Capitol Association Plans
P.O. Box 3040, Fair Oaks CA
Phone: (916) 944-1707 Fax: (866) 334-5346
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CA License Number: 0636993

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 or browse our website at 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 dependent 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 Delta PPO/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. 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 5/1/2019)

	Delta Dental PPO Plan A w/Ortho	Delta Premier Option 1	Delta Dental PPO Option 2
Employee Only	$ 53.00	$ 54.28	$ 44.68
Employee + One	$ 98.00	$ 99.93	$ 80.77
Employee + Family	$ 180.00	$ 176.38	$ 135.50

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, Delta PPO 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. 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	*Delta PPO	*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	
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:

Employee/Dependent Coverage	
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:

Plan Benefits	
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:

Employee/Dependent Coverage	
Employee Only	$15.00
Employee + One Dependent	$23.00
Employee + Family	$36.00

(Rates effective thru 5/31/2019)

VSP Voluntary Plan Benefits:

Vision Service Plan Benefits	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 $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)

Employee/Dependent Coverage	Vision Service Plan
Employee Only	$ 17.20
Employee + One Dependent	$ 26.72
Employee + Family	$ 42.38

ENROLLMENT INSTRUCTIONS

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 10th 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.

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)

Delta Dental PPO Plan A w/Ortho (3084-1100)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 53.00
+ 1 Dependant		$ 78.00
Family		$180.00

Delta Dental Premier Option 1 (3084-0177)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 54.28
+ 1 Dependant		$ 99.93
Family		$176.38

Delta Dental PPO Option 2 (3084-0147)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 42.14
+ 1 Dependant		$ 76.18
Family		$127.83

VOLUNTARY

Delta Dental PPO Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 39.00
+ 1 Dependant		$ 65.00
Family		$ 98.00

DeltaCare Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 36.00
+ 1 Dependant		$ 59.00
Family		$ 82.00

VISION PLAN PREMIUM

VSP Non-Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 10.87
+ 1 Dependant		$ 16.89
Family		$ 26.78

Superior Vision Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 15.00
+ 1 Dependant		$ 23.00
Family		$ 36.00

VSP-Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 17.20
+ 1 Dependant		$ 26.72
Family		$ 42.38

Superior Vision Non-Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 10.00
+ 1 Dependant		$ 15.00
Family		$ 24.00

STEP 3 – EMPLOYEE/ INDVIDUAL 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):

☐ Delta PPO Plan A w/ Ortho (3084-1100)

☐ Delta Premier Option 1 (3084-0177)

☐ Delta PPO Option 2 (3084-0147)

☐ Delta PPO Voluntary

☐ Delta Care Voluntary

☐ VSP Voluntary

☐ VSP Non-Voluntary

☐ Superior Vision Voluntary

☐ Superior Vision Non-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 3040, Fair Oaks CA 95628

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)	$
Total Amount Due	**$**

CAPITOL ASSOCIATION PLANS
PO Box 3040 Fair Oaks, CA 95628
Phone: (916) 944-1707 Fax: (866) 334-5346
E-mail: billing@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 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.

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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: _____

Capitol Association Plans, PO Box 3040, Fair Oaks, CA 95628
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