Long-Term Disability Benefits
The PNC Financial Services Group, Inc. and Affiliates
Long-Term Disability Plan
Plan Document and
Summary Plan Description
Amended and Restated Effective Jan. 1, 2018
This booklet describes the benefits for eligible employees under The PNC Financial Services Group, Inc. and Affiliates (PNC) Long-Term Disability Plan (the Plan). The Plan was originally established as of July 1, 1984, and is hereby amended and restated effective Jan. 1, 2018.

The Plan described in this booklet is an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This booklet serves as the plan document and the summary plan description (SPD) required under ERISA.

Nobody speaking on behalf of the Plan or PNC can alter the terms of the Plan. This document does not create a contract of employment between PNC or any related employer and any employee. PNC, as Plan Sponsor, reserves the right to amend or terminate the Plan or any benefit offered under this Plan at any time and for any reason.

Resources for You

If you have questions about PNC’s long-term disability benefits, contact the HR Service Center at 877-968-7762. Representatives are available from 9 a.m. to 5 p.m. ET weekdays.

However, please keep in mind that only the Plan Administrator or its delegate is authorized to make determinations regarding eligibility for benefits under the Plan.

Online Access: To access your current Long-Term Disability coverage and make allowable changes visit the applicable website:

- Current employees: Go to Pathfinder, the HR portal, from the PNC Intranet or directly to www.pncpathfinder.com. Expand the Benefits panel and choose the appropriate button.
- Employees on a long-term leave, former employees and beneficiaries: Go to Your PNC at www.yourpnc.com. (Your user ID and password are required.)

Both websites are available 24 hours a day Monday–Saturday and after 1 p.m. ET on Sunday.

Refer to pages 14-19 for important information about the claims and appeals procedures, including information about the statute of limitations applicable to claims for benefits and legal actions.
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DISABILITY BENEFITS OVERVIEW

PNC provides two types of income protection in the event you are unable to work due to illness or injury:

- Short-term disability (STD) benefits
- Long-term disability (LTD) benefits

This booklet provides information on LTD benefits only; refer to the separate STD Benefits booklet to learn how the STD benefits work.

If you become disabled and are unable to work for longer than 91 consecutive calendar days (13 weeks)—the Elimination Period during which STD benefits may be payable—you may be eligible to receive LTD benefits under the Plan.

PNC’s LTD coverage includes company-provided base coverage with a benefit equal to 60 percent (70 percent if you purchase the additional buy-up coverage) of your pre-disability eligible compensation (see definition of eligible compensation on page 6) if an approved total disability, due to injury or illness occurring on or off the job, keeps you out of work beyond 91 consecutive calendar days. The maximum monthly benefit is $10,000; there is no minimum benefit. LTD benefits provided under this Plan are subject to federal and state income taxes and certain adjustments and limitations may apply (see Payment Adjustments on page 8 and Plan Limitations on page 11).

While receiving LTD benefits, and during the application process, you are not eligible for paid occasional absence, vacation, personal days, award days or any other company-provided paid time off.

For purposes of LTD benefits, "full-time" service and employment status includes employees in both full-time and Reduced Schedule Professional (RSP) positions.

Who Is Eligible

You are eligible to participate in the Plan if you are an active full-time employee or Reduced Schedule Professional (RSP) of PNC or any related employer that participates in this Plan (collectively referred to as the employer).

However, you are not eligible to participate in this Plan if you are any one of the following:

- an employee who performs services for the employer as a leased employee within the meaning of section 414(n) or 414(o) of the Internal Revenue Code;
- an employee who is not on PNC’s United States payroll; or
- a person whose services are performed through a separate contract and who is classified by the employer as an independent contractor or otherwise is a person who is not treated by the employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding obligation.

Eligible employees will begin participation as described in When Coverage Begins below.

When Coverage Begins

For employees hired or newly-eligible prior to March 1, 2018, coverage begins as follows:

- Company-provided base coverage (60 percent coverage): Coverage begins on the first day of the month following your date of hire.
- Optional buy-up coverage (70 percent coverage): If you elect optional buy-up coverage, your additional 10 percent coverage also begins on the first day of the month following your date of hire. If you elect optional buy-up coverage during an annual enrollment period, your additional 10 percent coverage begins on the following Jan. 1.
For employees hired or newly-eligible on or after March 1, 2018, coverage begins as follows:

- **Company-provided base coverage (60 percent coverage):** Coverage begins after you complete 90 days of continuous full-time service or RSP service starting with your most recent date of hire or date of reclassification (from part-time or temporary status to full-time or RSP status).

- **Optional buy-up coverage (70 percent coverage):** You will have the opportunity to purchase optional coverage (additional 10 percent for a total 70 percent coverage) during any annual enrollment, provided you were hired or reclassified (as described above) prior to the Oct. 1 immediately preceding the regularly-scheduled annual enrollment period. Your additional 10 percent coverage will begin the Jan. 1 following enrollment.

See Enrollment on page 6.

### When Coverage Ends

Your LTD coverage ends when your active, full-time employment as an employee of the employer ends as a result of any of the following:

- unpaid leave of absence that is not job-protected;
- termination of employment*;
- reclassification to part-time status; or
- any other reason that affects your eligibility.

Any additional LTD coverage you elected will end if you fail to make the required contributions. Your coverage under the Plan also will end if the Plan is amended to exclude you or the Plan is terminated.

Note: This does not affect you if you are currently receiving a monthly LTD benefit (see Maximum Benefit Period on page 10). See Mental Illness Benefits (on page 10) and Plan Limitations (on page 11) for situations that may affect your ability to continue receiving LTD benefits.

*If a disabling event occurs while you are employed, you subsequently terminate employment, and then apply for LTD within 180 days of your disability date, you are eligible to be considered for LTD benefits.

### Cost of Coverage

**Company-provided Base Coverage**

PNC pays the full cost of the LTD base coverage equal to 60 percent income replacement of eligible compensation.

