



## Capitol Association Plans

P.O. Box 214190, Sacramento, CA 95821

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### CAPS Employer Dental & Vision Enrollment Form

Thank you for your interest in the **CAPS** dental and vision programs. This document contains the necessary enrollment documents to get you started. Should you have any questions, please contact our office by phone at (916) 944-1707, email us at [caps@capsplans.com](mailto:caps@capsplans.com) or browse our website at [www.capsplans.com](http://www.capsplans.com).

#### DENTAL PLANS:

CAPS' dental plans offer a variety of choices designed to meet the needs of employers wanting to offer quality dental care to their employees.

#### A. **EMPLOYERS: Delta Dental Non-Voluntary (Employer Paid ) Program**

Under this group plan, employers must contribute a minimum of 50% to the employee's premium, but are not required to contribute for dependant coverage. Also, all employees who work over 32 hours are required to be covered unless they sign a waiver declining coverage. (Employees declining coverage will not be eligible to enroll at a later date unless they can show proof of loss of prior coverage.

Employees are eligible on the first day of the month following six full months of employment; During the initial plan enrollment, Employers may choose to waive the waiting period for enrollees.)

CAPS dental benefits are provided by Delta Dental, California's largest dental benefits carrier. The DeltaPPO/Premier plans allow you to visit any licensed dentist, although you receive advantages, such as in-network contracted rates when choosing a network dentist. To find a Delta Dental dentist near you, please visit [www.deltadentalins.com](http://www.deltadentalins.com). See summary of plan benefits listed below:

Delta Dental Benefits	Delta Dental PPO Plan A w/ Ortho (3084-1100)	Delta Dental Premier Option 1 (3084-0177)	Delta Dental PPO Option 2 (3084-0147)
Provider Network	In Network/DPO Dentists Out of Network/ Any Dentist	In Network/DPO Dentists Out of Network/ Any Dentist	In Network/DPO Dentists Out of Network/ Any Dentist
Annual Deductible	\$25 Individual \$50 Family	\$25 Individual \$50 Family	\$25 Individual \$75 Family
Deductible Waived on Diagnostic & Preventative	In Network: Yes Out of Network: No	Yes	In Network: Yes Out of Network: No
Diagnostic & Preventative	In Network: Plan Pays 100% Out of Network: Pays 80%	Plan Pays 100%	In Network: Plan Pays 100% Out of Network: Pays 50%
Basic (Fillings, Tooth Extraction, etc.)	In Network: Plan Pays 80% Out of Network: Pays 80%	Plan Pays 80%	In Network: Plan Pays 80% Out of Network: Pays 50%
Crowns & Cast Restorations	In Network: Plan Pays 80% Out of Network: Pays 50%	Plan Pays 80%	In Network: Plan Pays 80% Out of Network: Pays 50%
*Prosthodontics	In Network: Plan Pays 50% Out of Network: Plan Pays 50%	Plan Pays 50%	Plan Pays 50%
Child Orthodontics	Plan Pays 50% (up to lifetime max)	N/A	N/A
Maximum Annual Benefit	\$1,500	\$1,000	\$1,500
Orthodontic Lifetime Maximum Benefit	\$1,500	N/A	N/A

\*12 month waiting period

#### **Delta Dental Non-Voluntary (Employer Paid) Plan Monthly Rate Comparison:**

(Rates are effective through 6/1/2020)

	Delta Dental PPO Plan A w/Ortho	Delta Premier Option 1	Delta Dental PPO Option 2
Employee Only	\$ 54.10	\$ 55.63	\$ 45.79
Employee + One	\$ 99.56	\$ 102.42	\$ 82.78
Employee + Family	\$ 184.33	\$ 180.83	\$ 137.83

**B. EMPLOYERS & INDIVIDUALS: Delta Dental Voluntary Program**

Voluntary programs allow individual members and their employees (part-time and full-time) a choice to participate in dental benefits on a voluntary basis. **These programs provide no waiting periods to receive benefits.** There are two coverage options in the voluntary program, DeltaPPO and DeltaCare.

