FREE HEALTHCARE!
TAKE ACTION NOW!

Already enrolled in the Fund's $50 or $100 COBRA coverage?

1. Fill out the Blue Form
2. Get a refund for April and May
3. Your Free COBRA coverage will continue for June through September if you qualify

How to fill out the Blue Form:

1. Find the Blue Form in this packet.
2. You will qualify for Free COBRA only if you can answer yes to all 4 questions on the Blue Form.
3. All of your dependents who need coverage must sign (or have an adult sign for them).
4. Return the Blue Form by mail, email or in person to:

Santa Monica UNITE HERE Health Benefit Trust Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
santamonicaunitehere@bpabenefits.com

5. Will you (or your dependents) become eligible for Medicare or insurance through another job before October? You must fill out the Yellow Form or you could get a tax penalty. Call the Fund at 866-345-5189 or 213-456-2012 for help filling out the Yellow Form.
6. This flyer is a summary only. You should read the important information included in this packet.

SANTA MONICA
UNITEHERE!
HEALTH BENEFIT FUND

Need help filling out the form?
Call **213-456-2012** to make an appointment.

Have questions?
Call **866-345-5189** for help over the phone.

Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021

President Biden signed the American Rescue Plan Act of 2021 (ARP) on March 11, 2021. This law subsidizes the full COBRA premium for "Assistance Eligible Individuals" for periods of coverage from April 1, 2021 through September 30, 2021.

To qualify for the premium assistance, you:

- **MUST** have a COBRA qualifying event that is a reduction in hours or an involuntary termination of a covered employee's employment;
- **MUST** elect COBRA continuation coverage (this means you must complete the Fund's "COBRA Election Form", if you have not already done so);
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a new employer or a spouse's employer. *

♦ IMPORTANT ♦

◊ If you do not elect to receive the premium assistance **within 60 days** of receipt of this form, you may be ineligible for the premium assistance.

◊ Each family member who is applying for ARP premium assistance must sign the "Blue Form": Request for Treatment As An Assistance Eligible Individual (either as the Employee or Dependent). A parent or guardian should sign the form for a minor child. *Domestic Partners are not eligible for premium assistance.*

◊ If you elect COBRA coverage with premium assistance, and then become eligible for Medicare or other group health plan coverage (not including coverage that is only excepted benefits such as dental or vision coverage, a Qualified Small Employer Health Reimbursement Arrangement, or a health flexible spending arrangement), you MUST notify the Fund in writing by using the "Yellow Form". If you fail to provide this notice, you may be subject to a penalty of $250 (or if the failure is fraudulent, the greater of $250 or 110% of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the Fund is due to reasonable cause and not due to willful neglect.

◊ Employers that don't satisfy COBRA coverage requirements may be investigated by the Department of Labor and may be subject to an excise tax under the Internal Revenue Code.

◊ If you elect COBRA coverage and are eligible for the premium assistance, you cannot claim the Health Coverage Tax Credit. You also cannot qualify for a premium tax credit to help pay for coverage through a Health Insurance Marketplace®[1], such as on HealthCare.gov, for any months that you are enrolled in COBRA coverage with or without the premium assistance.

For general information on the Fund's COBRA coverage, specific information about ARP premium assistance, or to notify the Fund of your ineligibility to receive premium assistance, you can contact the Administrative Office of the Fund at: **Santa Monica UNITE HERE Health Benefit Trust Fund, c/o Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, (866) 345-5189. For one-on-one assistance, call the COBRA Team at (213) 456-2012.**

For more information regarding ARP premium assistance and eligibility questions, visit https://www.dol.gov/cobra-subsidy or contact the Department of Labor at askebsa.dol.gov or 1-866-444-EBSA (3272)

* This restriction does not include coverage under a plan that provides only excepted benefits, a qualified small employer health reimbursment arrangement, or coverage under a health flexible spending arrangement.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

To apply for ARP Premium Assistance, complete this form and return it to the Administrative Office. If you do not return the completed form within 60 days of receipt, you may be unable to receive the premium assistance.

Santa Monica UNITE HERE Health Benefit Trust Fund c/o Benefit Programs Administration	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL** **(Fill out this "BLUE FORM" for Free COBRA)**	1200 Wilshire Blvd., Fifth Floor Los Angeles, CA 91746 (866) 345-5189

PERSONAL INFORMATION (List any dependents on the back of this form)

Name: _____

Mailing Address: _____

City: _____ **State:** ____ **Zip Code:** _____

Telephone number:

(_____) _____-_____

Date of Birth: _____/_____/_____

SSN: _____

To qualify, you must be able to check 'Yes' for all statements.

