Erie Indemnity Company
Long Term Disability Income Plan
Summary Plan Description

The Erie Indemnity Company Long Term Disability Income Plan (the "Plan") is a welfare benefit plan sponsored by Erie Indemnity Company (ERIE) that provides long-term disability income benefits to eligible employees under a group insurance contract with the long-term disability insurance carrier (currently Metropolitan Life Insurance Company).

This document, together with the certificate of insurance issued by the long-term disability insurance carrier (the "LTD Insurer") constitutes the summary plan description for the Plan as of January 1, 2025. The certificate of insurance may contain some of the same general information about ERIE 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 (and any affiliate of ERIE that has adopted the Plan) are eligible for coverage under the Plan after completing 90 days of continuous employment with ERIE (or an affiliate of ERIE that has adopted the Plan). A complete list of ERIE 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

If you are a full-time Employee, coverage will be effective for you on the day after the day you complete 90 days of continuous employment provided you are "actively at work" on the day before coverage would begin. If you change status from part-time to full-time, coverage will be effective for you on the later of (i) the day after the day you complete 90 days of continuous employment; or (ii) the day your status changes from part-time to full-time, provided you are "actively at work" on the day before coverage would begin.

The definition of "actively at work" is set forth in the certificate of insurance issued to you by the LTD Insurer. If you are not "actively at work" on the day before coverage would begin, coverage will not be effective until the day after you have been "actively at work" with ERIE (or an affiliate of ERIE that has adopted the Plan) for one day. For more information

on the requirement that you be "actively at work" on the day before coverage is to commence, see the certificate of insurance issued to you by the LTD Insurer.

Description of Benefits

The long-term disability income benefits provided under the group insurance contract are fully described in the certificate of insurance issued to you by the LTD Insurer. You should read the certificate of insurance in conjunction with this document. ERIE pays the entire cost of your coverage under the Plan.

Loss of Coverage

Your long-term disability coverage under the Plan will 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 injured or sick. For more information on when your coverage may be continued, see the certificate of insurance issued to you by the LTD Insurer.

Claim Procedures

A claim for long-term disability benefits should be made by contacting the LTD Insurer or the Absence Management Section of ERIE. For more information, see the certificate of insurance issued to you by the LTD Insurer. Upon receipt of a claim for long-term disability benefits, the LTD Insurer will investigate the claim and determine if you are entitled to disability benefits.

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

The LTD Insurer will decide whether you are entitled to disability benefits within 45 days of when it receives the claim for long-term disability benefits. This 45-day determination period may be extended for up to 30 days if the LTD Insurer determines that such extension is necessary for reasons beyond its control. If it is determined that such an extension is necessary, the LTD 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 LTD 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 LTD 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 entitlement to a disability benefit is based;
- The unresolved issues that prevent it from making a decision on the claim; and
- What additional information is needed by the LTD Insurer to resolve those issues.

If additional information is needed by the LTD 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 LTD Insurer to make a decision may be suspended 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 your claim is allowed, the LTD Insurer will begin providing you with disability benefits in accordance with the Plan. If your claim is denied, in whole or in part, the LTD 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 denial and your appeal is denied.

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

Appealing a Claim

If you do not agree with the denial of your disability claim, you have the right to appeal to the LTD Insurer for a full and fair review of the denial.

If you wish to appeal a denial, you must file a written notice of appeal with the LTD Insurer. In your appeal, you must state that you are requesting an official review of the denial of your disability claim and the reason(s) why you do not agree with the denial. You should also include any additional information pertinent to the claim. You should review the notice of denial from the LTD Insurer to determine

whom to contact to bring an appeal.

If you want to appeal a denied disability claim, the LTD Insurer must allow you at least 180 days after you receive notice of a denial to file the appeal. As part of the appeal, you or your representative may review and obtain from the LTD Insurer copies of all documents, records and information relating to your disability claim. If you wish, you or your representative may submit written issues, documents, comments and additional justification as to why the disability claim should be approved. The LTD 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 LTD Insurer reviews a denied disability claim, it may not afford any deference to the initial decision. The review will be conducted by a designated person or persons at the LTD 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 disability 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 who is not a subordinate of someone who was consulted on the initial denial.

The LTD 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 LTD 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 application 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 LTD Insurer receives your response to the request for additional information.

The LTD Insurer must provide you, free of charge, with any new or additional evidence, considered, relied upon or generated by the LTD Insurer in connection with your claim on appeal. Such evidence must be provided to you by the LTD 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 claim on appeal will be relied upon by the LTD 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 LTD Insurer will provide you with a written notice of the determination on appeal. If the LTD Insurer upholds the denial of your disability claim 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 LTD 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 LTD Insurer may offer.

Discretionary Authority

The LTD 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 LTD Insurer and to designate a new Insurer.

Benefit Plan Administration

The Plan Administrator is the Employer Benefits Administration Committee of ERIE. Many of the day-to-day administrative functions are performed through the Absence Management Section of ERIE. 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 of ERIE has the authority to adopt certain amendment 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 Administrators 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 employee benefit 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 a 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 Long Term Disability Income Plan

Plan Number

504

Plan Type

Welfare Plan (Long Term Disability)

Source of Contributions

Employer

Payment of Benefits

Plan insurer pays all plan benefits.

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

Metropolitan Life Insurance Co.

200 Park Avenue

New York, NY 10166

Adopting ERIE Affiliates

Erie Insurance Company of New York

Erie Resources Management Corp.

Plan Year

January 1st to December 31st