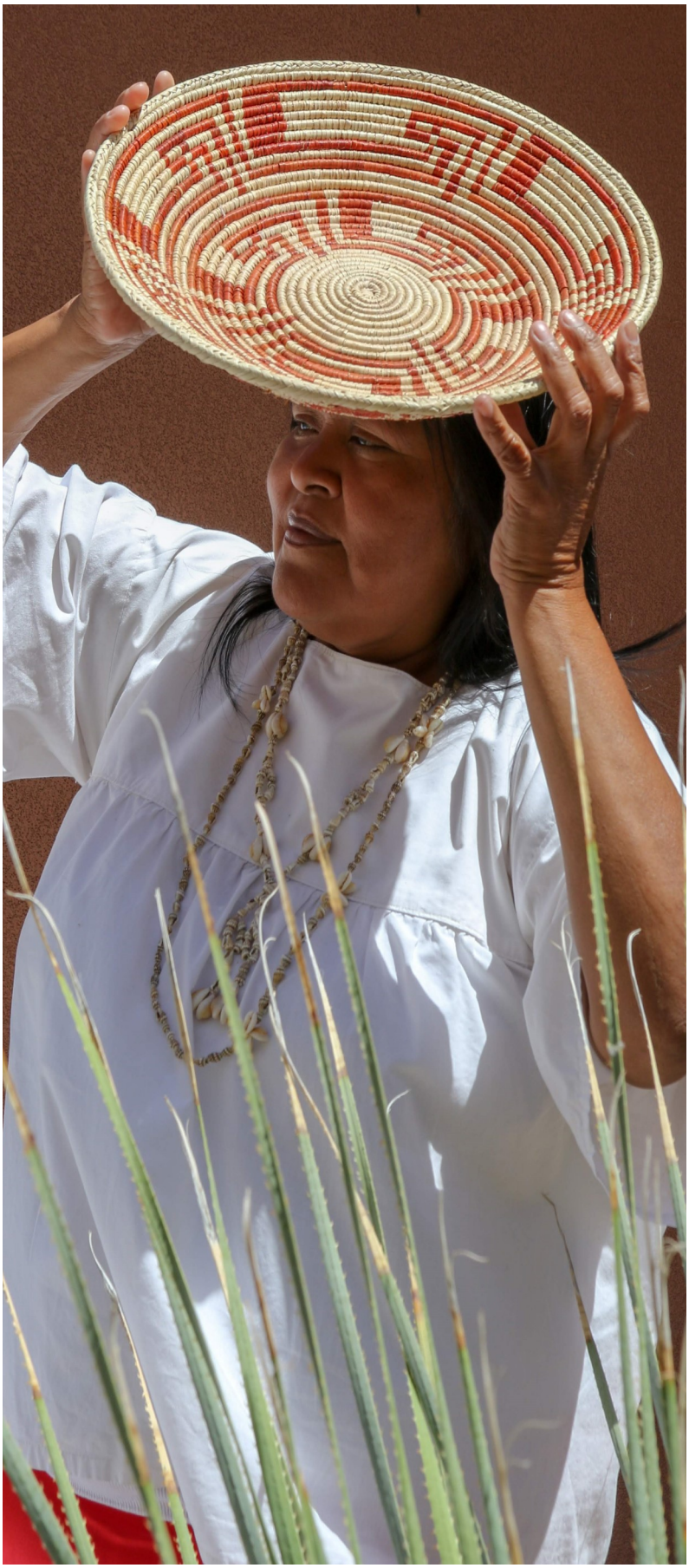


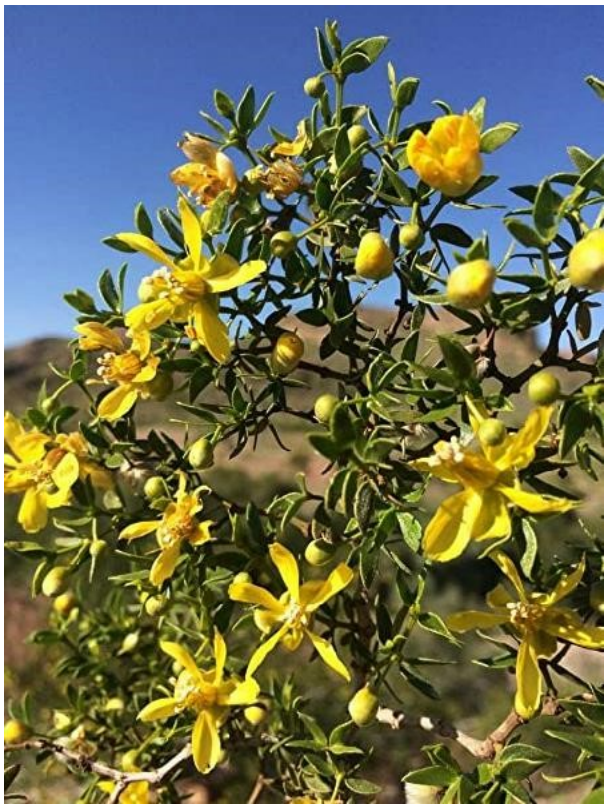
Gila River
HEALTH CARE

2025 - 2026

BENEFITS ENROLLMENT GUIDE

Protecting What's Important to You.

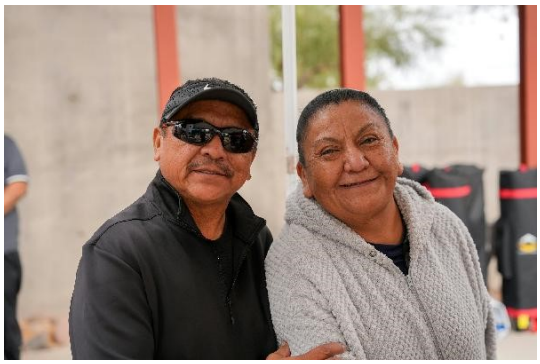
CONTENTS



Medicare Part D Notice:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices document for more details.

WELCOME TO YOUR BENEFITS GUIDE



Gila River Health Care (GRHC) values your contribution to our patients and wants to continue rewarding you with a premier and comprehensive benefits package. As GRHC grows, we are committed to offering excellent benefits coverage that supports our employees and their families, models regulatory requirements, and keeps us competitive in the marketplace.

This guide is about your benefits, but it's also about you and how to protect your health, your lifestyle, your future, and the people who are important to you.

You'll find details about your healthcare, life, disability and retirement benefits and tips on how to use your benefits.

