Work/Life Resources Program
Summary Plan Description

Portions of the Work/Life Resources Program are governed by the Employee Retirement Income Security Act (ERISA).

The Erie Indemnity Company Work/Life Resources Program is designed to provide Employees and their families with a wide range of resources, together with assistance in addressing problems they have at work and at home. All Employees of Erie Indemnity Company (ERIE) and each affiliate of ERIE are eligible to participate in the Program. A complete list of ERIE affiliates whose Employees are covered by the Program is set forth at the end of this summary plan description. ERIE pays for the entire cost of the Work/Life Resources Program for its Employees and their families.

Main Features of the Work/Life Resources Program:

- An employee assistance program (EAP) that allows an Employee or family member to address a personal problem on a confidential basis with a trained counselor.
- A LegalConnect® program to allow an Employee or family member to obtain limited legal information on certain legal issues they may be facing, as well as referral to a local attorney.
- A FinancialConnect® program that allows an Employee or family member to discuss certain financial issues with a financial professional.
- A FamilySource® program that provides an Employee or family member with information about services in their community to assist with certain family matters.
- GuidanceResources® Online, an on-line tool that an Employee or family member may use to obtain information on matters important to them.

The services under the Work/Life Resources Program are provided by ComPsych Corporation ("ComPsych").

Eligibility

All Employees of ERIE and any affiliate of ERIE are eligible to participate in the Work/Life Resources Program. An Employee does not have to enroll in the Work/Life Resources Program, but will automatically be entitled to participate on the Employee's date of hire.

An Employee's spouse and dependents, including any dependent children who are attending school away from the Employee's home are eligible for benefits under the Work/Life Resources Program. In addition, any person living in the Employee's household, other than a

person who is a tenant or boarder of the Employee (or who is a tenant or boarder of the Employee's spouse or other family member) is eligible for benefits under the Work/Life Resources Program.

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

Effective Date of Coverage

Coverage will be effective for you under the Work/Life Resources Program on your date of hire. Coverage for your spouse, dependent children and eligible household members will also be effective as of your date of hire (or such later date that the individual becomes your spouse, dependent child or eligible household member).

Coverage While on Approved Leave of Absence

Coverage under the Work/Life Resources Program 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 covered under the Family and Medical Leave Act Provision

Coverage will continue for the length of the leave.

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 health benefits under the EAP component of the Work/Life Resources Program, and which meets certain requirements as to form and substance. In accordance with ERISA, coverage 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 Program determines to be a qualified medical child support order regardless of whether the child is a dependent of the Employee or resides in the Employee's household. If you receive a medical child support order it should be submitted to the Benefits Operations & Planning Section of ERIE. The Administrator of the Program will promptly notify the involved individuals of the receipt of the order and of the Program's procedure for determining whether the order is a qualified order. You may request a copy of the Program's procedure for determining whether an order is a qualified medical child support order from the Benefits Operations & Planning Section.

Medical Privacy Rights

In certain instances, you may use the Employee Assistance Program component of the Work/Life Resources Program for counseling. Any counseling relating to your health 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 under

HIPAA and the Program from the Notice of Privacy Practices for the Program. You may obtain a copy of the Program's Notice of Privacy Practices from *ERIEweb* (Info Center – Benefits Information – Privacy Practices) or from the ERIE Benefits Operations & Planning Section.

Termination of Coverage

An Employee will lose coverage on the date he or she is no longer an employee of ERIE (unless he or she retains coverage by reason of being a spouse or household member of another employee of ERIE). A spouse of an Employee will lose coverage when the Employee and spouse are no longer married and the spouse no longer resides in the Employee's household. Any dependent child of the Employee will lose coverage when the child is no longer a dependent of the Employee and no longer resides in the Employee's household. Any other person will lose coverage when that person is no longer a member of the Employee's household.

