Erie Indemnity Company
Group Critical Illness Insurance Plan
Summary Plan Description

The Erie Indemnity Company Group Critical Illness Insurance Plan (the "Plan") is a welfare benefit plan sponsored by Erie Indemnity Company that allows eligible employees to obtain insurance that provides benefits in the event the employee or an enrolled spouse or dependent child incurs certain critical illnesses. Benefits are paid in accordance with the provisions of a group insurance contract with the critical illness insurance carrier (currently Continental American Insurance Company, a subsidiary of Aflac).

This document, together with the certificate of insurance issued by the critical illness insurance carrier (the "Insurer") constitutes the summary plan description for the Plan effective as of January 1, 2025. The certificate of insurance may contain some of the same general information about Erie Indemnity Company or the Plan that is specified in this document. If any of the general information in a certificate of insurance conflicts with the information in this document, the information in this document will be controlling.

Eligibility Requirements

All full-time Employees of Erie Indemnity Company and any affiliate of Erie Indemnity Company that has adopted the Plan (hereafter "ERIE") are eligible to obtain coverage under the Plan. A complete list of affiliates that have adopted the Plan is set forth at the end of this summary plan description. You are a full-time Employee if you are either: (i) a salaried Employee; or (ii) an hourly Employee and are regularly scheduled to work at least 37-1/2 hours in a normal workweek. However, any person who is a leased employee, who is on another company's payroll or who is treated as an independent contractor by ERIE for payroll tax purposes is not eligible to participate in the Plan. You are also not eligible if you are a temporary or seasonal employee.

Effective Date of Coverage

An eligible Employee must enroll for coverage within 31 days of when he or she first becomes eligible. If the eligible Employee does not enroll for coverage within this period, the Employee must wait until the annual open enrollment period to enroll in coverage. The annual open enrollment period occurs each fall.

If an Employee is enrolled for coverage, the Employee may enroll his or her spouse for coverage, provided the spouse has reached age 18. If an eligible Employee is married when he or she first becomes eligible and the Employee wishes to enroll his or her spouse, the spouse must be enrolled within the same 31-day period. Otherwise, the Employee must wait until the next open enrollment period in which to enroll the spouse. If an enrolled Employee becomes married, the Employee may enroll his or her spouse within 31 days of the marriage. Otherwise, the Employee must wait until

the next open enrollment period in which to enroll the spouse. If the Employee's spouse is under age 18 when the Employee first enrolls in coverage or becomes married, the Employee may enroll the spouse within 31 days following the spouse's 18th birthday. Otherwise, the Employee must wait until the next open enrollment period in which to enroll the spouse.

If you are an eligible Employee and enroll in coverage, your coverage will be effective in accordance with the provisions of the certificate of insurance the Insurer issues to you and it will be shown on the certificate of insurance.

If you have enrolled your spouse or a dependent child, their coverage will be effective in accordance with the provisions of the certificate of insurance issued to you by the Insurer.

In certain circumstances the Insurer may require evidence of insurability before providing coverage. For more information, see the certificate of insurance or contact the Insurer at 1.800.433.3036 or aflac.com/erieinsurance.

Description of Benefits

The critical illness benefits provided under the group insurance contract are fully described in the certificate of insurance issued to you by the Insurer. You should read the certificate of insurance in conjunction with this document. You pay the entire cost for coverage for yourself, your enrolled spouse and any enrolled dependent children. Payment is generally made through payroll deduction on an after-tax basis.

Loss of Coverage

You may cancel your coverage at any time. Otherwise, your coverage under the Plan will generally terminate on the last day of your employment or if you are no longer an active full-time Employee or in the class of employees eligible to participate in the Plan. In certain instances, your coverage may be continued while you are on a leave of absence or you are disabled. If you are disabled, in certain circumstances your coverage can be continued with a premium waiver. You may also be able to continue coverage outside the Plan when coverage would otherwise terminate. For more information on when your coverage ends, continuing your coverage while disabled with a premium waiver, and your ability to continue coverage outside the Plan, see the certificate of insurance issued to you by the Insurer or contact the Insurer at 1.800.433.3036 or aflac.com/erieinsurance.

Generally, coverage for your spouse or dependent child will end when your coverage ends, when that person no longer qualifies as your spouse or dependent child or when you notify the Insurer in writing to terminate such coverage. For more information on when coverage for a spouse or dependent child ends, see the certificate of insurance issued to you by the Insurer. **If you want to continue coverage outside the Plan when coverage otherwise would have ended, you should contact the Insurer as soon as possible because there are time limits on the ability to elect continued coverage.**

Claim Procedures

Different claim procedures apply to a claim for critical illness benefits under the Plan and a determination of total disability for waiver of premiums.

