North Davis Fire District
381 North 3150 West
West Point City, UT 84015
801-525-2850

Position Announcement

Deputy Fire Marshal

Opening Date: **8/2/2023**
Closing Date: **9/7/2023**

SALARY RANGE $74,983.68- $100,771.80
The benefit information is attached to this document.

The North Davis Fire District is currently recruiting qualified applicants for the position of Deputy Fire Marshal.

GENERAL

The North Davis Fire District (NDFD) provides emergency fire and medical service to West Point, Clearfield, and Sunset cities, and areas of unincorporated Davis County. The North Davis Fire District was created in 2005 and is governed by a Board of Trustees. The Board of Trustees consists of a nine-member board, three board members from each city within the district. NDFD has two fully staffed stations and responds to approximately 4,800 incidents annually. North Davis Fire District is a combination department with 36 full-time firefighters (three battalion chiefs, six captains, 27 firefighters),12 part-time firefighters, a full-time fire chief, a deputy fire chief, a human resource director/clerk, and a human resource coordinator.

POSITION DESCRIPTION

This position is responsible for but not limited to assisting in performing fire code inspections; identifies corrective actions necessary to bring properties into compliance; explains codes and corrective measures to property owners or representatives; Inspects and witnesses testing of fire protection and/or fire detections systems; performs follow up visits/inspections; inspect facilities that store, handle and use hazardous materials; write detailed reports of fire inspections,

fire code violations and corrective recommendations; conduct fire exit drills to monitor and evaluate evacuation procedures; attend training classes to maintain current knowledge of fire prevention, safety and firefighting practices; conduct investigations of fires within the jurisdiction as assigned by the Fire Marshal; assist in the development of pre-fire plans for structures; perform various plan reviews; input all data into the Districts current database software; have oversight and authority to conduct various projects or duties as assigned and other duties as described in the job description. May need to assist on emergency scenes and other duties as assigned. Acts as the Fire Marshal in the absence of the Fire Marshal or as assigned by the Chief.

CERTIFICATIONS

Please include copies of all certifications, licenses, diplomas, and other materials that document your qualifications for this position.

Failure to provide supporting documentation shall be cause for rejection of the application.

MINIMUM QUALIFICATIONS

Education and Experience:

A. Five (5) years experience with a full-time professional department (can be a combination of full-time experience with different departments (does not have to be with the District). The Chief has final discretion on qualifying experience.
B. Firefighter I and II
C. Fire Inspector I
D. Fire Officer I
E. Fire Investigator I
F. Within two years, obtain NIMS 100, 200, 300, 400, 700 and 800
G. Must know principles of inspections, code enforcement, modern prevention theories, and fire investigations.
H. Able to use fire reporting and fire inspection software programs.
I. Ability to pass a medical, physical exam, and other pre-employment testing.
J. Possess a valid Utah driver's license.
K. Have a valid EMT or AEMT certification.
L. Within 2 years, obtain ICC Fire Inspector I certification (this is not the same as Fire Inspector I through UFRA. This is a certification by the International Code Council).

M. within 3 years of appointment, obtain Fire Investigator I from the Utah Firefighter Certification System (UFCS) at the Utah Fire and Rescue Academy (UFRA)
N. Within 3 years, obtain Certified Fire and Explosives Investigator (NAFI) or Certified Fire Investigator (IAAI).

Note: At the discretion of the District Administration, some of these qualifications may be co-requisite (in progress at the time of application) or post-requisite (supplementary). If granted, this will be posted at the time of the position opening.

SELECTION GUIDELINES:

Formal application, review of education and experience, oral interview and reference check, and job-related tests may be required.

Applications will be reviewed for qualifications.

The duties listed above are intended only to illustrate the various types of work that may be performed. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or a logical assignment to the position.

The job description does not constitute an employment agreement between the employer and employee and is subject to change by the employer as the employer requirements of the job change. Candidates with qualifications that best meet the district's needs may be invited to return for a formal interview.

Failure to completely fill out the application may be a cause for rejection. Failure to provide supporting documentation may be a cause for rejection of the application.

