Small Business Service Bureau, Inc.®

Tufts Health Plan

SBSB Group Health Insurance Program for Sole-Proprietors and Small Employers in Massachusetts

Welcome! Enrollment in the health insurance plan of your choice is simple – ***only 3 easy steps***. Our Benefit Specialists are available to assist you and all information is confidential.

Step 1: **Obtain a premium quote** by contacting an SBSB Benefit Specialist at 1-800-472-7199, or by visiting us at www.SBSBHealth.com and click on Small Business Shopping for my Employees.

Step 2: **Apply for health insurance** by submitting the following to SBSB.

___ Completed Health Plan Group Census and Selection Form

___ Health Insurance Premium Quote

___ Have each employee participating in your group plan complete, sign, and date an Enrollment/Change Form. *(**Please note:** all dependent information including dates of birth must be accurate.)*

___ Waiver of Coverage Form for each employee opting out of your group insurance plan

___ Pediatric Dental Coverage Attestation Form (if applicable)

___ Include Proof of Business Documentation **(choose at least 1)**

- Tax Documentation: Schedule C, WR1 SE
- Business License or Permit for Commercial Operation
- Validation from MA Secretary of State's Office or applicable city/town clerk's office
- Copy of Business related Bank Statement
- Report from a business credit rating agency
- Declaration Statement of Worker's Compensation or Commercial Property/Casualty Insurance

___ Complete the SBSB Membership Application

Step 3: **Submit** the first month premium and SBSB Annual Membership Dues ($85 for 1-4 employees; $125 for 5-9 employees) payable to SBSB.

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872

or scan and email to:
enroll@sbsb.com

All groups subject to health plan eligibility and underwriting requirements.
All enrollment documents, including the employee's enrollment form, must be completed, signed, dated, and submitted to the Small Business Service Bureau, Inc. prior to the desired effective date.

Join SBSB!
A Big PLUS for Small Business Success!

Member Information

Business Name _____

Name of Owner/Operator ☐ Mr. ☐ Mrs. ☐ Ms.

_____

FIRST NAME MIDDLE INITIAL LAST NAME

_____

TITLE DATE OF BIRTH

Business Address

_____

STREET (NO P.O. BOXES)

_____

CITY STATE ZIP

Mailing Address (if different from street address above)

_____

STREET / P.O. BOX

_____

CITY STATE ZIP

Is your business address the same as your home address?

☐ Yes ☐ No Do you: ☐ Rent ☐ Own ☐ Lease?

Business Telephone (_____) _____

Home Telephone (_____) _____

Fax No. (_____) _____

E-mail _____

Number of Full-Time Employees _____

Description of Business: _____

_____

EXAMPLES: ACCOUNTING, LAW, RETAIL CLOTHING SALES, COMPUTER CONSULTING, ETC.)

Business Structure (check one)

☐ Corporation ☐ Sole Proprietorship
☐ Partnership ☐ Subchapter S

Does your company have a probationary period for new employees? ☐ No ☐ Yes If yes, what is it? _____

_____

AUTHORIZED SIGNATURE **TITLE**

/ /

_____

PRINT NAME **DATE**

Please use the SBSB return-addressed envelope provided to submit your application(s).

☐ **Yes, I want to save money on group insurance and other benefits for my small business!**

Complete this section only if applying for health insurance through SBSB.

Health Insurance Effective Date Desired / /

If you are applying for health insurance, do not cancel any insurance until you are certain your new coverage is in effect.

I hereby certify and attest the information provided herein is true and complete to the best of my knowledge, and that I have the legal authority to execute this document on behalf of the company named herein. I certify that 100% of eligible people who are not covered by a spouse, parent or Medicare are enrolled in the SBSB Health Insurance Program. Furthermore, I certify that all current and future employees to be enrolled actively work full-time, as defined by state and federal laws, for financial compensation. I understand all health coverage becomes effective upon the approval of the provider or carrier. I further state I am aware the health provider retains the right to terminate coverage at any time if the statements made herein are not true and complete.

For information or assistance with this application, call an SBSB Membership Representative Toll Free at

1-800-472-7199.

