Erie Indemnity Company
Vision Care Plan
Summary Plan Description

The Erie Indemnity Company Vision Care Plan (the "Plan" or "Vision Care Plan") is a welfare plan that provides eligible Employees and their covered dependents with certain vision benefits. This is a summary plan description of the Vision Care 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.

Introduction

Taking care of your eyesight is an important part of your overall health care program. That's why Erie Indemnity Company (ERIE) provides full-time Employees and their eligible dependents with the Vision Care Plan.

- If you are a full-time Employee, you and your eligible dependents can be enrolled in the Vision Care Plan. If you are a full-time Employee, you can elect coverage that is effective on your first day of employment. If you are a part-time Employee who becomes full-time, you can elect coverage that is effective on the date you become full-time.
- ERIE pays the majority of the cost of coverage for you and your covered dependents. You contribute a portion of the cost of coverage through payroll deduction. ERIE periodically determines the portion of the cost of coverage you will pay under each option. Each year you will be notified of your portion of the cost of coverage under the Plan's options.
- If you use a Davis Vision network provider, you will generally be covered for a higher level of benefits. Network providers are licensed providers in both private practice and retail locations who are extensively reviewed and credentialed by Davis Vision to ensure that stringent standards for quality service are maintained. Access Davis Vision's website at www.davisvision.com and utilize the "Find a Doctor" feature, or call 1.800.999.5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

Eligibility

If you are a full-time Employee of ERIE or any affiliate of ERIE that has adopted the Vision Care Plan, you are eligible to enroll in the Vision Care 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 Vision Care 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 that has adopted the Plan) 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 Plans.

If you participate in the Vision Care Plan, you may also enroll your eligible dependents for coverage under the Plan.

Your eligible dependents include:

- 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.

In addition, you may continue coverage for an unmarried child who is described above and who has attained age 26, provided the child is fully disabled and the child depends chiefly on you for maintenance and support. The disability must have commenced prior to the child attaining age 26.

Your child includes not only your natural child, but also:

- A legally adopted child or a child placed with you for adoption
- A stepchild
- A child for whom coverage is required pursuant to a qualified medical child support order (see the section entitled Qualified Medical Child Support Orders)

Note: ERIE reserves the right to require proof that a dependent satisfies the above requirements. In addition, you may be asked periodically to furnish current information about your dependent's continuing eligibility, such as support or disability status.

Under the Vision Care Plan, there are the following four types of coverage:

- Employee only coverage—Provides coverage only for you.
- Employee and child(ren) coverage—Provides coverage for you and your dependent children that you have enrolled, but does not provide coverage for your spouse.
- Employee and spouse coverage—Provides coverage for you and your spouse.
- Family coverage—Provides coverage for you and all your dependents that you have enrolled, including your spouse.

If you do not enroll a dependent, then coverage will not be provided for that dependent.

Finally, individuals who have continuation coverage rights under the Plan, including continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) are also eligible to participate in the Vision Care Plan. See the section entitled Continuation of Coverage.

Effective Date of Coverage

Coverage will be effective for you on your first day of employment if you are a full-time Employee (provided you don't opt out of coverage). Otherwise, coverage will be effective on the date on which you become a full-time Employee (provided you don't opt out of coverage). If you have dependents, coverage of your dependents will be effective on the date on which you become covered provided that you elect Employee and spouse coverage, Employee and child(ren) coverage or Family coverage. However, coverage will only be provided for a dependent that you actually enroll in the Vision Care Plan.

If you do not become covered under the Vision Care Plan when first eligible, then you must generally wait until the next open enrollment period to become covered beginning in the next year. Similarly, if you do not obtain coverage for your dependents when they are first eligible for coverage, then you must generally wait until the next open enrollment period to obtain coverage beginning in the next year.

In certain instances, you may obtain coverage for yourself or for your dependents during the year. For example, in the event you become married, or you acquire a dependent during the year, you may obtain coverage for them provided that you enroll them in the Vision Care Plan within 31 days of the event (birth, adoption or placement for adoption or marriage). If you have a newborn child or adopt a child and enroll them within 31 days of their birth or placement for adoption, coverage will be provided from the child's date of birth or placement for adoption.

You may also obtain coverage for yourself or your dependents if you declined coverage for yourself or did not obtain coverage for your dependents because you were covered under another group vision plan (such as the group vision plan of your spouse's employer) and (i) the maximum COBRA continuation coverage period under the other plan was exhausted; (ii) coverage was lost under the other plan due to divorce, legal separation, termination of employment or reduction in hours; or (iii) the other employer terminates the plan or ceases making any employer contributions for coverage. To obtain coverage, you must enroll within 31 days of when coverage was lost under the other plan. Documentation is required from the other plan confirming the cancellation date.

