Erie Indemnity Company
Pre-Tax Payment Plan
Summary Plan Description

The Health Care Flexible Spending Accounts under the Pre-Tax Payment Plan are governed by the Employee Retirement Income Security Act (ERISA).

The Dependent Care Flexible Spending Accounts are not governed by ERISA.

The Erie Indemnity Company Pre-Tax Payment Plan is a "cafeteria plan" that allows eligible Employees to obtain additional benefits on a pre-tax basis. This is a summary plan description of the Pre-Tax Payment Plan as of January 1, 2025. It is only a summary of the Plan. You may obtain a copy of the Plan document from the Benefits Operations & Planning Section. If there is a conflict between this summary plan description and the Plan document, the Plan document will govern.

Highlights

If you are enrolled in the Health Protection Plan, the Dental Assistance Plan and/or the Vision Care Plan, the Plan allows you to pay your share of the cost of coverage through payroll deduction before taxes are taken out of your pay.

You may also be able to contribute to a Health Care Flexible Spending Account or Dependent Care Flexible Spending Account under the Plan through payroll deduction. Your contributions to a flexible spending account (also referred to as an FSA) are taken out of your pay and credited to your FSA before taxes are taken out of your pay.

Finally, if you have elected the Consumer Directed Health Plan (CDHP) option under the Health Protection Plan, you may be able to contribute to a Health Savings Account (also referred to as an HSA) through payroll deduction. Note, however, that **if you contribute to an HSA you may not establish a Health Care FSA** (see Health Savings Account below).

Highlights of the Plan are:

- By paying your share of the cost of coverage under the Health Protection Plan, the Dental Assistance Plan and the Vision Care Plan through the Pre-Tax Payment Plan you do not pay FICA (Social Security) taxes on your payments, nor are income taxes withheld from your payments.
- If you establish a Health Care FSA, you can contribute to the Health Care FSA and use monies in the account to pay for qualifying expenses that are not covered under the Health Protection Plan, the Vision Care Plan or the Dental

Assistance Plan, such as deductibles, copayment and coinsurance amounts. Amounts withheld from your pay that are contributed to a Health Care FSA are not subject to FICA taxes or income tax withholding.

- Amounts you contribute to a Health Care FSA you have established can generally be used to reimburse you for qualifying unreimbursed medical expenses of your dependent even if your dependent is not covered under the Health Protection Plan, Vision Care Plan or Dental Assistance Plan.
- If you have a qualifying dependent you can establish and contribute to a Dependent Care FSA and have qualifying dependent care expenses reimbursed from the account. Your payroll deduction contributions to the account are not subject to FICA taxes and income tax withholding. Since reimbursements from the account are generally not taxable, you can save taxes on your dependent care expenses.
- If you elect to establish and participate in a Health Care FSA and/or a Dependent Care FSA you may only submit for reimbursement eligible expenses that were incurred during the year (or any shorter period within the year in which you participate). If you do not use all amounts in your account by the end of the plan year, any unused amounts are forfeited by you.
- If you have elected the CDHP option under the Health Protection Plan and you have established an HSA, your contributions to the HSA through the Plan are not subject to FICA (Social Security) taxes, nor are income taxes withheld from your payments. If you are contributing to an HSA you may not have a Health Care FSA (see Health Savings Account below).
- Enrollment in the Plan is on an annual basis. Once you make an election to participate in the Plan for the year you generally cannot change your election except in certain specific cases that are described in more detail later in this summary plan description.

Eligibility

If you are a full-time Employee of Erie Indemnity Company (ERIE) or any affiliate of ERIE that has adopted the Plan, you are eligible to participate in the Pre-Tax Payment Plan on your date of hire or the date you become a full-time Employee. A complete list of ERIE affiliates that have adopted the Pre-Tax Payment Plan is set forth at the end of this summary plan description. You are a full-time Employee if you are a common law employee of ERIE or any affiliate of ERIE, and 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 temporary employee, who is a leased employee, who is on another company's payroll or who is treated as an independent contractor for payroll tax purposes is not eligible to participate in the Plan.

Participation

You must enroll to participate in the Pre-Tax Payment Plan. If you are a new full-time Employee you must enroll when you are hired through the myBenefits online enrollment system at ERIE. If you are a part-time Employee and you change status to become a full-time Employee, you must enroll when your status changes from part-time to full-time by enrolling

through the myBenefits online enrollment system at ERIE.