**Optional Buy-up Coverage**

You may purchase additional LTD coverage of 10 percent for a total of 70 percent income replacement of your eligible compensation as described on pages 4 and 5. You pay the cost for this additional coverage.

The required contribution amount is shown in the materials provided to you before each annual enrollment period. While you are an active employee, the cost for additional LTD coverage is based on your current eligible compensation (see Eligible Compensation on page 6) and your age as of Dec. 31 of the upcoming calendar year. If your salary increases while you are actively at work, your coverage amounts and payroll deductions for additional LTD coverage will increase automatically on the effective date of the salary increase. PNC reserves the right to change the cost of coverage at any time in the future.

Your contribution amount is deducted from your pay on a pre-tax basis under The PNC Financial Services Group, Inc. Group Benefit Plan (the Group Benefit Plan), which is a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code. Your ability to make or change your pre-tax contribution elections is governed by the terms of the Group Benefit Plan.

Contributions are waived for any period of time that you are receiving LTD benefits.

### Key Concepts

**Definition of LTD**

For disabilities that extend beyond 91 consecutive calendar days and are considered long term, the definition of disability is as follows:

- **For the first 24 months (from the date LTD benefits begin):** you are disabled if your disability makes you unable to perform the material or essential duties of your own occupation as it is normally performed in the national economy.
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- After you have been disabled for 24 months: you are disabled if your disability makes you unable to perform the material duties of any occupation for which you are or can become qualified to perform by education, training or experience.

In order to establish your entitlement to LTD benefits, you must provide proof of your disability to the claims administrator, including objective evidence that you are disabled within the meaning of the Plan and meet all eligibility criteria for receipt of LTD benefits. The claims administrator has full and complete discretion to make all determinations concerning entitlement to and eligibility for benefits, including without limitation, whether a claimant is eligible for, and participating in, the Plan, whether a condition meets the Plan's disability definitions and whether any limitations on, or exclusions from, eligibility apply. The Plan's rules concerning eligibility, participation, coverage, limitations and exclusions are discussed elsewhere in this booklet.

Elimination Period
You can begin receiving LTD benefits after you have been disabled due to an injury or illness for 91 consecutive calendar days (13 weeks) not interrupted by a return to work of more than 30 consecutive calendar days. This is called the Elimination Period, during which you may receive Standard Short-term Disability or Maternity Leave benefits, if eligible.

If your disability ends and you return to work for 30 or fewer consecutive days during the Elimination Period and you become disabled again during the Elimination Period, you do not need to satisfy a new Elimination Period. The days worked will not count toward the Elimination Period. Only those days you are disabled will count toward the Elimination Period.

Eligible Compensation
For purposes of this LTD Plan, eligible compensation is defined as the total of:

- your base salary (excluding bonuses, overtime pay and extra compensation) as of Oct. 1 of the prior year; plus
- 100 percent of the first $25,000 and 50 percent of the next $225,000 of commissions paid during the 12 months ending Sep. 30 of the prior year.

That means, for the 2018 Plan Year your eligible compensation would include your base salary as of Oct. 1, 2017 and your commissions paid, if applicable, between Oct. 1, 2016 and Sep. 30, 2017.

This calculation excludes overtime, bonuses, incentives and other forms of extra compensation. Once your disability begins, salary changes will not result in an increase in LTD benefits, nor can you elect additional LTD coverage.

For purposes of LTD, eligible compensation is defined as the total of:

- your pre-disability base pay, plus
- 100 percent of the first $25,000 of commissions and 50 percent of the next $225,000 of commissions, based on the last 12 months of paid commissions as of the preceding Oct. 1.

Overtime, bonuses, incentives and other forms of extra compensation are excluded from the calculation of LTD eligible compensation.

LTD Commencement Date
Your LTD Commencement Date is the beginning of your LTD benefit period and is defined as the date upon which you are approved for long-term disability benefits by the claims administrator.

ENROLLMENT
No enrollment is required for the company-provided base LTD coverage. You may elect optional buy-up LTD coverage of 10 percent for a total of 70 percent of your pre-disability eligible compensation. Subject to the rules of the PNC Group Benefit Plan, you may elect this additional coverage as follows:

- For employees hired or newly eligible prior to Mar. 1, 2018: You may enroll within 31 days of your hire date or a status change, or during any annual enrollment.
- For employees hired or newly-eligible on or after Mar. 1, 2018: You may enroll during any annual enrollment, provided you were hired or reclassified (as described on pages 4 and 5) prior to the Oct. 1 immediately preceding the regularly-scheduled annual enrollment period. Your additional 10 percent coverage will begin on the Jan. 1 following enrollment.
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If you are not actively at work because of an injury or illness, the effective date of any initial or increased coverage will begin on the date you return to active employment.

Change in Status

Note: Effective Jan. 1, 2019, changes to your LTD buy-up coverage (additional 10%) will be permitted only during annual enrollment — mid-year coverage changes due to a change in status will no longer be permitted. Rules for status changes prior to Jan. 1, 2019 are described below.

A change in status (also called a qualified life event) is a change in your personal situation that allows you to make certain enrollment changes mid-year instead of during the next annual enrollment period. The rules about which status changes are considered qualified are set by the Internal Revenue Service (IRS). The IRS imposes these restrictions on mid-year coverage changes because you pay your share of the cost with pre-tax payroll deductions.

Status changes applicable to LTD coverage generally include:
- Marriage or domestic partner relationship
- Birth or adoption of a child
- Divorce, legal separation or dissolution of domestic partner relationship
- Change in a family member’s eligibility due to age (for example, your child reaches age 26 and is no longer eligible for coverage)
- Your spouse/domestic partner’s annual enrollment period
- Death of a spouse/domestic partner, child or other eligible family member
- Change in employment status for you or your spouse/domestic partner
- Start of or return from an unpaid leave for you or your spouse/domestic partner

You have 31 days from the date of a change in status to request any allowable coverage changes. To report a change in status, follow these steps:
- Go to Your Snapshot on Pathfinder, expand the Benefits panel and select the Change Coverage button.
- Follow the prompts to report the event and request benefit changes.