Continuation of Coverage Rights

COBRA Continuation Coverage. The Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the Work/Life Resources Program to extend temporary coverage to covered Employees and dependents in certain circumstances when they would otherwise lose their coverage under the Program. In the event that an Employee or dependent is a "Qualified Beneficiary" and loses coverage under the Program as a result of a "Qualifying Event" the Employee or dependent will have the right to elect COBRA continuation coverage under the Program. **The right to continuation coverage in the Work/Life Resources Program will only exist so long as health benefits are provided under the Employee Assistance Program (EAP) component of the Work/Life Resources Program.**

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).
2. A spouse of a covered Employee.
3. A dependent child (including an adopted child, a child placed for adoption with the Employee or a stepchild) of a covered Employee.

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 COBRA continuation coverage under the Program is a Qualified Beneficiary.

The following are Qualifying Events:

1. **Termination of Employment** - One Qualifying Event is the termination of a covered Employee's employment (other than for gross misconduct). If this Qualifying Event occurs, the Employee or any other Qualified Beneficiary may elect to continue coverage under the Program for up to 18 months following the date on which the termination of employment occurred. 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 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.

2. **Death of Employee**—If a covered Employee dies, 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 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. **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.

5. **Multiple Qualifying Events**—If an Employee lost coverage because of termination of employment and the Employee's spouse or dependents are receiving continuation coverage and then one of the events listed in paragraphs 2 through 4 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.

An 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 latter of the date coverage would otherwise end or the date that the COBRA Administrator, provided written notice of the right to purchase continuation coverage. 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.

An 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 coverage is lost because the Employee and his or her covered spouse are divorced or a

dependent child ceases to qualify as a dependent. The notice must be in writing.

A former Employee who is on COBRA must notify the COBRA Administrator, as soon as possible (but not later than 60 days) after the former Employee and his or her covered spouse are divorced or a covered dependent child ceases to qualify as a dependent or the former Employee or covered spouse or covered dependent child 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 request for a copy of the divorce decree may be made). 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).

It is important that you notify the Benefits Operations & Planning Section **of any changes in your marital status or the status of any person as your dependent.**

If the Qualifying Event is termination of employment (other than for gross misconduct), the COBRA Administrator will notify the Employee, his or her spouse 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.

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 premium for continuation coverage under a 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 Program, 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. Payment of the applicable premium is due by the first day of each month of continuation coverage, provided that the initial payment of the applicable premium must be made within 45 days after the election of continuation coverage.

Continuation coverage under the Program will end as of the date any of the following occur:

1. The required applicable premium is not paid on a timely basis. Except for the initial premium 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 Program or amends the Program to eliminate the provision of health benefits under the Program.
4. The date that the individual becomes covered under another employee assistance program 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 employee assistance program.

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

Discretionary Authority

The Employee Benefits Administration Committee is the Plan Administrator of the Program 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 Work/Life Resources Program. In addition, ComPsych has the discretionary authority to determine eligibility for benefits under the Program and to decide all claims for benefits and appeals of any denied claims.

Benefit Components

The Work/Life Resources Program includes the following components. ComPsych Corporation ("ComPsych") has been engaged by ERIE to provide all of these services to Employees and other individuals covered under the Work/Life Resources Program. For more information about the services provided, you may contact ComPsych directly at 1.877.369.1786 or on the internet at www.guidanceresources.com and entering ERIE's Company ID of ZM6757A.

Employee Assistance Program (EAP). The employee assistance program (EAP) component provides a means for an Employee or other person eligible for benefits to present a problem or issue of a personal nature on a confidential basis to a ComPsych counselor. By way of illustration, the EAP component of the Work/Life Resources Program is available to assist covered individuals with:

- Stress, anxiety or depression
- Substance abuse
- Interpersonal relationships

- Parenting issues
- Marital issues
- Grief and loss
- Job pressures
- Empty-nesting

Depending upon the nature of the problem or issue presented to the counselor, the individual will be provided with up to ten counseling sessions per incident by ComPsych counselors and/or may be referred to other resources for obtaining assistance in resolving the problem or issue.