If you do not begin participation in the Plan when first eligible, you may begin participation effective as of the beginning of the next plan year (a plan year is the calendar year) by enrolling during the annual open enrollment period for that year. See "Annual Open Enrollment Period." In certain instances, you may be able to enroll in the Plan (or a feature of the Plan) before the next plan year. See "Mid-Year Election Changes."

Dependents

The definition of who is your dependent differs for purposes of the Health Care FSA and the Dependent Care FSA.

Health Care Flexible Spending Account—Generally, a person is your dependent for a Health Care FSA if he or she qualifies as your dependent under the Health Protection Plan. For a Health Care FSA your dependent includes:

- Your spouse
- Your child who is under age 26. This includes not only your natural child, but also your stepchild and any child you have adopted.
- A child who is under age 26 and who is solely supported by you and is either related by blood or you are the child's legal guardian. If the child is your foster child, you will be treated as solely supporting the child.
- An unmarried child who is described above except that the child has attained age 26, provided that the child is fully disabled and depends chiefly on you for maintenance and support. The disability must have commenced prior to the child's attainment of age 26.

For more information, or if you have questions as to whether a person would be your dependent for purposes of the Health Care FSA, please contact the Benefits Operations & Planning Section.

Dependent Care Flexible Spending Account—A person is your dependent for a Dependent Care FSA if:

- The person is your "qualifying child" under Section 152 of the Internal Revenue Code and is under age 13.
- The person is your dependent under Section 152 of the Internal Revenue Code and is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year.
- The person is your spouse, if your spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year.

For more information or if you have any questions as to whether a person would be your dependent for purposes of the Dependent Care FSA, please contact the Benefits Operations & Planning Section.

Annual Open Enrollment Period

In the fall of each year, ERIE conducts an annual open enrollment period. At this time, you will have the opportunity to make elections under the Plan that will be effective on January 1st of the following year. For example, you can elect to establish a Health Care FSA or Dependent Care

FSA. If you would like an FSA for the upcoming plan year you **must** make an affirmative election to establish the account. **If you do not elect to establish an FSA for the upcoming plan year, you will not have an FSA even if you have one in the current year.**

Mid-Year Election Changes

Generally, you may not change your election during the plan year (January 1 to December 31). However, in certain circumstances the Internal Revenue Service allows mid-year election changes. These mid-year change in election rules do not apply to contributions you make to an HSA through the Plan (see Health Savings Accounts below). If you have elected to contribute to an HSA through the Plan, you may change that election at any time on a prospective basis.

Change in Status—If you have a change in status, you are permitted to make certain changes to your election. Changes in status include the following events that may affect your eligibility for coverage:

- **Legal Marital Status**—Events that change your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
- **Number of Dependents**—Events that change your number of dependents, including birth, adoption, placement for adoption or death of a dependent. Whether an individual is your dependent is different for purposes of the Health Care FSA and the Dependent Care FSA. See the section entitled "Dependents."
- **Employment Status**—Certain changes in your employment status or the employment status of your spouse, including termination or commencement of employment, a strike or lockout, any other event that causes you to cease to be eligible to participate in this Plan or a health related plan, and any event that causes a spouse or dependent to become eligible or cease to be eligible in a similar plan of his or her employer.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**—An event that causes your dependent to satisfy or cease to satisfy requirements for coverage under this Plan or a health related plan due to attainment of age, student status or similar circumstance.
- **Change in Residence or Worksite**—A change in your place of residence or work, or that of your spouse or dependent.

If you have a change in status, you should notify the Benefits Operations & Planning Section within 30 days of the change. **Any change you make in your election because of a change in status must be on account of and consistent with the change in status that you experience.**

Example—A married Employee has individual coverage under the Health Protection Plan. His spouse has coverage under her employer's group health plan. The spouse is laid off causing her to lose coverage under her former employer's group health plan. The Employee may change his coverage under the Health Protection Plan to provide coverage for her and change his contribution under this Plan to cover the increased amount he must pay for her coverage, since that change is on account of and

consistent with the spouse's loss of coverage under her former employer's plan. The Employee may not stop his contribution to this Plan because that change is not consistent with the spouse's loss of coverage.

Special Enrollment Rights—You are permitted to change your election if the election change corresponds to special enrollment rights that become available to you or your dependent(s) under the Health Protection Plan, the Dental Assistance Plan and the Vision Care Plan. Generally, special enrollment rights are available when you acquire a new dependent or when you and/or a dependent lose coverage under another health benefit plan. See the summary plan descriptions for each of those plans for more information on special enrollment rights.