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	☐ Yes ☐ No
2. I elected (or am electing) COBRA coverage. (If you are not yet enrolled in COBRA, you must complete the Fund's "COBRA Election Form.")	☐ Yes ☐ No
3. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming premium assistance).	☐ Yes ☐ No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

FOR FUND USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason in #4 below and return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	☐
2. Individual did not experience a reduction in hours.	☐
3. Individual did not elect COBRA coverage.	☐
4. Other (please explain)	☐

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Fund:

→ _____ Date → _____

Type or print name → _____ → Telephone number: (866) 345-5189

Need one-on-one help filling out this form? Call the COBRA team at (213) 456-2012 to make an appointment. General questions about COBRA? Call the Fund at (866) 345-5189.

For Further Assistance, you may also contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at https://www.askebsa.dol.gov/WebIntake.

DEPENDENT INFORMATION (Must fill out for every covered dependent applying for Free COBRA. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

1.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

2.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

3.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

DEPENDENT INFORMATION (Must fill out for every covered dependent. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

4.

First Name: _____ Last Name: _____

SSN : _____ Date of Birth:_____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

5.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

6.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

DEPENDENT INFORMATION (Must fill out for every covered dependent. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

7.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

8.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

9.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth:_____/_____/_____

To qualify, you must be able to check "Yes" for all statements.

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was a reduction in hours or an involuntary termination of employment.	☐ Yes ☐ No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Use this "Yellow Form" to notify the Fund that you are eligible for other group health plan coverage or Medicare and therefore NOT ELIGIBLE for premium assistance (Free COBRA) under the ARP.

DO NOT FILL OUT THIS FORM UNLESS YOU CALL THE FUND FIRST: (866) 345-5189

Santa Monica UNITE HERE
Health Benefit Trust Fund
c/o Benefit Programs
Administration

Participant Notification of Ineligibility for ARP Premium Assistance

(For assistance completing this form, call the COBRA Team at: 213-456-2012.)

1200 Wilshire Blvd.,
Fifth Floor
Los Angeles, CA 91746
(866) 345-5189

PERSONAL INFORMATION

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: (_____) _____

Date of Birth: _____/_____/_____

SSN: _____

PREMIUM ASSISTANCE INELIGIBILITY INFORMATION

I. ELIGIBILITY FOR OTHER GROUP HEALTH PLAN COVERAGE. *Complete this Section only if it applies to you or a Dependent.*

1. I am eligible for coverage under another group health plan ("GHP"): ☐ Yes ☐ No
2. Insert date you became (or will become) eligible for coverage under the other GHP: ____/____/_____
   ***Eligibility for coverage does not include any time spent in a waiting period. Thus, you become eligible for other GHP coverage on the earliest date you could start your other coverage even if you decline the other coverage.*
3. If your Dependents are also eligible for other GHP coverage, you must list their names here:

Names of Dependents Eligible for GHP Coverage	Date Eligible for GHP Coverage	Names of Dependents Eligible for GHP Coverage	Date Eligible for GHP Coverage
1.	/ /	6.	/ /
2.	/ /	7.	/ /
3.	/ /	8.	/ /
4.	/ /	9.	/ /
5.	/ /	10.	/ /

II. ELIGIBILITY FOR MEDICARE. *Complete this Section only if it applies to you or a Dependent.*

1. I am (or will become) eligible for Medicare: ☐ Yes ☐ No
2. Insert date you became (or will become) eligible for Medicare: _____/_____/_____
3. If any Dependents are (or will become) eligible for Medicare, you must list their names here:

Names of Dependents Eligible for Medicare	Date Eligible for Medicare
1.	/ /
2.	/ /

Form Continues on Back

CONTINUATION OF COBRA AFTER ARP PREMIUM ASSISTANCE (FREE COBRA) ENDS

This form notifies the Fund that you and/or your Dependents are no longer eligible for ARP Premium Assistance (free COBRA). However, if you do not enroll in the other GHP coverage or Medicare and are still within your maximum COBRA coverage period, you may be able to continue your COBRA coverage by making the full monthly COBRA payments (shown on the Fund's COBRA Rate Sheet). If you choose to continue COBRA for yourself and/or any family member(s), and you do not timely pay COBRA premiums to the Fund, COBRA coverage will end early.

Check the box that applies to you (check only one box):

☐ I would like to terminate COBRA coverage for myself and all of my Dependents when our ARP Premium Assistance (Free COBRA) ends.

