MARCC Health Fund: Active & Retiree

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **(866) 607-6272**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250**/person, **$750**/family. Doesn't apply to preventive care, prescription drugs, dental, and vision. Balance billing, excluded services, and the prescription drug **deductible** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$200**/person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: **$3,250**/person, **$9,750**/family. Prescription Drugs: **$3,350**/person, **$3,450**/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of PPO **providers**, see **www.carefirst.com, call (866) 607-6272**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This Plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Specialist visit	20% coinsurance		-- None --
	Other practitioner office visit	20% coinsurance		Chiropractic limited to $62.50 allowance per visit
	Preventive care/ screening/immunization	No charge	No charge	Subject to age and frequency limitations

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance		-- None --
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medco.com.	Generic drugs	$10 copay retail, $20 copay mail-order	Not covered	Up to a maximum of a 30-day supply for retail, 90-day for mail-order; maintenance drugs are subject to a mandatory mail-order program
	Preferred brand drugs	25% coinsurance; retail: $25 min/$200 max, mail-order: $50 min/$400 max	Not covered	
	Non-preferred brand drugs	40% coinsurance; retail: $50 min/$300 max, mail-order: $100 min/$600 max	Not covered	
	Specialty drugs	Same as above, as applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Physician/surgeon fees	20% coinsurance		-- None --
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Care must be provided within 72 hours of accident
	Emergency medical transportation	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Urgent care	20% coinsurance		-- None --

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Physician/surgeon fee	20% coinsurance		-- None --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	-- None --
	Mental/Behavioral health inpatient services	20% coinsurance		-- None --
	Substance use disorder outpatient services	20% coinsurance		-- None --
	Substance use disorder inpatient services	20% coinsurance		-- None --
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care, 20% coinsurance for postnatal care	No charge for prenatal care, 30% coinsurance for postnatal care (20% if you don't live within 25 miles of a PPO provider)	Postnatal only covered for participants and spouses (no dependent coverage)
	Delivery and all inpatient services	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	Only covered for participants and spouses (no dependent coverage)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	-- None --
	Rehabilitation services	20% coinsurance	30% coinsurance (20% if you don't live within 25 miles of a PPO provider)	Physical therapy: $100/visit & must be provided by a licensed physical therapist
	Habilitation services	20% coinsurance		Habilitation services related to speech and visual therapy are not covered
	Skilled nursing care	20% coinsurance		-- None --
	Durable medical equipment	20% coinsurance		Rental charges only covered up to the purchase price
	Hospice service	20% coinsurance		-- None --

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Under 18: no charge, $250 annual family max applies 18 and older	Under 18: no charge, $250 annual family max applies 18 and older	Limited to one exam/calendar year
	Glasses	Under 18: no charge, $250 annual family max applies 18 and older		Limited to one pair/calendar year
	Dental check-up	Under 18: no charge, 10% coinsurance & $800/person annual max 18 and older	Under 18: no charge, 10% coinsurance & $800/person annual max 18 and older	Limited to two routine exams/calendar year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery (Exceptions apply)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (Providers limited)
- Bariatric surgery (With specific diagnosis)
- Chiropractic care
- Dental care (Adult) (To Plan limits)
- Hearing aids
- Infertility treatment (To Plan limits)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (To Plan limits)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (866) 607-6272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at (866)607-6272. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al (866) 607-6272.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,140
- **Patient pays** $1,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$260
Copays	$20
Coinsurance	$970
Limits or exclusions	$150
Total	**$1,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,940
- **Patient pays** $1,460

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$450
Copays	$450
Coinsurance	$360
Limits or exclusions	$200
Total	**$1,460**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

MID-ATLANTIC REGIONAL COUNCIL OF CARPENTERS' BENEFIT FUNDS QUICK-REFERENCE SUMMARY

This handout provides a brief description of the benefits available to Plan participants. It is only a summary; please refer to the Summary Plan Description Book for complete information. In a case where a discrepancy between this summary and the plan documents arise, the plan documents will govern.

SUMMARY OF ELIGIBILITY RULES

To become eligible initially for benefits, you must have a minimum of 800 hours reported to the Fund and the corresponding contributions paid to the Fund in six (6) consecutive months or less. You will become eligible on the first day of the month following completion of 800 hours and payment of contributions therefore, and will remain eligible up to a maximum of two complete Benefit Quarters. You must only meet this initial eligibility requirement once in your lifetime. If you lose your eligibility, subsequent reinstatement will be based on the same rules as Continuing Eligibility.

To continue eligibility, you must have 400 hours reported in a work quarter to be eligible for benefits during the corresponding benefit quarter.

The Calendar Work Quarters and the corresponding Benefit Quarters of this Plan are as follows:

Work Quarter	Corresponding Benefit Quarter
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

- You may “bank” any extra hours you work to help you when you don’t meet eligibility requirements in a quarter. The maximum number of hours you can have in your “hours bank” is 400.

- If you lose eligibility and and have no hours in your hours bank, you may also make a personal contribution to continue your coverage for up to 2 quarters. The amount of the self-payment is the number of hours short, times the current health contribution rate. This option is NOT available if you are not available for work.