Judgment, Decree or Order—Certain election changes may be made in the case of a judgment, decree or order that results from a divorce, legal separation, annulment or change in legal custody, if the judgment, decree or order pertains to health benefit coverage with respect to your child.

Significant Cost Change—If there is a significant increase or decrease in the cost of a benefit option, you may be able to make an election change with respect to that option. In the case of a Dependent Care FSA, you may only make an election change if the cost change is imposed by a dependent care provider that is not a relative. You may not make a change in election for a Health Care FSA on this basis.

Significant Coverage Change—If there is a significant change in coverage or a coverage option under this Plan, or a new benefit package option is added under the Plan, you may be able to make an election change. You cannot make a change in election for a Health Care FSA on this basis.

Special Rule for COBRA Continuation Coverage—If your dependent becomes eligible and elects COBRA continuation coverage under the Health Protection Plan, the Dental Assistance Plan or the Vision Care Plan due to the dependent's loss of eligibility for coverage as your dependent, you may elect to pay for the dependent's COBRA continuation coverage on a pre-tax basis through this Plan. The election automatically terminates when the dependent ceases to be eligible for COBRA continuation coverage or ceases to qualify as your dependent for tax purposes.

The mid-year change in election rules can be complicated, so it is suggested that if an event occurs that may allow you to make a mid-year change in election you promptly contact the Benefits Operations & Planning Section with any questions you may have regarding your right to change your election.

Mid-Year Election Changes by ERIE — The Plan is subject to non-discrimination requirements under federal tax law. ERIE may unilaterally change or revoke the election of highly compensated participants or key employees if it determines that the Plan may otherwise fail to pass one of the non-discrimination requirements. If such an action is taken. ERIE will notify the affected employees.

Family and Medical Leaves

If you go on an unpaid leave of

absence that is treated as leave under the Family and Medical Leave Act (FMLA) you will be permitted to continue to pay for your share of the cost of coverage under the Health Protection Plan, the Dental Assistance Plan and the Vision Care Plan and continue participation in a Health Care FSA if you choose to do so. Depending on the method of payment used by you, the contributions may be on a pre-tax basis. If you choose not to continue participation during the leave, you will be allowed to resume participation upon returning from the leave. For more information on your rights under the FMLA and the payment methods you may use if you decide to continue participation, please contact the Benefits Operations & Planning Section.

Qualified Medical Child Support Orders

A qualified medical child support order is a judgment, decree or order issued by a court or a National Medical Support Notice issued by a state agency, which provides for child support or health benefit coverage, including coverage relating to benefits under a Health Care FSA, and which meets certain requirements as to form and substance. In accordance with ERISA, coverage under a Health Care FSA will be provided to a child of an Employee in accordance with the terms of any medical child support order that the Administrator of the Plan determines to be a qualified medical child support order. If you receive a medical child support order it should be submitted to the Benefits Operations & Planning Section. The Administrator of the Plan will promptly notify the involved individuals of the receipt of the order and of the Plan's procedure for determining whether the order is a qualified order. You may request a copy of the Plan's procedure for determining whether an order is a qualified medical child support order from the Benefits Operations & Planning Section.

Medical Privacy Rights

Information that is provided to the Pre-Tax Payment Plan regarding your medical care and payment for that care is subject to privacy rules issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes information provided to the Plan in order for you to be reimbursed for qualified medical expenses from your Health Care FSA. You can obtain more information about your medical privacy rights under the Plan from the Notice of Privacy Practices for the Plan. You may obtain a copy of the Plan's Notice of Privacy Practices from *ERIEweb* (Info Center – Benefits information – Privacy Practices) or from the Benefits Operations & Planning Section.

Termination of Participation

Participation will terminate under the Pre-Tax Payment Plan when:

- The Employee terminates employment with ERIE (and any affiliate of ERIE that has adopted the Plan).
- The Employee's hours are reduced so that the Employee is no longer full-time.
- The Employee elects to no longer participate during open enrollment or pursuant to a permissible mid-year election change.
- The Employee dies.
- The Plan is terminated or is

amended to exclude the class of employees to which the Employee belongs.

Coverage for a dependent will terminate under the Pre-Tax Payment Plan when:

- Participation ends for the Employee.
- The dependent no longer qualifies as a dependent under the Plan. Note that a person may be a dependent for purposes of the Health Care FSA and coverage under the Health Protection Plan, the Dental Assistance Plan and the Vision Care Plan and **not** be a dependent for purposes of the Dependent Care FSA.

