

UNDERSTANDING MAC

(MAXIMUM ALLOWABLE CHARGE)
FOR OUT-OF-NETWORK CARE



Our dental plan uses a Maximum Allowable Charge (MAC) for out-of-network services. Here’s how it works.



WHAT IS MAC?

The Maximum Allowable Charge (MAC) is the most the plan will consider for a covered service when you see an out-of-network dentist.



HOW IT WORKS

MetLife uses its scheduled fee (the MAC) to calculate your out-of-network benefits. If your dentist charges more than the MAC, you may be responsible for the difference, plus your normal deductible and coinsurance.



WHY IT MATTERS

You can see any dentist you choose, but you’ll usually save more when you visit an in-network MetLife dentist. They have agreed to negotiated fees.

HOW PAYMENT IS CALCULATED

For out-of-network care, the plan bases your benefit on the lesser of:



The dentist’s actual charge

OR



The MAC amount



Then the plan applies your benefit percentage to that amount (after any deductible).

EXAMPLE: HOW MAC WORKS

Assume a dentist charges \$1,000 for a covered procedure. MetLife’s MAC for that procedure is \$700. For illustration, assume the plan pays 50% of the MAC after any applicable deductible.

DESCRIPTION	AMOUNT
Dentist charges	\$1,000
MAC amount	\$700
Plan pays 50% of \$700 (Plan payment)	\$350
Employee coinsurance portion (50% of MAC)	\$350
Amount above MAC (Your responsibility)	\$300
EMPLOYEE’S TOTAL COST	\$650



KEY TAKEAWAY

Even though the plan may say it covers 50%, your total cost could be more than 50% of what the dentist charges because the plan payment is based on the MAC amount, not the full charge.