Finally, coverage may be obtained for your child during the year if such coverage is required under a qualified medical child support order (see the section entitled Qualified Medical Child Support Orders).

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 changes to your coverage that will be effective on January 1st of the following year. For example, you can:

- Change coverage from Employee Only Coverage to Employee and Spouse, Employee and Child(ren) or Family Coverage or vice versa.
- Enroll in the Vision Care Plan if you previously opted out of the Vision Care Plan.

Changes in Dependent Status

It is very important that you notify the

Benefits Operations & Planning Section of any change in status of your dependents, such as marriage or divorce, birth or adoption of a child, or the death of any dependent. Contact the Benefits Operations & Planning Section within 31 days of any change in family status. **If a new dependent is not enrolled for coverage within 31 days of the date the dependent first becomes eligible for coverage, the dependent generally will have to wait until the next annual open enrollment period to be enrolled for coverage.** (You may enroll a newborn child or newly adopted child more than 31 days after the date the child was born or placed for adoption with you; however, coverage will only be provided from the date of enrollment).

Special Circumstances for Enrollment

If both spouses are Employees and are eligible for coverage under the Vision Care Plan, either one may cover the other as a dependent, or each may receive coverage as an Employee. If a parent and a child under age 26 are both full-time Employees, the parent may cover the child as a dependent or the child may have coverage as an Employee. No Employee may have coverage both as an Employee and as a dependent at the same time.

Active Employees and Medicare

If you are actively employed and covered by the Vision Care Plan and you become entitled to Medicare, the Vision Care Plan will pay benefits on a primary basis with Medicare paying on a secondary basis, unless you elect Medicare as your primary coverage and refuse coverage under the Vision Care Plan. If you elect Medicare as your primary coverage and refuse coverage under the Vision Care Plan, the Vision Care Plan is prohibited by law from making any benefit payments on your behalf, even on a secondary basis.

Similarly, if you are actively employed and have coverage for a dependent and the dependent becomes entitled to Medicare, the Vision Care Plan will pay benefits on a primary basis, with Medicare paying secondary.

Note that there are special rules in the case of an individual who becomes entitled to Medicare because of end stage renal disease. For more information about the special rules, contact the Benefits Operations & Planning Section.

Regardless of whether you and your dependents are covered under the Plan each of you should apply for Medicare Part A coverage about three months before reaching age 65.

Coordinating Benefits When You Are Covered By More Than One Plan

When you are covered under the Vision Care Plan and you also have coverage under another plan or policy that provides vision benefits, the claims administrator will coordinate benefit payments under the Vision Care Plan with any benefit payments made under the other plan or policy. One plan or policy will pay the benefit as a primary benefit. The other plan or policy will pay secondary benefits, to the level covered by the plan or policy, if necessary, to cover your expenses. If the other plan or policy is primary, covered services which are allowable charges under the other plan or policy will first be reduced by the amount that plan or policy pays or would have paid on your behalf. Any remaining covered services are subject to any applicable deductible, coinsurance and

out-of-pocket limit under the Vision Care Plan. To the extent that a covered service is not an allowable charge under the primary plan or policy, the Vision Care Plan will pay the claim in accordance with the Plan's applicable cost sharing provisions.

In order to determine which plan or policy is primary, the claims administrator will coordinate benefits with the other plan, insurance carrier or HMO in accordance with rules in the plans. In order to properly coordinate benefits, you may be asked by the claims administrator to furnish information and to take necessary actions. For more information on the coordination of benefits provisions of the Vision Care Plan, contact the Benefits Operations & Planning Section of ERIE.

Coverage While on Approved Leave of Absence

Coverage under the Vision Care Plan will continue while an Employee is on an approved leave of absence. Eligible types of leave are:

- Short Term Disability Leave
- Long Term Disability Leave
- Work Injury Leave
- Family Medical Leave Act Leave
- Military Leave
- Other leaves approved by ERIE

Coverage will continue for the length of the leave provided the Employee pays the Employee portion of the cost of coverage under the Vision Care Plan. You may make arrangements for paying the Employee portion while on leave by contacting the Benefits Operations & Planning Section.

Note that if you are on a leave protected by the Family and Medical Leave Act, you may drop coverage under the Vision Care Plan while on leave and reacquire coverage when you return from the leave. For more information 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 the Vision Care Plan and which meets certain requirements as to form and substance. In accordance with ERISA, the Vision Care Plan will provide coverage to a child of an Employee in accordance with the terms of any medical child support order that the Plan Administrator 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 Plan Administrator 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 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 Vision Care Plan regarding your vision care and payment for that care is subject to privacy rules issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You can obtain more information about your medical privacy rights from the Notice of Privacy Practices. You may obtain a copy of the Notice of Privacy Practices from *ERIEweb* (Info Center—Benefits Information—Privacy Practices) or from the Benefits Operations & Planning Section.

