General Plan Information

For the PNC Financial Services Group, Inc.
Group Benefit Plan

Plan Document and Summary Plan Description

Effective Jan. 1, 2019

INTRODUCTION

The PNC Financial Services Group, Inc. (PNC, the Company or Plan Sponsor) sponsors The PNC Financial Services Group, Inc. Group Benefit Plan (the Plan) as in effect on Jan. 1, 2019. The Plan provides eligible employees and their eligible family members with a comprehensive benefit program. Some benefits under the Plan are paid for by PNC and provided automatically, and some are optional and require enrollment and employee contributions.

The purpose of the Plan is to offer eligible employees a choice between taxable and nontaxable benefits. The Plan is intended to comply with the requirements of Sections 79, 105, 106 and 129 of the Internal Revenue Code of 1986, as amended (the Code) and relevant provisions of the Employee Retirement Security Act (ERISA). PNC also intends that the Plan qualify as a cafeteria plan, with a pre-tax premium component within the meaning of Code Section 125(c), so that your contributions for Plan benefits made on a pretax basis are excludable from your gross income for federal income tax purposes to the extent permitted by law. Additionally, any contributions you pay for benefits under The PNC Financial Services Group, Inc. and Affiliates Long-Term Disability Plan may be made on a pre-tax basis and excluded from your gross income under the pretax premium component of this Plan. In some cases, your contributions may be paid on an after-tax basis as indicated in the Benefits Overview section on Page 4.

This document, together with the individual benefit booklets and other descriptive material made available to you by PNC and third-party providers or insurance companies, constitutes both the official plan document and the Summary Plan Description (SPD) for the Plan. It is written in a manner that is intended to be easily understood and to summarize the benefits available to you under the Plan. The individual benefit booklets and other descriptive material made available to you by PNC and third-party providers or insurance companies that also form part of this document are listed in Appendix A on Page 21.

Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency among these materials, it is PNC's responsibility as the Plan Administrator to interpret the conflicting provisions and determine what benefits will be provided under the Plan. Keep in mind that the Plan, and any benefits or payments provided to you under its terms, do not constitute a contract of employment between you and PNC. No one speaking on behalf of the Plan or the Plan Sponsor can alter the terms of the Plan.

Because benefits under the Plan are important to you and your family, you should retain this document as part of your permanent records.

Resources for You

If you have questions about your benefits or would like to request a printed copy of the SPD free of charge, contact the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 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 Information for Current Employees

- **PNC Benefits website:** Go to **www.pncbenefits.com** for information about all of your PNC benefits. This site is available from any computer with internet access; no login required. Simply select Documents and Forms at the bottom of any page for a complete list of downloadable SPDs.
- **Pathfinder HR portal:** Go to Pathfinder from the PNC Intranet or directly at **www.pncpathfinder.com**. To access all available SPDs, type Summary Plan Descriptions in the search box on the home page, then select Important Benefit Information.

Online Information for Former Employees, Beneficiaries and Employees on Leave of Absence

Go to Your PNC at **www.yourpnc.com** (your user ID and password are required). Links to available SPDs are available under the Knowledge Center. Your PNC is available 24 hours a day Monday through Saturday, and after 1 p.m. ET Sunday.

See Pages 12-13 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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BENEFITS OVERVIEW

You will automatically receive the core benefits below. If you are eligible, you may also elect coverage under any of the optional benefits listed below. Additional detail about the core and optional benefits is provided in the Description of Benefits section on Pages 9–11 and in the individual benefit booklets and other descriptive material listed in Appendix A on Page 21.

Core Benefits

The following benefits are provided by PNC at no cost to eligible employees (see Eligible Employees on this page). Once eligible, you will be enrolled automatically and are not required to make annual elections.