Small Business Service Bureau, Inc.

A National Membership Organization for Small Business
38 Austin Street • P.O. Box 15014 • Worcester, MA 01615-0014

FOR SBSB USE ONLY

DATE _____ 090 _____ 260 _____ 400 _____

250 _____ 210 _____ 490 _____ 410 _____

240 _____ INITIAL BILL _____ EFF. DATE _____

REASON _____

Small Business Service Bureau, Inc.

TUFTS HEALTH PLAN GROUP CENSUS AND PLAN SELECTION FORM

TUFTS Health Plan

Company Name: _____ Address: _____

EIN: _____ Company Email Address: _____

Tax ID: _____ SIC: _____

Total number of employees (ACA Definition)*:
Number of full-time and full-time equivalent employees (FTE's), including any part-time and seasonal employees who are employed at the time of the policy effective date working 30 or more hours per week. _____

Do you regularly employ at least one individual that is not an owner and/or spouse of an owner?
_____Yes _____No

SBSB Credentialed Broker Name: _____

Broker Phone #: _____ BR#: _____
(if applicable)

Tufts Health Plan Selection: *(only one benefit level per company)*

HMO Plans

Advantage HMO 1500 (90%) ____
Advantage HMO 2000 ____
Advantage Basic HMO 2000 ____
Advantage HMO 3000 ____
Advantage HMO 4000 ____
Advantage HMO Saver** 2500 (Plan Year) ____
Advantage HMO Saver** 3600 (Plan Year) ____

Limited Network Plans

Select* Advantage HMO 1000 ____
Select* Advantage HMO 2000 ____
Select* Advantage HMO 3000 ____

**Select provider network with a limited service area that excludes Berkshire, Dukes, and Nantucket Counties.*
***HSA qualified/Plan year*

All plans include Delta Dental coverage as required by the ACA. If you want the above plan without Pedi Dental coverage, please sign here _____ .
A Pedi Dental Attestation form is also required if choosing this option.

Include all benefit eligible employees on payroll and any COBRA participants. Please attach additional listing if needed.

Employee Name	Waivers** (Include Reason)	Date of Birth	Date of Hire
1.			
2.			
3.			
4.			
5.			
6.			
7.			

* *To determine the FTE count we recommend using https://www.healthcare.gov/shop-calculators-fte/.*
** *If waiving right to group health care coverage at this time, please attach a completed waiver of coverage form.*

Employer Certification & Eligibility Guidelines

1. I hereby certify that my company is an eligible small business as defined by the Massachusetts state regulations. I verify that my company is a "sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom work in Massachusetts."
2. If I have one eligible employee, or I am a sole proprietor, I certify that I work on a permanent full-time basis at least 30 or more hours a week and reside in the health plan's service area.
3. If I have 2-9 eligible employees, I certify that all current and future permanent full-time employees to be enrolled in the SBSB Group Health Program a) actively work for financial compensation at least 20 hours per week with at least one person working a minimum of 30 hours per week; b) receive an annual W-2 Form; and c) are hired to work for a period of not less than five months.
4. I certify that my company a) meets the Tufts Health Plan participation requirements; and b) contributes at least 50% toward the individual and 33% toward the family premiums.
5. I further state that I am aware the health plan retains the right to terminate coverage retroactive to the coverage effective date at any time if the statements made herein are not true and complete.
6. New Hires: a new employee must apply for Tufts Health Plan coverage within the first 30 days of the hire date if the employer does not have a waiting period. Coverage will be effective for the date of hire. If a waiting period exists, it must become effective on the first day following completion of the waiting period, consistently applied to all new employees and be no more than 90 days.

The group elects coverage for Domestic Partnerships (required for both same sex and opposite sex domestic partners). ❑ **Yes** ❑ **No** Groups offering domestic partnership coverage agree that coverage is extended to both same sex and opposite sex domestic partners. Group agrees that it is responsible for collecting and maintaining the Domestic Partner Affidavits (form available through SBSB). Group is responsible for verifying the eligibility of each domestic partner, as stated in the Tufts Health Plan Domestic Partners Policy. Upon request, Group will provide Tufts Health Plan with documentation verifying domestic partner eligibility.