Termination of Coverage

Employee coverage will terminate under the Vision Care Plan when:

- The Employee's employment with ERIE (and any affiliate of ERIE that has adopted the Vision Care Plan) terminates.
- The Employee's hours are reduced so that the Employee is no longer full-time.
- The Employee drops coverage.
- The Employee dies.
- The Vision Care Plan is terminated or is amended to exclude the class of employees to which the Employee belongs.
- The Employee ceases to make any required contributions for coverage.

Dependent coverage will terminate under the Vision Care Plan when:

- Coverage ends for the Employee.
- The dependent no longer qualifies as a dependent under the Vision Care Plan. If the dependent loses coverage because he/she attains age 26, coverage will be provided until the end of the month in which the dependent attains age 26.
- The Employee drops coverage for the dependent.
- The Employee ceases to make any required contributions for the dependent coverage.

If an Employee dies, coverage for the Employee's covered dependents will continue to be provided for 31 days after the date of the Employee's death.

Continuation of Coverage Rights

The Vision Care Plan provides continuation of coverage rights as described below to extend temporary coverage to covered Employees and dependents in certain circumstances when they would otherwise lose their coverage under the Vision Care Plan. These continuation of coverage rights are intended to comply with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In the event that an Employee or dependent is a "Qualified Beneficiary" and loses coverage under the Vision Care Plan as a result of a "Qualifying Event," the Employee or dependent will have the right to elect continuation coverage under the Vision Care Plan.

A Qualified Beneficiary is:

1. A covered Employee, but only if the Qualifying Event is the Employee's termination of employment (other than for gross misconduct) or the reduction of the Employee's hours so that the Employee is no longer a full-time Employee.
2. A spouse (including a same-sex spouse) of a covered Employee provided the spouse has coverage in effect at the time of the Qualifying Event.
3. Any other dependent of a covered Employee provided the dependent has coverage in effect at the time of the Qualifying Event.

Note: A child born to, or placed for

adoption with, the covered Employee or the Employee's spouse or former spouse while such person is on continuation coverage under the Vision Care Plan is a Qualified Beneficiary, provided the child is enrolled for coverage within 31 days following the date of birth or placement for adoption.

The following are Qualifying Events:

1. **Termination of Employment/Reduction in Hours**—One Qualifying Event is the termination of a covered Employee's employment (other than for gross misconduct) or the reduction in the covered Employee's hours so that the Employee is no longer a full-time Employee. If this Qualifying Event occurs, the Employee may elect to continue the coverage that he or she had in effect under the Vision Care Plan for up to 18 months following the date on which the Qualifying Event occurred. If the Employee's spouse or dependents have coverage, the spouse or dependents will have the right to purchase continuation coverage individually. However, if the form of coverage elected by the Employee provides coverage for the spouse or dependents, the spouse or dependents need not elect to continue coverage individually. The 18-month period may be extended for up to an additional 11 months in the event that an Employee, a spouse or dependent receiving continuation coverage is determined to be disabled for purposes of Social Security at any time during the first 60 days of continuation coverage. However, in order for the Employee or any dependent to obtain the additional 11 months of continuation coverage the Employee or dependent must notify the COBRA Administrator for the Vision Care Plan, UnitedHealthcare, in writing within 60 days of when Social Security makes its determination, but in no case later than the last day of the 18 month continuation coverage period. A copy of the Social Security Administration's disability award notice must also be provided to the COBRA Administrator, UnitedHealthcare.
2. **Death of Employee**—If a covered Employee has a form of coverage that provides coverage for his or her spouse or dependents at the time of his or her death, any covered spouse or covered dependents will have the right to purchase up to 36 months of continuation coverage from the date of the Employee's death. Coverage will automatically be provided to any covered spouse or covered dependents for the 31-day period following the date of the Employee's death.
3. **Divorce**—If a covered Employee has a form of coverage that provides coverage for his or her spouse and the Employee becomes divorced from his or her spouse, the spouse and any other dependent that will lose coverage as a result of the divorce will have the right to purchase up to 36 months of continuation coverage from the date of the divorce.
4. **Entitlement to Medicare**—If a covered Employee has a form of coverage that provides coverage to his or her spouse or dependents and the Employee becomes entitled to Medicare and elects Medicare as his or her primary coverage, the Vision Care Plan is prohibited from providing coverage to the Employee.