☐ I would like to terminate COBRA coverage for all of my family members (including myself), **except the family members listed in the box below who will continue their COBRA coverage** (*note: to continue COBRA coverage for yourself, your name must be listed in the box below)*. The family members who are continuing COBRA coverage (and are listed in the box below), did not (or will not) enroll in the other GHP coverage or Medicare and understand that we/they will have to pay the full cost of COBRA after ARP Premium Assistance ends.

Continue COBRA Coverage After ARP Premium Assistance Ends For the Listed Individuals	Date of Birth	Continue COBRA Coverage After ARP Premium Assistance Ends For the Listed Individuals	Date of Birth
1.	/ /	5.	/ /
2.	/ /	6.	/ /
3.	/ /	7.	/ /
4.	/ /	8	/ /

IMPORTANT

If you fail to notify the Fund when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance, you may be subject to a penalty of $250 dollars (or if the failure is fraudulent, the greater of $250 or 110% of the amount of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the Fund is due to reasonable cause and not due to willful neglect.

Eligibility for other coverage is determined without regard to whether you take or decline the other coverage. This means that you are considered eligible for other coverage, even if you decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period (i.e., your ARP Premium Assistance (free COBRA) will end on the earliest date you could start your other coverage, even if you decline the other coverage).

PLEASE SIGN BELOW

To the best of my knowledge and belief, all of the answers I have provided on this Form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

FOR FUND INTERNAL USE ONLY

COMMENTS:

SANTA MONICA UNITE HERE
HEALTH BENEFIT TRUST FUND

Administered By: Benefit Programs Administration
Telephone • (866) 345-5189 • (562) 463-5075 • FAX (562) 463-5894
www.santamonicauniteherefunds.org

COBRA Continuation Coverage Supplemental Notice

IMPORTANT INFORMATION: COBRA Coverage, ARP Premium Assistance, and other Health Coverage Alternatives

May 2021

To COBRA enrollees in the Santa Monica UNITE HERE Health Benefit Trust Fund:

This supplemental notice has important information about your new rights related to continued health care coverage in the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Fund"). Please read the information contined in this notice very carefully.

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA coverage (i.e., free COBRA for up to 6 months). You are also permitted to switch your coverage option to the Martin Luther King Community Healthcare Program for your COBRA coverage (see below for more information).

Premium assistance is available to certain individuals who are eligible for COBRA coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. *Premium Assistance is not, however, available to Domestic Partners who are enrolled in COBRA.*

If you qualify for premium assistance, you do not need to pay any of the COBRA premiums otherwise due to the Fund for the months you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA coverage beyond that date, you may have to pay the full COBRA premium amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace®[1] (see section on "other coverage options" below).

You are receiving this notice because you experienced a qualifying event that may have been a reduction in hours or an involuntary termination of employment, and you have not reached the maximum period for your COBRA coverage.

If your loss of Fund coverage was due to a reduction in hours or an involuntary termination of employment, you may be eligible for the ARP premium assistance (i.e., free COBRA) for up to 6 months.

To help determine whether you qualify for the ARP premium assistance, you should read this notice and the enclosed documents carefully. In particular, review the "Summary of the COBRA

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

Premium Assistance Provisions under the American Rescue Plan of 2021" with details regarding eligibility, restrictions, and obligations and the blue "Request for Treatment as an Assistance Eligible Individual" form.

If you believe you meet the criteria for the premium assistance, complete the enclosed blue form called the "Request for Treatment as an Assistance Eligible Individual," and submit it to the Administrative Office within sixty (60) days of receiving this notice.

Can I switch to the Martin Luther King Community Healthcare Program?

Yes, you have the right to change to the Martin Luther King Community Healthcare Program (the "MLK Program") for your COBRA coverage, even if you were not previously enrolled in that plan. If you would like to switch to the MLK Program, contact the Administrative Office to request a special form that you must complete and return within 90 days of the date of this notice.

The COVID-19-related deadline relief does not apply to elections related to ARP Premium Assistance

Note, due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued a Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak ("Joint Notice").[2] This notice provided relief for certain actions related to employee benefit plans required or permitted under Title I of ERISA and the Code, including the 60-day initial election period for COBRA coverage. The Department of Labor's Employee Benefits Security Administration (EBSA) provided further guidance on this relief in EBSA Disaster Relief Notice 2021-01.[3] ***The extended deadline relief provided in the Joint Notice and Notice 2021-01 does not apply, however, to the 60-day election period related to COBRA premium assistance under the ARP. Therefore, potential Assistance Eligible Individuals must submit the blue "Request for Treatment as an Assistance Eligible Individual" form within 60 days of receipt of this notice or forfeit their right to premium assistance (free COBRA).***

How much does COBRA coverage now cost?

