterm birth is defined as birth occurring between the 20th and 37th week of pregnancy and can be spontaneous following preterm labor and rupture of membranes or iatrogenic due to clinical interventions for maternal or fetal medical indications. The preterm birth rate was estimated by the Centers for Disease Control (CDC) to be 10.1% (about 360,000 births were preterm among 3,600,000 births) in 2020 in the United States and has consistently been approximately 10% for over a decade.[8]Preterm birth rates vary according to race and ethnicity independent of social determinants of health, ranging from 8.5% for Asian pregnant individuals to 14.4% for non-Hispanic Black pregnant individuals. Prior preterm birth is the strongest predictor of a subsequent preterm birth, although absolute risk varies according to the gestational age of the prior preterm birth and maternal clinical factors.[9] Characteristics in a current pregnancy that increase the risk of preterm birth include cervical changes (shortened length and/or early dilation), vaginal bleeding or infection, and maternal age under 18 years or over 35 years. Smoking, pre-pregnancy weight, interpregnancy interval, maternal stress, and lack of social support have also been associated with an increased risk of preterm birth. Despite recognition of risk factors, most preterm births occur without clearly identifiable maternal risk factors.[10] Maternal consequences of preterm delivery include intrapartum and postpartum infection. Psychosocial adverse effects including postpartum depression have been reported.

Infants born preterm have an increased risk of death up to 5 years of age relative to full-term infants. Preterm birth is also associated with morbidity extending into adulthood.[11]

Cervical length is one measure available to clinicians to assess risk of preterm birth. Shortened cervical length prior to 24 weeks gestation is associated with an increased risk of preterm birth. The ACOG recommends ultrasonographic assessment of cervical length in the second trimester to identify pregnant individuals at an increased risk of preterm birth.[11] In pregnant individuals with a prior history of preterm birth, serial measurement of cervical length using transvaginal ultrasound is recommended, although optimal timing of measurements has not been clinically established. In pregnant individuals without a history of preterm birth or other risk factors, universal ultrasonographic screening of cervical length in pregnant individuals has not been demonstrated to be an effective strategy due to the overall low incidence in this group. In pregnant individuals determined to have a shortened cervix and therefore an increased risk of preterm birth, the use of either vaginal or intramuscular progesterone supplementation has been associated with a reduced risk of preterm birth. There are some limitations in assessment of cervical length in predicting risk of preterm birth. These limitations include uncertainty as to what constitutes "shortened" length, with transvaginal ultrasound measurements ranging from <15 mm to <25 mm implicated in indicating increased risk and uncertainty regarding ideal timing of ultrasonographic assessment.[11]

Given the limitations of cervical length assessment in predicting risk of preterm birth, the use of other biomarkers has been suggested as a mechanism that could improve accurate identification of pregnant individuals at risk of preterm birth, including maternal serum biomarkers.[12]