The Employee's spouse and dependents who lose coverage as a result of the Employee's election will have the right to purchase up to 36 months of continuation coverage from the date on which the Employee's election is effective.

5. **Child Ceases to be Dependent**—If a child is covered as a dependent and the child ceases to qualify as a dependent of the covered Employee, the child can purchase up to 36 months of continuation coverage from the date the child ceases to qualify as a dependent.

6. **Multiple Qualifying Events**—If an Employee lost coverage because of termination of employment or reduction in hours and the Employee's spouse or dependents are receiving continuation coverage and then one of the events listed in paragraphs 2 through 5 occurs, the spouse or dependents may elect to continue coverage for an additional period of time not to exceed the date that is 36 months from the date of the Employee's termination of employment or reduction in hours.

Each individual who is eligible to elect continuation coverage must make a written election for continuation coverage no later than the day that is 60 days after the later of the date coverage would otherwise end or the date on which written notice of the right to purchase continuation coverage is provided to the individual. The written election must either be hand-delivered to the COBRA Administrator, UnitedHealthcare or postmarked on or before the 60th day or the individual will not be permitted to elect continuation coverage.

A covered Employee or the Employee's spouse or dependents must notify the Benefits Operations & Planning Section as soon as possible (but not later than 60 days) after the Employee and his or her covered spouse are divorced or a covered dependent child ceases to qualify as a dependent. The notice must be provided in writing.

A part-time Employee or former Employee who is on continuation coverage must notify the COBRA Administrator, UnitedHealthcare, as soon as possible, but not later than 60 days, after the part-time Employee or former Employee and his or her covered spouse are divorced, a covered dependent child ceases to qualify as a dependent or the part-time Employee or former Employee or covered spouse or dependent receives a Social Security disability determination. The notice must be provided in writing. In the case of a Social Security Administration determination of disability, a copy of the Social Security Administration disability award notice must be provided to the COBRA Administrator, UnitedHealthcare. Further, the COBRA Administrator or Plan Administrator may request that documentation or additional information be provided in the case of one of these Qualifying Events (for example, if the Qualifying Event is divorce, a copy of the divorce decree may be requested). If notice is not timely provided after one of these events occurs or documentation or additional information requested is not timely provided, continuation coverage will not be available (in the case of a disabled individual, extended continuation coverage will not be available).

If the Qualifying Event is termination of employment (other than for gross misconduct) or reduction in hours of employment, the COBRA Administrator will notify the Employee and any covered dependents of the right to purchase continuation coverage. Notice will be provided within 44 days of the date of the Employee's termination or reduction in hours.

If the Qualifying Event is the Employee's death or entitlement to Medicare (and the election of Medicare as the Employee's primary coverage) and the Employee's spouse and/or dependents have coverage, the COBRA Administrator will notify the Employee's spouse and/or dependents of their right to purchase continuation coverage. Notice will be provided within 44 days of the Employee's death or the effective date of the Employee's Medicare coverage.

If the Qualifying Event is divorce or loss of dependent child status and the Employee or dependent has provided proper notification on a timely basis and provided any additional information or documentation requested, the COBRA Administrator will provide a written notice of the right to purchase continuation coverage to the affected dependent(s) within 14 days of when the notice is provided.

The monthly amount you will pay for continuation coverage under the Vision Care Plan will be no more than 102 percent of the applicable premium (as determined in accordance with COBRA and regulations issued pursuant to COBRA) for coverage under the Vision Care Plan, and 150 percent of the applicable premium for coverage for the 19th through 29th months of coverage for disabled individuals who are eligible for 11 additional months of continuation coverage. P ayment of the monthly amount is due by the first day of each month of continuation coverage, provided that the initial payment of the monthly amount(s) must be made within 45 days after the election of continuation coverage.

Continuation coverage under the Vision Care Plan will end as of the date any of the following occur:

1. The required payment is not paid on a timely basis. Except for the initial payment (which is due within 45 days of when the election is made), a monthly payment will be treated as timely made if it is made within 30 days of its due date (the grace period).
2. The maximum (18-month, 29-month or 36-month) continuation coverage period ends.
3. ERIE terminates the Vision Care Plan.
4. The date that the individual becomes covered under another vision plan that does not contain any exclusion or limitation with respect to a pre-existing condition of the person who becomes covered or the date on which the exclusion period ends under the plan. Continuation coverage only ends for the person who becomes covered by the other vision plan.
5. The date that the individual becomes enrolled in Medicare. Continuation coverage only ends for the person who becomes enrolled in Medicare.
6. If extended coverage is being provided due to a Social Security disability determination, continuation coverage will end at the beginning of the month that begins after 30 days have passed from a final

determination that the individual is no longer disabled for purposes of Social Security.