Election changes become effective as follows as long as the change is made within 31 days of the change in status:
- generally the date of the change (for example marriage date, divorce date, etc.); and
- retroactively to the date of birth or date of adoption of a child.

If you wait longer than 31 days to report a change in status, you must wait until the next annual enrollment period (or until you have another change in status) to make allowable changes to your coverage.

In addition to the summary of Change in Status rules (as they apply to your LTD buy-up coverage) described above, further details about these rules are included in a separate booklet called the General Plan Information booklet of The PNC Financial Services Group, Inc. Group Benefit Plan. See Online Access on page 2 for instructions for accessing this separate booklet.

HOW LTD BENEFITS WORK

Applying for LTD Benefits

If you are receiving STD benefits, you will be contacted about your application for LTD benefits before the end of the 91-day Elimination Period.
- Your LTD case manager will call you to discuss details of your claim and will send some initial LTD paperwork that you must complete and return. Examples of paperwork include an Activities Questionnaire, Medical Authorization form, Claimant & Family Information forms, and a Supplemental Income Statement.
- It is important that you complete any necessary paperwork and assist in the process in order to ensure timely consideration of your claim for benefits.

If you wish to apply for LTD benefits and are not contacted directly, you must contact the claims administrator at 800-838-5290 and obtain the necessary claim forms. In all cases, you must submit a claim for LTD benefits within 180 days of the date your disability began or your claim will be denied.

How LTD Benefit Payments Are Calculated

The monthly LTD benefit you receive while you are unable to work is 60 percent or 70 percent of your pre-disability eligible compensation, depending on
Other sources may include:

- Recovery for any amounts received for loss of income as a result of claims against a third party or in settlement of such claims
- Disability benefits from the Department of Veterans Affairs only if a result of the same or related disability as LTD Plan benefits (Effective for LTD benefits that are first payable beginning on or after Jan. 1, 2014.)
- Any compromise, settlement, award or judgement

Amounts you receive are prorated monthly as follows:

- over the period of time such benefit payments would have been paid if not paid in a lump sum; or
- if such period of time cannot be determined, for the remainder of the maximum benefit period (see Maximum Benefit Period on page 10).

### Social Security Income

It’s important to understand that Social Security retirement benefits differ from Social Security disability benefits. Depending on your age, you may be eligible for Social Security retirement benefits. Or, depending on the extent of your disability, you may be eligible for Social Security disability benefits after you have been disabled for five months, regardless of your age. You must apply for Social Security benefits immediately upon becoming eligible for Social Security. Once you begin receiving Social Security benefits, your PNC LTD benefits will be reduced by the amount that you receive from Social Security.

Consistent with the plan requirements, you must complete and sign an overpayment-reimbursement agreement that will apply to both Social Security retirement and disability benefits. The claims administrator will send the form to you when you apply for PNC LTD benefits.

The overpayment-reimbursement agreement confirms your understanding that if you receive Social Security benefits, you will be required to reimburse the plan for the benefits you received from PNC’s LTD plan, up to the amount you received from Social Security. The claims administrator will suspend your PNC LTD benefits if this form is not completed and returned at the time that you apply for PNC LTD benefits.

If your disability begins on Jan. 1, 2015, or later, in addition to completing the overpayment-reimbursement agreement you must follow the steps...
described below related to Social Security disability benefits. If you don’t, your PNC LTD benefit will be reduced by an estimated Social Security benefit to which you may be entitled.

- When you reach the five-month point from your date of disability and become eligible to apply for Social Security disability benefits, you must begin the application process. The claims administrator will assist you.
- You will have 45 calendar days from the beginning of the fifth month of your disability to provide proof of your Social Security application. Proof should be provided to the claims administrator’s disability case manager.

If the claims administrator does not receive proof of your application by the deadline, your PNC LTD benefits will begin to be reduced by an estimated Social Security benefit to which you may be entitled. This reduction will continue until you supply the claims administrator with proof of one of the following:

- your Social Security application;
- a denial of Social Security benefits notice; or
- a Social Security award notice.

If your application for Social Security benefits is denied, you should request that the Plan’s claims administrator assist you in submitting the needed information for an appeal.

If your application for Social Security benefits is approved and you have received an overpayment of PNC LTD benefits, you must repay the overpayment in full upon receiving your Social Security disability award. If you don’t repay the entire overpayment, your monthly PNC LTD benefit will be reduced by PNC, or the matter will be referred to a collection agent. If you received an underpayment of PNC LTD benefits, an adjustment will be made to your benefit to compensate for the underpayment.

If your Social Security benefits are increased due to an earnings credit after you begin receiving PNC LTD benefits, the increase in your Social Security benefits will reduce the amount of PNC LTD benefits you are receiving under this Plan retroactively to the date of the Social Security benefit increase. Cost-of-living adjustments to Social Security benefits, however, will not reduce LTD benefits under this Plan.

### LTD EXAMPLE 2
**LTD benefits calculation with Social Security**

Zack is approved for a Social Security disability or retirement benefit of $700 a month. As a result, his PNC LTD benefit is reduced by the amount of the Social Security payment, as shown below. Zack still receives the same total monthly disability income, but it comes from two sources.

<table>
<thead>
<tr>
<th></th>
<th>LTD 60% Coverage</th>
<th>LTD 70% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Benefit</td>
<td>$700</td>
<td>$700</td>
</tr>
<tr>
<td>LTD Benefit</td>
<td>$500</td>
<td>$700</td>
</tr>
<tr>
<td>Total Monthly Disability Income</td>
<td>$1,200</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

### LTD EXAMPLE 3
**LTD benefits calculation with Social Security and Workers’ Compensation**

Zack is approved for a Social Security disability or retirement benefit of $700 a month and a Workers’ Compensation benefit of $400 a month. His LTD benefit is reduced by the amount of those other payments, as shown below. Zack still receives the same total monthly disability income, but it comes from three sources.