LegalCONNECT®. The LegalCONNECT® component of the Work/Life Resources Program is a service provided by ComPsych. It provides a means for a covered individual to obtain limited legal information, as well as a local referral upon request. In the event a local referral is obtained, the individual is eligible for a free 30 minute consultation with the attorney and a 25 percent reduction in the attorney's customary rates. The decision as to whether or not to engage the attorney rests solely with the individual.

FinancialCONNECT®. The FinancialCONNECT® component of the Work/Life Resources Program is a service provided by ComPsych. It provides covered individuals with the ability to discuss financial issues, such as retirement planning, debt reduction, taxes and savings strategies over the telephone with financial professionals employed by ComPsych.

FamilySOURCE®. The FamilySOURCE® component of the Work/Life Resources Program is a service provided by ComPsych. It provides covered individuals with information about services in the community to assist in the care of children and the elderly.

FamilySOURCE® also provides information on other services in the community to assist covered individuals, such as home repair services, pet services, apartments or relocation services. The covered individual decides whether or not to engage a service that he or she discovers through FamilySOURCE®.

GuidanceRESOURCES®ONLINE. The GuidanceRESOURCES®ONLINE component of the Work/Life Resource Program is a service provided by ComPsych. Covered individuals are provided with an online tool to obtain various information on matters important to the individual. It can be accessed at www.guidanceresources.com and by entering ERIE's Company ID of ZM6757A.

Claims Review Procedures

These claims review procedures (including appeal rights) apply to any claim for health benefits under the Employee Assistance Program component of the Work/Life Resources Program. As claims administrator, ComPsych will undertake both the initial claims review, as well as reviewing any appeals of denied claims, to determine whether you are entitled to health benefits under the Employee Assistance Program (EAP) component of the Work/Life Resources Program and what health benefits you are entitled to.

Generally, you submit a health benefit claim by calling ComPsych at

1.877.369.1786 and speaking with a ComPsych guidance coordinator. The guidance coordinator will determine whether to have you speak with a ComPsych counselor or to refer you to other resources in your community. If you do not agree with the decision of the ComPsych guidance coordinator, you should discuss it with the guidance coordinator and try to reach an agreement on what health benefits you will receive under the EAP. If you cannot reach an agreement and request other health benefits, your request will be treated as a claim for health benefits.

Designation of Personal Representative. You may designate a personal representative to act on your behalf in claiming a health benefit or in appealing a denial of your claim. You should contact ComPsych in order to find out how to designate a representative. Even if you do not designate a representative, your attending doctor may act on your behalf as your authorized representative if the claim is an "Urgent Care Claim."

Claims Requiring Pre-Approval. If your claim requires pre-approval as a prerequisite to obtaining a health benefit, you must obtain pre-approval from ComPsych. If you contact ComPsych to obtain pre-approval for a pre-service claim, but fail to follow the procedure for pre-approval, ComPsych will notify you of the failure and of the proper procedure for filing a pre-service claim. ComPsych will provide this notice to you as soon as possible, but not later than five days after the failure, or, in the case of an "Urgent Care Claim" within 24 hours of the failure. The notice by ComPsych may be given orally unless you request a written notice.

Period for Determining Claims. The period during which ComPsych is required to decide a health benefit claim depends on the type of health benefit claim being made. There are generally three types of health benefit claims—a Pre-Service Claim, an Urgent Care Claim, and a Post-Service Claim. **Most health benefit claims under the Program will be either a Pre-Service Claim or an Urgent Care Claim.**

Pre-Service Claim—A Pre-Service Claim is a health benefit claim that requires some form of pre-approval by ComPsych before the health benefit is provided. ComPsych must decide a Pre-Service Claim (other than an Urgent Care Claim) within 15 days. This 15-day period may be extended for up to an additional 15 days if ComPsych determines that the extension is necessary for reasons beyond its control. ComPsych will notify you in writing or electronically if there is an extension. The notice must include an explanation of the reason for the extension, as well as the date by which ComPsych expects to render its decision. If the extension is due to a faulty claim, the notice of extension of time to decide the claim will describe the specific information you must provide to ComPsych to complete the claim. You will be provided at least 45 days from receipt of the notice to provide the necessary information. During that period the time for ComPsych to respond to your claim is suspended.