APPLICATION PROCESS:

To be considered for the position, candidates must complete and submit a District application (available at www.northdavisfiredistrict.com), a resume (with a cover letter) outlining their qualifications, and certifications. The application, cover letter, resume, and certifications ***must be received by the District by 9/7/2023 by 5:00 PM.***

<u>The testing Process will consist of the following:</u>

- ***Project and Written Response***
- ***Code Reference & Research***
- ***In Basket Prioritization***
- ***Oral resume / Interview Questions***

Applicants will be screened in relation to the criteria outlined in this announcement. Candidates deemed to possess the most relevant qualifications will be invited to an interview. Interviews are tentatively planned for the week of **9/14/2023**. Candidates will be notified of test/interview dates and times.

The above statements are intended to describe the general nature and level of work being performed by the person(s) assigned to this job. They are not intended to and do not infer or create employment, compensation, or contract rights to any person(s). This job description reflects that Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. North Davis Fire District is an equal-opportunity employer. Contact the NDFD Fire Chief if you have any questions regarding equal employment. The North Davis Fire District considers all applicants for positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status. If you have need of special accommodations, please call 801-525-2850 and speak to with the Human Resource Director.

NORTH DAVIS FIRE DISTRICT BUDGET DETAIL SHEET

Fiscal Year 2024 (July 1, 2023 - June 30, 2024)

DESCRIPTION: insurance Benefit Info

Health Insurance - Traditional Plan		
PEHP Traditional (Summitt & Advantage Network)	Employee Montly Cost	Employee Pay Period Cost (24 pay periods)
Family	$ 376.40	$ 188.20
Double	$ 278.27	$ 139.14
Single	$ 134.43	$ 67.22

Health Insurance - HSA Plan		
PEHP HSAPlan (Summitt & Advantage Network)	Employee Montly Cost	Employee Pay Period Cost (24 pay periods)
Family	$ 23.62	$ 11.81
Double	$ 16.88	$ 8.44
Single	$ 8.45	$ 4.23

Dental Insurance Benefit		
PEHP Preferred Dental	Employee Montly Cost	Employee Pay Period Cost (24 pay periods)
Family	$ 17.05	$ 8.53
Double	$ 11.27	$ 5.63
Single	$ 8.24	$ 4.12

Vision Benefit		
Vision - Eyemed	Employee Montly Cost	Employee Pay Period Cost (24 pay periods)
Family	$ 2.35	$ 1.18
Double	$ 1.73	$ 0.87
Single	$ 1.11	$ 0.56

See Attached Documents for Health Insurance

Other Benefits Offered to 40-Week Full-time Employee
Utah Retirement Systems
Life Insurance Policy
Aflac Cancer Rider - individual plan
Paid Holidays - 13 Per year
Sick Leave 96 hours per year / 3.692 hours per pay period
Sick Leave Sell Back - see policy
Vacation Leave - 96 hours per year / 3.692 hours per pay period
Vacation Leave Sell Back - see policy

Plan Summaries

Medical

- The LGRP offers five Traditional plan options and five HSA-qualified STAR HSA plan options.
- All LGRP plans are available on Preferred, Advantage, Capital, and Summit medical networks.
- All Traditional plans can be offered either with In-Network and Out-of-Network provider benefits or In-Network provider only benefits.
- The STAR HSA Plan options are only available with In-Network and Out-of-Network provider benefits.

Traditional	Deductible Individual / Family	Out-of-Pocket Individual / Family	Coinsurance Amount	Office co-pay Amount Primary / Specialist / Urgent
Option 1	$250 / $500	$3,000 / $6,000	90 / 10	$15 / $25 / $35
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

STAR HSA	Deductible Single / Family	Out-of-Pocket Single / Family	Coinsurance Amount	Office co-pay Amount Primary / Specialist / Urgent
Option 1	$1,500 / $3,000	$2,800 / $5,600	80 / 20	20% of In-Network Rate after deductible
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

The table is for comparison purposes only.

Please refer to the medical benefits grid or renewal packet for more detailed benefit information.

