St. Moritz Security Services, Inc. / St. Moritz Building Services, Inc.

2027 Medical Plan Options

Coverage Summary

Your new plan starts 1/1/2027.

Benefit	Apex Tres Premier $1,000		Apex Tres MEC Advantage with GLI			Apex Tres MEC Advantage		Guardian Hospital Indemnity
	Copay	Annual limit	MEC Adv. copay	MEC Adv. limit	w/Globe Limited Indemnity	Copay	Annual limit	Benefit
Deductible / cost share	Deductible EE/Fam: $1,000 / $2,000; Coinsurance: 0%		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		Employee $7,900; Family $15,800		N/A	Employee $7,900; Family $15,800		N/A
Preventive services & meds	$0	Unlimited	$0	Unlimited	N/A	$0	Unlimited	N/A
Office visits (PCP / specialist)	$25 / $50	Unlimited	$20 / $50	3 per year (6 combined)	Not Covered	$20 / $50	3 per year (6 combined)	$50 per day; max 3 days per insured; 5 days per covered family
Chiropractor & acupuncture	$75	10 per year	Not Covered		Not Covered	Not Covered		Not covered
Minor lab & imaging (office / hosp. outpt.)	1 Radiology $0 preferred; $50 lab, 30% after ded.	Unlimited	$50 (in offices)	5 per year	Not Covered	$50 (in offices)	5 tests per year	$100 per day; max 1 day per year (diagnostic tests)
Major lab & imaging (office / hosp. outpt.)	$0 preferred/$350	2 per year	$200	1 per year	Not Covered	$200	1 test per year	
Urgent care	$75	Unlimited	$50 Copay	3 per year	Not Covered	$50 Copay	3 per year	$100 ER or $50 UC per day; max 1 day per year
Emergency room	$750	1 per year	Not covered		Sickness: $50 (2 days PPY); Injury: $400 (2 days PPY)	Not covered		
Outpatient surgery (office / hosp. outpt.)	$350 / 30% after deductible	2 per year / 1 per year	Not covered		Minor: $300 (1 day PPY); Major surgery: $1,000 (2 days PPY)	Not covered		Not covered
Home health care	$50	15 per year	Not covered		Not Covered	Not covered		Not covered
Rehab & habilitative services	$75	10 per year	Not covered		Not Covered	Not covered		$200 per day; max 10 days per year; must follow hospital confinement
Mental health & substance use	$75	10 per year	Not covered		Not Covered	Not covered		Not covered
Inpatient services	30% after deductible	7 Days	Not covered		Hospital admission: $2,750 (2 days); Inpatient: $1,250/day (30 days); Inpatient surgery: $1,000 (2 days PPY)	Not covered		$2,500/admission; max 2 admissions/year. $300/day confinement; max 31 days/year
Pharmacy	**Member Cost**	**Annual Limit**	**Member Cost**	**Annual Limit**	**Paid to Member**	**Member Cost**	**Annual Limit**	**Paid to Member**
Rx Tier 1	Preventative: $0; Tier 1: $10	Unlimited	Generic: $0; Tier 1: 10% coinsurance	Unlimited	Not Covered	Generic: $0; Tier 1: 10% coinsurance	Unlimited	$10 per day; max 5 days/yr per insured; max of 10 days/yr per covered family
Rx Tier 2	—	—	—	—	—	—	—	—
Rx Tiers 3 & 4	—	—	—	—	—	—	—	—

MONTHLY PAYROLL DEDUCTIONS				
Employee	**10.22% of earnings**	**$182.44**	**$118.76**	**$29.28**
Employee + Spouse	**$981.14**	**$370.56**	**$240.00**	**$61.92**
Employee + Child(ren)	**$801.29**	**$354.52**	**$240.00**	**$49.08**
Family	**$1,572.05**	**$545.28**	**$355.00**	**$81.72**

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