USERRA Continuation Coverage. A covered Employee who is absent from work to serve in the military service may elect to continue coverage under the Vision Care Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") under certain circumstances. These rights only apply to an Employee and his or her dependents that have coverage under the Vision Care Plan before the military service begins. These rights are in addition to any other rights the Employee and dependents may have for continuation coverage. For more information about your rights under USERRA contact the Benefits Operations & Planning Section.

Discretionary Authority

The Employee Benefits Administration Committee of ERIE is the Plan Administrator of the Vision Care Plan under the Employee Retirement Income Security Act (ERISA). As Plan Administrator, the committee has the discretionary authority to interpret and construe the terms of the Vision Care Plan. In addition, Davis Vision has been provided with the discretionary authority to interpret and construe the terms of the Vision Care Plan for the purpose of administering claims and deciding appeals of denied claims.

Covered Services

Eye Examinations—The Vision Care Plan provides coverage for a comprehensive routine vision examination once every calendar year. There is a $10 co-payment for in-network eye examinations. You will be reimbursed up to $30 for an out-of-network eye examination.

Eyeglass Lenses—The Vision Care Plan provides coverage for eyeglass lenses once every calendar year. In-network there is a $25 co-payment plus any fixed costs from the table below if any of the specialty lens options in that table are provided. Out-of-network the Plan will reimburse in accordance with the table below.

Frames—Subject to the following, eyeglass frames are covered once every calendar year. For frames not in the Davis Frame Collection that are purchased in-network other than at Visionworks, the Vision Care Plan pays for up to $130, plus there is a 20% discount on any amount over $130 at participating locations. For frames not in the Davis Frame Collection that are purchased at Visionworks, the Vision Care Plan pays for up to $180, plus there is a 20% discount on any amount over $180. The Vision Care Plan covers the full cost of the Fashion Collection and the Designer Collection of frames in the Davis Vision Exclusive Collection, while frames in the Premier Collection are covered after a $25 co-payment. The Davis Vision Frame Collection is available at most independent participating providers, but is not available at retail chain locations. Out-of-network, the Vision Care Plan reimburses up to $30 for frames (the Davis Frame Collection is not available out-of-network).

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied through the Davis Vision Collection.

Payment will not be made for both frames and contact lenses within the same calendar year.

Contact Lenses in Lieu of Eyeglasses—Subject to the following, the Vision Care Plan provides coverage for contact lens fittings and the purchase of contact lenses once every calendar year. When using an in-network provider and purchasing Davis Collection contact lenses, the Plan covers the full cost of the evaluation, fitting and follow-up care and, after a $25 co-payment, will pay for (i) one pair of standard daily wear lenses, **or** (ii) up to four boxes/multi-packs of disposable lenses, **or** (iii) up to two boxes/multi-packs of planned replacement lenses.

When using an in-network provider but purchasing non-Davis Collection lenses, there is a 15% discount on the cost of evaluation, fitting and follow-up care, plus the Vision Care Plan will reimburse up to $130 and provide a 15% discount on any amount over $130 for the purchase of contact lenses.

When using an out-of-network provider, the Vision Care Plan will not cover the cost of evaluation, fitting and follow-up care and will only reimburse up to $75 for the cost of the contact lenses.

Payment will not be made for both frames and contact lenses within the same calendar year.

Medically Necessary Contact Lenses—The Vision Care Plan provides in-network coverage in full at all provider locations with prior approval for the purchase of medically necessary contact lenses. Out-of-network the Vision Care Plan will reimburse up to $225 with prior approval for the purchase of medically necessary contact lenses. Contact lenses will be considered medically necessary if they are for one or more of the following reasons:

- Following cataract surgery
- To correct extreme visual acuity problems not correctible with eyeglass lenses
- To correct for significant anisometropia
- Keratoconus

A letter from your doctor documenting medical necessity as described above is required for this benefit. Coverage for this benefit is provided once every calendar year.

Low Vision Services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to twice per lifetime. Up to four follow-up care visits will be covered during the five-year period. This benefit is only available in-network.

Vision Retinal Imaging - You and your covered dependents may obtain this service at certain participating in-network providers once every calendar year. There is a $39 member co-payment. For information on which in-network providers offer this service, contact Davis Vision at 1.800.999.5431. This benefit is only available in-network.

Laser Vision Correction Services—Davis Vision provides you and your covered dependents with the opportunity to receive Laser Vision Correction Services at set discounted prices. Please check the discount available to you with the participating provider. For more information, please visit Davis Vision at www.davisvision.com or call 1.800.999.5431.