Summary of Evidence

For individuals who are pregnant without known risk factors for preeclampsia who receive maternal serum biomarker testing with or without additional algorithmic analysis, the evidence includes systematic reviews of observational clinical validity studies and a randomized controlled trial (RCT) that selected eligible participants based on an algorithm that included biomarker testing results. . Relevant outcomes are test validity, maternal and perinatal morbidity and mortality, symptoms, functional outcomes, quality of life, hospitalizations, and resource utilization. The clinical validity studies primarily included populations from Europe and tests that are not cleared for use in the US. Placental growth factor (PlGF) cutoffs for identifying high risk pregnant persons were not prespecified and varied significantly. The RCT used a test not cleared for use in the US to identify people for enrollment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are pregnant with known risk factors for preeclampsia who receive maternal serum biomarker testing with or without additional algorithmic analysis, the evidence includes systematic reviews of observational clinical validity studies and RCTs. Relevant outcomes are test validity, maternal and perinatal morbidity and mortality, symptoms, functional outcomes, quality of life, hospitalizations, and resource utilization. Studies evaluating the predictive ability of maternal serum biomarker testing have found measurement of sFlt-1, PlGF, and the sFlt-1/PlGF ratio can identify pregnant individuals at risk of developing preeclampsia. One sFlt-1/PlGF ratio test system (KRYPTOR) has been cleared in the US. One prospective observational study (PRAECIS) has been conducted in a second and third trimester, US population reporting clinical validity of the KRYPTOR test system. PRAECIS included a racially diverse population reflective of US diversity. While PRAECIS proposed a cutoff for the sFlt-1: PlGF ratio of 40, other publications have proposed various cutoffs. The clinical decision that would be informed by the test is unclear. While five RCTs have been conducted using various biomarker tests, the KRYPTOR test system has not been used in any RCTs. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are pregnant without known risk factors for spontaneous preterm birth who receive maternal serum biomarker testing with or without additional algorithmic analysis, the evidence includes an RCT and cohort studies. Relevant outcomes are test validity, maternal and perinatal morbidity and mortality, symptoms, functional outcomes, quality of life, hospitalizations, and resource utilization. Measurement of the insulin-like growth factor binding protein-4 (IBP4) and sex hormone binding globulin (SHBG) ratio demonstrated acceptable discrimination in identifying asymptomatic pregnant individuals who may be at risk of preterm birth, based on evidence from two industry-sponsored cohort studies. However, a randomized trial did not find a difference in risk of preterm birth with use of the commercially produced PreTRM test, which includes the IBP4/SHBG ratio as part of an algorithmic analysis, versus no use. There were also no differences in neonatal outcomes in infants of pregnant individuals who underwent PreTRM testing versus no testing. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are pregnant with known risk factors for spontaneous preterm birth who receive maternal serum biomarker testing with or without additional algorithmic analysis, the evidence includes a systematic review of observational studies. Relevant outcomes are test validity, maternal and perinatal morbidity and mortality, symptoms, functional outcomes, quality of life, hospitalizations, and resource utilization. The systematic review did not identify any individual biomarker that adequately identified pregnant individuals at risk of spontaneous preterm birth based on high sensitivity and specificity. No studies assessing maternal serum biomarkers as part of an algorithmic analysis were identified. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

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

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
ISRCTN85912420[b]	Does repeat placental growth factor blood sample testing reduce harm from pre-eclampsia to babies? (PARROT 2)	1280	Mar 2023
NCT03231657	Randomizated Open-label Control Trial to Evaluate if the Incorporation of sFlt1/PlGF Ratio in the Diagnosis and Classification of PE Improves Maternal and Perinatal Outcomes in Women With the Suspicion of the Disease (EuroPE Study)	2536	Nov 2023
NCT04766866	Protocol of the PE37 Study: A Multicenter Randomized Trial of Screening With sFlt1/PlGF and Planned Delivery to Prevent Preeclampsia at Term	9132	Dec 2024
NCT05131282	A Case-control Study to Investigate SerumMarkers in Predicting Preeclampsia	300	Dec 2023
NCT04301518[a]	Prematurity Risk Assessment Combined With Clinical Interventions for Improving Neonatal outcoMEs	6500	Dec 2026
NCT03151330	Serum Assessment of Preterm Birth: Outcomes Compared to Historical Controls	2100	Nov 2023
NCT05521776	Impact of First-trimester Preeclampsia Screening on Perinatal and Maternal Morbidity : a Multicenter Randomized Trial	14500	Oct 2025
NCT05228002	sFlt-1/PlGF Ratio: Impact on the Management of Patients With Suspected Pre-eclampsia	160	Jul 2025
Unpublished			

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT03455387	Evaluation of the SerumMarkers sFLt1 and PlGF for the Prediction of the Complications of the Placental Vascular Pathologies in the 3rd Quarter of the Pregnancy	233	Dec 2019
NCT03289611	Preeclampsia Ratio (sFlt-1/PlGF) Evaluation for Clinical and Obstetrical Guidance (PRECOG)	84	Aug 2020

NCT: national clinical trial. [a] Denotes industry-sponsored or cosponsored trial.
b Registered in the ISRCTN registry. ISRCTN registry is a clinical trial registry recognized by the World Health Organization (WHO) and the International Journal of Medical Journal Editors (ICMJE).