PEHP Health & Benefits

Traditional Option 1

Summit, Advantage, Preferred, Capital

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $250 Double/family plans: $250 per person, $500 per family *One person cannot meet more than $250*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $3,000 Double/family plans: $3,000 per person, $6,000 per family *One person cannot meet more than $3,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	30% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$15 co-pay per visit	30% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit	30% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	10% after deductible	30% after deductible
Emergency Room Specialist Visits	$25 co-pay per visit	$25 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	10% after deductible	30% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	10% after deductible	30% after deductible
Urgent Care Facility	$35 co-pay per visit	30% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$125 co-pay after deductible per visit	$125 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	10% after deductible	30% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	10% after deductible	30% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	30% after deductible
Mental Health & Substance Abuse	10% after deductible	30% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	10% after deductible	30% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	10% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	10% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	10% after deductible	30% after deductible
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	30% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	30% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge	30% after deductible
Hospice	No charge	30% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible	30% after deductible
Infertility Services | *Select services only. See Master Policy for details*	10% after deductible	30% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	10% after deductible	30% after deductible

PEHP Health & Benefits

STAR HSA Option 1

Summit, Advantage, Preferred, Capital

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,500 Double/family plans: $3,000 *One person or a combination can meet the $3,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $2,800 Double/family plans: $5,600 *One person or a combination can meet the $5,600 double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	20% after deductible	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	20% after deductible	Not applicable
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	20% after deductible	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 visits per plan year*	20% after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Medical Networks

Find Participating Providers at www.pehp.org

PEHP Advantage

36 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Intermountain Health (IH) providers and facilities.

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Intermountain Layton Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Alta View Hospital
Intermountain Medical Center
The Orthopedic Specialty Hospital (TOSH)
LDS Hospital

Salt Lake County (cont)
Primary Children's Medical Center
Riverton Hospital

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Spanish Fork Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

Weber County
McKay-Dee Hospital

PEHP Summit

40 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Steward Health, MountainStar, and University of Utah hospitals & clinics providers and facilities.

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital
Brigham City Community Hospital

Cache County
Cache Valley Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Lakeview Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Huntsman Cancer Hospital
Jordan Valley Hospital
Jordan Valley Hospital - West
Lone Peak Hospital

Salt Lake County (cont)
Primary Children's Medical Center
Riverton Children's Unit
St. Marks Hospital
Salt Lake Regional Medical Center
University of Utah Hospital
University Orthopaedic Center

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
Mountain View Hospital
Timpanogos Regional Hospital
Mountain Point Medical Center

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

Weber County
Ogden Regional Medical Center

PEHP Capital

33 PARTICIPATING HOSPITALS, 7,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Steward Health, and University of Utah hospitals & clinics providers and facilities.

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Huntsman Cancer Hospital
Jordan Valley Hospital
Jordan Valley Hospital - West
Primary Children's Medical Center
Riverton Children's Unit
Salt Lake Regional Medical Center

Salt Lake County (cont)
University of Utah Hospital
University Orthopaedic Center

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
Mountain Point Medical Center

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

PEHP Preferred

52 PARTICIPATING HOSPITALS, 12,000+ PARTICIPATING PROVIDERS

Network consists of providers and facilities in both the Advantage and Summit networks.

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

Preferred Dental Care	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	**20%** of In-Network Rate	**40%** of In-Network Rate

Note: Six month waiting period applies to prosthodontic, implant, and orthodontics benefits unless you show PEHP you were covered by a qualified dental insurance plan for at least six consecutive months before joining PEHP dental.

PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All eligible related services	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS | 6-month Waiting Period		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum	

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

For dental services covered by PEHP medical plans, there is no dental plan coverage.

