Disclaimer: This is only a comparison as required by the Illinois Consumer Coverage Disclosure Act. For detailed benefit information regarding the coverage provided under the **State Farm Insurance Companies Group Medical QHDHP Plan Option 4E (HSA),** or to get a copy of the complete terms of coverage, contact Accolade customer service at **1-844-287-3859,** or visit the BlueCross BlueShield of Illinois website at **www.bcbsil.com/statefarm.** This disclosure is not a substitute for actual plan language. In the event of a conflict with this disclosure and the actual plan language, the plan language will control.

Employer Name:	State Farm Mutual Automobile Insurance Company
Employer State of Situs:	Illinois, Location of Corporate Headquarters
Name of Issuer:	Not applicable; Self Insured ERISA Plan
Plan Marketing Name:	Not applicable; Plan is not marketed to any other indivdiual, group, or association.
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- **Ambulatory patient services (outpatient care you get without being admitted to a hospital)**
- **Emergency services**
- **Hospitalization (like surgery and overnight stays)**
- **Laboratory services**
- **Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)**
- **Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)**
- **Pregnancy, maternity, and newborn care (both before and after birth)**
- **Prescription drugs**
- **Preventive and wellness services and chronic disease management**
- **Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)**

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes, subject to Deductible and Coinsurance. No out of network coverage.
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes, subject to Deductible and Coinsurance. No out of network coverage.
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes, subject to Deductible and Coinsurance. No out of network coverage.
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes, subject to Deductible and Coinsurance. No out of network coverage.
5	Hospice	Ambulatory	Pg. 28	Yes, subject to Deductible and Coinsurance. No out of network coverage.
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Partially, subject to Deductible and Coinsurance. No out of network coverage. Limited to those services for the diagnosis and treatment of infertility; coverage does not include charges resulting from or incurred in connection with in vitro fertilization or other forms of artificial insemination.
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes, subject to Deductible and Coinsurance. No out of network coverage.

8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes, subject to Deductible and Coinsurance. No out of network coverage. Some surgeries may be covered at 100% once the deductible has been met if coordinated through the Lantern (formerly SurgeryPlus) program.
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes, limitations may aply to these services. Subject to Deductible and Coinsurance. Limited to 40 visits per calendar year. No out of network coverage.
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes, subject to Deductible and Coinsurance. No out of network coverage.
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes, subject to Deductible and Coinsurance. No out of network coverage.
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes, subject to Deductible and Coinsurance. No out of network coverage.
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes, subject to Deductible and Coinsurance. $200 Copayment per visit (Copay waived if admitted). Out of network coverage for emergency situations only.
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes, subject to Deductible and Coinsurance. Out of network coverage for emergency situations only.
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes, Bariatric Surgery will only be a covered expense once deductible is met when provided through Lantern (formerly Surgery Plus) ; Obesity diagnosis will be covered, subject to deductible and coinsurance. No out of network coverage.
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes, subject to Deductible and Coinsurance. No out of network coverage.
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes, subject to Deductible and Coinsurance. No out of network coverage (only for correcting congential deformities or conditions resulting from accidental injuries, scars, tumors or diseases).
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes, subject to Deductible and Coinsurance. No out of network coverage.
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes, subject to Deductible and Coinsurance. No out of network coverage. Limited to 100 days per admission.
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes, subject to Deductible and Coinsurance. No out of network coverage. Lower out of pocket costs when treatment is received at a BDC or BDC+ provider for certain services related to transplant services. Benefits for lodging up to a maximum of $50 per day per person; Transportation and lodging are limited to a combined maximum of $10,000 per transplant at BDC facilites; $5,000 per transplant for non-BDC facilities.
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes, subject to Deductible and Coinsurance. No out of network coverage.
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Refer to CVS Caremark for pharmacy benefit details.
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes, subject to Deductible and Coinsurance. No out of network coverage.
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes, subject to Deductible and Coinsurance. No out of network coverage. Medication Assisted Treatment (MAT) combines medication with counseling and behavioral therapies to provide comphrensive substance abuse treatment. Counseling would be covered under the medical benefit in conjunction with methadone. Methadone is used for addition and is typically covered by a medical plan (not through pharmacy coverage) because it is provided in methadone clinics. Refer to CVS Caremark for pharmacy benefit details for the other two medications for treating opiod dependence: buprenorphine and naltrexone.

25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes, subject to Deductible and Coinsurance. No out of network coverage.
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes, subject to Deductible and Coinsurance. No out of network coverage. Services provided by Accolade Care or Teladoc, including mental health, are provided at $0 cost share to the member.
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Refer to CVS Caremark for pharmacy benefit details.
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Dental related services other than those caused by an external accident are not covered.
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Covers vision screensing as part of preventive screening sor children and adolescents only. No out of network coverage.
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes, subject to Deductible and Coinsurance. No out of network coverage.
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes, subject to Deductible and Coinsurance. No out of network coverage.
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes, deductible does not apply. Certain preventive care is covered before you meet your deductible, if in-network. No out of network coverage.
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes, deductible does not apply. Certain preventive services are covered without cost sharing before deductible is met, if in-network. No out of network coverage.
33	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes, subject to Deductible and Coinsurance. No out of network coverage.
33	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes, benefits are available for Medically Necessary diabetic supplies.
33	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes, deductible does not apply. Certain preventive care is covered before you meet your deductible, if in-network. No out of network coverage.
33	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes, subject to Deductible and Coinsurance. No out of network coverage.
33	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes, deductible does not apply. Certain preventive care is covered before you meet your deductible, if in-network. No out of network coverage.
33	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes, deductible does not apply. Certain preventive care is covered before you meet your deductible, if in-network. No out of network coverage.
33	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes, subject to Deductible and Coinsurance. No out of network coverage.
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes, limitations may apply to these services. Subject to Deductible and Coinsurance. Limited to 30 visits per calendar year. No out of network coverage.
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes, subject to Deductible and Coinsurance. Limited to 100 visits per benefit period for occupational therapy, speech therapy and physical therapy. No out of network coverage.

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.