You will also discover the programs that GRHC provides to help you save time and money, and balance your work and home life.

This guide is an overview.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

All benefits are subject to change without notice.

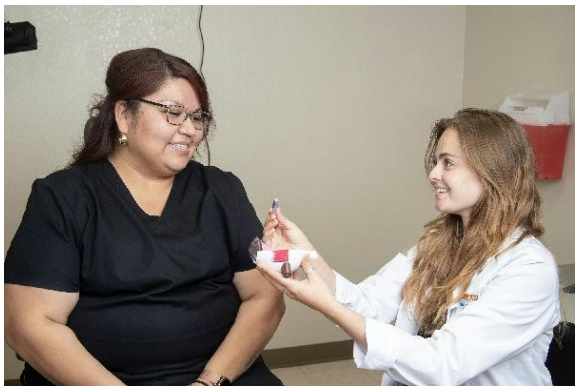
The benefits in this summary are effective:

October 1, 2025

through

September 30, 2026

WHO'S ELIGIBLE FOR BENEFITS?



DO I NEED TO RE-ENROLL?

NO, it is not mandatory that you log into Employee Self Service (ESS) during open enrollment. However, we highly suggest you do log in and review your benefit elections and dependent information for the upcoming 2025-2026 plan year. This is also a good opportunity to review your beneficiary information in the event it has changed recently.

Employees

You are eligible if you are a regular full-time employee.

Eligible dependents

- Your legal spouse
- Your dependent children up to age 26 for medical, dental and vision plans regardless of student status or if they are married
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit.

When you can enroll

As a New Hire: When you enroll as a new hire, your coverage begins on the first of month following 30 days from date of hire. Enrollment is done online through Employee Self Service (ESS) and Human Resources will guide you through the enrollment process.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason) or as explained in the "Changing Your Benefits" section on page 6.

At Open Enrollment: During the annual Open Enrollment period, you should consider your benefit plan choices carefully. All benefit elections done during the annual Open Enrollment will be effective on October 1st and will remain in effect until the end of the plan year. You can only change your coverage within 31 days of a qualified change in family status, as explained in the "Changing Your Benefits" section on page 6.

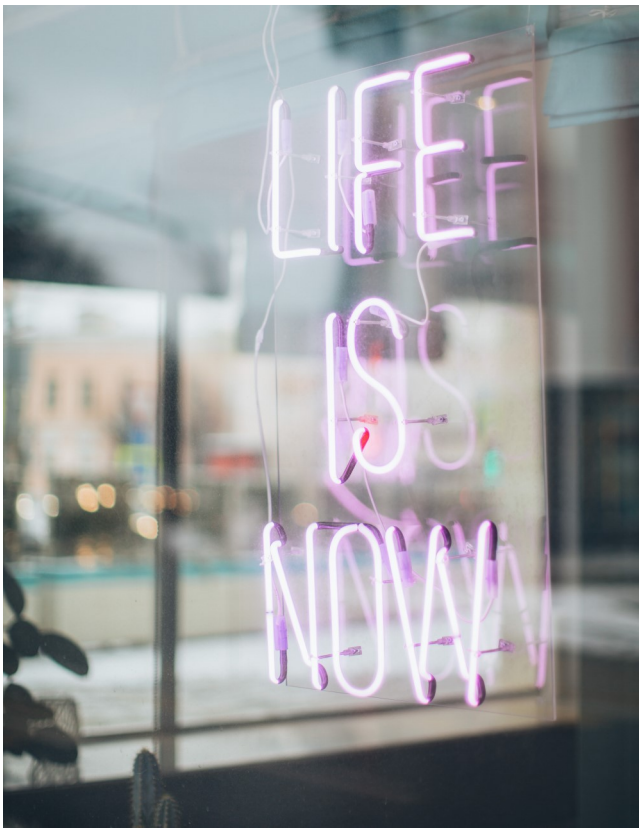
Required Documentation

Employees are required to provide a copy of the:

- **Birth Certificate** and **SSN Card** for all covered dependents
- **Marriage License** for legally married spouses
- **Court Order** for legally appointed guardianship

Note: Documents must be submitted to Human Resources, failure to do so will result in dependents being dropped from coverage.

CHANGING YOUR BENEFITS



Outside of open enrollment, you may be able to enroll or make changes to your benefit elections. Per IRS regulations, you can add or drop coverage for yourself or your dependent mid plan year, if you have a qualifying change in family status, such as:

- Change in legal marital status (marriage, divorce or widowed)
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must notify Human Resources of your qualified change of status within 31 days after the event. **IT IS YOUR RESPONSIBILITY TO NOTIFY HUMAN RESOURCES.**

NOTE: Any dependents added during New Hire, Open Enrollment, or a Change of Status Life Event will be subject to verification prior to approval of the enrollment. **A Birth Certificate, Marriage License or Death Certificate must be provided to HR.**

MEDICAL

WORDS TO KNOW

Learn these terms to help understand how your plan works.

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

MEDICAL

The GRHC Employee Medical Plan provides access to an extensive network of BlueCross BlueShield providers. By utilizing the contract network providers and facilities, you will pay less in out-of-pocket expenses.

Employee contributions are outlined on page 24.

BlueCross BlueShield Arizona	GROUP # GHC001 Claims paid by Summit Administrators	
	In-network	**Out-of-network**
Deductible *Individual* *Family*	 None None	 $500 $1,000
Coinsurance *(% you pay after deductible is met)*	0%	50%
Max Out-of-Pocket *Individual* *Family*	*Includes Deductible & ALL copays* $3,000 $6,000	$10,000 per person
Office Visits *PCP OR Specialist*	 $20	 50%*
Preventive Care	No charge	50%*
Lab & X-ray	No charge	50%*
Advanced Imaging *(MRI, PET, CT)*	$20	50%*
Outpatient Surgery/Procedure	$100 per visit	50%*
Inpatient Hospitalization	$150 per admit	50%*
Teledoc	$0	N/A
Convenience Care Clinic	$20	50%*
Urgent Care	$25	50%*
Emergency Room	$75 *(copay waived if admitted)*	50%*
Hearing Exam *Appliances*	$20 50% to $2,000 annual max	50%* 50%* to $2,000 annual max
Prescription Drugs *Retail* *Mail Order (90-day supply)***	OPTUMRx® $5 / $20 / $35 $10 / $40 / $70	
****Save time and money by visiting **optumrx.com** or using the OptumRx app to get a 3-month supply, in most cases, of your maintenance medication sent directly to your home and shipping is free! OptumRx customer service is also available 24 hours a day, 7 days a week to assist by calling 855.524.0381.		