Vision Plan Schedule of Benefits

For information, please visit Davis Vision's Web site at: www.davisvision.com, or call 1.800.999.5431 (toll free).

Benefits		In-Network	Out-of-Network
Eye Examination	Benefit frequency – Members are covered once every calendar year.	Plan pays in full after $10 member copayment.	Plan pays up to $30
Vision Retinal Imaging	Benefit frequency - Members are covered once every calendar year	Plan pays in full at participating in-network providers after $39 member copayment	No Benefit Available
Frames: * Frames are Covered once every calendar year for all members.	Retail Frame	Member pays balance over $130 plan allowance or $180 plan allowance at Visionworks locations	Plan pays up to $30.
	Davis Frame, Fashion Collection	Member pays $0. Plan pays in full.	No Benefit Available
	Davis Frame, Designer Collection	Member pays $0. Plan pays in full.	
	Davis Frame, Premier Collection	Plan pays in full after $25 member copayment.	
Please note: Most participating providers send eyeglass orders to a Davis Vision lab for fabrication. *This may result in wait times of up to two weeks for your eyeglasses. Certain retail locations can fill your prescription immediately at the time the service is provided. Check with your provider for details.*			
Eyeglass Lenses: Eyeglass lenses are covered once every calendar year for all members.	**Standard** [1] Single Vision Lenses	Plan pays in full after member pays a $25 copayment toward the eyeglass lenses.	Plan pays up to $25
	Bifocal Lenses		Plan pays up to $35
	Trifocal Lenses		Plan pays up to $45
	Lenticular Lenses		Plan pays up to $60

Chart continued on next page...

Vision Plan Schedule of Benefits *Continued*

For information, please visit Davis Vision's Web site at: www.davisvision.com, or call 1.800.999.5431 (toll free).

Eyeglass Lenses ***Continued***: Eyeglass lenses are covered once every calendar year for all members.	**Specialty Lens Options**	**Member's Copayment**	
	Fashion and Gradient Tinting of Plastic Lenses	$0	
	Glass-Grey #3 Prescription lenses	$0	
	Oversized Lenses	$0	
	Progressive Addition Multifocal Lenses – Standard	$50	
	Progressive Addition Multifocal Lenses – Premium	$90	
	Progressive Addition Multifocal Lenses – Ultra	$140	
	Progressive Addition Multifocal Lenses – Ultimate	$175	
	Glass Photochromic Lenses	$20	
	Plastic Photochromic Lenses	$65	
	Scratch Resistant Coating	$0	Member pays for full cost for out-of-network lens options.
	Premium Scratch Resistant Coating	$0	
	Standard Anti-Reflective Coating (ARC)	$35	
	Premium Anti-Reflective Coating (ARC)	$48	
	Ultra Anti-Reflective Coating (ARC)	$60	
	Ultimate Anti-Reflective Coating (ARC)	$85	
	High-index Lenses – 1.67 Lenses	$55	
	High-index Lenses – 1.74 Lenses	$120	
	Polarized Lenses	$75	
	Polycarbonate Lenses [(2)] (adults)	$0 or $30	
	Trivex Lenses	$50	
	Blended Invisible Lenses	$20	
	Digital Single Vision Lenses	$30	
	Blue Light Filtering	$15	
	Scratch Protection Plan – Single Vision Lenses	$20	

	Scratch Protection Plan – Multifocal Lenses	$40	
	Ultraviolet Coating	$12	
Contact Lenses: * Members are covered Once every calendar year.	Contact Lens Evaluation and Fitting	Paid in full when using in-network Provider and purchasing Davis Collection lenses. Member receives a 15% discount on cost of exam when using an in-network provider but purchasing non-Davis Collection lenses.	No Benefit Available
	Contact Lens Material Allowance	If Davis Collection lenses are purchased the Member pays a $25 co-payment and receives 1 pair of Standard Daily Wear Lenses **or** up to 4 boxes/multipacks of Disposable Lenses **or** up to 2 boxes/multipacks of Planned Replacement Lenses. If using an in-network Provider and purchasing non-Davis Collection lenses the Plan pays up to $130 and the Member receives a 15% discount on charges above $130.	Plan will reimburse up to $75.
	Medically Necessary	Plan pays in full, with prior approval.	Plan pays up to $225, with prior approval.
Value Added Features from Davis Vision Participating Providers	Laser Vision Discount	Member receives set discounted prices from network Lasik network participating providers	No Benefit Available
	Low Vision Services	Maximum allowances for evaluation, low vision aids, and follow-up visits	No Benefit Available
	Unconditional 1-Year Eyeglass Warranty for products completely supplied through Davis Vision Collection.	Covered in Full	No Benefit Available

(1) In the Davis Collection standard lenses include glass or plastic lenses in all ranges of prescriptions.

