Capitol Association Plans
PO Box 3040 Fair Oaks, CA 95628
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, Delta PPO 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	**Delta PPO**	**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	***Delta PPO**	***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	$ 30.00	$ 3050	$ 31.50	$ 61.00
Employee + One	$ 54.63	$ 49.00	$ 50.50	$ 52.00	$ 99.79
Employee + Family	$ 83.76	$ 72.50	$ 75.00	$ 77.00	$ 147.00

*Rates are effective through 10/1/2022

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 06/01/2022

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 3040 Fair Oaks CA 95628

PREMIUM CALCULATION

Coverage	Total
Delta PPO	$
DeltaCare (HMO)	$
VSP Plan B	$
Account set up fee ($10.00) Admin Fee: Individual Member Enrollees - $6) (Waived for initial enrollment) Add ACH Fee - $2	$ 10.00
Total Monthly Premium	**$**

This section must be completed.

CAPITOL ASSOCIATION PLANS
PO Box 3040 Fair Oaks, CA 95628
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.