*You must meet the deductible, then you are responsible for 50% of the remaining charges.

IMPORTANT INFORMATION

Some medical procedures require pre-certification from our case management partner, Hines & Associates. Examples include: hospital admissions, outpatient hospital services, ER admissions, mental health/substance abuse services, skilled nursing home care and home health care. **Call 800.944.9401** to notify Hines of your admission! In the event of an emergency, a call should be made within 24 hours. Failure to call can result in additional out-of-pocket costs for you.

Know where to go

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Average Cost*
Nurseline 	Quick answers from a trained nurse **Call 24—7—365 888.557.2056**	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit TELADOC	General Medicine—Minor illnesses and conditions	▪ Common cold, flu, fever ▪ Headache, migraine ▪ Skin conditions ▪ Allergies	24/7	**$0**
TELADOC	Mental Health	▪ Therapist ▪ Psychologist ▪ Psychiatrist	7am –9pm *7 days a week*	**$20** **$20** **$20**
Office visit 	Routine medical care and overall health management	▪ Preventive care ($0—see page 10) ▪ Illnesses, injuries ▪ Managing existing conditions	Office hours	$20
Urgent care, Walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Varies up to 24/7	$25
Emergency Room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	$75 and up

*Average out-of-pocket cost is your cost based on utilizing in-network providers and facilities.

800.835.2362 OR **www.teladoc.com**

Preventive care screening benefits

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer
- Depression
- STIs

Preventive care for women should include breast and gynecological exams

For men, preventive care should include prostate cancer screening and a testicular exam

You take your car in for maintenance.

Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious. AND, they are available at **NO COST** to you, due to the Affordable Care Act (ACA).

What is Preventive Care?

The ACA requires health insurers to cover a set of preventive services at **no cost** to you. The preventive care services you need to stay healthy vary by age, gender and medical history. Visit cdc.gov/prevention for recommended guidelines and personalized recommendations.

Not all exams and tests are considered preventive

Exams performed by specialists are not generally considered preventive and may not be covered at 100%. **Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition.** You may be responsible for paying all or a share of the cost for those services. If you have a question about whether a service will be covered as preventive care, contact your medical plan beforehand.

Furthermore, preventive care is covered in full only when obtained from an IN-NETWORK provider. You can find an IN-NETWORK provider by using this tool from BCBS AZ: https://azblue.com/CHSNetwork

TELADOC®

Primary360 is a new Teladoc service that helps you manage your primary and preventive health care through virtual doctor visits. Time and access issues are reduced when you can get your annual physical via a virtual visit!

After creating your Teledoc account you will select a Primary Care Provider to fit your needs, and schedule a virtual Preventive Care visit for a day, time, and place that works for you. You can then continue to use the same PCP for all your primary health care.

Your selected PCP can order the lab work and testing for you to complete on your schedule. And **Teladoc** preventive care visits are also covered at **no charge to you!**

FLEXIBLE SPENDING ACCOUNTS (FSA)

FSA PLAN YEAR

January 1st

through

December 31

Set aside pre-tax dollars for the coming year

The healthcare and dependent care FSA's allow you to set aside tax-free money to pay for eligible expenses you expect to have over the coming year.

How the Healthcare Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year.
- The annual limit is set annually by the IRS. The contribution limit is $3,300 for calendar year 2025.
- Contributions are deducted from your pay pretax, meaning no federal or state tax on that amount.
- You can access the entire amount on the 1st day of the plan year.
- You can rollover up to **$660 from plan year 2025 to 2026**.

How the Dependent Care Flexible Spending Account works

- You can contribute up to $5,000 each year for dependent care expenses, such as:
  - Daycare centers
  - In home child care
  - Before or after school care for dependent children under age 14

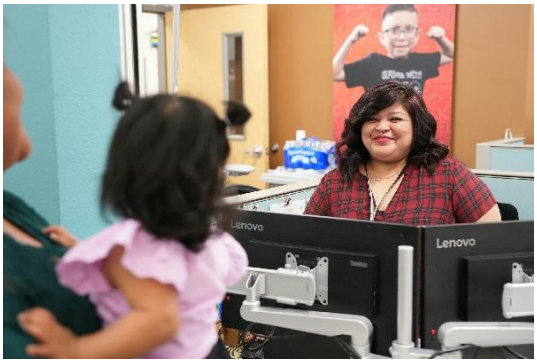
Note: There is **no rollover** for the Dependent Care FSA.

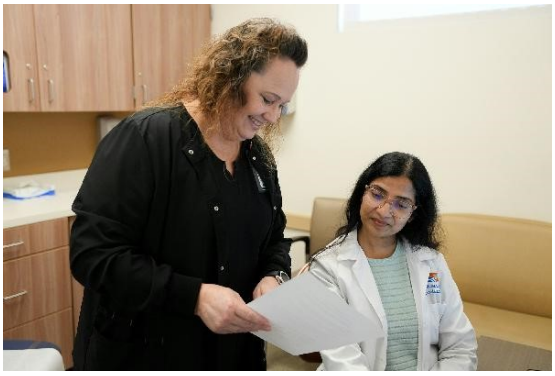
FSA SAVINGS EXAMPLE

	Without FSA	With FSA
Annual Pay	$60,000	$60,000
Pre-tax FSA Contributions for Healthcare Expenses	$0	($2,000)
Taxable Income	$60,000	$58,000
Federal Taxes	($10,852)	($10,259)
After-tax Healthcare Expenses	($2,000)	$0
NET INCOME	**$47,148**	**$47,741**

Your savings will depend on your income, tax bracket, and FSA contribution amount.

EMPLOYEE ASSISTANCE PROGRAM (EAP)





OPTUM®

866.248.4096

www.liveandworkwell.com

Help for you and your household members

The challenges you face each day can sometimes overwhelm you. Your home life, your happiness and your performance at work can all suffer. The EAP and WorkLife Services through Optum can help you handle a wide variety of personal issues.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7.
- In-person or video counseling for short-term issues; up to 5 sessions per incident per family member, per year, including visits for substance/alcohol issues.
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Available Services

- Counseling Benefits
- Parenting & Childcare
- Financial Coaching
- Legal Consultation
- Adult and Eldercare Resources
- Online Resources

How does it work?