<table>
<thead>
<tr>
<th></th>
<th>LTD 60% Coverage</th>
<th>LTD 70% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Benefit</td>
<td>$700</td>
<td>$700</td>
</tr>
<tr>
<td>Workers’ Compensation Benefit</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>LTD Benefit</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Total Monthly Disability Income</td>
<td>$1,200</td>
<td>$1,400</td>
</tr>
</tbody>
</table>
Partial Disability Benefit
The claims administrator has full and complete discretion to determine if an LTD benefit recipient can return to work on a part-time basis. If the claims administrator approves your return to work on a part-time basis after you begin receiving monthly LTD benefits, you may be eligible to receive a partial disability benefit if your disability limits your ability to work full-time and results in you earning between 20 percent and 80 percent of your pre-disability eligible compensation. In this case, you may be eligible for a partial LTD benefit equal to 60 percent or 70 percent of your lost income, not to exceed 100 percent of your pre-disability eligible compensation.

You are eligible for partial disability if you can perform one, more or all of the material and substantial duties of a position on a part-time basis. The determination of your pre-disability income (your eligible compensation prior to the disability date) will be subject to an increase of the lesser of the consumer price index or 7 percent on each annual anniversary of benefit payments.

LTD EXAMPLE 4
LTD partial disability benefit
John becomes disabled when his monthly pre-disability eligible compensation is $2,000. After receiving LTD benefits for two months, John’s doctor and the claims administrator allow him to work part-time. His monthly pay for this part-time work is $900. Here is how John’s partial disability benefit is calculated for both the 60 percent and 70 percent LTD coverage options.

<table>
<thead>
<tr>
<th></th>
<th>LTD 60% Coverage</th>
<th>LTD 70% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly pre-disability eligible compensation</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Less pay from part-time work</td>
<td>- $900</td>
<td>- $900</td>
</tr>
<tr>
<td>Lost pay</td>
<td>$1,100</td>
<td>$1,100</td>
</tr>
<tr>
<td>Monthly LTD Partial Disability Benefit (60% or 70% of lost pay)</td>
<td>$660</td>
<td>$770</td>
</tr>
<tr>
<td>Plus pay from approved part-time work</td>
<td>+ $900</td>
<td>+ $900</td>
</tr>
<tr>
<td>Total Monthly</td>
<td>$1,560</td>
<td>$1,670</td>
</tr>
</tbody>
</table>

Successive Periods of Disability
If you have a second period of disability that occurs within six months of returning to your regular job on an active full-time basis and is due to the same or a related cause as your first disability, it will be considered a continuation of your earlier disability. LTD benefits will be resumed, and you will not need to complete another 91-day Elimination Period.

A new 91-day Elimination Period will be required in either of the following cases:
- the second period of disability is for the same or a related cause and is separated by more than six months from the original disability’s return-to-work date; or
- the second period of disability is for a different cause, regardless of how much time has passed since the original disability’s return-to-work date

Mental Illness Benefits
If you are disabled due to mental illness (mental, nervous or emotional disorders), LTD benefits are limited to 24 monthly benefit payments, unless you meet one of the following conditions:
- If you are in a hospital or institution* at the end of the 24-month period, the Plan will continue to pay the monthly LTD benefit during the period of confinement until discharge.
- If you are still disabled when discharged, the monthly LTD benefit will be paid for a recovery period of up to 90 days after discharge.
- If you are re-confined during the recovery period for at least 14 consecutive days, the Plan will pay the LTD benefits for the confinement and another recovery period of up to 90 days following discharge.

In no circumstance will the monthly LTD benefit be payable beyond a period longer than 180 days from the expiration of the 24-month period.

Maximum Benefit Period
The maximum benefit period for LTD is based on your age and the date on which you become disabled:
- If you become disabled before age 61, your LTD benefits continue as long as you remain disabled under the Plan or until you reach 65, whichever occurs first.

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*Hospital or institution refers to a facility where you are admitted for medical or psychiatric treatment.
If you are age 61 or older when your disability starts, LTD benefits will continue as shown below while you remain disabled:

<table>
<thead>
<tr>
<th>If your disability begins at age:</th>
<th>You are eligible for benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 or earlier</td>
<td>Until age 65 or as long as you remain disabled under the Plan, whichever comes first</td>
</tr>
<tr>
<td>61</td>
<td>54 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Your LTD benefits will end earlier than the time shown in the chart if you no longer meet the definition of disabled, or other plan limits apply (see Plan Limitations on page 11).

*Hospital or institution means a facility licensed to provide care and treatment for the condition causing your disability.

**Pre-existing Conditions**

A pre-existing condition results from an injury or sickness that was diagnosed, or for which you have received medical treatment, consultation or care, or have taken a prescribed medication, within three months prior to the LTD coverage effective date.

LTD benefits are not payable for a pre-existing condition that causes you to be unable to work during the first 12 months (365 days) after your LTD coverage under this Plan takes effect. However, a pre-existing condition will be covered once you have been at your job for at least 12 months or newly elected LTD coverage has been effective for at least 12 months.

This applies to both the company-provided 60 percent LTD coverage and to the 70 percent LTD coverage, if elected. The pre-existing condition exclusion applies if you:

- are a newly hired employee; or
- are reclassified to full-time employment and therefore newly eligible for LTD benefits; or
- elect to purchase additional LTD coverage during annual enrollment. In that case, only the difference in coverage between the 60 percent LTD benefit and the 70 percent LTD benefit is subject to the pre-existing condition exclusion period.