(2) Polycarbonate lenses covered in full for dependent children under age 26, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters.

∗Payment will not be made for both frames and contacts within the same calendar year

Limitations and Exclusions

The Vision Care Plan is designed to cover visual needs rather than cosmetic materials, so it has certain limits to control costs. The following items or services will generally result in additional charges to the patient or are not covered under the Plan.

If a patient selects any specialty lens options not specifically referenced in the Vision Plan Schedule of Benefits, the patient will be responsible for the additional charges.

Except as provided above, the Plan provides no benefits for professional services or materials connected with the following:

- Orthoptics, vision training, subnormal vision aids and tonography
- Examinations and materials which are not listed as a covered service or supply
- Plano lenses (non-prescription)
- Two pairs of eyeglasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- Any eye examination or corrective eyewear required by an employer as a condition of employment
- Services or materials provided as a result of any Workers' Compensation Law or similar legislation
- Eyeglasses and contacts during the same calendar year
- Any treatment or materials for which you have no legal obligation to pay or for which you incur no charge or which are provided by any government program
- Services provided prior to the effective date of coverage, or after the date on which coverage ends except for lenses and frames prescribed prior to termination of coverage and delivered within 31 days of the date coverage ends
- The cost of any insurance premiums indemnifying against losses for frames or lenses
- Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form
- Treatment or services for injuries resulting from the maintenance or operation of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan
- Services or supplies that are received from a medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar organization
- Services, supplies or materials the cost of which has been or is later recovered in any action of law or in compromise or settlement of any claim
- Temporary devices, appliances or services
- Drugs or other medications
- Diagnostic services, such as diagnostic x-rays, cardiographic or encephalographic examinations and pathological or laboratory tests

Lenses and frames covered under the Plan, which are lost or broken, will not be covered for replacement except at the normal intervals when the services and materials are otherwise covered.

Commonly Used Terms

The following definitions identify the different types of eye care providers and are provided to assist you in deciding on the appropriate type of provider for your needs.

An **ophthalmologist** is a medical doctor who specializes in the anatomy, functions and diseases of the eye. In addition to testing vision and prescribing corrective lenses, an ophthalmologist is trained to detect, diagnose and treat disorders of the eye.

An **optometrist** is skilled in testing vision and prescribing corrective lenses but is not trained to diagnose or treat diseases or disorders of the eyes.

An **optician** makes eyeglasses or contact lenses for correcting defects of vision in accordance with the prescription of an optometrist or ophthalmologist.

The Vision Care Plan is intended to assist you with the costs associated with routine vision testing and corrective lenses. If you are concerned about a disease or other disorder of the eye, refer to the Health Protection Plan (if enrolled for coverage) or other health insurance or health plan.

How to File a Claim

In network providers file electronic claims directly to Davis Vision, so it is not necessary to complete any forms. For out of network reimbursement, please obtain an itemized statement from the eye care provider, attach it to your completed claim form and mail it to the address listed on the form.

Claim forms are available:

- From the Benefits Operations & Planning Section
- On *ERIEweb* (Forms & Tools – Benefits Forms – Vision Claim Form)

Claims Review Procedure

As Claims Administrator, Davis Vision will undertake both the initial claims review, as well as reviewing any appeals of denied claims, to determine whether you are entitled to benefits and what benefits you are entitled to.

Except for a claim for medically necessary contact lenses where you must obtain pre-approval, Davis Vision will make a decision on your claim within 30 days of when it receives your claim. If your claim is for pre-approval of medically necessary contact lenses, Davis will decide your claim within 15 days. However, if for reasons beyond its control, Davis Vision cannot decide the claim within 30 days (or 15 days in the case of medically necessary contact lenses), it may extend the period to decide the claim by up to 15 additional days. If an extension of time is necessary, Davis Vision will provide you with a written notice of the extension before the end of the initial 30-day period (15-day period in the case of medically necessary contact lenses). This notice will explain why the extension is necessary and provide you with the date by which Davis Vision expects to decide your claim.

If the reason why Davis Vision needs an extension is because it did not receive all of the information and documentation necessary to make a decision, the notice of extension will explain what information and documentation it needs to decide the claim. You will be given at least 45

days to provide the information or documentation to Davis Vision. During this time, the 15-day extension period for deciding your claim is suspended until your information is received.

