

State of Utah and Risk Pool 2026 » Dental Benefits Grid » Preferred & Traditional Dental Care

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		Traditional Dental Care	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS				
Deductible <small>(Does not apply to diagnostic or preventive services)</small>	\$25 per person, \$75 maximum per family	\$25 per person, \$75 maximum per family	\$0	\$0
Annual Benefit Max	\$1,500 per person	\$1,500 per person	\$1,500 per person	\$1,500 per person
DIAGNOSTIC	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Periodic Oral Examinations	\$0	20% of In-Network Rate	\$0	20% of In-Network Rate
X-rays	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
PREVENTIVE				
Cleanings and Fluoride Solutions	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
Sealants Permanent molars only through age 17	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
RESTORATIVE				
Amalgam Restoration	20% of In-Network Rate AD*	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
Composite Restoration	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
ENDODONTICS				
Pulpotomy	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
Root Canal	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
PERIODONTICS				
	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
ORAL SURGERY				
Extractions	20% of In-Network Rate AD	40% of In-Network Rate AD	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 AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
Prosthodontic, implant, and orthodontic services below are not eligible for six months from the date coverage begins unless prior, continuous dental coverage can be shown				
PROSTHODONTIC BENEFITS Preauthorization may be required				
Crowns	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
Bridges	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
Dentures (partial)	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
Dentures (full)	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
IMPLANTS				
All related services	50% of In-Network Rate AD	70% of In-Network Rate AD	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		\$1,500 Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum AD		50% of eligible fees to plan maximum	

If you live outside of Utah and visit an out-of-state dentist, your benefits will be paid at the in-network rate. Note: You may be balance billed by the dentist for the full cost of your visit.

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](#). If coverage is provided by a PEHP medical plan, then there is no dental plan coverage.

* AD = After Deductible

State of Utah and Risk Pool 2026 » Dental Benefits Grid » EMI Health Dental Coverage



Corporate (801)262-7475
 Customer Service (800)662-5851
EMIHealth.com

DENTAL COVERAGE
 BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

OUTLINE OF COVERAGE

Read Your Policy Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Group: [State of Utah \(Plan #1580\)](#)
Plan: [Choice Indemnity](#)
Underwritten & Administered by: [Educators Health Plans Life, Accident & Health, a Utah Company](#)
Effective Date: 7/1/2026
Benefit Year: [Contract](#)
Plan Type: [Contributory / Fully Insured](#)

	In-Network	In-Network	Out-of-Network
Network / Reimbursement Schedule	Advantage Plus-D	Premier-D	R & C (80th)
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	100%	100%	100% up to R&C*
Type 2 - Basic Fillings	80%	80%	80% up to R&C*
Type 3 - Major Crowns, Bridges, Prosthodontics	50%	50%	50% up to R&C*
Type 4 - Orthodontics Dependent children ages 7 through 18 Adult Orthodontics	50% No Coverage	50% No Coverage	50% No Coverage
Sealants	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Space Maintainers	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Endodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Simple Extractions	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Oral Surgery	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Waiting periods			
Type 2 - Basic		None	
Type 3 - Major		None	
Type 4 - Orthodontics		None	
Deductible	In and Out of Network Deductibles are Combined		
Per Person		\$0.00	
Family Max		\$0.00	
Deductible Applies To		Type 2 & 3	
Annual Maximum Per Person	\$2,000.00	\$1,500.00	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum		\$1,500.00	
	Applies to dependent children ages 7 through 18		
Provisions / Limitations / Exclusions			
Exams (including Periodontal), Cleanings and Fluoride			2 per year
Fluoride			Up to age 16
Sealants			Up to age 16
Space Maintainers			Up to age 16
Bitewing X-Rays			Up to 4, twice per year
Periapical X-Rays			6 per year
Panoramic X-Ray			1 every 3 years
Impacted Teeth			Covered in Type 2 - Basic
Anesthesia - (Age 8 and over for the extraction of impacted teeth only)			Covered in Type 3 - Major**
Anesthesia - (For children age 7 and under, once per year)			Covered in Type 3 - Major**
Implants / Implant Abutments			Covered in Type 3 - Major
Crowns, Bridges, Onlays and Dentures			1 every 5 years per tooth
Occlusal Guards			Covered in Type 3 - Major
Fillings on the same surface			1 every 18 months
* When using a Non-participating Provider, the insured is responsible for all fees in excess of the Reasonable and Customary Charges (R&C).			
** Anesthesia is not subject to waiting periods.			