**Plan Limitations**

LTD benefits may be less than expected, not paid at all, or stopped if:

- you are no longer disabled, as defined by the Plan and determined by the claims administrator;
- you recover or engage in any occupation for wage or profit other than a job approved for a partial disability benefit;
- you do not satisfy the Plan requirements, such as:
  - You do not file a claim with the claims administrator within 180 days of the date your disability begins.
  - You refuse to undergo a medical examination and/or participate in a rehabilitation program, as requested by the claims administrator.
  - You do not satisfy the Plan requirements, such as:
    - ♦ You do not file a claim with the claims administrator within 180 days of the date your disability begins.
    - ♦ You fail to submit proof of your disability or continuing disability upon request.
    - ♦ You fail to cooperate in the administration of your claim. Cooperation includes, but is not limited to:
      - ♦ providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
      - ♦ providing proof of a continued disability or partial disability; and
      - ♦ providing proof of continued regular treatment by a licensed physician."

*Physician means a person who is licensed to practice medicine and is practicing within the terms of his/her license; or is a licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the treatment is received and is practicing within the terms of his/her license and is not you, any family member or domestic partner.
LONG-TERM DISABILITY PLAN

- you reach your maximum benefit period (see Maximum Benefit Period on page 10);
- you have received 24 months of LTD benefits from the Plan for a mental illness with up to 180-day extension (see Mental Illness Benefits on page 10);
- you refuse any appropriate, available treatment or fail to comply with your treatment plan. Treatment means:
  ♦ consulting, receiving care or services provided by or under the direction of a physician including diagnostic measures;
  ♦ being prescribed drugs and/or medicines, whether you choose to take them or not; and
  ♦ taking drugs and/or medicines.
- you refuse a job with PNC where workplace modifications or accommodations have been made to allow you to perform the material and substantial duties of the job;
- you fail to meet the eligibility requirements for an LTD benefit under the Plan; or
- you die.

Survivor Benefit

PNC LTD coverage includes a survivor benefit that becomes effective once you have received LTD benefits from the Plan for three consecutive months. For example, if your LTD benefits begin on February 10 and you receive benefits for three consecutive months, you may become eligible for a survivor benefit as of May 10. If you have received LTD benefits from the Plan for three consecutive months and then have a successive period of disability (as defined on page 10) that does not require a new Elimination Period, you continue to be eligible for a survivor benefit once your LTD benefit resumes.

If you die after becoming eligible for the survivor benefit, your LTD coverage will pay your survivor an amount equal to three times your last monthly LTD payment from the Plan, less any adjustments that applied to you (see Payment Adjustments on page 8).

The Plan will make the payment in a lump sum to your spouse/domestic partner, if living. Otherwise, the amount will be paid in equal shares to your unmarried dependent children under age 25, including step-children and legally adopted children. Benefits payable to a minor or incapacitated child are made on their behalf to the court-appointed guardian of the child’s property.

For purposes of the survivor benefit, your spouse is the person to whom you are legally married at the time of your death, and your domestic partner means an individual of the same or opposite sex who is recognized under the laws of any state as your domestic partner or who otherwise meets the definition of domestic partner under the Group Benefits Plan. The claims administrator may require proof of survivor status.

If you do not have survivors as described above when you die, no LTD survivor benefit is paid under the Plan.

Exclusions

You are not eligible for LTD benefits if your claim arose from, or if any of the following apply:
- Disability occurring while you are on an unpaid leave of absence that is not job-protected or is taken for purposes other than your own illness or injury
- An intentionally self-inflicted injury or illness
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Commission or attempted commission of a crime
- Cosmetic surgery
- Any condition for which you are not being treated by a licensed physician
- Refusal to be examined or to submit any medical or other relevant information that the claims administrator requests
- Disability occurring during incarceration
- In the case of one or more pre-existing conditions

The maximum benefit period for LTD is based on your age and the date on which you become disabled. See Maximum Benefit Period on page 10.
EFFECT OF DISABILITY ON OTHER BENEFITS

If you become disabled and qualify to receive benefits under the LTD Plan, you may continue certain PNC health care, insurance and retirement benefits for which you are otherwise eligible. Coverage may continue for you and your eligible family members as described below for a limited time, provided you pay any required contributions. You will receive an invoice from PNC for your portion of the cost of any benefit coverage you elected that requires a contribution. When you return to work, you are responsible for paying any outstanding contribution owed, and PNC will resume payroll deductions for your benefit contributions.

After you satisfy the LTD Elimination Period and meet the Plan requirements to receive LTD benefits as approved by the claims administrator, the following treatment applies:

- **70 percent LTD**: If you elected to participate in the 70 percent LTD coverage, contributions are waived for any period of time that you are receiving LTD benefits.

- **Medical, Dental and Vision**: Coverage for you (and eligible family members who were covered before your disability began) continues until the earlier of:
  - three years following the beginning of your LTD benefit period (called the LTD Commencement Date); or
  - when you become eligible for Medicare, provided you pay the active employee rate for such coverage until becoming eligible for Medicare.

This continuation of coverage runs concurrent with and satisfies the continuation of coverage requirement under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and generally exceeds the extension of coverage as provided by COBRA.

If your spouse/domestic partner is enrolled in your PNC benefits, his or her benefits may end earlier if he or she becomes eligible for Medicare:

- before you become eligible for Medicare; or
- before the end of the three years following the beginning of your LTD benefit period.

In this case, his or her PNC benefits will end effective with his or her Medicare eligibility date.

In the event that your eligible family members would lose medical, dental and/or vision coverage earlier than the time described above as a result of one of the following:

- your death;
- your divorce or legal separation from your spouse; or
- the loss of dependent child status under the Plan, they may be eligible for up to an 18-month extension of coverage under COBRA — for a maximum total coverage period not to exceed three years following your LTD Commencement Date. (Note that your Medicare entitlement is not an event that would result in an extension of coverage for your family members.)

- **Health Savings Account (HSA)**: If enrolled, your payroll contributions and, if applicable, the company’s contributions to your HSA, end on the date your Standard Short-term disability (STD) or Maternity Leave benefits end.