PEHP Eyewear Only

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Progressive – Standard	$75 copay	Up to $40
Progressive – Premium Tier 1 - 3	$95 - 120 copay	Up to $40
Progressive – Premium Tier 4	$75 copay; 20% off retail price less $120 allowance	Up to $40
LENS OPTIONS		
Anti Reflective Coating – Standard	$45	Not covered
Anti Reflective Coating – Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating – Premium Tier 3	20% off retail price	Not covered
Photochromic – Non-Glass	$75	Not covered
Polycarbonate – Standard	$40	Not covered
Polycarbonate – Standard < 19 years of age	$40	Not covered
Scratch Coating – Standard Plastic	$15	Not covered
Tint – Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts – Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts – Disposable	$0 copay; 100% of balance over $130 allowance	Up to $104
Contacts – Medically Necessary	$0 copay; paid in full	Up to $200
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

(Plan allows member to receive either contacts and frame, or frames and lens services)

PREMIUMS - monthly	
Subscriber only	$6.53
Subscriber + 1	$10.18
Subscriber + family	$13.83

PEHP Life & Accident

NOTE: Depending on your employer's choice of Life & Accident plans, this brochure's benefits may not apply. Please refer to your employer or contact PEHP Group Term Life and AD&D for details.

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

COVERAGE	AMOUNT
Up to Age 70	50,000
Age 71 to 75	25,000
Age 76 and over	12,500

LINE-OF-DUTY DEATH BENEFIT

If you're enrolled in basic coverage, you get an additional $50,000 Line-of-Duty Death Benefit at no extra cost. Enrollment is automatic.

ACCIDENTAL DEATH RIDER

If you're enrolled in basic coverage, you get an additional $10,000 Accidental Death Benefit, subject to the provisions of the PEHP Group Accident Plan, at no extra cost. Enrollment is automatic.

EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

- You want more coverage than the guaranteed issue;
- You apply for any amount of coverage 60 days after your hire date.

After you apply for coverage, PEHP will guide you through the necessary steps to get evidence of insurability. They may include:

- Completing a health questionnaire;
- Basic biometric testing and blood work;
- Furnishing your medical records.

EMPLOYEE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date, you can purchase up to $200,000 as guaranteed issue. After 60 days, or for coverage greater than $200,000 you must provide evidence of insurability.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.20	2.40	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 30 to 34	1.30	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
Age 35 to 39	1.80	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00
Age 40 to 44	2.20	4.40	8.80	13.20	17.60	22.00	26.40	30.80	35.20	39.60	44.00
Age 45 to 49	4.20	8.40	16.80	25.20	33.60	42.00	50.40	58.80	67.20	75.60	84.00
Age 50 to 54	5.10	10.20	20.40	30.60	40.80	51.00	61.20	71.40	81.60	91.80	102.00
Age 55 to 59	8.10	16.20	32.40	48.60	64.80	81.00	97.20	113.40	129.60	145.80	162.00
Age 60 to 69	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes											
Coverage Amounts	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	12,500	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	6,250	12,500	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life & Accident

SPOUSE BASIC COVERAGE: Your employer funds $10,000 of spouse basic coverage at no charge to you.

SPOUSE ADDITIONAL TERM COVERAGE

You can buy up to $500,000 in spouse coverage. If you apply within 60 days of your hire date or marriage date, up to $50,000 is guaranteed issue. After 60 days, and for all amounts above $50,000, you must complete a health statement.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.20	2.40	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 30 to 34	1.30	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
Age 35 to 39	1.80	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00
Age 40 to 44	2.20	4.40	8.80	13.20	17.60	22.00	26.40	30.80	35.20	39.60	44.00
Age 45 to 49	4.20	8.40	16.80	25.20	33.60	42.00	50.40	58.80	67.20	75.60	84.00
Age 50 to 54	5.10	10.20	20.40	30.60	40.80	51.00	61.20	71.40	81.60	91.80	102.00
Age 55 to 59	8.10	16.20	32.40	48.60	64.80	81.00	97.20	113.40	129.60	145.80	162.00
Age 60 to 69	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes											
Coverage Amounts	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	12,500	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	6,250	12,500	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

Your employer funds $10,000 of dependent children coverage at no charge to you. If you apply within 60 days of your hire date or the date of the child's birth, all amounts are guaranteed issue. After 60 days, a health statement will be required for each child. All eligible children will be covered at the same level for one premium. Children can be covered until married or age 26, whichever comes first.

CHILD BASIC COVERAGE: Your employer funds $10,000 at no cost to you.

Coverage Amount	10,000	15,000
Monthly cost	0	0.52

Accidental Death and Dismemberment (AD&D)

AD&D provides benefits for death, loss of use of limbs, speech, hearing or eye sight due to an accident, subject to the limitations of the policy.