Access your EAP and WorkLife Services Benefit is easy and available 24 hours a day. Simply call the toll-free number 866.248.4096. A specialist will help you identify the nature of your problem and the appropriate resources to address it. If you need financial or legal services, you will be referred to an expert in that field. If you want a clinician, you will be matched with one in the network who has the appropriate experience to help.

Other Convenience Services

The WorkLife benefit also includes convenience requests. One call can help you find tickets for local entertainment venues, specialty restaurants, or personal and household services and shopping information.

EMPLOYEE WELLNESS PROGRAM

Wellness is… "the act of practicing healthy habits on a daily basis to attain better physical and mental health outcomes, so that instead of just surviving, you are thriving."

- Dr. David Batman MD
Physician/ International occupational health advisor

Gila River Health Care recognizes that everyone's "thriving" goals are different. With this in mind, GRHC offers employees a variety of wellbeing resources through our Employee Wellness programming and web-based platforms.

One of our most valuable wellbeing resources is the ***Personify Wellness*** web platform, which is FREE to ALL employees. On this wellness platform you will find cutting-edge health content that you can customize to your own interests, as well as many ways to connect with fellow employees and your own friends and family - who can walk alongside you in your wellness journey.

Completing activities through ***Personify Health*** allows all members to earn points and recognition prizes. Employees enrolled in GRHC health insurance can also complete four *Priority* actions on the ***Personify*** platform to earn the discounted *wellness rate* on their insurance premiums:

- Complete a personalized & confidential *Health Check* survey.
- Complete a *Tobacco Attestation* activity that fits your current lifestyle habits.
- Submit a *Biometric Screening* (lab panel & assessments) directly to your ***Personify*** account.
  You may submit your *Biometric Screening* using a *Physician Form* and health data from your regular preventive care physical; OR locate an approved Quest lab facility on ***Personify***.
- Meet a *Triple Tracker 7,000 step OR 15 minutes* daily activity goal for just 20 days out of one calendar month.

Insured members who complete all four *Priority* actions by November 30 will qualify to receive the discounted *wellness rate* on their insurance premiums - beginning in January of the next year. See page 23 for the cost-savings you can achieve!

Get started earning rewards!

Go to the Employee Wellness webpage on the GRHC intranet.

From there, locate the link for the ***Personify*** platform.

Sign in or *Sign up* for access to your personal wellness account.

Questions? Contact Employee Wellness:
employeewellness@grhc.org or (520) 610-4873.

DENTAL

OUR PLAN

Delta Dental PPO Plus Premier

Did you know?

Bacteria in your mouth - when left unchecked - can lead not only to tooth decay, but also to inflammatory gum disease (periodontitis)? Studies suggest that periodontitis and inflammation may contribute to a variety of serious health conditions, including: infections in the heart muscle, cardiovascular disease and stroke, pneumonia, and difficulties managing blood glucose. Taking care of your dental health is a low-cost way to invest in your overall health!

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- Preventive care includes exams, cleanings and x-rays.
- Basic care focuses on repair and restoration with services such as fillings, root canals and gum disease treatment.
- Major care goes further than basic and includes bridges, crowns and dentures.

In addition, the plan provides orthodontia benefits.

DENTAL

	DELTA DENTAL AZ Group # 3883	
	In-Network	**Out-of-Network**
Calendar Year Deductible*		
Individual	$50	
Family	$150	
Waived for Preventive?	Yes	
Calendar Year Maximum		
Per covered Person	$2,000	
Coinsurance	*Delta Dental pays:*	
Preventive	100%	100%*
Basic	80%	80%*
Major	50%	50%*
Coverage		
Preventive	Oral Exams, Cleanings, X-rays Fluoride Treatment, Space Maintainers, Sealants	
Basic	Fillings, Extractions, Emergency Treatment, Oral Surgery, Endodontics, Periodontics	
Major	Crowns, Dentures, Bridges, Inlays, Onlays, Implants	
Ortho Benefits	***Child Only***	
Lifetime Maximum	$1,500	
Deductible	None	None
Coinsurance	50%	50%*

*If you meet your deductible in the last 3 months of the calendar year, your deductible is met for all of the following year!

IMPORTANT INFORMATION

- Dependent children coverage is **NOT** subject to student status. Dependents are covered up to their 26th birthday.
- Orthodontic treatment is covered for children age 8—19. Children must be banded prior to age 17.
- Preventive care expenses **DO NOT** count toward you calendar year maximum benefit!!

* Out-of-Network dentists will be paid based on the non-participating dentist Table of Allowance. Members are responsible for the difference between the non-participating dentist Table of Allowance and the full fee charged by the provider.

VISION & HEARING

OUR PLAN

VSP Vision

Note:
Premium cost is included in Medicare premium for Vision and Hearing.

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK,

Hearing Aid Benefit

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing provides VSP members access to a national network of more than 6,000 hearing healthcare providers with discounted pricing on a wide selection of the latest brand name hearing aids. High quality, low cost batteries can also be delivered right to your door.

VISION & HEARING

VSP is the vision carrier for quality eye care services. VSP's Network consists of private practice optometrists, ophthalmologists, opticians, and optical retailers. Costco is even in VSP's Provider Network! To locate a contracted vision provider, visit their website at www.vsp.com or call 1.800.877.7195.

	VSP Group #12316909	
	In-Network	**Out-of-Network Reimbursement**
Exam	$5 copay	up to $50
Retinal Digital Scan	$20 copay	
Frequency		
Exam	1x every 12 months	
Lenses	1x every 12 months	
Frames	1x every 12 months	
Contacts	1x every 12 months	
Lenses*		
Single Vision	$10 copay	up to $50
Bifocal—lined	$10 copay	up to $75
Trifocal—lined	$10 copay	up to $100
Standard Progressives	$10 copay	up to $75
Polycarbonate for children	paid @ 100%	N/A
Anti-reflective Coating	$30 copay	N/A
Frames		
Allowance	$180 ($100 @ Costco) *(20% discount over allowance)* **Includes Sam's Club & Walmart**	up to $70
Contact Lenses	***Contacts are in lieu of frames and lenses.***	
Contact Lens Exam	Up to $60 copay	N/A
Standard Contacts	$180 Allowance	Up to $105
Medically Necessary Contacts	covered in full	up to $210
Lasik	average 15% discount	N/A