- **Dependent Care Reimbursement Account (DCRA)**: If you are on a leave of absence, paid or unpaid, your participation in the DCRA ends on your last day of work. You cannot make contributions to your DCRA or incur eligible DCRA expenses after that date while you are on leave. However, if you return to work from your leave in the same calendar year, your DCRA contributions will automatically restart (unless you chose to end your DCRA participation due to a change in status). You have until the following March 31 to submit claims for reimbursement of expenses incurred before your last day of work, up to the amount in your account on that date.

- **Life Insurance**:
  - Company-provided Basic Life Insurance continues for three years following your LTD Commencement Date.
  - If you are currently enrolled in Optional Life Insurance for yourself, that coverage will continue for one year from your LTD Commencement Date, provided you continue to pay the required contribution.
  - If you are currently enrolled in Spouse/Domestic Partner and/or Child Life Insurance, that coverage will continue for three years following your LTD Commencement Date, provided you continue to pay the required contribution.
Conversion and portability options may be available; contact the HR Service Center at 877-968-7762 for more information.

- **Business Travel/Criminal Act Insurance (BTA):** Company-provided BTA ends on your LTD Commencement Date.
- **Personal Accident Insurance:** If you are currently enrolled in Personal Accident Insurance, coverage will continue for three years from your LTD Commencement Date. Contributions are waived for any period of time that you are receiving LTD benefits. Conversion options may be available; contact the HR Service Center at 877-968-7762 for more information.
- **Pension:** Pension earnings accruals under the PNC Pension Plan stop on the earliest of:
  - three years from your LTD Commencement Date;
  - the date you are no longer disabled; or
  - the date you are no longer employed by PNC.
- **Incentive Savings Plan 401(k):** If enrolled, your contributions and the company match end on the date your STD benefits end.
- **Vacation Buy:** If you elected vacation buy and do not return to work within the same calendar year in which the LTD leave began, it is your responsibility to call the HR Service Center at 877-968-7762 by December 1 of such year to request that the days purchased be cashed out. If you do not call, the paid days will be forfeited and you cannot be cashed out, per IRS rules.

See the individual booklets for each of the benefits listed above for more details, or call the HR Service Center at 877-968-7762.

**Note:** If you have not returned to work and no longer qualify for PNC’s LTD benefits, as determined by the claims administrator, all PNC health care, insurance and retirement benefits will end the first of the month following 30 days of the date of LTD denial. You may be eligible to continue medical, dental and vision coverage through COBRA if the maximum coverage period has not been reached.

**CLAIMS AND PLAN ADMINISTRATION**

**Claims and Appeals Procedures**

The claims administrator is the named fiduciary for purposes of the Plan’s claims and appeals procedures and, in making its decisions, has full and complete discretionary authority to interpret the terms and provisions of the Plan and to resolve all questions under the Plan, including, without limitation, the authority to determine eligibility for benefits and the amount of such benefits; the right to make factual determinations; the right to determine whether any limitations, exclusions or other restrictions apply; and the right to resolve and remedy ambiguities, inconsistencies or omissions in the Plan in making such decisions.

**Claims**

Claims for benefits under the Plan must be submitted in writing to the claims administrator. If your claim is wholly or partially denied, written or electronic notice of the decision shall be furnished within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by up to 30 days if the claims administrator determines that such an extension is necessary due to special circumstances or matters beyond the control of the Plan and notifies you prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If, prior to the end of the first 30-day extension period, the claims administrator determines that, due to special circumstances or matters beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days if the claims administrator notifies you prior to the expiration of the first 30-day extension of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you will be afforded at least 30 days within which to provide the specified information.

If your claim is denied, the notice of denial will include:

- the specific reason or reasons for the denial;
- specific reference to the pertinent Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and an
If your appeal is wholly or partially denied, written findings.

A hearing may be held in the discretion of the plan administrator for the purpose of making factual findings. In connection with your appeal, you are entitled to review pertinent documents and submit issues and comments in writing to the Plan. A hearing may be held in the discretion of the claims administrator for the purpose of making factual findings.

If your appeal is wholly or partially denied, written or electronic notice of the denial will be furnished within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by up to 45 days if the claims administrator determines that such an extension is necessary due to special circumstances or matters beyond the control of the Plan and notifies you prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If your claim is denied, the notice of denial will include:

- the specific reason or reasons for the denial;
- specific reference to the pertinent Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive without charge reasonable access to any document:
  - relied on in making the determination,
  - submitted, considered or generated in the course of making the determination,
  - that demonstrates compliance with the required administrative process and safeguards, or
  - constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit without regard to whether the statement was relied on;
- a description of any voluntary appeals procedure, as well a statement of your right to bring a civil action under section 502(a) of ERISA if your claim is denied on appeal; and
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request.

The claims administrator’s decision on appeal will be binding on all parties.

**Court Review**

No person may bring an action in a court of law for benefits under this Plan unless the Plan’s claims and appeals procedure is exhausted (excluding any voluntary appeals) and a final determination has been issued by the Plan. If a decision made by the Plan is challenged in court, the court’s review will be limited to the facts, evidence and issues presented during the claims review procedure set forth above and shall be limited to a determination of whether the decision was arbitrary and capricious. The facts and evidence that become known to the participant...
or any other interested person after the appeals process has been exhausted may be submitted for reconsideration only in accordance with the time limits set forth above. Issues not raised during the initial appeal will be deemed waived.

**Plan Administration**

**Plan Administrator**

The Plan Administrator shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator shall have the discretionary authority to determine eligibility for benefits under the Plan, to construe the terms of the Plan and to determine any question which may arise in connection with its operation or administration. Its decisions or actions in respect thereof shall be conclusive and binding upon the employer and upon any and all participants and survivors, their beneficiaries and their respective heirs, distributees, executors, administrators and assignees; subject, however, to the right of the participant or survivor to file a written claim or appeal to file a written claim or appeal under the procedures described above. The Plan Administrator may delegate in any manner it deems appropriate any of its duties hereunder to such person or persons it may designate from time to time, including, without limitation, the claims administrator. The Plan Administrator has delegated to the claims administrator full fiduciary responsibility for purposes of the Plan's claims and appeals procedures as set forth in the Claims and Plan Administration section of this booklet.