If Davis Vision approves your claim for benefits, it will either reimburse you or will pay the eye care provider directly. If Davis Vision denies your claim, in whole or in part, it will notify you in writing. The notice will include:

- The specific reason or reasons for the denial of all or any part of your claim.
- The specific provision of the Vision Care Plan and any other document on which the denial is based. If the decision to deny the claim is based, in whole or in part, on a specific internal rule, guideline, protocol or similar criteria, either a copy of that document will be provided to you or you will be advised that you may obtain a copy of the document upon request and free of charge from Davis Vision. If the decision to deny benefits is based, in whole or in part, on an exclusion or limitation that the benefit claimed is not medically necessary, either an explanation that applies the appropriate terms to your circumstances and which details the scientific or clinical judgment that led to the decision to deny benefits will be provided to you or you will be advised that you may obtain it upon request and free of charge from Davis Vision.
- A description of any additional material or information necessary for you to complete the claim and an explanation as to why such material or information is necessary.
- Information on how you may appeal the denial and the applicable time limits.
- A statement regarding your right to bring a suit under Federal law should you appeal the denial and the denial is upheld on appeal.

Personal Representative—You may designate a representative to act on your behalf in pursuing a claim or appealing the denial of a claim. You should contact Davis Vision directly to find out how to designate a representative for your claim or the appeal of your claim. In order for the Claims Administrator 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 a written authorization allowing such disclosure.

You may appeal a claim denial by following the appeal procedure below.

Appealing a Denied Claim

You may appeal any claim denied by Davis Vision directly to Davis Vision. If you wish to appeal a denied claim, you must file a written request for an official review of your claim. The appeal request must be filed within 180 days of the date on which you receive the notice from Davis Vision denying your claim. The appeal request must be filed with Davis Vision. You should follow the instructions for appealing a claim that are set forth in the notice denying your claim.

In your appeal, you must state that you are requesting an official review

of your claim and the reasons why you do not agree with the denial or partial denial of the claim. You should also include any additional information pertinent to the claim. You and your designated representative have the right to review and obtain copies of all documents, records and information relating to your claim. If you wish, you or your representative may submit written issues, comments and additional justification of why your claim should be allowed. You will be provided with the name of any medical or vocational expert whose advice was obtained in connection with your claim regardless of whether the advice was relied upon.

When Davis Vision reviews the denied claim, it cannot provide any deference to the initial decision. A person or persons at Davis Vision who were not involved in the original decision of your claim, and who are not subordinate to the person at Davis Vision who initially denied your claim, will do the review of your appeal. If the benefit denial is based in whole or in part on a medical judgment, such as whether the service is medically necessary, Davis Vision will consult with a health care professional that has appropriate training and experience in the particular field of medicine relating to your claim. The health care professional will not be someone who was previously consulted on the claim.

Davis Vision will decide the appeal within 60 days of receiving your appeal request (30 days if the claim is for pre-approval of medically necessary contact lenses). You will be provided with a written notice of the decision on appeal. If the denial of your claim is upheld, in whole or in part, the notice will include the following information:

- The specific reason or reasons for the adverse determination.
- The specific provision of the Vision Care Plan and any other document on which the denial 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. If any internal rule, guideline, protocol or similar criteria was relied upon in making the adverse determination, either a copy of that document will be provided to you or you will be advised that you may obtain a copy of the document upon request and free of charge from Davis Vision. If the adverse determination is based, in whole or in part, on an exclusion or limitation that the benefit claimed is not medically necessary, you will be provided with an explanation of the scientific or clinical judgment for the adverse determination or advised that you may obtain it upon request and free of charge from Davis Vision.
- A statement regarding your right to bring a suit under federal law.

This Plan does not have other voluntary alternative dispute resolution options.

Benefit Plan Administration

The Plan Administrator of the Vision Care Plan is the Employee Benefits Administration Committee of ERIE. Many of the day-to-day administrative functions are performed through the 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 Vision Care 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 Vision Care 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 amendments to the Vision Care Plan. A copy of a plan amendment or modification shall be provided to the Plan Administrator of the Vision Care Plan and, to the extent necessary or appropriate, to any outside service provider of the Vision Care Plan. The Plan Administrator of the Vision Care Plan shall notify all covered participants and beneficiaries of any modification or amendment that changes the substantive terms of the Vision Care 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 Vision Care 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 Vision Care 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 if there is a loss of vision coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such 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 the plan's decision 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 Vision Care Plan

Plan Number

506

Plan Type

Welfare Plan (Vision)

Source of Contributions

Employer and Employee

Payment of Benefits

Self funded by Employer – Claims paid by Claims Administrator.

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

Claims Administrator

Davis Vision
159 Express Street
P.O. Box 9104
Plainview, NY 12110

Adopting ERIE Affiliates

Erie Insurance Company of New York

Erie Resources Management Corp.

Plan Year

January 1st to December 31st