CAPS dental benefits are provided by Delta Dental, California's largest dental benefits carrier. To find a Delta Dental dentist near you, please visit [www.deltadentalins.com](http://www.deltadentalins.com). See summary of plan benefits listed below:

Dental Coverage	DeltaPPO	DeltaCare
Provider Network	16,500	1500+ Offices
Deductible	\$50 Individual \$150 Family	None
Complete series x-ray including bitewings	Plan Pays \$53	Plan Pays 100%
Cleaning – adult or child	Plan Pays \$43	Plan Pays 100%
Silver Filling – One Surface	Plan Pays \$46	Member Pays \$2
Single Tooth Extraction	Plan Pays \$48	Member Pays \$5
Root Canal Therapy, Front Tooth	Plan Pays \$238	Member Pays \$50
Crown – porcelain (with non-precious metal)	Plan Pays \$190	Member Pays \$100
Complete denture, upper	Plan Pays \$302	Member Pays \$125
Orthodontic	Not Covered	Requires Co-Payment \$1,600 for Child + \$350 \$1,800 for Adult
Maximum Annual Benefit	\$1,000	No Maximum, Except for Accidental Injury

**Delta Dental Voluntary Plan Monthly Rate Comparison:**

(Rates are effective through 10/31/2019)

Employee/Dependent Coverage	*DeltaPPO	*DeltaCare
Employee Only	\$ 39.00	\$ 36.00
Employee + One	\$ 65.00	\$ 59.00
Employee + Family	\$ 98.00	\$ 82.00

## VISION PLANS:

### A. EMPLOYERS: VSP and Superior Vision Non-Voluntary (Employer Paid ) Program

CAPS' vision program offers you and your full-time employees high quality eye care services. As with CAPS dental plans, employers must contribute a minimum of 50% to the employee's premium, but are not required to contribute for dependent coverage. All employees who work over 32 hours are required to be covered unless they sign a waiver declining coverage and employees declining vision coverage upon their eligibility will not be eligible to enroll at a later date unless they can show proof of loss of prior coverage.

CAPS' vision benefits are provided by Vision Service Plan (VSP) and Superior Vision. See below for a summary of plan benefits.

#### VSP Non-Voluntary (Employer Paid) Plan Benefits:

Vision Coverage	Vision Service Plan
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, and lined trifocal lenses)	Every 12 Months
Frames** (Frame of your choice covered up to \$150. Plus, %20 off any out-of pocket costs)	Every 24 Months
-- OR -- Contacts	Every 12 Months

\*\*Subject to a \$20 Copay

#### VSP Non-Voluntary (Employer Paid) Plan Monthly Rate Comparison:

(Rates are effective through 7/31/2020)

Employee/Dependent Coverage	Vision Service Plan
Employee Only	\$ 10.87
Employee + One Dependent	\$ 16.89
Employee + Family	\$ 26.78

#### Superior Vision Non-Voluntary Plan Benefits:

Plan Benefits	Vision Service Plan
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, lined trifocal lenses, progressive and lenticular)	Every 12 Months
Frames** (Frame of your choice covered up to \$150. Plus, %20 off any out-of pocket costs)	Every 12 Months
-- OR -- Contacts	Every 12 Months

\*\*Subject to a \$20 co pay

**Superior Non-Voluntary Plan Monthly Rate Comparison:**

<b>Employee/Dependent Coverage</b>	
Employee Only	\$10.00
Employee + One Dependent	\$15.00
Employee + Family	\$24.00

**VISION PLANS:**

**CAPS MEMBER EMPLOYERS & INDIVIDUALS: VSP and Superior Vision Voluntary Program**

Voluntary programs allow individual members and their employees (part-time and full-time) a choice to participate in vision benefits on a voluntary basis. ***These programs provide no waiting periods to receive benefits.***

**Superior Vision Voluntary Plan Benefits:**

<b>Plan Benefits</b>	
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, lined trifocal lenses, progressive and lenticular)	Every 12 Months
Frames** (Frame of your choice covered up to \$150. Plus, %20 off any out-of pocket costs)	Every 12 Months
-- OR -- Contacts	Every 12 Months