- Basic Life Insurance*
- Business Travel/Criminal Acts Insurance (BTA)
- Employee assistance program (EAP)

** While Basic Life Insurance is provided to you at no cost, imputed income may be assessed if the dollar amount of that coverage exceeds $50,000 per year.*

Optional Benefits

You may elect the following benefits, if eligible, and the cost is either shared by you and PNC, or paid entirely by you.

Optional Benefit	Who Pays?	Pretax or After-tax?
Medical (includes prescription drug benefits)	Shared	Pretax
Vision	You	Pretax
Dental	Shared	Pretax
Dependent Care Reimbursement Account (DCRA)	You	Pretax
Optional Life Insurance	You	After-tax
Spouse/Domestic Partner Life Insurance and Child Life Insurance	You	After-tax
Personal Accident Insurance (PAI)	You	After-tax
Supplemental Disability Benefit (limited eligibility)	You	After-tax
Vacation Buy	You	Pretax
Adoption Assistance Benefits	PNC	N/A

While employee pretax HSA payroll contributions are made possible under the terms of the Plan, the HSA itself is not part of the Plan, is not covered by ERISA and is not sponsored or endorsed by PNC. Although PNC intends to continue its contribution to the HSA, it reserves the right to change, modify, amend or terminate this at any time and for any reason.

ELIGIBILITY

Eligible Employees

Who is an Eligible Employee

There are several categories of eligible employees. The benefits offered to eligible employees under the Plan may vary by employment classification. Only employees of PNC and its related entities designated by the Plan Sponsor as participating employers may be eligible employees under the Plan.

- **Full-time Employees:** Generally, all exempt and non-exempt (hourly) full-time employees are eligible.
- **Reduced Schedule Professionals:** Generally, employees coded as Reduced Schedule Professionals (RSPs) on PNC's payroll system are eligible.
- **Part-time Employees:** Generally, employees coded as part time on PNC's payroll system are eligible for certain benefits under the Plan.

Keep in mind that some benefit options under the Plan may have different terms, conditions or limitations affecting eligibility. For more information, refer to the individual benefit booklets and other descriptive material made available to you by PNC and third-party providers or insurance companies.

Who is Not Eligible

Individuals classified by PNC in the following categories are not eligible for coverage under the Plan:

- employees not on PNC's U.S. payroll;
- independent contractors;
- temporary employees; and
- leased employees.

Individuals classified in these categories remain ineligible for coverage even if subsequently reclassified as an employee by a governmental agency or court of law. In that case, eligibility for coverage may be available prospectively but will not apply retroactively.

Employees who are otherwise ineligible for coverage but are determined by the Company to be regular full-time employees under the Patient Protection and Affordable Care Act of 2010 and related guidance (the Affordable Care Act) may be eligible for medical coverage under the Plan. This rule does not apply to independent contractors and leased employees.

Eligible Family Members

You can elect medical, dental, vision, life insurance and personal accident insurance (PAI) benefits for your family members who meet the eligibility requirements described in the individual benefit booklets listed in Appendix A on Page 21. You must be covered under the Plan in order to cover eligible family members under the Plan. Keep in mind that some benefit options under the Plan may have different terms, conditions or limitations affecting eligibility of family members. You should refer to the individual benefit booklets listed in Appendix A on Page 21 for more information.

For purposes of your benefits, a domestic partner is an individual of any gender who has a signed and notarized PNC Affidavit of Qualifying Domestic Partnership or is registered as your domestic partner in any state or local municipality (regardless of where you reside) and with whom you have an exclusive relationship, who is at least 18 years of age, is not legally married to any other person, has shared financial responsibility and resides with you, and is not related to you to a degree that marriage would be forbidden by law. For PNC's benefits, domestic partner also includes a person of the same sex who is legally recognized as your civil union partner under the laws of any U.S. state.

You will receive all required eligibility verification forms from a third party vendor, HMS, including the PNC Affidavit of Qualifying Domestic Partnership, when you elect to cover family members. See Eligibility of Verification below.

