Capitol Association Plans
PO Box 214190, Sacramento, CA 95821
Phone: 916.944.1707 Fax: 866.334.5346
E-mail: caps@capsplans.com

Thank you for your interest in the California Veterinary Medical Association (CVMA) Voluntary Dental and Vision programs. Attached please find the necessary enrollment documents to get you started. Should you have any questions, please contact our office by phone at 916.944.1707 or email at caps@capsplans.com.

DELTA DENTAL VOLUNTARY DENTAL BENEFITS

Voluntary programs allow individual CVMA 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.

CVMA's voluntary 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. See below for a summary of plan benefits.

Dental Coverage	**DeltaPPO**	**DeltaCare (HMO)**
Provider Network	22,000+	1500+ Offices
Deductible	$50 Individual $150 Family	None
Complete series x-ray including bitewings	Plan Pays $45	Plan Pays %100
Cleaning – adult or child	Plan Pays $36	Plan Pays %100
Silver Filling – One Surface	Plan Pays $35	Plan Pays %100
Single Tooth Extraction	Plan Pays $39	Member Pays $3
Root Canal Therapy, Front Tooth	Plan Pays $193	Member Pays $55
Crown – porcelain (with non-precious metal)	Plan Pays $163	Member Pays $90 – 240
Complete denture, upper	Plan Pays $240	Member Pays $110
Orthodontic	Not Covered	Requires Co-Payment $1,600 for Child $1,800 for Adult
Maximum Annual Benefit	$1,000	No Maximum, Except for Accidental Injury

DELTA DENTAL MONTHLY RATE COMPARISON

Employee/Dependent Coverage	***DeltaPPO**	***DeltaCare (HMO)** **Rates are based on network service area. See chart below for locations.**			
		Level 1 & 2	Level 3	Level 4	Level 5
Employee Only	$ 30.28	$ 27.81	$ 28.62	$ 29.41	$ 56.72
Employee + One	$ 54.63	$ 45.93	$ 47.24	$ 48.52	$ 93.59
Employee + Family	$ 83.76	$ 67.93	$ 69.94	$ 71.80	$ 138.46

*Rates are effective through 10/1/2019

DELTACARE COUNTY RATE GUIDE

Level 1 & 2 – Los Angeles and Orange Counties

Level 3 – Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura Counties

Level 4 – Alpine, Amador, Calaveras, Colusa, El Dorado, Imperial, Inyo, Kings, Madera, Marin, Merced, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Solano, Sonoma, Stanislaus, Tuolumne, Tulare, and Yolo Counties

Level 5 – Butte, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity, and Yuba Counties

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VSP VOLUNTARY VISION BENEFITS

The voluntary vision program is available to all individual CVMA members and individual employees (including part-time employees). This program provides no waiting period to receive benefits.

CVMA's voluntary vision benefits are provided by Vision Service Plan (VSP), the Nation's largest provider of exceptional eye care coverage. VSP offers the most extensive national doctor network of independent, private practitioners, for more information, or to find a provider near you, please visit www.vsp.com. See below for a summary of plan benefits.

Vision Coverage	**Plan B (Voluntary)**
Exam	Every 12 Months
Prescription Glasses	
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

VSP VOLUNTARY RATES

VISION SERVICE PLAN **MONTHLY RATE COMPARISON**	**Plan B (Voluntary)**
Employee Only	$ 10.37
Employee + One Dependent	$ 16.10
Employee + Family	$ 25.55

*Rates are effective through 6/01/2019.

CVMA VOLUNTARY DENTAL & VISION ENROLLMENT

*CVMA Member:

Enrollee Name:

Social Security #: Date of Birth:

Home Address:

City, State, Zip:

Home Phone #:

Member's Billing Address:
(if different than above)
City, State, Zip:

Work Phone #:

Fax #:

Email:

Non-members must be billed through their employer.

Dependent: Relationship:

Social Security #: Date of Birth:

Dependent: Relationship:

Social Security #: Date of Birth:

Dependent: Relationship:

Social Security #: Date of Birth:

Dependent: Relationship:

Social Security #: Date of Birth:

Plan Choice(s):

☐ DeltaPPO ☐ DeltaCare (HMO) ☐ VSP Plan B

Employee/Dependent Coverage:

☐ Employee Only ☐ Employee + One ☐ Employee + Family

DeltaCare Enrollees – Please Note: If you do not specify a dentist of your choice, a dentist will be automatically selected for you. Your dentist choice must be submitted no later than 7 days before the end of the month. For a list of DeltaCare Dentists, please visit www.deltadentalins.com

Dentist Name _____ Dentist #: _____

Enrollee Signature: _____ Date: _____

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

PREMIUM CALCULATION

Coverage	Total
DeltaPPO	$
DeltaCare (HMO)	$
VSP Plan B	$
Account set up fee ($10.00) Admin Fee: Individual Member Enrollees - $5) (Waived for initial enrollment)	$ 10.00
Total Monthly Premium	**$**

This section must be completed.

CAPITOL ASSOCIATION PLANS
PO Box 214190, Sacramento, CA 95821
Phone: (916) 944-1707 Fax: (866) 334-5346
E-mail: caps@capsplans.com Website: www.capsplans.com

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 future 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 10th 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.