St. Moritz SECURITY SERVICES, INC.

ST. MORITZ BUILDING SERVICES, INC

2027 Medical Plan Changes:
Side-by-Side Comparison

Your 2026 plan ends 12/31/2026. Your new plan starts 1/1/2027.

Benefit	2026 FlexWork MEC w/EHIP → 2027 Apex Tres MEC Advantage with GLI					
	2026 plan (ends 12/31/2026)			2027 plan (starts 1/1/2027)		
	MEC copay	MEC limit	w/EHIP	MEC Adv. copay	MEC Adv. limit	w/Globe Limited Indemnity
Deductible / cost share	Deductible $0; Coinsurance 0%		N/A - supplemental health only	Deductible $0; Coinsurance 0%		N/A - supplemental health only
Annual out-of-pocket max	Employee $9,100; Family $18,200		N/A	Employee $7,900; Family $15,800		N/A
Preventive services & meds	$0	Unlimited	N/A	$0	Unlimited	N/A
HealthiestYou virtual care	—	—	—	—	—	—
Employee Assistance Plan	—	—	—	—	—	—
Office visits (PCP / specialist)	$25 / $50	4 combined	$70; up to 6 days per year (combined limit)	$20 / $50	3 per year (6 combined)	Not Covered
Chiropractor & acupuncture	$15	10 combined	Not covered	Not Covered		Not Covered
Minor lab & imaging (office / hosp. outpt.)	$50 / $150	1 service date	$50; 1 day per year	$50 (in offices)	5 per year	Not Covered
Major lab & imaging (office / hosp. outpt.)	$50 / $150	1 service date	$100; 1 day per year	$200	1 per year	Not Covered
Urgent care	$150	2 per year	Included in physician office benefit	$50 Copay	3 per year	Not Covered
Emergency room	Not covered		Not covered	Not covered		Sickness: $50 (2 days PPY); Injury: $400 (2 days PPY)
Outpatient surgery (office / hosp. outpt.)	Not covered		$1,000; 2 days per year	Not covered		Minor: $300 (1 day PPY); Major surgery: $1,000 (2 days PPY)
Home health care	Not covered		Not covered	Not covered		Not Covered
Rehab & habilitative services	Not covered		Not covered	Not covered		Not Covered
Mental health & substance use	Not covered		Not covered	Not covered		Not Covered
Inpatient services	Not covered		Hospital Admission: $1,500 admission; Inpatient: $200 daily (364 days per year); Inpatient Surgery: $1,000 per surgery (2 days per year)	Not covered		Hospital admission: $2,750 (2 days); Inpatient: $1,250/day (30 days); Inpatient surgery: $1,000 (2 days PPY)
Pharmacy	**Member Cost**	**Annual Limit**	**Paid to Member**	**Member Cost**	**Annual Limit**	**Paid to Member**
Rx Tier 1	$15	Unlimited	$10; 12 days per year	Generic: $0; Tier 1: 10% coinsurance	Unlimited	Not Covered
Rx Tier 2	$30			—	—	—
Rx Tiers 3 & 4	50% cost share			—	—	—

MONTHLY PAYROLL DEDUCTIONS		
Employee	**$180.26**	**$182.44**
Employee + Spouse	**$424.91**	**$370.56**
Employee + Child(ren)	**$322.06**	**$354.52**
Family	**$587.39**	**$545.28**

This is a summary only; official plan documents govern. Questions? Contact Benefit Simply at 888-744-0037.