Urgent Care Claim—An Urgent Care Claim is a Pre-Service Claim where application of the normal period for deciding Pre-Service Claims could

jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is being requested. ComPsych is required to decide an Urgent Care Claim within 72 hours. If the claim is incomplete, so that a determination cannot be made of whether you are eligible for the proposed health benefit under the Program, ComPsych will notify you within 24 hours of receipt of the claim, or sooner if possible, of the information needed to complete the claim. You will have 48 hours after receipt of the notice to provide the information. Once the additional information is received by ComPsych, the health benefit claim will be decided within 48 hours of the earlier of (i) the receipt of the specified information by ComPsych, or (ii) expiration of the 48-hour period afforded to you to provide the specified information.

Post-Service Claim—A Post-Service Claim is any health benefit claim that is not a Pre-Service Claim. It would include a health benefit claim in which the procedure has already occurred and you are seeking coverage for it. ComPsych is required to decide a Post-Service Claim within 30 days. This 30-day period may be extended for up to an additional 15 days if ComPsych determines the extension is necessary for reasons beyond its control. ComPsych is required to notify you in writing or electronically if there is an extension. The notice must include an explanation of the reason for the extension, as well as the date by which ComPsych expects to render its decision. If the extension is due to a faulty claim, the notice of extension of time to decide the claim will describe the specific information you must provide to ComPsych to complete the claim. You will be provided at least 45 days from receipt of the notice to provide the necessary information. During that period the time for ComPsych to respond to your claim is suspended until your information is received.

Concurrent Care Decisions—In addition, some special rules apply where ComPsych has already approved an ongoing course of treatment over a period of time or number of treatments. First, if ComPsych reduces or terminates the course of treatment before it otherwise would have ended, that reduction or termination is a benefit denial. ComPsych must notify you in writing or electronically sufficiently in advance of the reduction or termination to allow you to appeal the decision (see "Claim Appeal Rights"), and to obtain a decision on any appeal. Second, if you request an extension of the course of treatment at least 24 hours before the course of treatment ends and it is an urgent care situation (see "Urgent Care Claim"), ComPsych must notify you within 24 hours of its decision on the extension request.

Notice of Determination. If your health benefit claim is denied in whole or in part, ComPsych will provide you with a written or electronic notice of the adverse determination. The notice will set forth:

- The specific reason or reasons for the denial or partial denial of the claim.
- The specific provisions of the Program 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, either a copy of the document will be provided to you or you will be notified that you may request a copy of the document from ComPsych at no charge. If the decision to deny benefits is based, in whole or in part, on an exclusion or limitation that the medical treatment is experimental or investigational, or that the treatment is not medically necessary and appropriate, either an explanation that applies the appropriate terms to your medical 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 request such an explanation from ComPsych at no charge.

- A description of any additional material or information necessary for you to complete the claim, and an explanation of why such information or material is necessary.
- Information as to how you can appeal the denial and the applicable time limits.
- A statement regarding your right to bring a civil suit under federal law should you appeal the claim denial and the denial is upheld on appeal.

When an urgent care claim is involved, the notice of denial may initially be provided orally to you, with a written or electronic notice provided within three days of the oral notice.

Claim Appeal Rights

You are entitled to appeal an adverse health benefit claim decision to ComPsych for a full and fair review of your claim. ComPsych provides two levels of appeal, except for Urgent Care Claims which have only one appeal level.

If you decide to appeal an adverse determination, you will have 180 days in which to file the appeal following your receipt of the notice of the denial or partial denial of your health benefit claim.

As part of your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. Also, you are entitled to receive upon request, free access to and copies of all documents, records and other information relating to your claim. Upon request, ComPsych must provide you with the name of each medical or vocational expert whose advice was obtained by ComPsych in connection with the denied health benefit claim, regardless of whether the advice was relied upon by ComPsych.