An Employee or dependent that would otherwise lose coverage under a Health Care FSA may have the right to continue that coverage through the end of the plan year. See "Continuation of Coverage Rights."

Continuation of Coverage Rights

If your participation in the Plan ends due to your termination of employment or reduction in hours so you are no longer a full-time employee and you have a Health Care FSA under the Plan, you (and your spouse or dependents) may be able to elect COBRA continuation coverage for the remainder of the plan year. You may elect COBRA continuation coverage for a Health Care FSA only if the maximum amount of reimbursements you may receive for the balance of the plan year exceeds the total amount of what your payments would be to continue coverage for the remainder of the plan year. If a person elects COBRA continuation coverage, the Plan may charge 102 percent of the monthly amount the employee would have contributed under his or her original election.

Example—An Employee elected to contribute $1,200 to a Health Care FSA for a plan year. On June 30th, the Employee terminated employment after having made $600 in contributions to his Health Care FSA. The amount the Employee would be required to pay for COBRA continuation coverage for the remainder of the plan year is $612 (102 percent of the monthly amount of $100 for 6 months). If the Employee had only received reimbursement of $400 from the Health Care FSA when he terminated employment, he could elect COBRA continuation coverage because the maximum amount of reimbursements he could receive for the remainder of the plan year ($1,200 minus $400, or $800) exceeds the $612 he would have to make in COBRA continuation coverage payments. However, if the Employee had received reimbursements of $590 when he terminated employment he would not be eligible to elect COBRA continuation coverage because the maximum amount of reimbursements he could receive for the remainder of the plan year ($1,200 minus $590, or $610) is less than the $612 he would have to make in COBRA continuation coverage payments.

If you are eligible to elect COBRA continuation coverage when you stop participating in the Plan because of termination of employment or reduction in hours (both of which are "qualifying events"), you will be provided with additional information regarding your rights to COBRA

continuation coverage, as well as a form to elect COBRA continuation coverage. If you are eligible to elect COBRA continuation coverage, you must make the election within 60 days following the later of when your Health Care FSA coverage would otherwise end or when you have been notified of your right to elect COBRA continuation coverage.

If a "qualifying event" occurs, your spouse and/or your dependents may have COBRA continuation coverage rights. A qualifying event is one of the following events that will cause your spouse or dependent to lose coverage under your Health Care FSA:

- Your death
- Your termination of employment or the reduction in your hours
- Your spouse's divorce from you
- Your dependent ceasing to meet the requirements for being a dependent

In the case of your divorce from your spouse or your child ceasing to qualify as your dependent, you or the spouse or dependent must notify the Benefits Operations & Planning Section as soon as possible (but not later than 60 days) after the divorce or the dependent child ceases to qualify as a dependent. The notice must be provided in writing.

An election may only be made by the spouse or dependent if the maximum amount of reimbursements for the remainder of the plan year exceeds the total amount of COBRA continuation coverage payments your spouse or dependent would make for the remainder of the plan year under rules similar to those described above. If your spouse or a dependent has a right to elect COBRA continuation coverage, the spouse or dependent must make the election within 60 days following the later of the date the Health Care FSA coverage would end or when the spouse or dependent has been notified of their right to elect COBRA continuation coverage.

In the case of your termination of employment or reduction in hours, if you are eligible to elect COBRA continuation coverage and do so, your spouse and dependents will be covered under your election and need not make their own election.

If an election of COBRA continuation coverage is made, the initial payment of the monthly amount(s) must be made within 45 days. Subsequent monthly payments are due on the first of each month, with a 30-day grace period for payment.

For more information regarding your COBRA continuation rights, please contact the Benefits Operations & Planning Section.

Health Care Flexible Spending Account

Each plan year there is a maximum amount and a minimum amount that you may contribute to a Health Care FSA. For 2025, the maximum amount is $3,200 and the minimum amount is 1.00 per pay period. The maximum amount is adjusted each year, as necessary to comply with federal law. If you establish a Health Care FSA during the plan year, a reduced minimum and/or maximum amount may apply for that plan year. For more information you should contact the Benefits Operations & Planning Section.

Each plan year that you would like a Health Care FSA, you must

affirmatively elect to establish the account, as well as elect the amount you wish to contribute for the year (subject to applicable minimum and maximum amounts). Note that **if you are contributing to an HSA at any time during the year, you may not establish a Health Care FSA**.