IMPORTANT INFORMATION

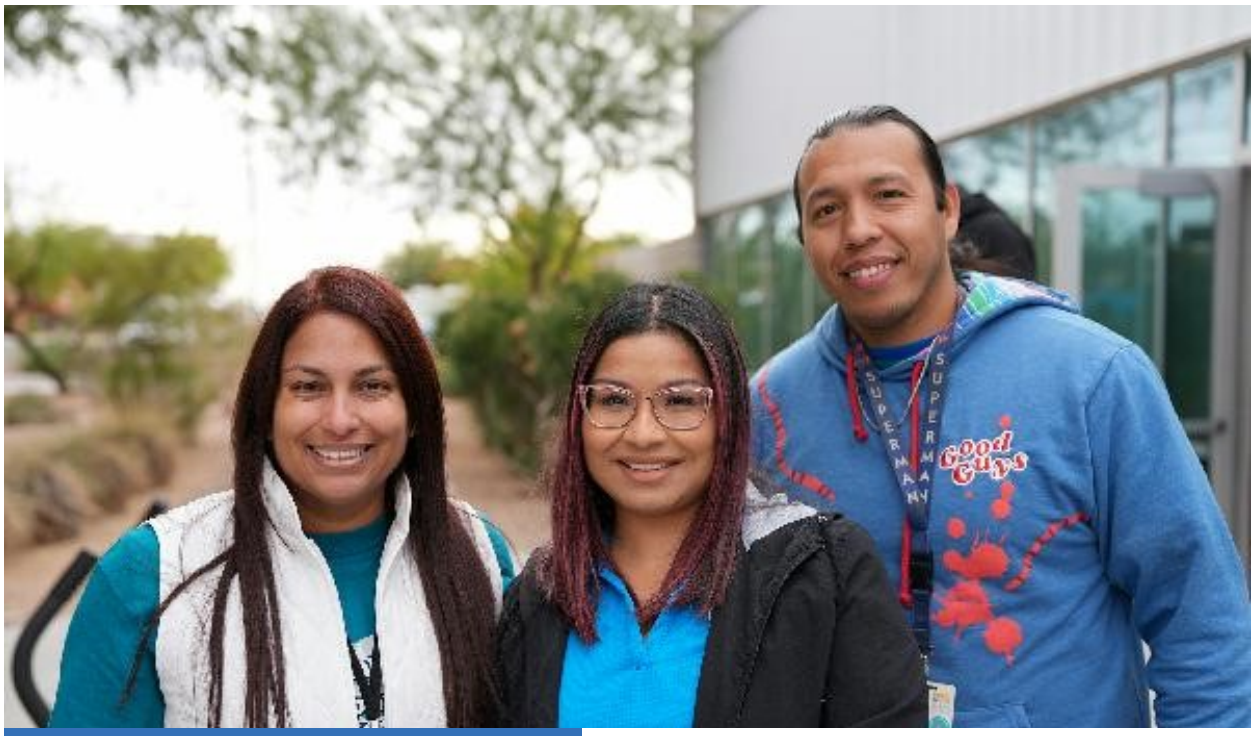
- Your vision benefits are available every 12 months. The date of your initial service determines the date you are eligible for your next vision service. (**Example:** Eye exam is done March 13, 2025, your next eye exam can be done on, or after, March 13, 2026).
- Remember medical conditions of the eye, such as glaucoma, cataracts, and diabetic retinal exams are covered under your medical plan.

TruHearing

VSP members can schedule an exam with a TruHearing provider to get the following:

- 3 provider visits for fitting and adjustments
- 45-day trial
- 3-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Truhearing.com/vsp
Or call: 877.396.7194



LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. **Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.**

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps for a family recovering from an illness, injury or worse. After a loss of income, many families have to reduce their standard of living after the loss of an income. Consider what your family would need to cover:

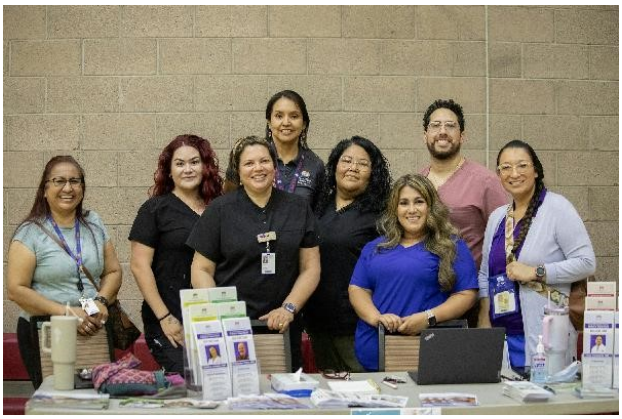
- Medical bills and funeral expenses
- Living expenses (housing, food, clothing, utilities)
- Large expenses (rent or mortgage, education)
- Taxes and debts that need to be settled.

We provide a base amount of life and AD&D insurance.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

LIFE AND AD&D COVERAGE



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

OneAmerica Basic Life and AD&D

One times your annual salary to a maximum benefit of **$300,000**.

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

Voluntary Life and AD&D

You can purchase additional life insurance to protect your family in the event of your death, especially if you have financial obligations such as a mortgage or children in college.

The accidental death and dismemberment coverage (AD&D) pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing the plan pays a benefit to you.

Coverage is available at VERY affordable rates for your spouse and/or child(ren) if you purchase coverage for yourself.

OneAmerica Voluntary Life and AD&D

EMPLOYEE	Increments of $5,000 up to $300,000 (not to exceed 10x annual salary). Guarantee issue is $300,000 (or 10x annual salary) when initially eligible as a new hire.
SPOUSE	Increments of $5,000 up to $150,000, not to exceed 50% of employee benefit. May be subject to submit EOI (Evidence of Insurability) form for OneAmerica's approval. Guarantee issue is $50,000
CHILD	Increments of $1,000 up to $10,000. Guarantee issue is $10,000

DISABILITY COVERAGE

NOTE: Eligibility for disability coverage is the 1st of the month following 90 days of continuous employment.

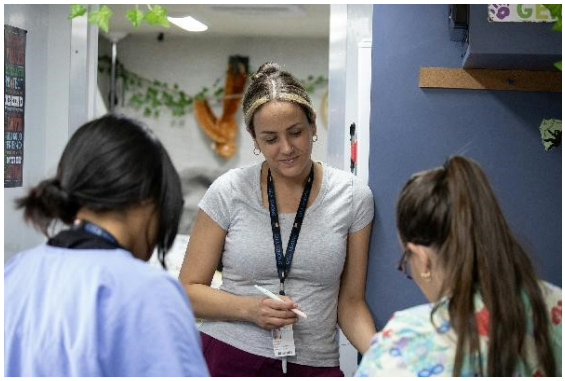
Short-term Disability (STD)

STD insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. Company pays the cost of the base coverage and you have the option to buy-up to a higher benefit.