Claim for Critical Illness Benefits

A claim for critical illness benefits must be filed with the Insurer. You may obtain the form to file a claim from the Benefits Operations & Planning

Section of ERIE or directly from the Insurer. For information on what you will need to include with the form, see the certificate of insurance issued to you by the Insurer. Upon receipt of the completed form, the Insurer will investigate and determine if you are entitled to critical illness benefits.

You may designate a representative to act on your behalf in pursuing a claim for critical illness benefits or appealing a denial of a claim for critical illness benefits. You should contact the Insurer to find out how to designate a representative.

A decision on a critical illness benefit claim must be made and the claimant notified of the decision within 90 days of when the Insurer receives the claim. However, if the Insurer determines that special circumstances require an extension of time to make its decision, the 90-day period may be extended by up to an additional 90 days. If an extension is necessary, the Insurer will notify you of the extension within the first 90-day period. The notice must be in writing and it must set forth the special circumstances requiring the extension as well as a date by which the Insurer expects to render a decision on the claim.

If the critical illness claim meets the requirements set forth in the certificate of insurance, the Insurer will pay the claim in accordance with the group insurance contract. If the claim does not meet the requirements set forth in the certificate of insurance and the claim is denied, the Insurer will notify you of the denial. The notification will be in writing and will include the following information:

- The specific reason or reasons for the denial of the critical illness claim.
- A reference to the specific provisions of the group insurance contract, the Plan and any other document, on which the denial is based.
- A description of any additional material or information necessary for you to complete the critical illness claim and an explanation of why such information is needed.
- A description of the procedures by which you can appeal the denial, including applicable time limits.
- A statement regarding your right to bring a civil suit under federal law should you appeal the denied claim and your appeal is denied.

You may appeal a denial of a benefit claim by following the appropriate appeal procedure explained below under Appealing a Claim.

Disability Determination

To file a claim for determination of total disability for continuation of critical illness insurance coverage with a premium waiver, you should contact the Insurer. Upon receipt of the claim for determination of total disability, the Insurer will investigate and determine if you are totally disabled and entitled to continued critical illness insurance coverage with a premium waiver.

You may designate a representative to act on your behalf in pursuing a claim for determination of total disability or appealing a denial of a claim for determination of total disability. You should contact the Insurer to find out how to designate a representative.

The Insurer will decide whether you are totally disabled within 45 days of receipt of a claim for determination of total disability. This 45-day determination period may be extended for up to 30 days if the Insurer determines that such extension is necessary for reasons beyond its

control. If it is determined that such an extension is necessary, the Insurer will notify you in writing of the circumstances requiring the extension of time and the date by which it expects to make a decision on your claim. If before the end of the 30-day extension period, the Insurer determines that, due to matters beyond its control, a decision cannot be made within the extension period, it can extend the determination period for another 30 days. Again, the Insurer will notify you in writing of the circumstances requiring the second extension and the date by which it expects to make a decision on your claim. Any notice of extension that it provides to you will specifically explain:

- The standards on which determination of total disability is based.
- The unresolved issues that prevent it from making a decision.
- What additional information is needed by the Insurer to resolve those issues.

If additional information is needed by the Insurer to make its decision, you will be provided with at least 45 days from the date you are notified of the extension to provide the information. The period of time for the Insurer to make a decision will not include the period from the date on which the notice of extension and request for additional information is sent to you until the date on which you respond to the request for additional information.

If the Insurer determines you are totally disabled, your coverage will be provided without premium payment in accordance with the Plan and the group insurance contract. If your claim is denied, in whole or in part, the Insurer will provide you with a written notice that must include the following information:

- The specific reason or reasons for the denial of the claim.
- A reference to the specific provisions of the group insurance contract, the Plan and any other document, on which the denial is based.
- A description of any additional material or information necessary for you to complete the claim, and an explanation as to why such information or material is necessary.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained in connection with your claim, without regard to whether the advice was relied upon in denying the claim; and (iii) any disability determination made by the Social Security administration that you provided to the Plan.
- If the decision to deny the claim is based on medical necessity or experimental treatment, or any similar exclusion or limit, you will either be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or the group insurance contract to your medical circumstances, or notified that you may request a copy of the explanation free of charge.
- A copy of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in

denying the claim, or a statement that such documents do not exist.

