

Effective Dates: January 1, 2027 – December 31, 2027

Attachment A to Summary Plan Description

The Plan's services and benefits, with their Copayments and some of the limitations, are listed below. This is only a brief listing. For further information, please see the Summary Plan Description. **Please keep this Attachment A for your records.**

BENEFITS

ANNUAL OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental health, and substance use disorder services, prescription drugs, and Specialty Drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details.

CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment.

COVERAGE

\$1,600 per individual up to \$4,800 per family. Covered expenses will be paid at 100% for these services thereafter for the remainder of the Calendar Year

\$200 per individual;
\$400 per family

PREVENTIVE CARE:

- **Well Baby Care** (Children under age 3)
- **Routine Physicals** (One per Calendar Year for ages 3+)
- **Covered Immunizations**
- **Preventive prenatal care**
- **OB/GYN preventive visit** (One per Calendar Year)
- **Nutritionist Preventive Visits** (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)
- **Other preventive items and services** (See Certificate of Coverage for details)

100% Coverage

OTHER PRIMARY CARE SERVICES:

- **Medical Physician Services**
- **Hearing Exams**
- **Illness and Injury**
- **X-Ray and Laboratory Procedures**

\$20 Copayment per visit

SPECIALTY CARE: (No PCP Referral Required)

- **Medical Physician Services**
- **Illness and Injury**
- **X-Ray and Laboratory Procedures**
- **OB/GYN Services**

\$30 Copayment per visit
\$30 Copayment per visit
100% Coverage
\$30 Copayment per visit

URGENT CARE CENTER SERVICES:

- **Medical Physician Services**
- **Illness and Injury**

\$50 Copayment per visit

TELEMEDICINE: (Provided through MD Live)

\$15 Copayment per consultation

VISION CARE: (No PCP Referral Required)

- **One routine vision exam per Calendar Year**
- **Other eye care office visits**

\$0 Copayment per visit
\$30 Copayment per visit

ALLERGY SERVICES: (No PCP Referral Required)

- **Physician Services**
- **Testing and Treatment**

\$30 Copayment per visit
80% Coverage

DIAGNOSTIC SERVICES: (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)

\$0 Copayment per service

OUTPATIENT SERVICES: Including but not limited to:

- **Surgery, Observation, Heart Catheterization, and other invasive procedures**

\$50 Copayment per service

OTHER OUTPATIENT SERVICES: Including but not limited to:

- **Diagnostic lab and x-ray, IV therapy, radiation therapy, chemotherapy and hemodialysis**

\$0 Copayment

HOSPITAL INPATIENT SERVICES:

- **Physician and Facility Services**

\$350 Copayment per admission

MATERNITY SERVICES:

- **Physician Services** (Prenatal, delivery, and postnatal care)

100% coverage after \$30
Copayment upon first visit to
OB/GYN per delivery

- **Maternity Hospitalization**

\$350 Copayment per admission

EMERGENCY ROOM SERVICES: (Copay waived if admitted through ER)

\$200 Copayment per visit



SOUTHERN COMPANY

PRE-65 RETIREE



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BENEFITS	COVERAGE
EMERGENCY AMBULANCE SERVICES: (Includes emergency transportation and “Treat in Place” services. Must be Medically Necessary)	80% Coverage
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, & OSTOMY SUPPLIES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: (Limited to 120 days per member each Calendar Year)	80% Coverage
MEDICAL NUTRITION SERVICES: (Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)	\$30 Copayment per visit
DIABETIC SUPPLIES: (For Diabetic Supplies call VIVA HEALTH. Insulin covered under your prescription benefits; call Navitus)	\$0 Copayment for 30-day supply
REHABILITATION SERVICES: (Requires Prior Authorization from VIVA HEALTH) <ul style="list-style-type: none">Physical, Speech, and Occupational Therapy	80% Coverage
HOME HEALTH CARE SERVICES: (Limited to 100 Visits per member per Calendar Year)	80% Coverage
TRANSPLANT SERVICES:	\$350 Copayment per admission
CHIROPRACTIC SERVICES: (No PCP Referral Required. Limited to 25 visits per member per Calendar Year.)	80% Coverage
SLEEP DISORDERS¹:	\$50 Copayment per visit

¹For an annual fee of \$250, Southern Company Members have access to sleep studies through the Nox Sleep Care program. This program includes, but is not limited to, Home Sleep Apnea Testing (HSAT) or Mobile Type II sleep testing, teleclinic and physician services, consultation and oversight management, physician interpretation and medical diagnosis, and treatment supplies. For coverage information, please contact **Nox Health** at 1-877-615-7257.

BENEFITS	COVERAGE
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	Benefits provided by Credence BlueCross BlueShield . Contact Credence BlueCross BlueShield at 1-800-232-3973 for coverage information.
PRESCRIPTION DRUGS:	Prescription benefits provided by Navitus . Contact Navitus at 1-855-213-0141 for coverage information. This includes prescriptions for Specialty Drugs.
EMPLOYEE ASSISTANCE PROGRAM (EAP): <ul style="list-style-type: none">24/7 access to counseling services	Benefits provided by Credence BlueCross BlueShield . Contact Credence BlueCross BlueShield at 1-877-312-5927 for coverage information.

VIVA HEALTH Customer Service: (205) 558-7633 or 1-877-320-7504 | Visit our Website at www.vivahealth.com/apco

Pre-Existing Condition Policy: Eligibility:

No pre-existing condition exclusions or waiting period.

If you live in Alabama, have not reached age 65, and are a retiree of one of the following Employing Companies, you may enroll in this VIVA HEALTH Benefit Option:

- Alabama Power Company;
- Southern Company Services, Inc. – Alabama;
- Southern Communications Services, Inc. – Alabama (doing business as Southern LINC); or
- Southern Power Company

Lifetime Coverage Limit:

\$2,000,000