Eligibility Verification

When you elect to cover family members, PNC requires that you provide documentation verifying their eligibility (including verification of adult child disability). You will receive a communication within two weeks of your enrollment from a third party vendor called HMS (see Page 23 for contact information) that administers eligibility verification for PNC. The communication will detail the required documentation and the process for submitting it.

If you do not complete this verification process by the required deadline, your applicable family member(s) will be removed from coverage.

PARTICIPATION

When Participation Begins

Core Benefits

You will be enrolled automatically in the core benefits for which you are eligible under the Plan. Your coverage begins the first day of the month following your date of hire.

Optional Benefits

- **Initial Enrollment:** If you are an eligible employee, you may elect to participate in one or more optional benefits for which you are eligible under the Plan. You will be required to complete the enrollment process established by PNC within 31 days of initial eligibility and agree to pay required contributions. Your coverage begins the first day of the month following your date of hire.
- **Annual Enrollment:** Before the close of each plan year, PNC will provide annual enrollment materials to eligible employees currently enrolled in benefits or eligible to become enrolled in benefits under the Plan for the upcoming plan year. If you elect to participate in one or more optional benefits under the Plan, you will be required to complete the enrollment process established by PNC and agree to pay the required contributions. You must complete the enrollment process by the end of the enrollment period designated by PNC. Your coverage will become effective or will continue as of the first day of the upcoming plan year.

Outside of initial or annual enrollment, you may elect to participate in or change your optional benefits only if you experience a change in status, as described in the Changing Your Elections section on Page 6.

If You Do Not Enroll

- **When First Eligible:** If you fail to make an election for optional benefits upon your initial eligibility for coverage, you will be deemed to have elected no optional benefits, and you will receive only the core benefits. Therefore, it is extremely important that you complete the election process within the initial period prescribed.
- **Annual Enrollment:** If you fail to make an election for optional benefits during any annual enrollment

period, your elections from the prior year may carry over, with the exception of participation in the Dependent Care Reimbursement Account (DCRA) and the Health Savings Account (HSA)*, which must be affirmatively elected each year. It is important that you refer to your annual enrollment materials each year to confirm whether you must make an affirmative election that year.

Actively at Work

Some benefits may require you to be actively at work in order for coverage to begin or for changes to take effect. Actively at work means coded as active on PNC's payroll system, except that an employee will be deemed to be actively at work on each day of a regular paid vacation or on a regular non-working day, provided he/she was actively at work on the last preceding regular working day. However, with respect to coverage under a medical benefit option, you will be treated as actively at work on any day you are absent due to a health factor.

If You are Reclassified

If you experience a change in your employment at PNC that involves a reclassification, the following rules apply:

- **Reclassification from Temporary to Full-Time:** You will be eligible to elect one or more benefits under the Plan, effective on the first day of the month following the date your employment classification changed.
- **Reclassification from Part-Time to Full-Time:** Effective the date of your employment classification change, you will be eligible to elect one or more benefits available to full-time employees under the Plan.
- **Reclassification from Full-Time to Part-Time:** Effective the date of your employment classification change, you will be eligible to continue or change coverage under the medical, dental and vision benefits. You will no longer be eligible to participate in benefits not available to part-time employees.

If You are Rehired

In general, if you terminate employment or otherwise cease to be an eligible employee and are later rehired and again become an eligible employee, you will be treated as a new hire and your benefits begin the first of the month following your date of rehire.

If the period between the date you are no longer eligible under the Plan and when you again become eligible is less than 30 days, your prior benefit elections will be restored, and you will not be permitted to make new elections. If that period is 30 days or more, you will be permitted to make new benefit elections.

Changing Your Elections

During each annual enrollment period, you will be given the opportunity to select your optional benefits for the upcoming plan year. If you do not make new elections, PNC may continue your prior year elections with the exception of the Dependent Care Reimbursement Account (DCRA), Health Savings Account (HSA) and Tobacco User Contribution (as applicable to medical), which must be elected each year. It is important that you refer to your annual enrollment materials to confirm whether you must make affirmative elections that year.