Please Note:

Tufts Health Plan requires 100% participation for groups with 1-5 eligible employees (excluding those who waive for spousal coverage) and a minimum of 75% participation for groups with 6-9 eligible employees (excluding those who waive for spousal coverage).

Tufts Health Plan's Select HMO plans are not available to employers located in the following Massachusetts counties: Berkshire, Dukes, and Nantucket Counties.

Tufts Health Plan's Select HMO plans offer a limited network of providers. These plans are only available to employers in Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties.

Steward Community Choice and Select are limited provider network products. Employer group must have a work site in the respective Steward Community Choice Service Area or the Select Service Area. Employees must reside or physically work in the respective Steward Community Choice Service Area or the Select Service Area.

Under Massachusetts State Law, the coverage described must be offered to all full-time employees who reside in the Commonwealth of Massachusetts. The employer group may not make a smaller premium contribution percentage amount to any employees than it makes to any other employees who receive an equal or greater total hourly or annual salary for each specific health plan offered. Separate contribution percentages for employees covered by collective bargaining agreements may be established.

Signed: _____ Date: _____

Authorized Company Representative

Name: _____

Please Print

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872
or scan and email to:
enroll@sbsb.com

Small Business Service Bureau, Inc.

WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

New Members—Register at mytuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the "subscriber" sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. Keep a copy of this completed form as verification of employer coverage until you receive your permanent member ID card.

Subscriber Section

- Personal Information: Complete all enrollment information. For all plans, please select a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- Primary Care Provider: It is important that you choose a PCP right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. You are an established patient if you have routinely received health care services from this provider in the past. If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- Dependent Children: Dependent children are covered until their 26th birthday. Please be sure to fill out all appropriate information for each dependent, including primary care provider (if applicable).
- Other Health Coverage: If you have other insurance (including Medicare), please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the No box.

Intermediary Section

This section must be filled out by your Intermediary.

When the Application Is Complete

Please return this form to your Intermediary.

- Employee keeps a copy of form as temporary ID
- Tufts Health Plan and/or your Intermediary receives the original

If You Need Emergency Care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP, if your plan requires one.

Please Note

By enrolling, you agree to and understand that if you or any of your enrolled dependents obtain a health care benefit or payment that you know you are not entitled to receive or be paid, or knowingly present or cause to be presented with fraudulent intent a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

Tufts Health Plan arranges for the provision of health care services but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance selecting a PCP, visit mytuftshealthplan.com and use the doctor search feature.
If you need help filling out this form, call a member services specialist at 800.462.0224.

MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. **PLEASE RETURN THIS COMPLETED FORM TO YOUR INTERMEDIARY.**

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

INTERMEDIARY USE ONLY

Name of Intermediary_____

Intermediary Group Number_____

TUFTS Health Plan

EMPLOYER SECTION

Group/Company Name_____ Group Number_____

Office Location_____ Date of Hire_____ Effective Date of Coverage_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date_____

SUBSCRIBER SECTION

Last Name_____ First Name_____ Middle Initial_____ Primary Language_____

Employee Social Security Number (required)_____–_____–_____ Date of Birth (MM/DD/YYYY)_____ / _____ / _____ Gender: ❑ Male ❑ Female

Residential Address (required)_____ City_____ State_____ ZIP_____

P.O. Box (optional) _____ City _____ State_____ ZIP_____

Email Address_____ Home Telephone (_____) _____ Work Telephone (_____) _____ Cell Phone (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Subscriber & Spouse ❑ Subscriber & Child ❑ Subscriber & Children ❑ Family ❑ Other_____

Primary Care Provider First Name_____ Last Name_____ PCP/NPI # _____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling First Name / Last Name (if different)	Gender M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (PCP First Name/Last Name)	Check if existing patient	PCP/NPI #
❑ Spouse ❑ Domestic Partner			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan_____ Name of Plan Holder_____ Health Plan Number_____ Effective Date_____

Names of Family Members Covered_____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature_____ Date_____ Benefits Dept. Signature (required)_____ Telephone_____ Date_____

Small Business Service Bureau, Inc.®

Waiver/Verification of Alternative Coverage

Eligible Employees who refuse the SBSB Group Insurance Plan offered through their employer must verify they have alternative coverage.