You can use the amount credited to your Health Care FSA to reimburse you for qualifying medical expenses you incur during the plan year for yourself, and your dependents (including your spouse). A qualifying medical expense is generally any expense for "medical care" (as that term is used in section 213 of the Internal Revenue Code) that is incurred during the plan year by you or your dependent and that is **not** reimbursable by insurance or otherwise. Effective January 1, 2020 over-the-counter drugs qualify for reimbursement regardless of whether they are prescribed. In addition, effective January 1, 2020 certain menstrual care products are qualifying medical expenses. Effective January 1, 2021, the purchase of personal protective equipment, such as masks, hand sanitizers and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 are qualifying medical expenses. However, certain expenses are **not** reimbursable from your Health Care FSA, even if they meet the definition of "medical care", such as health insurance premiums and long-term care expenses.

Examples of items that can be qualifying medical expenses are:

- Acupuncture
- Artificial limbs
- Birth prevention surgery
- Chiropractic Care
- Contact lens equipment and materials
- Copayments
- Coinsurance
- Deductibles
- Guide dogs
- Hearing aids
- Insulin
- Lasik surgery (Laser-Assisted in Situs Keratomileusis)
- Menstrual care products such as tampons, liners, pads, cups, sponges or similar products
- Organ transplants
- Orthodontia
- Over-the-counter drugs and medicines, regardless of whether they are prescribed
- Oxygen and related equipment
- Routine physical exams
- Special TV and telephone equipment for the deaf
- Stop smoking program fees and related medications
- Weight loss programs if undertaken at a physician's direction to treat an existing disease such as hypertension, heart disease, high cholesterol and Type II diabetes
- Wheelchairs

Examples of items that are **not** qualifying medical expenses are:

- Cosmetic surgery
- Expenses reimbursed under or paid by the Health Protection Plan, Dental Assistance Plan or Vision Care Plan or any other health, vision, dental or drug plan
- Vitamins

- Weight loss programs (except as noted above)

For further information on whether an expense may be a qualifying medical expense, please contact the Claims Administrator, HealthEquity.

To be eligible for reimbursement a qualifying medical expense must have been incurred during the plan year. However, if you established a Health Care FSA after the beginning of the year, the qualifying medical expense must have been incurred during the period within the plan year in which you had the account. A medical expense is incurred when the service is performed, not when you are billed or pay for the service.

When you establish a Health Care FSA, the entire amount you elect for the plan year (or shorter period if, for example, you are a new Employee who establishes an account during the plan year) is available for reimbursements.

If you do not use the entire balance in your Health Care FSA by the end of the plan year, any balance in your account will be forfeited. This "use it or lose it" rule makes it important for you to plan your Health Care FSA election carefully.

Dependent Care Flexible Spending Account

Each plan year you would like a Dependent Care FSA you must affirmatively elect to establish the account together with the amount you wish to contribute for the year. The maximum amount you may contribute to a Dependent Care FSA Spending Account for a plan year is $5,000 (in order to satisfy non-discrimination requirements under the Internal Revenue Code, ERIE may limit contributions by highly compensated employees to a lower amount). **However, the maximum amount that you may receive in reimbursements from a Dependent Care FSA that are excluded from your taxable income may be lower, depending upon your spouse's earnings and whether you and your spouse file separate Federal income tax returns.** The maximum amount of reimbursements for dependent care expenses you receive in a plan year that are excludible from your taxable income is limited to the **smallest** of the following:

- Your actual earned income for the plan year;
- Your spouse's actual earned income for the plan year (or deemed earned income in the case of a spouse who is a full-time student or who is mentally or physically incapable of self-care);
- Five thousand dollars ($5,000); or
- Two thousand five hundred dollars ($2,500) if you and your spouse file separate Federal income tax returns for the year.

If your spouse is a full-time student or is physically or mentally incapable of self-care, your spouse will be treated as earning $250 per month if you have one dependent and $500 per month if you have more than one dependent.

You must have one or more dependents (see Dependents above) in order to contribute to a Dependent Care FSA. Dependent care expenses are eligible for reimbursement only if they meet the following criteria:

- The dependent care expenses must be incurred in order for you and your spouse to work (unless your spouse is physically or mentally

incapable of caring for himself or herself, or is a full-time student).

- The expenses must be for the care of a dependent, either inside or outside of your house by a babysitter, eligible day care center or other dependent care provider.
- If care is provided by a day care center, the center must be properly licensed under all applicable state and local laws, provide care for more than six individuals who do not live at the center, and receive a fee for its services.
- The expenses must not have been paid to someone who can be claimed as a dependent on your or your spouse's Federal income tax return, or to a child of yours who is under age 19.