INDIVIDUAL PLAN

Your employer funds $50,000 of AD&D coverage at no charge to you. Select additional coverage from $25,000 to $200,000 for a maximum coverage of $250,000.

Employee's Coverage Amount	Individual Plan Monthly Cost	Family Plan Monthly Cost
50,000	0	0.50

FAMILY PLAN

- Upgrade your individual AD&D plan to a family plan. Convert your employee-funded $50,000 individual plan to a $50,000 family plan at a cost of 0.50 per month.
- Select a coverage amount ranging from $25,000 to $200,000, and your spouse and dependents will be automatically covered as follows:
  - Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;
  - Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.
- If injury to an insured person covered for this benefit results within one year of the date of the accident in any of the losses set forth, the plan will pay the sum specified opposite such loss, but the total amount payable for all such losses as a result of any one accident will not exceed the Principal Sum applicable to the insured person. The Principal Sum applicable to the insured person is the amount specified on the enrollment form.

PEHP Life & Accident

Accidental Death and Dismemberment (AD&D)

Additional AD&D Coverage and Cost

INDIVIDUAL PLAN		FAMILY PLAN
Coverage Amount	Monthly Cost	Monthly Cost
25,000	0.50	0.75
50,000	1.00	1.50
75,000	1.50	2.25
100,000	2.00	3.00
125,000	2.50	3.75
150,000	3.00	4.50
175,000	3.50	5.25
200,000	4.00	6.00

AD&D Payment Schedule

FOR LOSS OF	BENEFIT PAYABLE
Life	Principal Sum
Two Limbs	Principal Sum
Sight of Two Eyes	Principal Sum
Speech and Hearing (both ears)	Principal Sum
One Limb or Sight of One Eye	Half Principal Sum
Speech or Hearing (both ears)	Half Principal Sum
Use of Two Limbs	Principal Sum
Use of One Limb	Half Principal Sum
Thumb and Index Finger On Same Hand	Quarter Principal Sum
Thumb or Index Finger	Eighth Principal Sum
Any Two Fingers on One Hand	Tenth Principal Sum

*Total benefit for loss of digits on one hand shall not exceed 25%. Benefits may not be combined upon the loss of multiple digits.

LIMITATIONS AND EXCLUSIONS

Refer to the Group Term Life and Accident Plan Master Policy for details on plan limitations and exclusions. Call 801-366-7495 or visit www.pehp.org for details.

Master Policy

This brochure provides only a brief overview. Complete terms and conditions are available in the Group Term Life and Accident Plan Master Policy. It's available when you log in to PEHP for Members at www.pehp.org. Or request a copy by emailing publications@pehp.org.

PEHP Health & Benefits
www.pehp.org
560 East 200 South
Salt Lake City, UT 84102-2004
801-366-7495 | 800-753-7495

Accident Weekly Indemnity

- Employee coverage only
- If you enroll in AD&D coverage, you may also purchase Accident Weekly Indemnity coverage, which will provide a weekly income if you are totally disabled due to an accident that is not job-related.
- The maximum eligible weekly amount is based on your monthly gross salary at the time of enrollment. You may purchase a lower amount of coverage than the eligible monthly gross salary, but may not buy coverage for more than the eligible monthly gross salary.

Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	MONTHLY COST
250 and under	25	0.28
251 to 599	50	0.52
600 to 700	75	0.76
701 to 875	100	1.00
876 to 1,050	125	1.28
1,051 to 1,200	150	1.52
1,201 to 1,450	175	1.76
1,451 to 1,600	200	2.04
1,601 to 1,800	225	2.28
1,801 to 2,164	250	2.52
2,165 to 2,499	300	3.00
2,500 to 2,899	350	3.52
2,900 to 3,599	400	4.04
3,600 and over	500	5.04

Accident Medical Expense

- Employee coverage only
- This benefit is available to help you pay for medical expenses that are in excess of those covered by all group insurance plans and no-fault automobile insurance.
- This benefit will provide up to $2,500 to help cover medical expenses incurred due to an accident that is not job-related.

Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	MONTHLY COST
$ 2,500	$ 1.18