When you file an appeal, you will receive a review of the claim that takes into account all comments, documents, records and other claim-related information. No deference will be given to the initial determination. The review will be conducted by a person at ComPsych who is neither the individual who made the initial decision to deny the health benefit nor a subordinate of such individual. If the benefit denial is based in whole or in part on a medical judgment, such as whether the procedure is experimental or investigational or is not medically necessary and appropriate, the person deciding the appeal of the denied claim at ComPsych is required to consult with a health care

professional who has appropriate training and experience in the particular field of medicine relating to your claim. The health care professional will be someone who was not consulted on the initial claim review by ComPsych.

In the case of an Urgent Care Claim, you will be provided expedited review upon request, regardless of whether the request is made orally or in writing.

Information relating to the appeal may be transmitted between you and ComPsych by phone, fax or other expeditious means.

Following your appeal, ComPsych will review all of the information and documents relating to your claim, make a determination on the appeal and communicate its decision to you or your representative within the following timeframes:

Urgent Care Claims—Decisions on review of Urgent Care Claim appeals will be made and communicated in writing or electronically within 72 hours of receipt of the request for review.

Pre-Service Claims—For each of the two levels of appeal, a decision on review of a Pre-Service Claim will be made and communicated in writing or electronically as soon as reasonable, but not later than 15 days of the receipt of the request for review.

Post-Service Claims—For each of the two levels of appeal, a decision on review of a Post-Service Claim will be made and communicated in writing or electronically as soon as reasonable, but not later than 30 days of the receipt of the request for review.

In the case of a Pre-Service Claim or a Post-Service Claim, you have 30 days from the receipt of a notice of adverse determination on the first level of appeal to file the second appeal.

Any decisions on an appealed claim will be communicated to you or your representative in writing or electronically. If the denial of your claim is upheld on appeal, the notice will contain:

- The specific reason or reasons for the adverse determination.
- The specific provisions of the Program and any other document on which the adverse determination is based.
- A statement that you may obtain, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to your claim. If an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse determination, ComPsych must either provide a copy to you with the written notice or advise you that ComPsych will provide you with a copy free of charge upon request. If the adverse determination is based on medical necessity, experimental treatment or a similar exclusion, ComPsych must either provide you with an explanation of the scientific or clinical judgment for the adverse determination with the written notice, or advise you that ComPsych will provide you with the explanation free of charge upon request.
- A statement regarding your right to bring a civil suit under federal law.
- A description of any voluntary alternative dispute resolution

options that ComPsych offers.

Benefit Plan Administration

The Plan Administrator is the Employer Benefits Administration Committee of ERIE. Many of the day-to-day administrative functions are performed through the 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.

Plan Modification and Amendment

Erie Indemnity Company may modify or amend the Work/Life Resources Program 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 participants. The Board of Directors of Erie Indemnity Company may modify or amend the Program 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 Program. A copy of a plan amendment or modification shall be provided to the Plan Administrator of the Work/Life Resources Program and, to the extent necessary or appropriate, to any outside service provider of the Program. The Plan Administrator of the Work/Life Resources Program shall notify all covered participants and beneficiaries of any modification or amendment that changes the substantive terms of the Program 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 Work/Life Resources Program at any time and for any reason. Except as otherwise required by applicable law and regulations, any termination of the Program may be done without prior notice to participants. Any termination of the Program shall be done by resolution of the Board of Directors of Erie Indemnity Company, and the 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 Work/Life Resources Program and, to the extent necessary or appropriate, to any outside service provider. The Plan Administrator shall notify participants and beneficiaries of the 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 Administrator 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 health 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 rights.

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.

Enforce Your Rights

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 Work/Life Resources Program

Plan Number

510

Plan Type

Welfare Plan (Employee Assistance Program)

Source of Contributions

Employer

Payment of Benefits

All benefits under the Plan are paid by the Benefit 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

Benefit Administrator

ComPsych Corporation
NBC Tower, 13th Floor
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322

Adopting ERIE Affiliates

Erie Insurance Company of New York

Erie Resources Management Corp.

Plan Year

January 1st to December 31st