If the dependent care is provided outside your home to your spouse or other dependent who is incapable of self-care, it will only be eligible for reimbursement if your spouse or dependent still spends at least 8 hours per day in your home or the dependent is under age 13 and you are entitled to a dependency exemption for Federal income tax purposes.

To be eligible for reimbursement, a dependent care expense must have been incurred during the plan year (or if you established a Dependent Care FSA after the beginning of the year, the period within the plan year in which you had the account). A dependent care expense is incurred when the service is performed, not when you are billed or pay for the service.

When you establish a Dependent Care FSA, only the amount you have actually contributed, minus any reimbursements you have already received from the account, is available for reimbursements.

If you do not use the entire balance in your Dependent Care FSA by the end of the plan year, any balance in your account will be forfeited. This "use it or lose it" rule makes it important for you to plan your Dependent Care FSA election carefully.

You may not claim any other tax benefit for the amount of your pre-tax contributions to your Dependent Care FSA, although your dependent care expenses in excess of your pre-tax contributions may be eligible for the dependent care tax credit under section 21 of the Internal Revenue Code. For most individuals, a greater tax savings will be achieved by contributing to a Dependent Care FSA instead of taking the dependent care tax credit under section 21 of the Internal Revenue Code. However, in some cases an individual will have a greater tax savings by taking the dependent care tax credit instead of contributing to and receiving reimbursements from a Dependent Care FSA. For more information on how the Federal dependent care tax credit works, see IRS Publication No. 503. You may also wish to consult with a tax advisor.

Filing a Claim for Reimbursement

The Pre-Tax Payment Plan allows you to obtain reimbursements from your flexible spending accounts, by filing an online request for reimbursement at healthequity.com, or by filing a paper claim for reimbursement with the Plan's Claims Administrator, HealthEquity. In addition, for certain reimbursements from your Health Care FSA, you may

use a debit card. A direct deposit reimbursement option is available. The claims administrator has been hired to process all medical reimbursement and dependent care reimbursement claims.

You must submit paper claims for reimbursement to the Claims Administrator, HealthEquity at Claims Administrator, P.O. Box 14053 Lexington, KY 40512; Phone: 1-877-924-3967; FAX 1-877-353-9236 (toll free). Reimbursement claim forms are available online at healthequity.com or on *ERIEweb* (Info Center – Benefits Info – Pre-Tax Payment Plan). You may file a claim electronically by logging into your account at www.HealthEquity.com/WageWorks.

A claim for reimbursement from your Health Care FSA must include supporting documentation. Acceptable documentation includes copies of receipts or statements containing the provider's name or store name, a clear itemized description of the service or item purchased, the actual date the item was purchased or service provided (not the billing date) and the amount of the eligible expense. In the case of certain over-the-counter items, such as vitamins and mineral supplements, that can have either a medical purpose or be for general health and well-being, a letter of medical needs is required.

Other documentation including prescription drug receipts, office visit co-pay receipts, and Explanation of Benefits (EOBs) from an insurance company, which reflect the patient responsibility are necessary when any health, dental or vision plan or insurance partially covers the medical expense. If there is no coverage under insurance or any plan, itemized bills showing the item or service and the date the expense was incurred are acceptable so long as you indicate on the itemized bill that there is no coverage.

You will also need to certify that the medical expense is not eligible for reimbursement through a group health plan, insurance or otherwise, and that the expense was incurred for yourself, your spouse or your dependent. Under the Health Care FSA, you will be reimbursed up to the total amount you elected to contribute for the Plan Year less any prior reimbursements you received for the year, even if it exceeds the amount you have actually contributed at the time of reimbursement.

A claim for reimbursement from your Dependent Care FSA must include the name of the care provider, the care provider's signature and taxpayer identification number, the dates on which the care was provided, the amount of the charge, and the name and age of the dependent. Under the Dependent Care FSA, you will be reimbursed only up to the amount that is actually credited to your account at the time you submit your claim. If your claim is in excess of the amount actually credited to your account, the excess will be reimbursed to you as you make additional contributions to your Dependent Care FSA. A direct payment option is available that would allow your dependent care provider to receive checks directly for services rendered.

Except where your participation in the Plan ends during a plan year, you have until March 31st of the following year to submit a claim for reimbursement. If your participation

in the Plan ends during a plan year, you have 90 days from when your participation ends to submit a claim for reimbursement.