Generally, federal law prohibits changes to your coverage elections during the plan year. However, you may change your elections if you have a change in status (see Change in Status on this page), and the change is on account of and consistent with the change in status.

Change in Status

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 pretax payroll deductions.

Common allowable status changes are listed below. If you have a question about a specific status change, contact the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. to 5 p.m. ET weekdays.

- 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 (the date the coverage takes effect)
- 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

The election change must be on account of and correspond with the change in status event as determined by the Plan. As a general rule, a desired election change will be found to be consistent with a change in status event if the event affects eligibility for coverage under the Plan. Examples of allowable elections changes are included in the individual benefit booklets listed in Appendix A.

You have 31 days from the date of a status change to request any allowable benefit changes. To report a status change, follow these steps:

- Go to Pathfinder > Benefits and select the Change Coverage button.
- Follow the prompts to report the event and request benefit changes.

You may also report a status change and request benefit changes by calling the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. to 5 p.m. ET weekdays.

Note that to enroll a new eligible family member, you will need their Social Security number. Information will be sent to you to verify the eligibility of any family members you enroll; you must respond by the deadline specified.

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

Election changes (including coverage and contribution changes) generally become effective as of the date of the change (for example, marriage date, divorce date, date of birth or adoption of a child, etc.), as long the benefit change is made within 31 days of the status change.

Failure to Provide Timely Notice or Necessary Documentation

If you fail to provide notice or any required supporting documentation within the applicable timeframe, your request to change your elections will be denied. You will not be allowed to make changes until the next annual enrollment period or sooner if you experience another change in status and provide timely notice and documentation. This includes adding eligible family members due to marriage, birth or adoption.

Special Enrollment Rights

You may also revoke or change your benefit election during the plan year if you experience an event covered by Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights that would lead to the loss or gain of eligibility under the Plan. Some of the HIPAA special enrollment rights duplicate the change in status rules described above. You and/or eligible family members will have a HIPAA special enrollment right if you and/or an eligible family member:

- were covered under another group health plan or had health insurance coverage at the time coverage was previously offered; and
- lost your coverage under the other group health plan or health insurance coverage for reasons such as:
  - expiration of COBRA continuation coverage;
  - legal separation;
  - divorce/marriage;
  - death/birth of a child (including adoption or placement for adoption);
  - termination of employment; or
  - reduction in hours of employment.

You have 31 days to notify the HR Service Center of a HIPAA special enrollment right. If you fail to notify the HR Service Center of a HIPAA special enrollment right within 31 days of the occurrence of the event, you will lose your right to make any benefit changes until the next annual enrollment period or until you or your family member experience another change in status.

Special Rule Relating to Medicaid and Children's Health Insurance Program (CHIP)

You may also change your benefit election during the plan year if you or your family members:

- lose Medicaid or CHIP coverage, and you request enrollment within 60 days after the loss of such coverage; or

- become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage within 60 days after the eligibility determination date.

A Medicaid/CHIP notice explaining your rights with respect to premium assistance is available from the HR Service Center.

When Participation Ends

Generally, your participation under the Plan will end automatically as of the earliest of the following (see participation details for specific benefits in the individual benefit booklets listed in Appendix A):

- the date on which the Plan, or any coverage that is part of the Plan, ends;
- the date on which your coverage ends due to your failure to satisfy the eligibility criteria for a benefit under the Plan;
- the date on which your election to receive benefits under this Plan ends, is revoked due to a change in status or expires;
- the date on which you become entitled to Medicare due to a disability*;
- the date on which you cease to be an active employee for any reason;
- the date you fail to make any required contributions; or
- the date of your death.

Coverage for eligible family members will end on the earlier of the date your coverage ends or the date the family member no longer satisfies the eligibility criteria or the definition of eligible family member, as described in this document or the applicable individual benefit booklets.