	Employer Paid STD	Employee Paid STD
Maximum Weekly Benefit:	60% of salary up to $500/week	additional 30% up to $1,500/week
Elimination Period:	14 days	14 days
Maximum Benefit Period:	26 weeks	26 weeks
Guarantee Issue:	automatically enrolled	as a new hire and at open enrollment
Employee Cost:	none—GRHC pays premium	based on employee salary
Benefit taxable:	taxable	non-taxable
Pre-existing Condition Limitations:	none	If treated for a condition in the 3 mos. prior to effective date, no benefit will be payable for a disability related to that condition until you have been on the plan for 6 mos.



EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

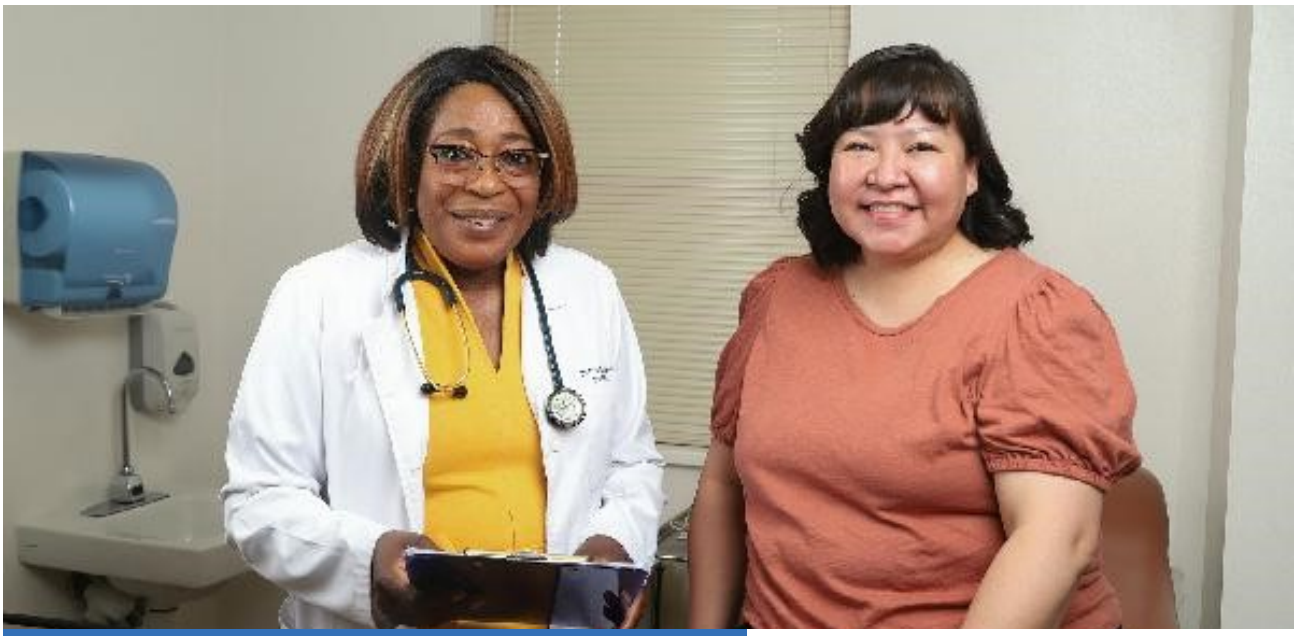
Long-term Disability (LTD) - **Employer Paid**

LTD insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits automatically begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. GRHC pays the cost of this coverage.

Maximum Monthly Benefit:	60% of salary up to $9,000/month
Elimination Period:	180 days
Maximum Benefit Period:	to age 65 or normal retirement age
Minimum Benefit:	$100/month
Benefit Amount:	determined by your salary and age



FINANCIAL WELLNESS

401(k) Retirement Savings Plan

WHAT ARE YOUR PLANS?

Whether your retirement plans include traveling the world, enjoying a hobby, or relaxing with family, you need a plan to get there.

Our 401(k) plan provides a convenient and tax-advantaged way to save so you can achieve your retirement goals.

The earlier you start, the more you'll save!

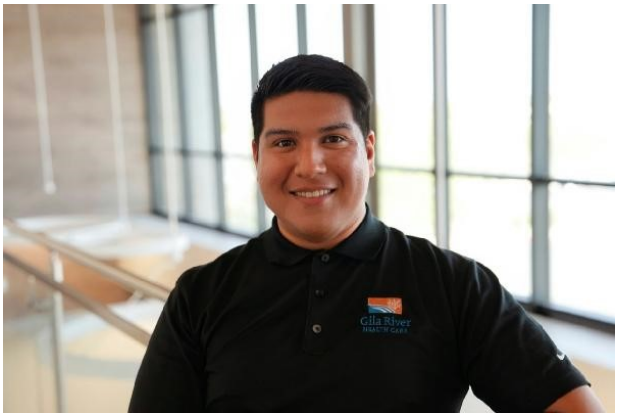
Is it time for a "financial wellness" checkup?

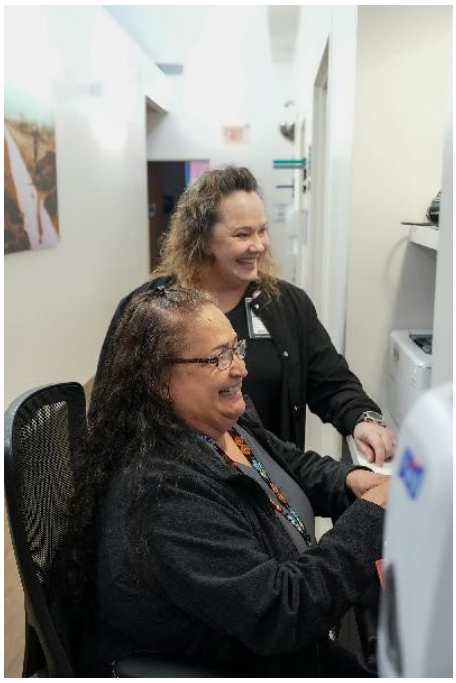
Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes; and work toward your retirement goals.

SAVE NOW, ENJOY LATER





Taylor Jones
Financial Consultant

taylor@jonesadvisor.com
858.200.4855

401(k) Retirement Savings Plan

Our 401(k) Retirement Savings Plan helps you save for retirement. The plan offers tax benefits through traditional pre-tax or Roth contributions.

