MetLife | Dental Insurance

Maximum Allowable Charge (MAC) dental plan – Stay in the network and save!

The best time to dig into the details of your dental insurance coverage is long before you file a claim. When using your dental plan offered by your employer, spend a few minutes reviewing your different plan options and how they determine your coverage if you visit an in-network or out-of-network provider.[1]

In a **Maximum Allowable Charge (MAC)** dental plan, there is a maximum amount your insurance company pays for a covered service from a provider, whether they're in-network or out-of-network.

How do I save by staying in the network?

It comes down to your out-of-pocket cost. For example, an in-network dentist may charge more for a procedure than your plan's **MAC fee**. Because you're in-network, though, they've agreed to accept a negotiated fee. Your insurance company would then cover a percentage of the negotiated fee, and you would owe any outstanding balance (coinsurance), assuming your deductible has been met.

An out-of-network dentist, however, isn't contractually obligated to accept the negotiated fee. That means you're responsible for coinsurance and any difference between the provider's charge and the **MAC** fee.

Let's look at a hypothetical example for two employees — Katie and Cindy — who each need a filling.

Based on the dentist they choose to visit (in-network vs. out of network), each will be responsible for paying different portions of the costs under the same MAC Dental Plan.

If you need a filling...	Katie goes to an **in-network dentist** who agrees to accept MetLife's negotiated fees	Cindy goes to an **out-of-network dentist**
Dentist's Charge	$189.86	$189.86
Negotiated Fee	$84	N/A
MAC[2]	N/A	$87
Plan Coverage % for filling	50%	50%
MetLife pays	$67.20	$69.60
Member pays	**$16.80**	**$120.26**

This is a hypothetical example that reviews a filling (D2391) in the El Paso County, Texas area, zip 79928. It assumes that the annual deductible has been met and the annual maximum benefit has not been reached. Actual negotiated fees, MAC amounts and out-of-pocket expenses may differ.

Dental Definitions

Negotiated fees —Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

Maximum Allowable Charge (MAC)[2] — caps payment for services provided by an out-of-network dentist at a scheduled amount, the Maximum Allowable Charge. Depending on the plan, payment may be made for all or part of the Maximum Allowable Charge for different types of services.

Take charge of your dental care

- **Talk to your dentist**

  Before you get any major dental work, talk to your dentist about getting a pre-treatment estimate.[3] That's when your dentist sends the plan for your care to MetLife. For most procedures, you and your dentist will receive the estimate — online or by fax — during your visit. The statement shows amounts for what your plan covers. Then you and your dentist can talk about your care and costs before your treatment. It's a great way to be prepared and plan ahead.

- **Get your plan information — fast!**

  Managing your dental benefits has never been easier. You've got MyBenefits — your secure member website. Just log on at metlife.com/mybenefits. With the 24/7 website you can:[4]

  - Review your plan information, including what's covered and coinsurance
  - Track your deductible and plan maximums
  - Find a dentist or view your claim history
  - Read up on the oral health information you need to make informed decisions about your care

1. Example provided for illustrative purposes. Please refer to the materials provided by your employer for details about the plan options available to you.
2. Payment for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable . Charge is a scheduled amount determined by MetLife.
3. MetLife strongly recommends that you have your dentist submit a pretreatment estimate to MetLife if the cost is expected to exceed $300. When your dentist suggests treatment, have him or her send a claim form, along with the proposed treatment plans and supporting documentation, to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pretreatment estimate depending upon annual maximums, deductibles, plan frequency limits and other plan provisions at time of payment.
4. With the exception of scheduled or unscheduled systems maintenance or interruptions, the MyBenefits website is typically available 24 hours a day, 7 days a week.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY 10166.
Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions of benefits, limitations and terms for keeping them in force. Ask your MetLife representative for cost and complete details.

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