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Obstetricians and Gynecologists and The Society for Maternal-Fetal Medicine

The American College of Obstetricians and Gynecologists (ACOG) issued practice bulletins in 2020 on preeclampsia[4], and 2021 on preterm birth.[11] Maternal serum biomarker screening is described as investigational and is not recommended by ACOG as a factor included in risk assessment for either preeclampsia or spontaneous preterm birth.

The 2021 joint ACOG-Society for Maternal-Fetal Medicine (SMFM) guidance on the use of aspirin for prevention of preeclampsia does not include results of maternal serum biomarker testing among the risk factors to be used to identify pregnant individuals at risk of preeclampsia.[42] The guidance was reaffirmed in October 2022.

International Federation of Gynecology and Obstetrics

The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Preeclampsia (PE) published a guide for first trimester screening and prevention of preeclampsia in 2019.[6] The writing committee included representation from the National Institutes of Health (US Department of Health and Human Services) and the Society for Maternal-Fetal Medicine (Washington, DC). The guideline states that 'All pregnant individuals should be screened for preterm PE during early pregnancy by the first-trimester combined test with maternal risk factors and biomarkers as a one-step procedure.' The guidance further states that 'The best combined test is one that includes maternal risk factors, measurements of mean arterial pressure (MAP), serum placental growth factor (PlGF) and uterine artery pulsatility index (UTPI).' The combined test referred to in the guidance is the Fetal Medicine Foundation (FMF) risk calculator.

International Society for the Study of Hypertension in Pregnancy

The International Society for the Study of Hypertension in Pregnancy (ISSHP) issued practice guidelines in 2021 on classification, diagnosis, and management of hypertension in pregnancy.[43], The ISSHP committee included US representation. The guidelines make the following recommendation: 'To the assessment of pregnant individuals suspected of having pre-eclampsia (<37 weeks), we recommend adding evaluation of angiogenic imbalance, when available, as a marker of uteroplacental dysfunction to be used in conjunction with other clinical tests.' The quality of the evidence for the recommendation was rated as 'Moderate' and the strength of recommendation was rated as 'Strong'. Angiogenic imbalance was defined as reduced PlGF (<5th centile for gestational age) or increased sFlt/PlGF ratio.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) published guidance in 2022 on PLGF-based testing to help diagnose suspected preterm pre-eclampsia.[44], The guidance recommends use of four tests to help decide on care (to help rule in or rule out pre-eclampsia) for people with suspected preterm (between 20 weeks and 36 weeks and 6 days of pregnancy) pre-eclampsia. The tests are: DELFIA Xpress PLGF 1 2 3, DELFIA Xpress sFlt 1/PLGF 1 2 3 ratio, Elecsys immunoassay sFlt 1/PLGF ratio, Triage PLGF Test. The guidance states that "BRAHMS sFlt 1 KRYPTOR/BRAHMS PLGF plus KRYPTOR PE ratio is not recommended for routine use in the NHS. Further research is needed to show the accuracy of this test when using specified thresholds."

US Preventive Services Task Force Recommendations

The US Preventive Services Task Force (USPSTF) issued updated recommendations in 2023 on on screening for hypertensive disorders of pregnancy.[16] The recommendation states: "Several models have been developed with the aim of identifying pregnant individuals who are at risk of developing preeclampsia. Many of these models include variables for medical history, patient characteristics, blood serum biomarkers (e.g., serum placental growth factor), mean arterial pressure (MAP), and ultrasound readings (e.g., Doppler uterine artery pulsatility index). The most extensively researched of these are various iterations of the Fetal Medicine Foundation (FMF) model. Currently, risk assessment and risk prediction tools are being used to inform the use of aspirin for prevention of preeclampsia; however, no randomized controlled trials (RCTs) have incorporated the use of a risk prediction model to evaluate the optimal frequencies or intervals of screening for hypertensive disorders of pregnancy. In the absence of clinical implementation studies, it is not yet clear whether screening informed by risk prediction models would necessarily be superior to risk evaluations based on clinical history taking. Moreover, it remains to be seen whether risk-based screening protocols, regardless of the risk-assessment approach used, could improve outcomes relative to usual care screening.