Your normal monthly cost for COBRA coverage depends on the plan in which you are enrolled (e.g., Kaiser, Health Net, or MLK Program) and the family members in COBRA, and is shown on the enclosed COBRA Rate Sheet. The ARP reduces the COBRA premium to zero for certain individuals who are eligible for COBRA coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for this premium assistance, you need not pay any of the COBRA premium otherwise due to the Fund for the months you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA coverage beyond that date, you may have to pay the full amount due. See the enclosed "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan of 2021" for more details, restrictions,

[2] 85 FR 26351 (May 4, 2020).
[3] Available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf.

and obligations, as well as the blue form that must be completed to establish eligibility for premium assistance (entitled "Request for Treatment as an Assistance Eligible Individual").

If you qualify as an "Assistance Eligible Individual," this monthly premium cost will be zero from April 1, 2021 through September 30, 2021, and you do not have to send any payment for the months you are eligible for premium assistance.

Are there other coverage options besides COBRA Coverage?

Yes. There may be other coverage options for you and your family through the Health Insurance Marketplace® (in California, it's called "Covered California"), Medicare, or other group health plan coverage options (such as a spouse's or parent's plan) through a special enrollment period. Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. If you are not eligible for premium assistance under the ARP, some of these options may cost less than COBRA coverage.

If you are eligible for other group health plan coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement, or a health flexible spending arrangement), or if you are eligible for Medicare, you are not eligible for ARP premium assistance. However, if you have individual market health insurance coverage, like a plan through the Marketplace, or if you have Medicaid, you may be eligible for ARP premium assistance if you elect COBRA coverage. Note, however, that you will not be eligible for a premium tax credit, or advance payments of the premium tax credit, for your Marketplace coverage for months that you are enrolled in COBRA coverage, and you may not be eligible for months during which you remain an employee but are eligible for COBRA coverage with premium assistance because of a reduction of hours. If you're eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

You should compare your other coverage options with COBRA coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA, because the new coverage may impose a new deductible. Also, keep in mind that if you elect COBRA coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a tax credit if you end your COBRA coverage when your premium assistance ends and you are otherwise eligible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

For more information

This notice doesn't fully describe COBRA coverage or other rights under the Fund. More information about COBRA coverage and your rights under the Fund is available in your summary plan description or from the Administrative Office.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact the Administrative Office at: **Santa Monica UNITE HERE Health Benefit Trust Fund, c/o Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, (866) 345-5189 or (562) 463-5075**.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's EBSA website at https://www.dol.gov/agencies/ebsa, go to www.askebsa.dol.gov, or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace®, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, still keep the Administrative Office informed of any changes in your address and the addresses of family members. You should also still keep a copy of any notices you send to the Administrative Office.

Enclosures:

1. Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021
2. Request for Treatment as an Assistance Eligible Individual ("Blue Form")
3. Participant Notification of Ineligibility for ARP Premium Assistance ("Yellow Form")
4. COBRA Rate Sheet

COBRA Rate Sheet

Kaiser HMO COBRA Rates
Effective June 1, 2021

CORE (medical rx only) COBRA rates:

Employee Only	$587.93
Employee plus One	$1,074.89
Employee plus Family	$1,479.07

CORE Plus (medical rx United Concordia dental & vision) COBRA rates:

Employee Only	$612.78
Employee plus One	$1,102.26
Employee plus family	$1,509.51

CORE Plus (medical rx Delta dental & vision) COBRA rates:

Employee Only	$686.35
Employee plus One	$1,175.83
Employee plus family	$1,583.09

HEALTH NET HMO COBRA Rates
Effective June 1, 2021

CORE (medical rx only) COBRA rates:

Employee Only	$440.46
Employee plus One	$830.88
Employee plus Family	$1,102.48

CORE Plus (medical rx United Concordia dental & vision) COBRA rates:

Employee Only	$465.31
Employee plus One	$858.24
Employee plus family	$1,132.93

CORE Plus (medical rx Delta dental & vision) COBRA rates:

Employee Only	$538.88
Employee plus One	$931.82
Employee plus family	$1,206.50

MLK COBRA Rates
Effective March 1, 2021

CORE (medical rx only) COBRA rates:

Employee Only	$210.85
Employee plus One	$390.16
Employee plus Family	$535.64

CORE Plus (medical rx United Concordia dental & vision) COBRA rates:

Employee Only	$234.84
Employee plus One	$415.81
Employee plus family	$563.33

CORE Plus (medical rx Delta dental & vision) COBRA rates:

Employee Only	$303.62
Employee plus One	$484.59
Employee plus family	$632.11