Employees are automatically enrolled at 1% of pay with auto-increases of 1% yearly, to 7% of pay. You may save more, less or opt out of the 401(k) Plan. The employer match is 100% of deferrals up to the first 7% of compensation. Other plan terms (such as Super Match) are not described but may be reviewed.

Example: if you save 7% of your pay, or more, GRHC will match 7%. The annual limit is $23,000 in 2025 and increases to $24,000 on 1/1/2026.

To register and access the participant website go to sentinelgroup.com and select “I am an Individual”. From the login box dropdown menu select “Retirement Accounts”. If you are logging in for the first time, click “New User”. When creating your profile on the Sentinel Group portal, you’ll be asked for a Plan Access Code. Don’t worry—it’s quick and easy! Just reach out to Human Resources Benefit Team and we’ll provide the code so you can complete your setup.
After you are registered you will be able to assign a beneficiary, as well as manage our account.

Sentinel Group manages enrollment, online access, account statements, employee loans and any

Who to contact for more information

Retirement Benefits Group is your first point of contact for plan inquiries and act as an Investment Advisor providing employee enrollment support and education. They can be contacted at **800.520.4461** or via the scheduling link: meetjones.com

Additional resources for GRHC employees

- Access to a financial advisor during one-on-one planning and education meetings.
  - Topics include: Retirement & Income Planning, Life Insurance Review, Money Management, 529 College Savings and Estate Planning.
- eMoney—Personal Financial Website—A powerful financial aggregation, spend/budget tracking and income planning tool, upon request.

VOLUNTARY BENEFITS—Unum

Group Accident

Nobody expects an accident to happen. But if it does, your main focus should be on recovery, not how you're going to pay your bills. Accident insurance provides benefits directly to you to use however you like – from medical costs to everyday expenses. Whether it's a fall or a car accident, your benefits offer support when you need it.

Accident insurance can help with medical or other costs associated with a covered accident or injury that your health insurance may not cover. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses. Please see the accident plan summary for specific benefit amounts.

Gila River's Group Accident coverage includes a $50 Health Screening Benefit, see the plan summary to see how to take advantage of this annual wellness benefit.

Employee contributions are outlined on page 25.

Unum Voluntary Benefits help fill in the gaps of lost income and other expenses. Three important points about these plans:

- The benefit PAYS REGARDLESS of any other coverage you have
- The benefit PAYS DIRECTLY TO YOU (not the doctor or hospital)
- You can spend the money as YOU SEE FIT.

Although your participation in these plans is totally voluntary, we strongly encourage each of you to consider the value of the financial protection they can give you, REGARDLESS of your current health plan. These plans fill a need that is not met by any health coverage to help cover your personal financial needs.

Coverage options are available for you, your spouse and eligible dependent children.

Group Hospital

No matter how well you plan, you can't predict when sudden medical expenses could impact your way of life. If you're admitted to the hospital for a covered accident or covered sickness, Unum's hospital indemnity insurance, could help pay for out-of-pocket costs.

Gila River's group hospital coverage includes childbirth coverage. Meaning there are benefits for expectant mothers. There is no waiting period for this benefit. Please note there is no pre-existing conditions exclusion for this benefit. Meaning that if you have a pre-existing condition that would cause you trigger this benefit, it would be covered.

Hospital Benefits:

Admission *(1 day per year):*	$1,000
ICU Admission *(1 day per year)*:	$1,000
Daily Stay *(up to 365 days)*:	$100
ICU Daily Stay *(up to 30 days)*:	$200

VOLUNTARY BENEFITS—Unum

Group Critical Illness

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want. The money can help you pay out-of-pocket medical expenses, like co-pays, deductible, or even alternative options for treatment. **You can select $10,000, $20,000 or $30,000 face amount.** If enrolled, dependents are covered at 100% of the employee face amount.

Covered conditions include:

- End Stage Renal (Kidney) Failure
- Heart Attack (Myocardial Infarction)
- Major Organ Failure Requiring Transplant
- Stroke
- Sudden Cardiac Arrest
- Coronary Artery Disease
- Cancer
- Benign Brain Tumor
- Coma
- Loss of Hearing, Sight or Speech
- Permanent Paralysis
- Addison's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Dementia (including Alzheimer's Disease)
- Huntington's Disease
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Parkinson's Disease

This is not an all inclusive list and all conditions are not covered at 100%. More information can be found in the full benefit summary located in the benefit enrollment portal.

Additional Covered Conditions for Children:

- Cerebral Palsy
- Cleft Lip or Palate
- Congenital Heart Disease
- Cystic Fibrosis
- Down Syndrome
- Sickle Cell Anemia
- Spina Bifida
- Type 1 Diabetes

Be Well Benefit – Applies to All UNUM Voluntary Benefits

$50 per insured per Calendar Year

Be Well Screenings include: Cholesterol and Diabetes screenings, Cancer screenings, Cardiovascular Function screenings, Imaging Studies, Annual Examinations by a Physician, & Immunizations

For example, if you have the accident, hospital, and critical illness plans as an individual you have the potential to get $150 per year, if you and spouse have all three you can possibly get $300.

Employee contributions are outlined on page 25.

YOUR SEMI-MONTHLY BENEFIT COST

	MEDICAL / VISION		DENTAL
	Base Rates	Wellness Rates	Rates
Salary Range		**$20,000—$29,999**	
Employee Only	$13.75	$1.25	$1.75
Employee +Spouse	$85.51	$73.01	$6.50
Employee +Child(ren)	$82.89	$70.39	$4.80
Employee +Family	$140.33	$127.83	$9.21
Salary Range		**$30,000—$39,999**	
Employee Only	$16.78	$4.28	$2.20
Employee +Spouse	$93.25	$80.75	$8.12
Employee +Child(ren)	$90.64	$78.14	$6.25
Employee +Family	$153.13	$140.63	$11.38
Salary Range		**$40,000—$49,999**	
Employee Only	$20.24	$7.74	$2.80
Employee +Spouse	$100.99	$88.49	$9.75
Employee +Child(ren)	$98.51	$86.01	$7.90
Employee +Family	$162.97	$150.47	$13.54
Salary Range		**$50,000—$74,999**	
Employee Only	$25.19	$12.69	$3.50
Employee +Spouse	$108.44	$95.94	$11.38
Employee +Child(ren)	$99.21	$86.71	$9.21
Employee +Family	$172.79	$160.29	$15.71
Salary Range		**$75,000—$99,999**	
Employee Only	$30.75	$18.25	$4.30
Employee +Spouse	$117.24	$104.74	$13.10
Employee +Child(ren)	$106.21	$93.71	$10.86
Employee +Family	$193.72	$171.22	$18.23
Salary Range		**$100,000+**	
Employee Only	$36.69	$24.19	$5.20
Employee +Spouse	$127.46	$114.96	$14.87
Employee +Child(ren)	$113.60	$101.10	$12.51
Employee +Family	$195.99	$183.49	$20.71