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.
- Information as to how you may appeal the denial of the claim and the applicable time limits.
- A statement regarding your right to bring a civil suit under federal law should you appeal the denied claim and your appeal is denied.

You may appeal a denial of a claim for determination that you are totally disabled by following the appropriate appeal procedure explained below under Appealing a Claim.

Appealing a Claim

Different appeal procedures apply to a claim for critical illness benefits under the Plan and a determination of total disability for waiver of premiums.

Claim for Critical Illness Benefits

If you want to appeal a denied critical illness benefit claim, the Insurer must allow you at least 60 days after you receive the notice of denial to file the appeal. During the 60 days (or any longer period the Insurer may allow), you or your representative may review and obtain from the Insurer copies of all documents, records and information relating to the benefit claim. If you wish, you or your representative may submit written issues, comments and additional justification as to why the benefit claim should be allowed.

The review of the denied claim must take into account all comments, documents, records and other information submitted by you, regardless of whether such information was submitted or considered in the initial benefit determination.

The Insurer will notify you of the decision on appeal within 60 days of its receipt of the request for an appeal. However, if the Insurer determines that an extension of time is necessary, the 60-day period may be extended by up to an additional 60 days. If an extension is necessary, the Insurer will notify you of the extension within the first 60-day period. The notice shall be in writing and shall set forth the special circumstances that require an extension of time, as well as the date by which the Insurer expects to determine the appeal.

The Insurer will provide you with a written notice of the decision on appeal. If the Insurer upholds the denial on appeal, the notice shall include the following:

- The specific reason or reasons for the denial of the claim on appeal.
- A reference to the specific provisions of the group insurance contract, the Plan and any other document, on which the denial is based.
- A statement that you may obtain, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.
- A statement of your right to bring a civil suit under section 502(a) of the Employee Retirement Income Security Act (ERISA).
- A description of any additional voluntary appeal procedures the Insurer may offer.

Disability Determination

If you do not agree with a determination that you are not totally

disabled and eligible for a premium waiver, you have the right to appeal to the Insurer for a full and fair review of the determination.

If you wish to appeal a determination that you are not totally disabled and eligible for a premium waiver, you must file a written notice of appeal with the Insurer. In your appeal, you must state that you are requesting an official review of the determination that you are not totally disabled and the reason(s) why you do not agree with the determination. You should also include any additional information pertinent to the claim. You should review the notice from the Insurer to determine whom to contact to bring an appeal.

If you want to appeal a determination you are not totally disabled and eligible for a premium waiver, the Insurer must allow you at least 180 days after you receive notice of that determination to file the appeal. As part of the appeal, you or your representative may review and obtain from the Insurer copies of all documents, records and information relating to your claim. If you wish, you or your representative may submit written issues, documents, comments and additional justification as to why you should be determined to be totally disabled. The Insurer will provide you with the name of each medical or vocational expert whose advice was obtained in connection with your denied claim, regardless of whether the advice was relied upon.

When the Insurer reviews a denied claim that you are totally disabled and eligible for a premium waiver, it may not afford any deference to the initial decision. The review will be conducted by a designated person or persons at the Insurer who will not be the person who made the initial decision to deny the claim, or a subordinate of the person who made the initial decision. If the denial is based in whole or in part on a medical judgment, the person (or persons) reviewing the claim is required to consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will be someone who was not consulted on the initial denial and is not a subordinate of someone who was consulted on the initial denial.

The Insurer will make a decision on appeal within 45 days of when you file the appeal. The time period for deciding the appeal may be extended for one additional 45-day period provided that, prior to the extension, the Insurer notifies you in writing that an extension is needed due to special circumstances, identifies those circumstances and gives you the date by which it expects to render a decision on your appeal. If the extension is due to your failure to submit information necessary to decide your claim on appeal, the time for making the decision shall be tolled from the date on which the notification of extension is sent to you until the date the Insurer receives your response to the request for additional information.

The Insurer must provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Insurer in connection with your disability claim on appeal. Such evidence must be provided to you by the Insurer as soon as possible and sufficiently in advance of the date on which the decision on appeal is to be made in order to provide you a reasonable opportunity to respond. In addition, if

a new or additional rationale for denying the disability claim on appeal will be relied upon by the Insurer, it must provide you, free of charge, such rationale sufficiently in advance of the date on which the decision on appeal is to be made in order to provide you with a reasonable opportunity to respond.