Coverage for an eligible family member will terminate prospectively if they are no longer eligible. However, coverage may terminate retroactively if coverage was obtained by fraud or intentional misrepresentation.

Termination of Participation in the Event of Fraud

Notwithstanding any of the above, participation in the Plan may also terminate if you or your covered eligible family members:

- provide false information or make a misrepresentation in connection with a claim for benefits;
- permit a non-eligible person to use a membership or other identification card for the purpose of wrongfully obtaining benefits;
- obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; or
- fail to provide documents requested by the Plan to verify representation made by you in connection with eligibility or continued eligibility for benefits for yourself or your family members.

If participation ends for you or your eligible family members due to any of the reasons described above, you and your eligible family members are not eligible to enroll again until the next annual enrollment period, unless one of you experiences a change in status during the plan year.

Approved Leaves of Absence

PNC may continue coverage during certain periods of absence, such as absence by reason of sickness, disability or other approved leave of absence (including family and medical leave or military leave), in accordance with its HR policies and practices, and to the extent prescribed by law. PNC's HR policies and practices describe the different types of leaves of absence, how long benefits are continued during a leave of absence, what employee contributions are required during the leave and how those contributions are made, as well as your rights and obligations under those policies and applicable federal and state law.

** If you are eligible for Medicare before age 65 due to endstage renal disease, the Plan will continue your medical coverage to the extent required by law.*

PAYING FOR YOUR COVERAGE

If you elect to purchase optional benefits under the Plan or contribute to a Dependent Care Reimbursement Account (DCRA), you may be required to contribute a portion of your compensation for such coverage through completion of a compensation reduction agreement. The contribution you are required to pay is determined by PNC each year and may be adjusted during the year to reflect any increases or decreases in the cost of coverage. You will be notified of the cost of coverage when you become eligible for benefits under the Plan and again during each annual enrollment period. The cost of coverage may be different for different classifications of employee.

You pay for coverage with pretax dollars, except as described below. That means your contributions for medical, dental and vision benefits and the DCRA (if you contribute) will be deducted from your pay before federal income taxes and Social Security taxes are withheld. In most cases, your contributions are also deducted before state taxes are withheld, and in many cases, before local taxes are withheld. As a result, you will be taxed on a slightly lower gross income and your taxes will be lower. Because your pretax contributions are not subject to Social Security taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are less than the Social Security Taxable Wage Base (adjusted annually). Many individuals find that any reduction in Social Security benefits due to paying for this coverage with pretax dollars is offset by the tax savings from the reduced taxable income.

Your contribution for coverage will be deducted from your pay on a pretax basis in all cases except if you choose to cover a domestic partner who is not your federal tax dependent. In that case, IRS regulations require that the payroll deduction for the premiums relating to the domestic partner's coverage be taken on an after-tax basis. In addition, your taxable gross income will be increased by the value of that additional coverage (less amounts that you paid for that coverage). This increase, called imputed income, is reported on your pay. If you have questions, call the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m. ET weekdays.

In addition to your payroll contributions, some benefits under the Plan have cost-sharing provisions; see the individual benefit booklets for details. Note: PNC reserves the right to change the cost of coverage—both the payroll contributions and any of the cost-sharing provisions—at any time in the future.

DESCRIPTION OF BENEFITS

This section briefly summarizes the benefits available under the Plan. Additionally, more detailed information about each benefit option is included in individual booklets and insurance certificates, benefit summaries or other explanatory information made available to you directly from the providers. See Resources for You on Page 2 or call the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m ET weekdays.

See Appendix B–Claims Administrator Contact List on Pages 22-23 for provider contact information.

Keep in mind that the terms and conditions of the actual contracts or policies between PNC and the insurers and other providers will always govern if there are any questions or inconsistencies between this document and an actual contract or policy. You may obtain additional information or request insurance certificates or other explanatory information by calling the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m ET weekdays.

Medical and Prescription Drug Benefits

The Plan provides medical options for eligible employees and their eligible family members for certain preventive care and medically necessary treatments administered by licensed medical practitioners.