Debit Card—The Internal Revenue Service has set forth certain requirements that must be met in order for a cafeteria plan, such as the Pre-Tax Payment Plan, to use debit cards. The ERIE has adopted Debit Card Substantiation Procedures to ensure that the use of debit cards satisfies the IRS requirements. The following discussion summarizes some of the Debit Card Substantiation Procedures. You may obtain a copy of the Debit Card Substantiation Procedures from the Benefits Operations & Planning Section.

In order to be eligible to use a debit card, you must certify that (i) you will only use the card for eligible medical expenses, (ii) that the expenses for which you are seeking reimbursement will not be reimbursed from any other source, and (iii) that you will acquire and retain documentation for the expenses (including invoices and receipts) and, upon request, supply this documentation to the Plan's Claims Administrator, HealthEquity. The documentation that you should obtain and retain is the same information and documentation you need to obtain and submit for paper claims for reimbursement.

If your claim is reimbursed through use of the debit card and it is subsequently determined that the claim should not have been reimbursed for any reason, including a failure to properly substantiate the claim, the Plan shall request that you repay the reimbursement to the Plan. In the event that you do not repay the claim, the Plan may take other actions to recover the improper payment, including the offset of future reimbursements from your account or, to the extent allowable by law, withholding on your wages. Further, if an improper payment is made and you fail to repay the improper payment, use of the debit card will be suspended until the improper payment is repaid.

Health Savings Accounts

If you have elected the CDHP option under the Health Protection Plan you may contribute to a Health Savings Account (HSA) by payroll deduction through the Pre-Tax Payment Plan.

If you contribute to an HSA then you may not establish a Health Care FSA.

Federal tax law limits who may contribute to an HSA during a calendar year, and imposes limits on the total amount of contributions to an HSA during a calendar year. The rules on HSAs can be complex, so if you wish to contribute to the HSA, it is strongly recommended that you consult with your tax advisor. For more information about HSAs see IRS Publication 969 entitled Health Savings Accounts and Other Tax-Favored Health Plan.

Claim Procedures - Medical Reimbursements

Under Federal law, the Pre-Tax Payment Plan is required to have a claim procedure for the Health Care FSAs maintained in the Plan. The ERIE has adopted the following claim procedure for reimbursement claims from Health Care FSAs. **This claim procedure applies only to claims for reimbursement from Health Care FSAs.**

Submission of Claims—You may submit a claim for reimbursement of

medical expenses from your Health Care FSA by either (i) providing a completed claims form, together with documentation substantiating the claim for reimbursement of medical expenses, to the Plan's Claims Administrator, HealthEquity, (ii) filing a claim electronically with the Claims Administrator, HealthEquity at www.HealthEquity.com/WageWorks, or (iii) using a debit card. You may file a claim with HealthEquity by obtaining and completing an FSA Reimbursement Request form (from healthequity.com) and mailing it, emailing it or faxing it (with documentation) to Claims Administrator, P.O. Box 14053 Lexington, KY 40512; Phone: 1-877-924-3967; FAX 1-877-353-9236 (toll free). If a claim is submitted by use of a debit card, the Claims Administrator may require you to submit written documentation of the medical expenses in accordance with the Plan's Debit Card Substantiation Procedures.

Determination of Claim—If a claim is allowed, you will be reimbursed for the claim or, in the case of a debit card, payment may be made directly to the provider. If a claim is denied in whole or in part, the Claims Administrator will notify you of the denial within 30 days after receipt of the claim. This 30-day period may be extended for up to an additional 15 days if the Claims Administrator determines the extension is necessary for reasons beyond its control. The Claims Administrator shall notify you in writing of any extension of the time needed for the Claims Administrator to determine the claim. The Claims Administrator shall provide such notice before the expiration of the 30-day period, and the notice will explain why the extension is necessary as well as when a decision on the claim is expected to be made.

If a claim is denied in whole or in part, the Claims Administrator shall provide you a written or electronic notice setting forth the following information:

1. The specific reason or reasons for the denial of all or any portion of the claim.
2. The specific provisions of the Plan and any other document, on which the denial is based. If the decision to deny benefits is based, in whole or in part, on a specific internal rule, guideline, protocol or similar criteria, the notice will so indicate and will advise you that you may request a copy of such document from the Claims Administrator at no charge.
3. A description of any additional material or information needed from you to complete the claim, and an explanation of why the information is needed.
4. Information on how you can appeal the denial, together with the applicable time limits for appealing the denial of the claim.
5. A statement regarding your right to bring a civil suit under ERISA should the claim be denied on appeal.