The Insurer will provide you with a written notice of the determination on appeal. If the Insurer upholds the denial of your claim that you are totally disabled and eligible for a premium waiver, the notice is required to include the following information:

- The specific reason or reasons for the adverse determination.
- The specific provisions of the group insurance contract, the Plan and any other document on which the adverse determination is based.
- A statement that you may obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained by the Insurer in connection with your claim, without regard to whether the advice was relied upon in denying the claim; and (iii) any disability determination made by the Social Security administration that you provided to the Plan.
- If the decision to deny the claim is based on medical necessity or experimental treatment, or any similar exclusion or limit, you will either be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or the group insurance contract to your medical circumstances, or notified that you may request a copy of the explanation free of charge.
- A copy of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that such documents do not exist.
- A statement regarding your right to bring a civil suit under section 502(a) of the Employee Retirement Income Security Act (ERISA). This will include any applicable contractual limitations period that applies to your right to bring a civil suit, together with the calendar date on which the contractual limitations period expires for the claim.
- A description of any additional voluntary appeal procedures the Insurer may offer.

Discretionary Authority

To the extent allowed by law, the Insurer has full discretionary authority to interpret and construe the terms of the group insurance contract and to determine eligibility for benefits under the group insurance contract. The Employee Benefits Administration Committee has full discretionary authority to interpret and construe the terms of the Plan, other than the group insurance contract. The Employee Benefits Administration Committee has the sole authority to replace an Insurer and to designate a new Insurer.

Benefit Plan Administration

The Plan Administrator is the Erie Indemnity Company Employee

Benefits Administration Committee. Many of the day-to-day administrative functions are performed through the Erie Indemnity Company Benefits Operations & Planning Section. Legal notices may be filed with and legal process served upon the agent for legal services as identified at the end of this summary plan description.

Plan Modification and Amendment

Erie Indemnity Company may modify or amend the Plan at any time and for any reason. Except as otherwise required by applicable law, any amendment or modification may be done without prior notice to plan participants. The Board of Directors of Erie Indemnity Company may modify or amend the Plan by a duly adopted resolution, and the amendment or modification shall be effective as of the date specified in the enabling resolution. In addition, the Employee Benefits Administration Committee has the authority to adopt certain amendments to the Plan. A copy of a plan amendment or modification shall be provided to the Plan Administrator of the Plan and, to the extent necessary or appropriate, to any outside service provider of the Plan. The Plan Administrator of the Plan shall notify all covered participants and beneficiaries of any modification or amendment that changes the substantive terms of the Plan within the timeframe required under applicable law and regulations. Any such notice shall contain such information and be in such form as is required by applicable law and regulations.

Plan Termination

Erie Indemnity Company may terminate the Plan at any time and for any reason. Except as otherwise required by applicable law and regulations, any plan termination may be done without prior notice to plan participants. Any plan termination shall be done by resolution of the Board of Directors of Erie Indemnity Company, and the plan termination shall be effective as of the date specified in the enabling resolution. A copy of the resolution shall be provided to the Plan Administrator of the Plan and, to the extent necessary or appropriate, to any outside service provider of the Plan. The Plan Administrator of the Plan shall notify plan participants and beneficiaries of the plan termination in accordance with applicable law and regulations.

ERISA Rights

You are entitled to certain rights and protections. ERISA provides that all plan participants of plans covered by ERISA are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Plan Administrator's office and at other specific locations, such as worksites, all documents governing the Plan including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain upon request to the Plan Administrator copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan

Administrator is required by law to furnish you with a copy of the summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a Federal or state court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have questions about the Plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Information

Plan Name

Erie Indemnity Company Group Critical Illness Insurance Plan

Plan Number

512

Plan Type

Welfare Plan (Critical Illness Indemnity)

Source of Contributions

Employee

Payment of Benefits

Plan Insurer pays all plan benefits.

Plan Year

January 1st to December 31st

Plan Sponsor

Erie Indemnity Company

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Employer Identification Number:

25-0466020

Plan Administrator

Erie Indemnity Company Employee

Benefits Administration Committee

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Service of Legal Process

Erie Indemnity Company

Law Division

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Plan Insurer

Continental American Insurance Co.

2801 Devine Street

Columbia, SC 29205

Adopting ERIE Affiliates

Erie Insurance Company of New York

Erie Resources Management Corp.