{returnAddress1}

{returnAddress2}

{returnAddress3}

{returnCity}, {returnState} {returnZip}

{sendAddress1}

{sendAddress2}

{sendCity}, {sendState} {sendZip}

{systemDate}

Dear {firstName},

Thank you for being a Blue Shield member.

Here is your bill for coverage from {billingFirstDay} to {billingLastDay}. Please make sure to pay the full amount due by {billDueDate}. This will help us keep your coverage active. You can pay using one of the ways listed on the back of the slip that came with this letter.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Bill date: | {billDate} | | | | |
| Billing period: | | | {bDate}-{bDate} | | |
| Previous amount due: | | | | | {prev} |
| Payments: | | {pay} | | | |
| Current charges: | | | | {curr} | |

If you want to know more about how you can pay, go to blueshieldca.com/medicarewaystopay.

Your health is important. Thank you for choosing Blue Shield for your coverage.

Sincerely,

Blue Shield of California

**Member Name:** {firstName} {lastName}

**Group Number:** {groupNumber}

**Member Number:** {memberNumber}

**Account Number:** {accountNumber}

**Invoice Number:** {invoiceNumber}

**Total due: {due}**

Bill due date: {billDueDate}

**SUMMARY**

**HAVE QUESTIONS?**

Call Customer Service at **(888) 239-6469** [TTY: 711] Hours of Operation: 8 a.m. - 8 p.m., 7 days a week

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An independent member of the Blue Shield Association

**See more about your bill on page 3.**

1

**COVERED MEMBER: {memberFullName}**

**Coverage effective date: {coverageEffectiveDate}**

**Invoice Number: {invoiceNumber}**

|  |  |  |
| --- | --- | --- |
| **PLAN DETAILS** |  | |
| **Plan 1** | **Billing period** |  |
| Blue Shield Rx Enhanced (PDP)  **Plan price:** | 09/01/2024-09/30/2024 | **$188.40** |
| **Charges right now:** |  | **$188.40** |
| **PAYMENT DETAILS** |  |  |
| Other | 07/04/2024 | -$188.40 |

3

**Member Name:** CARMEN CHAVEZ **Group Number:** W0051752 **Member Number:** 902201168

**Account Number:** W0051752902201168

**Invoice Number:** 242180011289

**Total due: $188.40**

Bill due date: 08/31/2024

**Please send payment to:**

BLUE SHIELD OF CA- MEDICARE

P.O. Box 745843

Los Angeles, CA 90074-5843

Address Change?

Call Customer Service at (888) 239-6469 [TTY: 711] Hours of Operation: 8 a.m. - 8 p.m., 7 days a week

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**WAYS TO PAY** 4

 **Online:** blueshieldca.com/ medicarewaystopay

 **Phone:**

Call (888) 239-6469

TTY: 711

Hours of Operation: 8 a.m. - 8 p.m.,

7 days a week

 **Mail (allow 7-10 days):** BLUE SHIELD OF CA - MEDICARE

P.O. Box 745843

Los Angeles, CA 90074-5843

**Social Security/Railroad Retirement Board withhold:** Call (888) 239-6469

TTY: 711



Hours of Operation: 8 a.m. - 8 p.m.,

7 days a week

You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage may be canceled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. For questions related to your billing statement or benefits, please contact us at the number listed below. Our Customer Service representatives are always ready to assist you. Payments made on this account will be credited first toward any outstanding balance amounts and then to the current amount due.



NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California provides:

* Aids and services at no cost 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)
* 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 Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator

P.O. Box 629007

El Dorado Hills, CA 95762-9007 Phone: (844) 831-4133 (TTY: 711)

Fax: (844) 696-6070

Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.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)

Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html.](http://www.hhs.gov/ocr/office/file/index.html)