\*\*Subject to a \$20 co pay

**Superior Voluntary Plan Monthly Rate Comparison:**

<b>Employee/Dependent Coverage</b>	
Employee Only	\$15.00
Employee + One Dependent	\$23.00
Employee + Family	\$36.00

(Rates effective thru 5/31/2019)

**VSP Voluntary Plan Benefits:**

<b>Vision Service Plan Benefits</b>	<b>Vision Service Plan</b>
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, and lined trifocal lenses)	Every 12 Months
Frames** (Frame of your choice covered up to \$130. Plus, %20 off any out-of pocket costs)	Every 24 Months
-- OR -- Contacts	Every 12 Months

\*\*Subject to a \$20 co pay

**VSP Voluntary Plan Monthly Rate Comparison:**

(Rates are effective through 10/31/2019)

<b>Employee/Dependent Coverage</b>	<b>Vision Service Plan</b>
Employee Only	\$ 17.20
Employee + One Dependent	\$ 26.72
Employee + Family	\$ 42.38

## ENROLLMENT INSTRUCTIONS

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To apply for dental and/or vision benefits, complete the application by following these five simple steps.

- **Step 1** – Complete contact information.
- **Step 2** – Calculate your total monthly premium. This amount will be your down payment and monthly premium amount (minus the setup fee where applicable).
- **Step 3** – Complete the Employee/Individual Enrollment Form (one for each employee/individual): Select the dental (only one non-voluntary plan per group, unlimited voluntary plans) and/or vision plan, fill out all employee/individual information and make sure to include any dependent information for the covered individual.
- **Step 4** – Payment and Billing Information.
- **Step 5** - Return the application, enrollment forms and any waivers, along with your first payment. You will receive a confirmation letter upon enrollment. Each employee who chooses to waive coverage must complete the attached Waiver of Coverage Form. Please submit the originals with your application and keep a copy for your records.
- Please note that we must receive your application for enrollment, along with payment no later than the 10<sup>th</sup> of the current month in which you want your benefits to begin.

We look forward to working with you. Please feel free to contact us by phone at (916) 944-1707 or by email at caps@capsplans.com if you have any questions or would like additional information.

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### STEP 1 – CONTACT INFORMATION (please print)

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Billing Contact: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone/ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

\*Total # of Full Time Employees: \_\_\_\_\_

\*Total # of Enrollees: \_\_\_\_\_

***\*Please note that for non-voluntary programs, all full time employees are required to participate in plans unless they provide a waiver of coverage. All waivers must accompany applications for coverage. Employees waiving coverage will not be eligible for benefits at a later date unless they can provide proof of a loss of prior coverage (see page 9 for Waiver of Coverage).***

## STEP 2 – MONTHLY PREMIUM CALCULATION WORKSHEET

### DENTAL COVERAGE

NON-VOLUNTARY (Select *one* non-voluntary plan only per group)

<b>Delta Dental PPO Plan A w/Ortho (3084-1100)</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 49.78
+ 1 Dependant		\$ 91.62
Family		\$ 169.62

<b>Delta Dental Premier Option 1 (3084-0177)</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 51.19
+ 1 Dependant		\$ 94.25
Family		\$ 166.40

<b>Delta Dental PPO Option 2 (3084-0147)</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 42.14
+ 1 Dependant		\$ 76.18
Family		\$127.83

### VOLUNTARY

<b>Delta Dental PPO Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 39.00
+ 1 Dependant		\$ 65.00
Family		\$ 98.00

<b>DeltaCare Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 36.00
+ 1 Dependant		\$ 59.00
Family		\$ 82.00

### VISION PLAN PREMIUM

<b>VSP Non-Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 10.87
+ 1 Dependant		\$ 16.89
Family		\$ 26.78

<b>Superior Vision Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 15.00
+ 1 Dependant		\$ 23.00
Family		\$ 36.00

<b>VSP-Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 17.20
+ 1 Dependant		\$ 26.72
Family		\$ 42.38

<b>Superior Vision Non-Voluntary</b>		
<i>Coverage Type</i>	<i># of Employees</i>	<i>Monthly Rate</i>
Employee Only		\$ 10.00
+ 1 Dependant		\$ 15.00
Family		\$ 24.00

### STEP 3 – EMPLOYEE/ INDIVIDUAL ENROLLMENT

Please complete one form for each employee.