The US Preventive Services Task Force (USPSTF) issued updated recommendations in 2021 on the use of aspirin for the prevention of preeclampsia.[5]The USPSTF recommendation notes "predictive models that combine risk factors to identify pregnant persons at risk for preeclampsia, such as serum biomarkers, uterine artery Doppler ultrasonography, and clinical history and measures, have been developed. However, there is limited evidence from external validation and implementation studies to demonstrate sufficient accuracy of predictive models for clinical use."

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). Laboratories that offer laboratory-developed

tests must be licensed by the CLIA for high-complexity testing. To date, the US Food and Drug Administration (FDA) has chosen not to require any regulatory review of these tests. Therefore, maternal serum biomarker tests would be provided by CLIA licensed laboratories.

The B·R·A·H·M·S sFlt-1/ PlGF KRYPTOR Test System (Thermo Fisher Scientific) was cleared for marketing by the FDA as a prognostic test through the De Novo process (DEN220027) in May 2023.[13], The Test System includes quantitative determination of placental growth factor (PlGF) and soluble fms-like tyrosine kinase-1 (sFlt-1) in human serum and plasma. The clearance letter states that the Test System is to be used 'along with other laboratory tests and clinical assessments to aid in the risk assessment of pregnant individuals (singleton pregnancies between gestational age 23+0 to 34+6/7 weeks) hospitalized for hypertensive disorders of pregnancy (preeclampsia, chronic hypertension with or without superimposed preeclampsia, or gestational hypertension) for progression to preeclampsia with severe features (as defined by the American College of Obstetricians and Gynecologists (ACOG) guidelines) within 2 weeks of presentation.'

Commercially produced, maternal serum biomarker tests for preeclampsia include the Triage PlGF (Quidel), Elecsys sFlt-1/PlGF (Roche Diagnostics), and DELFIA Xpress PlGF 1-2-3™ (PerkinElmer).[13] These commercially produced tests are not currently available in the United States.

The PreTRM test (Sera Prognostics)[15] uses maternal serum biomarkers (insulin-like growth factor binding protein-4 [IBP4] and sex hormone binding globulin [SHBG]) in combination with biometric measures to assess the risk of spontaneous preterm birth. According to the manufacturer, the PreTRM test is only intended to be used in pregnant individuals aged 18 years or older, who are asymptomatic (that is, with no signs or symptoms of preterm labor, with intact membranes, and with no first trimester progesterone use) with a singleton pregnancy. The PreTRM test is performed via a single blood draw during the 19th week of gestation.

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History

Date	Comments
07/01/23	New policy, approved June 13, 2023. Policy created with literature review through December 21, 2022. Maternal serum biomarker testing is investigational. Added new CPT code 0390U (new code effective 7/1/2023).
05/01/24	Annual Review, approved April 8, 2024. Policy updated with literature review through January 2, 2024; references added. Policy statements unchanged. Changed the wording from "women" to "pregnant individuals" throughout the policy for standardization. Removed HCPCS code 0390U.

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.

LifeWise

Discrimination is Against the Law

LifeWise Health Plan of Washington (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-817-3056 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-817-3056（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-817-3056 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-817-3056 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-817-3056 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-817-3056 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-817-3056 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-817-3056 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-817-3056（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-817-3056 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-817-3056 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-817-3056 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-817-3056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-817-3056 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-817-3056 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-817-3056 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-817-3056 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-817-3056 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-817-3056 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-817-3056 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-817-3056 (TTY: 711) تماس بگیرید.