- Your coverage will terminate on the first day of the benefit quarter for which you do not meet eligibility requirements OR, if sooner, the first day that you cease to be available for work covered by the plan.

- Eligible dependents include your spouse and dependent children up to age 26. Make sure that you have a current enrollment card on file at the Fund Office.

SUMMARY OF HEALTH FUND BENEFITS FOR PARTICIPANTS, RETIREES AND DEPENDENTS

This summary provides general information about the benefit program. The payment for specific claims is subject to the rules, regulations and limitations that have been adopted or may be adopted by the Joint Board of Trustees. Benefit levels are maintained at the highest level the Trustees feel is appropriate based on the current and projected financial condition of the Fund. Benefits must be reviewed from time to time, as economic circumstances indicate, and adjusted upward or downward as required. Any change in benefit levels will affect claims incurred on or after the effective date of change. The Trustees have the discretionary authority to amend the Plan in any respect. They may increase or reduce benefits, eliminate benefits, change eligibility rules and/or change rules for one or more categories of persons covered by the Plan.

The Death Benefit and Accidental Dismemberment Benefit apply whether or not the claim is work related. All other benefits cover only injuries and illnesses that are not work-related.

You may obtain detailed schedules of benefits upon written request. This information is provided without cost to you. Send your request to the Fund Office.

BENEFITS	**DESCRIPTION**
Death Benefits for Active Participants: Death Benefits for Retirees: Accidental Death Benefits (Active Participants Only):	 $10,000 $1,000 $15,000
Accidental Dismemberment (Active Participants Only)	$2,500 for two (2) limbs, eyes or combination. $1,250 for one (1) limb or one (1) eye.
Loss of Time from Work (Active Participants Only)	A maximum of 26 weeks for all causes in a calendar year. No more than a total of 26 weeks for any one cause. $300/week for the first 13 weeks; $200/week for periods in excess of 13 weeks.

Unless otherwise stated, eligible charges are subject to a $250 annual deductible (maximum of 3 deductibles per family) and, if a PPO provider is utilized, covered at 80% until the annual out-of-pocket limit of $3,250 per person has been met (maximum of $9,750 per family). Charges are then covered at 100%. If a non-PPO provider is used, services will be covered at 70% (an exception to this reduction in benefits will be made if you are not located within 25 miles of a PPO provider).

BENEFIT	DESCRIPTION
Hospital Room and Board	Daily Hospital semi-private, ICU or CCU rate up to the Plan's Maximum Benefit. Private room is limited to the semi-private rate unless Medically Necessary.
Hospital Ancillary Charges	All Reasonable and Customary Hospital charges incurred during an in-patient confinement including operating room, drugs, x-rays, laboratory tests, supplies, and anesthesia.
Hospital Inpatient Physician Benefits	All Reasonable and Customary charges while Hospital confined.
Outpatient Hospital Services for Accident (within 72 hours), Emergency Illness or Surgery	All Reasonable and Customary Hospital charges, including the professional fees for lab, x-ray and anesthesia are payable up to the Plan's Maximum Benefit.
Outpatient Hospital Services for Non-Emergency Treatment	All Reasonable and Customary Hospital charges for lab and x-ray, including the professional fees are payable up to the Plan's maximum Benefit.
Surgery	All Reasonable and Customary Physician charges are payable up to the Plan's maximum Benefit.
Second Surgical Opinion	All Reasonable and Customary charges covered at 100% up to the Plan's Maximum Benefit.
Outpatient X-ray and Laboratory	All Reasonable and Customary charges up to the Plan's Maximum Benefit.

Unless otherwise stated, eligible charges are subject to a $250 annual deductible (maximum of 3 deductibles per family) and, if a PPO provider is utilized, covered at 80% until the annual out-of-pocket limit of $3,250 per person has been met (maximum of $9,750 per family). Charges are then covered at 100%. If a non-PPO provider is used, services will be covered at 70% (an exception to this reduction in benefits will be made if you are not located within 25 miles of a PPO provider).

BENEFIT	DESCRIPTION
Preventive/Well Care, Immunizations, and Routine screening tests	100% of all Reasonable and Customary charges up to the Plan's Maximum Benefit. Charges are NOT subject to annual deductible.
Physician Visits	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Hospice Care: Bereavement Counseling (within 3 months of death)	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Home Health Care	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Private Duty Nursing (Registered Nurse only)	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Physical Therapy	All Reasonable and Customary charges up to a maximum allowance of $100 per visit,
Radiation and Chemotherapy	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Home Infusion Therapy	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Speech Therapy	All Reasonable and Customary charges up to the Plan's Maximum Benefit if performed for rehabilitative purposes after an injury or illness.
Ambulance	All Reasonable and Customary charges up to the Plan's Maximum Benefit for transportation to and from the Hospital when Medically Necessary.
Medical Supplies, Durable Medical Equipment (i.e., casts, braces, oxygen, etc.)	All Reasonable and Customary charges up to the Plan's Maximum Benefit.