I,_____ , certify that I am an employee of and that I am eligible for group health care coverage through_____ , my employer. I also certify that I am waiving my right to group health care coverage through my employer at this time because I have chosen health care coverage through ***(Check box that applies)***:

❑ COBRA ❑ Parent/Spouse ❑ Union ❑ Medicare ❑ Alternate group health program

Parent's / Spouse's Name: _____

Current Health Plan: _____

Health Plan Identification Number: _____

Group / Policy Number:_____

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that any person choosing to enroll later must meet the health plan's requirements for eligibility and for late enrollees.

Employee Name *(please print)*

Signature Date

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that the health plan has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Signature of Authorized Company Representative Date

If you have any questions, please contact SBSB at 1-800-472-7199.

Return with the completed census and required documents to:
Small Business Service Bureau, Inc.
38 Austin Street • PO Box 15014 • Worcester, MA 01615-0014

SBSB Intermediary Benefit Comparison

Plan options for April 1, 2021 - March 31, 2022
for Massachusetts-based companies with 1-9 full-time employees

TUFTS Health Plan

Plan Name	Metallic Tier	Member Coins	Deductible (IND / FAM)	OOPM (IND / FAM) Combined Med / RX	PCP	Specialist	UCC **	PT/OT/ST	Chiro	Lab Testing	LTI	HTI	Outpatient Procedures	Inpatient Hospital	ER	LCG	RX Tier 1	RX Tier 2	RX Tier 3	RX Tier 4	RX Coins Max ***	Rx Deductible (IND / FAM)
HMO Deductible Plans																						
Advantage HMO 2000	Gold	0%	$2,000 / $4,000	$7,000 / $14,000	$25	$50	$40	$40	$25	Ded then $25	Ded then $50	Ded then $125	Ded then $150	Ded then $250	$300	$5	$30	$60	$90	$160	N/A	N/A
Advantage Basic HMO 2000	Silver	0%	$2,000 / $4,000	$8,550 / $17,100	$50	$100	$100	$50	$50	Ded then $80	Ded then $80	Ded then $500	Ded then $1,000	Ded then $1,000	Ded then $1,000	$5	$50	Rx Ded then $85	Rx Ded then $150	Rx Ded then 10%	$250	$250 / $500
Advantage HMO 3000	Silver	0%	$3,000 / $6,000	$8,550 / $17,100	$40	$60	$40	$45	$40	Ded then $75	Ded then $75	Ded then $300	Ded then $350	Ded then $500	Ded then $350	$5	$35	$85	$110	10%	$250	N/A
Advantage HMO 4000 - New	Silver	0%	$4,000 / $8,000	$8,550 / $17,100	$40	$60	$40	$45	$40	Ded then $75	Ded then $75	Ded then $300	Ded then $350	Ded then $500	Ded then $350	$5	$40	$85	$110	10%	$250	N/A
HMO Coinsurance Plans																						
Advantage HMO 1500 (90%)	Gold	10%	$1,500 / $3,000	$8,550 / $17,100	$35	$60	$40	$45	$35	Ded then 10%	Ded then 10%	Ded then 10%	Ded then 10%	Ded then 10%	Ded then 10%	$5	$35	Rx Ded then $85	Rx Ded then $100	Rx Ded then 10%	$250	$250 / $500
HMO Saver Plans (HSA-Qualified)																						
Advantage HMO Saver 2500	Silver	0%	$2,500 / $5,000 *	$6,900 / $13,800	Ded	Ded then $35	Ded	Ded	Ded	Ded then $35	Ded then $35	Ded	Ded then $200	Ded then $300	Ded then $200	Ded then $5	Ded then $30	Ded then $70	Ded then $100	Ded then $125	N/A	Combined
Advantage HMO Saver 3600	Bronze	0%	$3,600 / $7,200	$7,000 / $14,000	Ded then $100	Ded then $150	Ded	Ded then $150	Ded then $100	Ded then $55	Ded then $140	Ded then $1,000	Ded then $500	Ded then $2,000	Ded then $1,750	N/A	Ded then $30	Ded then $150	Ded then $225	Ded then $225	N/A	Combined
HMO Select Network Plans																						
Select Advantage HMO 1000	Gold	0%	$1,000 / $2,000	$7,000 / $14,000	$25	$45	$40	$40	$25	$25	Ded then $50	Ded then $125	Ded then $150	Ded then $250	$300	$5	$25	$60	$90	$160	N/A	N/A
Select Advantage HMO 2000	Gold	0%	$2,000 / $4,000	$7,000 / $14,000	$25	$50	$40	$40	$25	Ded then $25	Ded then $50	Ded then $125	Ded then $150	Ded then $250	$300	$5	$30	$60	$90	$160	N/A	N/A
Select Advantage HMO 3000 - New	Silver	0%	$3,000 / $6,000	$8,550 / $17,100	$40	$60	$40	$45	$40	Ded then $75	Ded then $75	Ded then $300	Ded then $350	Ded then $500	Ded then $350	$5	$35	$85	$110	10%	$250	N/A