Note: Rates Subject to Change

EMPLOYEE COST FOR VOLUNTARY BENEFITS

EMPLOYEE & SPOUSE VOLUNTARY LIFE

Employee Age*	Rate per $1,000
<30	$0.06
30—34	$0.07
35—39	$0.08
40—44	$0.14
45—49	$0.20
50—54	$0.36
55—59	$0.63
60—64	$0.78
65—69	$1.35
70+**	$2.46

* Use employee's age to calculate spouse's premium.
**Spouse not covered over age of 69.

EMPLOYEE & SPOUSE VOLUNTARY AD&D

Age	Rate per $1,000
All Ages	$0.02

VOLUNTARY CHILD LIFE

Age	Rate per $1,000
Up to age 26	$0.09

VOLUNTARY CHILD AD&D

Age	Rate per $1,000
up to age 26	$0.02

SHORT TERM DISABILITY (STD)

Benefit	Rate
EMPLOYER PAID 60% of weekly salary up to $500	N/A
EMPLOYEE BUY-UP 30% of weekly salary up to $1,500	$1.03 per $10 of benefit

VOLUNTARY GROUP ACCIDENT

Tier	Rate per month
Employee Only	$11.28
Employee +Spouse	$16.42
Employee +Child(ren)	$23.30
Employee +Family	$28.46

VOLUNTARY CRITICAL ILLNESS

Cost is determined by benefit amount and age of the employee and will be outlined in the benefits enrollment system when reviewing your options.

VOLUNTARY GROUP HOSPITAL

Tier	Rate per month
Employee Only	$21.48
Employee +Spouse	$39.32
Employee +Child(ren)	$29.18
Employee +Family	$47.00

NOTE: After calculating the monthly rate for the above voluntary benefits, divide the premium by 2 for the semi-monthly payroll deduction.

PLAN CONTACTS

HELPFUL RESOURCES

MEDICAL

Summit
Pays medical claims
Policy # GHC001
summit-inc.net
Customer Service
(888) 690-2020

BlueCross BlueShield of AZ
Arizona Provider Network
Find a provider at:
azblue.com/chsnetwork

OptumRx
Pharmacy/Mail Order Rx
optumrx.com
Customer Service
(855) 524-0381

First Health Network
Outside AZ Provider Network
Find a provider at:
myfirsthealth.com
or call:
(800) 226-5116

Hines
For pre-certification call:
(800) 944-9401

Hines 24-Hour Nurseline
24—7–365 Health Resource
(888) 557-2056

Teladoc
Virtual Visits
teladoc.com
Or call:
(800) 835-2362

Optum
Employee Assistance Program (EAP)
liveandworkwell.com
Or call:
(866) 248-4096

EMPLOYEE WELLNESS

employeewellness@ghrc.org
(520) 610-4873

VIRGIN PULSE

support@virginpulse.com
(888) 671-9395

DENTAL

Delta Dental of AZ
Policy # 3883
deltadentalaz.com
Customer Service
(602) 938-3131 in AZ
(800) 352-6135 outside AZ

VISION

VSP
Policy # 12316909
vsp.com
Customer Service
(800) 877-7195

Hearing

TruHearing *(VSP Members Only)*
Policy # 12316909
truhearing.com/vsp
Customer Service
(877) 396-7194

LIFE & DISABILITY

OneAmerica
Policy # G 00624108
employeebenefits.aul.com
Customer Service
(855) 517-6365

LEAVE ADMINISTRATION

Sedgwick
Family & Medical Leave
Timeoff.sedgwick.com
Or call:
(888) 436-9530

RETIREMENT

Taylor Jones Retirement
401(k)

Or call:
Taylor Jones: (858) 200-4855
taylor@jonesadvisors.com

VOLUNTARY BENEFITS

Unum
Policy #'s
- Accident: 969888
- Hospital: 969890
- Critical Illness: 969890

Customer Service:
800.421.0344
Unum.com

REQUIRED PLAN NOTICES

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document:

- Medicare Part D Notice: Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act: Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act: Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights: Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- HIPAA Notice of Privacy Practices: Describes how health information about you may be used and disclosed.
- Notice of Grandfathered Plan Status: Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

- You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents, such as the Summary Plan Descriptions (SPD) and Summary of Benefits and Coverage (SBC) for our health plan and retirement plan are available on MyBenefits.Life. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Gila River Health Plan** has determined that the prescription drug coverage offered by **Optum** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan

Since the existing prescription drug coverage is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	Gila River Health Care
Contact-Position/Office:	Human Resources
Address:	534 West Gu U Ki Street, Sacaton, AZ 85147
Phone Number:	602-528-1200

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in your health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the

health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request

this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

AHCCCS

AHCCCS contracts with several health plans to provide covered services. An AHCCCS health plan works like a Health Maintenance Organization (HMO). The health plan works with doctors, hospitals, pharmacies, specialists, etc. to provide care. You will choose a health plan that covers your zip code area. If you are approved, you will choose a primary care doctor that works with that health plan. Your primary doctor will:

- Be the first person you go to for care
- Authorize your non-emergency medical services
- Send you to a specialist when needed

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Nondiscrimination in Health Programs and Activities

Gila River Health Care complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). **Gila River Health Care** does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) .

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

- **Language assistance services. Gila River Health Care** will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
    - Electronic and written translated documents
    - Qualified interpreters
- **Appropriate auxiliary aids and services. Gila River Health Care** will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication. Appropriate auxiliary aids and services may include:
    - Qualified interpreters, including American Sign Language interpreters
    - Video remote interpreting

- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

- **Reasonable modifications. Gila River Health Care** will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification.

If you believe **Gila River Health Care** has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can:

- File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or via mail at:
    - U.S. Department of Health & Human Services
    - 200 Independence Avenue, S.W. – 509F
    - Washington, D.C. 20201

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge

Español

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles.

Gila River
HEALTH CARE