If the Plan Administrator has not exceeded the time limitations set forth above for claims and appeals, no person may bring an action against the Plan Administrator in a court of law, unless the procedures set forth above are exhausted and a final determination is made by the Plan Administrator or its delegate. If the participant, survivor or other interested person challenges the Plan Administrator’s or its delegate’s decision, a review by a court of law shall be limited to the facts, evidence and issues presented to the Plan Administrator or its delegate during the Plan’s claims and appeal procedure and shall be limited to a determination of whether the Plan Administrator’s or its delegate’s decision regarding the claim was arbitrary and capricious.

Facts and evidence that become known to the claimant or other interested person after having exhausted the appeal procedure shall be brought to the Plan Administrator’s attention for reconsideration of the appeal in accordance with the time limits established above. Issues not raised with the Plan Administrator or its delegate during the appeal procedure shall be deemed waived.

**Records**

The Plan Administrator shall maintain or cause to be maintained such accounts and records as shall be necessary and appropriate to reflect the administration of the Plan and the interests of all participants and their survivors. Any participant or survivor shall be entitled to examine at any reasonable time any such accounts and records directly pertaining to his or her interest. The Plan Administrator shall provide such reports and statements to each participant or survivor as it shall deem appropriate.

**Compensation for Services**

The Plan Administrator shall not be entitled to compensation for its services as such. All fees, salaries and other costs of providing services to the Plan shall be paid by the employer.

**Duties of Plan Administrator**

The Plan Administrator or its delegate shall have the right and discretionary authority to discharge its duties hereunder, including, but not by way of limitation, the following:

- to interpret the terms and provisions of the Plan and to resolve all questions arising thereunder, including, without limitation, the authority to determine eligibility for benefits and the amount, manner and time of payment of such benefits, the right to make factual determinations and the right to resolve and remedy ambiguities, inconsistencies or omissions in the Plan. This authority shall include the right to make a determination as to whether or not a particular limitation, exclusion or other restriction under the Plan is applicable in a particular situation, including, without limitation, the right to determine whether or not a person’s condition is physical or mental in nature;

- to prescribe procedures to be followed by participants filing applications for benefits;

- to direct any third party as to the payment of benefits hereunder.
to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;

to receive from participants such information as shall be necessary for the proper administration of the Plan;

to prepare such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

to appoint persons to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel.

Rules
The Plan Administrator or its delegate may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator or its delegate shall be uniformly and consistently applied to all participants in similar circumstances. When making a determination or calculation, the Plan Administrator or its delegate shall be entitled to rely upon information furnished by a participant or the legal counsel of the employer.

Documentation by Participant
The Plan Administrator or its delegate may require a participant to complete and file with the Plan Administrator or its delegate an application for a benefit and all other forms approved by the Plan Administrator or its delegate, and to furnish all pertinent information requested by the Plan Administrator or its delegate. The Plan Administrator or its delegate may rely upon all such information provided.

Liabilities
To the extent permitted by law, neither the Plan Administrator nor any director, officer or employee of the employer shall be liable for any action or failure to act under or in connection with the Plan, except for his or her own gross misconduct or bad faith. The Plan Administrator or a director, officer or employee of the employer shall be indemnified and held harmless by the employer against and from any and all loss, cost, liability or expense that may be imposed upon or reasonably incurred by that person in connection with or resulting from any claim, action, suit or proceeding to which the person may be party or in which the person may be involved by reason of any action taken or failure to act under the Plan and against and from any and all amounts paid by him or her in settlement thereof (with the employer’s written approval) or paid in satisfaction of a judgment in any such action, suit or proceeding, except a judgment based upon a finding of bad faith; subject, however, to the condition that, upon the assertion or institution of any such claim, action, suit or proceeding against such person, he or she shall in writing give the employer an opportunity, at its own expense, to handle and defend the same before the person undertakes to handle and defend it on his or her own behalf. The foregoing right of indemnification shall not be exclusive of any other right to which such person may be entitled as a matter of law or otherwise, or any power that the employer may have to indemnify him or her or to hold him or her harmless.

Named Fiduciary
The Plan Administrator shall be the named fiduciary (within the meaning of section 402(a)(2) of ERISA) with the authority to control and manage the operation and administration of the Plan. The named fiduciary may allocate or delegate fiduciary responsibilities, in whatever manner it deems appropriate, to other persons (including insurance companies and third party administrators).

Claims Administrator
The claims administrator has been delegated by the Plan Administrator full and complete discretionary authority in carrying out its duties set forth under the terms of the Plan and delegated to it by the Plan Administrator, including full fiduciary responsibility for purposes of the Plan’s claims and appeals procedures as set forth in the Claims and Plan Administration section of this booklet. The terms of the Plan shall be interpreted consistent with such authority and, as such, references in the Plan to the Plan Administrator shall mean claims administrator as required by the context.

Miscellaneous
Amendment and Termination
The Board of Directors of PNC may amend, modify or terminate this Plan at any time. Notwithstanding the foregoing, a committee appointed by the Board or its duly appointed delegate, acting together, may make all technical, administrative, regulatory and compliance amendments to the Plan, and any other amendment which will not significantly increase the cost of the Plan to the employer, as such committee or its duly appointed delegate, shall deem necessary or appropriate without prior Board approval.
No amendment shall deprive any participant or survivor of any benefit to which the participant or survivor is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of participants and their survivors, except as may be specifically authorized by statute or regulation. Any termination or partial termination of the Plan shall not adversely affect the payment of Benefits to which participants or their survivors were entitled under the terms of the Plan prior to the date of termination or partial termination.