Deductible, Out-of-Pocket Maximum (OOPM), and visit limits are calculated on a calendar year for all plans (except Saver plans, which are calculated on a plan year from April 1 - March 31) regardless of the effective date of the group.

These charts provide benefit highlights for general comparison purposes only. There are also services that the plans do not cover.

Please refer to the Summary of Benefits and Coverage (SBC) or your Evidence of Coverage (EOC) for complete information.

All of these 2021 small group plans meet Minimum Creditable Coverage (MCC) standards for MA employees.

All of these 2021 small group plans meet Medicare Part D Creditable Coverage when Medicare is the primary payer.

Select Network plans have a limited service area that excludes Berkshire, Dukes, and Nantucket counties.

All of these 2021 small group plans include coverage for acupuncture, with no visit or dollar limits. Cost share mirrors that of chiro.

*Per IRS regulation, this Saver plan does not feature an embedded family deductible. An individual member of a family plan may need to meet the full family deductible.

** Urgent Care Center cost share applies to non-hospital affiliated centers.

*** Rx Coins Max is the maximum amount of coinsurance a member would pay per fill for drugs in any tier with coinsurance. The amounts on this grid represent the maximum coinsurance for a 30-day supply. The maximum Rx coinsurance for a 60-day or 90-day supply (if allowed) is 2x and 3x the 30-day amount, respectively.

LTI: Low-Tech Imaging (services such as X-rays)
HTI: High-Tech Imaging (services such as MRI, CT Scan, PET Scan)
OOPM: Out-of-Pocket Maximum
CIF: Covered-in-Full
OON: Out-of-Network
PCP: Primary Care Physician
LGC: Low Cost Generic
PT/OT/ST: Physical Therapy, Occupational Therapy, Speech Therapy
ER: Emergency Room
UCC: Urgent Care Center

Small Business Service Bureau, Inc.®

A National Membership Organization for Small Business
Small Business Service Bureau, Inc.
38 Austin Street
Worcester, MA 01609

800-472-7199

DISCRIMINATION IS AGAINST THE LAW

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

Tufts Health Plan:

- Provides full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes free aids and services to people with disabilities to communicate effectively with us, such as:
  - — 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 any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800.462.0224.
To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change".*

Please note that if you have complaints regarding provider directory inaccuracies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

If you believe that Tufts Health Plan 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:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000,
[TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan 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
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

tuftshealthplan.com | 800.462.0224

For no cost translation in English, call the number on your ID card.

Arabic . للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang kreyòl ayisyen, rele nimewo ki sou kat ID ou a.

Italian Per richiedere la traduzione in italiano senza costi aggiuntivi, chiamare il numero indicato sulla carta di identità.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통번역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee nééł ho'dílzingo nantinígíí bikáá'.

Persian. بزنید زنگ تان شناسائی کارت در مندرج تلفن شماره بهـ فارسی رایگانن ترجمهـ برای

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para o português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Para servicios de traducción gratuitos en español, llame al número que aparece en su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

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