
MetaSense,Inc – UnitedHealthcare – Dental and Vision Plan Rates 2026

Dental Plan – LIN02

Employee - $12.28 / Month

Empl +Spouse - $24.55 / Month

Empl +Child - $31.26 / Month

Empl +Family - $46.04/ Month

Vision Plan – S1043

Employee - $5.49 / Month

Empl + Spouse - $10.43 / Month

Empl + Child - $12.19 / Month

Empl + Family - $17.18 /Month

Dental Benefit Summary

Renewal		
Plan: LIN02 / Type: Voluntary		
	Benefit	In/Out
Plan Maximums	Annual In/Out of Network	Unlimited
	Ortho Lifetime	NA/NA
Deductible	Individual/Family	$0/$0
Waiting Period	Major Services	NO WAIT
Coinsurance	Preventive	100%/NA
	Minor Restore	NA/NA
	Endodontic Services	NA/NA
	Periodontic Services	NA/NA
	Oral Surgery Services	NA/NA
	Major Services	NA/NA
	Orthodontia	NA/NA

	Enrollment	Rate
Employee	2	$12.28
Empl + Spouse	0	$24.55
Empl + Child	1	$31.26
Empl + Fam	4	$46.04

Vision Benefit Summary

Renewal		
Plan: S1043 / Type: Voluntary		
	Services & Materials	Amount
In-Network Copay	Exam	$15
	Materials	$30
Allowances	Frame	$130
	Elective Contact Lens	$105
	Contact Lens Fit & Eval	$30
Coinsurance	Necessary Contact Lens	100%
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frame	1 x per 24 mos
Out-of-Network Reimbursement	Exam	Up to $40
	Eyeglass Lenses	Up to $40
	Frame	Up to $45
	Elective Contact Lens	Up to $80
	Necessary Contact Lens	Up to $210

	Enrollment	Rate
Employee	3	$5.49
Empl + Spouse	0	$10.43
Empl + Child	1	$12.19
Empl + Fam	4	$17.18