Unless otherwise stated, eligible charges are subject to a $250 annual deductible (maximum of 3 deductibles per family) and, if a PPO provider is utilized, covered at 80% until the annual out-of-pocket limit of $3,250 per person has been met (maximum of $9,750 per family). Charges are then covered at 100%. If a non-PPO provider is used, services will be covered at 70% (an exception to this reduction in benefits will be made if you are not located within 25 miles of a PPO provider).

BENEFITS	DESCRIPTION
Hearing Aids	All Reasonable and Customary charges for a hearing aid for one or both ears and related expenses.(hearing aid must be prescribed by a Physician).
Maternity (Active and retired Participants and spouses only.)	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Assisted Reproductive Technology (Active and retired Participants and spouses only.)	50% of all Reasonable and Customary charges, with a maximum payment of $5,000 per cycle, and a lifetime maximum of two cycles.
Mental, psychoneurotic and personality disorders treatment, Inpatient	Daily Hospital semi-private room and Hospital Ancillary Services .
Mental, psychoneurotic and personality disorders treatment, Outpatient	All Reasonable and Customary charges.
Alcohol and Substance Abuse, Inpatient	Daily Hospital semi-private room and Hospital ancillary services.
Alcohol and Substance Abuse, Outpatient	All Reasonable and Customary charges.
Human Organ Transplants	All non-experimental transplants will be paid the same as any other illness. Experimental transplants (as determined by the Centers for Medicare & Medicaid Services) are not covered.

Unless otherwise stated, eligible charges are subject to a $250 annual deductible (maximum of 3 deductibles per family) and, if a PPO provider is utilized, covered at 80% until the annual out-of-pocket limit of $3,250 per person has been met (maximum of $9,750 per family). Charges are then covered at 100%. If a non-PPO provider is used, services will be covered at 70% (an exception to this reduction in benefits will be made if you are not located within 25 miles of a PPO provider).

Podiatry	All Reasonable and Customary charges up to the Plan's Maximum Benefit.
Chiropractic Services	All Reasonable and Customary charges up to a maximum allowance of $62.50 per visit .
Vision Benefits	Benefits for one pair of contacts, frames, lenses, laser eye surgery and one exam per calendar year at 100%, no deductible, up to an annual maximum of $250 per family. Max does not apply to children 18 and under.
Prescription Drug Benefits	Prescriptions paid by MEDCO. $200 deductible, then copay applies: $10 for generic medications; 25% for formulary medications; 40% for non-formulary medications. Long-term medications purchased through mail-order program. Maximum out-of-pocket is $3,350/person, $3,450/family
TMJ Services	50% of All Reasonable and Customary charges.
Smoking Cessation Benefits	Payable at 100%.

BENEFITS	DESCRIPTION
Dental Benefits	There is no deductible for dental services. Services are covered at 90% Plan covers preventive services only. These services include: • Two routine exams every calendar year • Two cleanings every calendar year • Full mouth x-rays once every calendar year • Bitewing x-rays • Fluoride • Sealants

SUMMARY OF PENSION FUND BENEFITS FOR PARTICIPANTS, RETIREES AND DEPENDENTS

Vesting requirements: You must have five years of vesting in order to be eligible for a pension. Each calendar year you work at least 1,000 earns you a vesting credit.

Normal Pension requirements: You may retire at age 62 if you have at least 5 vesting credits. Between ages 62 and 65, there will be a reduction in your pension for retiring prior to age 65.

Early Retirement Pension requirements: You may retire at age 55 if you have 10 vesting credits or 16,000 work hours. There will be a reduction in your pension for retiring early.

Unreduced Early Retirement Pension requirements: You may retire at age 62 on a full, unreduced pension if you have 30 vesting credits.

Calculation of Pension: You pension is calculated based upon a percentage of contributions made on your behalf. This contribution rate may change from year to year.

Plan also includes disability pension benefit, pre-retirement death benefit, surviving spouse benefit. Credit may be given for time lost due to Worker's Comp, disability, and time serving in the military.

SUMMARY OF ANNUITY FUND BENEFITS

Vesting requirements: Immediately vested; no waiting period.

Withdrawal of Benefits: You may apply for your benefit at the same time you apply for you pension. You must be retired, and at least age 55.

Early Withdrawal: You may withdraw your contributions early, if you completely withdraw from covered employment and have not worked for at least 6 months. Hardship distributions are also available.

Loans: Once you have participated in the Plan for a minimum of 5 years, you may be eligible to apply for a loan of a portion of your annuity balance in certain situations, such as purchase of a house, funeral expenses, and education expenses.

CONTACT INFORMATION FOR GEMGROUP

Eligibility/Work History Information

- Roberta White: 301.839.8800 ext. 808
- Jonatan Camacho: 301.839.8800 ext. 826 (Jonatan is also Spanish-Speaking Customer Service Rep for all inquiries)

Pension

- Missy Kramer: 301.839.8800 ext. 815

Annuity

- Jennifer Collins: 800.242.8923, ext. 773

Health Benefits and Claims

- Dedicated MARC Claims Unit: 866.607.MARC or 866.607.6272

Reciprocal Authorization Questions

- Susan Hoffman: 800.242.8923 ext. 620