VIVA HEALTH

SOUTHERN COMPANY PRE-65 RETIREE

Effective Dates: January 1, 2026 – December 31, 2026

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	COVERAGE
ANNUAL OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental 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.	$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
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.	$100 per individual; $300 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**	$10 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**	$75 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)* • **Maternity Hospitalization**	100% coverage after $30 Copayment upon first visit to OB/GYN per delivery $350 Copayment per admission
EMERGENCY ROOM SERVICES: *(Copay waived if admitted through ER)*	$200 Copayment per visit
EMERGENCY AMBULANCE 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

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BENEFITS	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)* • **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 DISORDERS[1]:	$50 Copayment per visit

[1]For an annual fee of $250, Southern Company Members have access to sleep studies through Nox Health's SleepCharge 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): • 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: No pre-existing condition exclusions or waiting period.

Eligibility: 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