If the Plan is terminated, each Participant and beneficiary shall receive the benefits purchased on his or her behalf to the date of termination. Thereafter, the employer shall not have any liability or obligation to make any further contributions under the Plan.

**Effect of Plan on Employment**
The Plan shall not be deemed to constitute an employment contract between the employer and any participant or employee, or to be a consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any participant or employee at any time regardless of the effect which such discharge will have upon him or her as a participant of this Plan.

**No Alienation or Assignment of Benefits**
Except as otherwise provided by law and by any contract governing any benefit offered under this Plan, no benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

**Incapacity**
Whenever, in the Plan Administrator’s or its delegate’s opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person’s financial affairs, the Plan Administrator may make payments to such person or to the person’s legal representative or to a relative or friend of such person for such person’s benefit, or the Plan Administrator may make payment in such manner as the Plan Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

**Proof of Claim**
As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the claims administrator or the Plan Administrator may require (either directly to the claims administrator or the Plan Administrator or to any person delegated by it).

**Applicable Law**
The Plan shall be construed and enforced according to the laws of the Commonwealth of Pennsylvania, to the extent not pre-empted by any federal law.

**Lost Distributees**
Any Benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the participant or his or her survivor to whom payment is due; provided, however, that such benefit shall be reinstated if a claim is made by the participant or survivor for the forfeited benefit.

**Severability**
If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

**Heirs and Assigns**
This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each participant and survivor.

**Headings and Captions**
The heading and captions set forth in the Plan are provided for convenience only shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

**Examination of Records**
As a condition of receiving benefits under the Plan, the participant and his or her survivor shall grant the Plan Administrator its delegate the right to examine any medical or hospital and other records that pertain directly to any case for which benefits are claimed under the Plan.

**Gender**
The feminine whenever used in this booklet shall include the masculine and vice versa.
Legal Actions and Statute of Limitations

If you wish to bring a claim-related legal action against the Plan with regard to your disability benefits, you must first exhaust the claims and appeals procedures described in this document.

If you challenge the decision of the claims administrator, as applicable, the courts of competent jurisdiction in Pittsburgh, Pennsylvania will have exclusive jurisdiction for all claims, actions and other proceedings involving or relating to the Plan, a Plan fiduciary, or any party in interest, including by way of example and without limitation, a claim or action (a) to recover benefits allegedly due under the Plan or by reason of any law; (b) to enforce rights under the Plan; (c) to clarify rights to future benefits under the Plan; or (d) that seeks a remedy, ruling or judgment of any kind against the Plan, a Plan fiduciary or a party in interest.

Any such court review will be limited to the facts, evidence and issues presented during the claims procedure. Facts and evidence that become known to you after exhausting the claims procedure may be submitted for reconsideration of the appeal in accordance with the established time limits. Issues not raised during the appeal are waived.

Any claim or lawsuit must be brought no later than 24 months after the earliest of the:
- date your first benefit payment was made or allegedly due;
- date your benefit was first formally denied, in whole or in part; or
- the date of the incident (e.g., injury) that is the basis of the LTD claim.

However, if you start the claims and appeals procedure and submit your claim to the claims administrator within the 24-month claims period, the deadline for you to file your lawsuit will not expire until the later of:
- the last day of the 24-month claims period; or
- three months after the final notice of denial of your appealed claim is sent to you by the claims administrator.

Any claim or action filed under the administrative claims and appeals procedures described in this booklet, or for any lawsuit against the Plan, is time-barred after the end of:
- the 24-month claims period; or
- three months following exhaustion of the administrative claims and appeals procedures if the claim was submitted to the claims administrator within the 24-month claims period.
LONG-TERM DISABILITY PLAN

GENERAL PLAN INFORMATION

Plan Name:
The PNC Financial Services Group, Inc. and Affiliates Long-Term Disability Plan

Plan Sponsor:
The PNC Financial Services Group, Inc.
One PNC Plaza
249 Fifth Avenue
Pittsburgh, PA 15222
Call HR Service Center at 877-968-7762

Plan Year:
Jan. 1 – Dec. 31

Plan Sponsor’s EIN:
25-1435979

Plan Number:
509

Type of Plan:
Welfare Benefits Plan

Plan Funding:
The benefits provided under the Plan are paid from the general assets of the Employer, or through a voluntary employee beneficiary association (VEBA).

Plan Administrator:
The Plan Sponsor is the Plan Administrator for the Plan. The Plan Administrator has delegated certain administrative and discretionary functions to the claims administrator.

Service of Process:
Service of legal process with respect to the Plan may be made on the Plan Administrator.

Claims Administrator:
The Liberty Life Assurance Company
Group Market Disability Claims
P.O. Box 7210
London, KY 40742-7210
800-838-5290

Appeals should be submitted to the attention of:
LTD Case Manager - Appeals

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified 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 written 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 each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of 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.
LONG-TERM DISABILITY PLAN

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of 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 materials from the Plan and do not receive them within 30 days, you may file suit in a 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 state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a qualified medical child support order, you may file suit in a federal court. If it should happen that the 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 any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest 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 NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA from the Employee Benefits Security Administration by calling the participant assistance number, 866-444-EBSA (3272).

LONG-TERM DISABILITY CLAIMS ADMINISTRATOR CONTACT LIST

<table>
<thead>
<tr>
<th>Provider</th>
<th>Claims</th>
<th>Appeals</th>
<th>Member Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liberty Life Assurance Company</td>
<td>Liberty Life Assurance Company Group Market Disability Claims P.O. Box 7210 London, KY 40742-7210</td>
<td>Liberty Life Assurance Company Group Market Disability Claims P.O. Box 7210 London, KY 40742-7210 Attn: LTD Case Manager</td>
<td>Phone: 800-838-5290</td>
</tr>
</tbody>
</table>

Long-Term Disability Benefits