Determination of Appeal—You may appeal a claim denial by following the following appeal procedure. The decision on appeal will be made by the Plan's Claims Fiduciary. The Claims Fiduciary will not be the person who made the original decision to deny the claim, nor will the Claims Fiduciary be a subordinate

of the person who made the original decision to deny the claim. The Claims Fiduciary will not afford any deference to the initial decision to deny the claim. The Claims Fiduciary is the Director of Benefits, or his or her successor. You must file an appeal in writing with the Claims Administrator. An appeal must be filed within 180 days from when you receive the notice of claim denial (or partial denial) from the Claims Administrator. During the 180-day period, and after the appeal is filed, you may review and obtain copies of all documents, records and information relating to the claim that are in the Claims Administrator's or the Claims Fiduciary's possession.

You may submit written issues, comments and additional justification as to why the claim should be allowed. You will be provided with the name of any medical or vocational expert whose advice was sought in connection with the denied claim regardless of whether the Claims Administrator relied upon such advice.

The Claims Fiduciary shall decide an appeal within 60 days of when the Claims Administrator receives written notice of the appeal. The Claims Fiduciary shall provide you with written or electronic notice of the determination on appeal. If the denial (or partial denial) of the claim is upheld (in whole or in part) on appeal, the notice shall include the following:

1. The specific reason or reasons for the denial of the claim on appeal.
2. The specific provisions of the Plan and any other document on which the decision to deny the claim on appeal is based.
3. 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 for reimbursement. If the Claims Fiduciary relied upon any internal rule, guideline, protocol or similar criterion, the notice shall either include a copy of it, or advise you of it and that you may obtain a copy free of charge upon request.
4. A statement of your right to bring a civil suit under ERISA.

There are no other voluntary dispute resolution options.

Personal Representative—You may designate a personal representative to represent you with respect to a claim for reimbursement, or the appeal of the denial of a claim. A designation of a personal representative must be made in writing and must be filed with the Claims Administrator, the Claims Fiduciary or the Benefits Operations & Planning Section. In addition, in order for the Claims Administrator, the Claims Fiduciary or the Plan to disclose any "protected health information" (as such term is defined in privacy regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA) to the designated representative, the individual to whom the protected health information relates must provide the Plan with a written authorization allowing such disclosure.

Benefit Plan Administration

The Employee Benefits Administration Committee of ERIE is the Plan Administrator of the Pre-Tax Payment

Plan. Many of the day-to-day administrative functions are performed through the Benefits Operations & Planning 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.

Discretionary Authority

The Employee Benefits Administration Committee has full discretionary authority to interpret and construe the terms of the Pre-Tax Payment Plan. The Claims Fiduciary has full discretionary authority to interpret and construe the terms of the Pre-Tax Payment Plan when deciding appeals of denied claims.

Plan Modification and Amendment

Erie Indemnity Company may modify or amend the Pre-Tax Payment 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 Pre-Tax Payment 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 Pre-Tax Payment Plan. A copy of a plan amendment or modification shall be provided to the Plan Administrator of the Pre-Tax Payment Plan and, to the extent necessary or appropriate, to any outside service provider of the Pre-Tax Payment Plan. The Plan Administrator of the Pre-Tax Payment Plan shall notify all covered participants and beneficiaries of any modification or amendment that changes the substantive terms of the Pre-Tax Payment 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 Pre-Tax Payment 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 Pre-Tax Payment 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 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 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.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents under certain circumstances if there is a loss of coverage under a health care flexible spending account in the plan as a result of a qualifying event. You or your dependents will have to pay for any continuation coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage.

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. In addition, if you disagree with a decision by the plan, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in a Federal 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 Pre-Tax Payment Plan

Plan Number

508

Plan Type

Welfare Plan (health care flexible spending accounts)

Source of Contributions

Employee

Payment of Benefits

All benefits under the Plan are paid by the Employer.

Plan Sponsor

Erie Indemnity Company
100 Erie Insurance Place
Erie, PA 16530
814-870-2000
Employer ID: 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

Claims Administrator

HealthEquity
15 W Scenic Pointe Dr
Suite 100
Draper, UT 84020

Claims Fiduciary

Director of Benefits
Erie Indemnity Company
100 Erie Insurance Place
Erie, PA 16530
814-870-2000

Adopting ERIE Affiliates

Erie Insurance Company of New York

Erie Resources Management Corp.

Plan Year

January 1st to December 31st