Employee Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dependent: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Plan Choice(s):**

- |  |  |
|--|--|
| <input type="checkbox"/> Delta PPO Plan A w/ Ortho (3084-1100) | <input type="checkbox"/> VSP Voluntary                 |
| <input type="checkbox"/> Delta Premier Option 1 (3084-0177)    | <input type="checkbox"/> VSP Non-Voluntary             |
| <input type="checkbox"/> Delta PPO Option 2 (3084-0147)        | <input type="checkbox"/> Superior Vision Voluntary     |
| <input type="checkbox"/> Delta PPO Voluntary                   | <input type="checkbox"/> Superior Vision Non-Voluntary |
| <input type="checkbox"/> Delta Care Voluntary                  |  |

**Enrollees:**

- Employee Only     Employee + One     Employee + Family

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## STEP 4 – PAYMENT AND BILLING INFORMATION

Please select preferred method of billing (how you would like to receive your statements):

E-mail       Regular Mail

Please select preferred method of payment:

Check/ Money Order       ACH

*Make Checks Payable to Capitol Association Plans  
Mail Payments to P.O. Box 214190, Sacramento, CA 95821*

### TOTAL PREMIUM CALCULATION

TOTAL PREMIUM CALCULATION	
Coverage	Total
DeltaPPO Plan A	\$
DeltaPremier Option 1	\$
DeltaPPO Option 2	\$
DeltaPPO Voluntary	\$
DeltaCare Voluntary	\$
VSP Voluntary	\$
VSP Non-Voluntary	\$
Superior Vision Non-Voluntary	\$
Superior Vision Voluntary	\$
Setup Fee \$10 (New Clients Only)	\$
Admin (\$1 per Employee, \$5 Min.) (Waived at initial setup)	\$
<b>Total Amount Due</b>	<b>\$</b>



**CAPITOL ASSOCIATION PLANS**

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**AUTOMATIC BANK DEBIT (ACH) AUTHORIZATION FORM**

**FAX TO: 866-334-5346**

I authorize Capitol Association Plans to debit my bank account as follows:

Automatically debit my bank account for my insurance premiums

One time only bank account debit in the amount of \$ \_\_\_\_\_

**BILLING FREQUENCY (for automatic payments)**

Monthly

Quarterly

Bi-Annually

Annually

**BANK ACCOUNT INFORMATION**

Bank: \_\_\_\_\_

Name on Account: \_\_\_\_\_

Bank Routing No.: \_\_\_\_\_

Checking Acct. No.: \_\_\_\_\_

Customer Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**POLICIES & FEES:**

If you select automatic billing, your account will be debited automatically by the 10<sup>th</sup> of the month which corresponds with your frequency of payment. You will not be mailed an invoice; however one can be mailed upon request. **NOTE: A \$2.00 transaction fee for each ACH (automatic debit) will apply.**

If you wish to cancel this authorization, you must notify Capitol Association Plans in writing at least 10 days in advance of the scheduled transaction.



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## WAIVER OF COVERAGE

I do hereby attest that I have been offered the opportunity to participate in

\_\_\_\_\_ 's Dental and/or Vision Insurance Plans (if eligible).  
(Name of Company)

I do not wish to participate in the plan(s) I have checked below. I understand that I will not be eligible to join the below checked plans (if eligible) at a later date, unless I can provide proof of a loss of prior coverage.

Coverage(s) waived:

- Delta Dental
- Vision Service Plan

Reason for waiving coverage:

- I (and my dependents) are covered by my spouse's plan
- Other \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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