High-Deductible Health Plan Options with Health Savings Account (HSA)

The medical options offered under the Plan are intended to qualify as high-deductible health plans under Internal Revenue Code Section 223(c)(2).

PNC's medical options provide benefits for both in-network and out-of-network care for most services, but you will receive the highest level of benefits if you use in-network providers. All options are subject to the applicable deductible and out-of-pocket maximum provisions. Details can be found in your enrollment materials and the Medical Benefits booklet.

If you enroll in medical coverage under the Plan, you may be eligible for a Health Savings Account (HSA). The HSA is an individual trust or custodial account, separately established and maintained by you with a qualified trustee/custodian. If you enroll in a PNC medical option and establish the associated PNC BeneFit Plus HSA, PNC may make a contribution into your account each pay period. While employee pretax HSA payroll contributions are made possible under the terms of this Plan, the HSA itself is not part of the Plan, is not sponsored or endorsed by PNC and is not subject to ERISA. Additional information about establishing an HSA is available on the websites described under Online Access on Page 2.

Wellness Programs

From time to time, the Plan may offer one or more wellness programs designed to promote the health and well-being of all employees. These wellness programs may provide financial incentives to engage in activities that encourage healthy behaviors, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health coaching, and provide online resources and tools. The goal is to help mitigate risks and encourage employees to be more involved in their health care, which may lead to a healthier workforce with lower health care costs for both employees and PNC.

All wellness programs/activities are completely confidential and handled by an independent external vendor that strictly protects employees' privacy. PNC receives only aggregate data on the entire population, which is used to evaluate the program's effectiveness and help determine future wellness programs and/or future benefit changes affecting all employees.

For information about PNC's wellness programs, visit the websites described under Online Access on Page 2. Any wellness program and related financial incentives offered under the Plan will comply with the requirements and limitations of applicable laws.

Medicare Part D Prescription Drug Creditable Coverage

The Plan Administrator has determined that the prescription drug coverage offered as part of PNC's medical options is, on average for all Plan participants, expected to pay as much as the standard Medicare prescription drug coverage and is considered creditable coverage. Based on this determination, employees can keep this coverage and not pay a higher premium (a penalty) if they later decide to join a Medicare prescription drug plan.

PNC will distribute certificates of creditable coverage to employees when they are first eligible for benefits, during each subsequent annual enrollment period and any time PNC's prescription drug coverage ends or is no longer considered creditable coverage. Call the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m ET weekdays, if you have questions or would like a copy of the certificate.

Dental Benefits

The Plan provides dental options for eligible employees and their eligible family members for certain preventive care and medically necessary treatments administered by licensed dental practitioners. Details can be found in your enrollment materials and the Dental Benefits booklet.

Vision Benefits

The Plan provides vision benefits and/or discounts for eligible employees and their eligible family members for eye exams, eye glasses and contact lenses. Benefits and discounts are provided for both in-network and out-of-network care for most services, but you will receive the highest level of benefits and discounts if you use in-network providers. Additional coverage features and discounts for hearing, low vision services and laser vision correction (LASIK) are also included. Details can be found in your enrollment materials and the Vision Benefits booklet.

Employee Assistance Program

The Plan provides an employee assistance program (EAP) to eligible employees and family members at no cost. The program provides confidential assistance with issues of daily living such as parenting, relocation, financial matters, relationships and elder care, as well as mental health counseling and health coaching. Details can be found on the websites listed under Your Resources on Page 2.

Basic Life Insurance Benefits

The Plan provides basic life insurance for eligible employees at no cost. No enrollment is required, and you do not need to submit evidence of insurability. The level of coverage is based on employee classification, as detailed in the Life Insurance Benefits booklet for details.

Optional Life Insurance Benefits

The Plan provides optional life insurance coverage to full-time and RSP employees. This benefit is not available to part-time employees. The coverage may be purchased in amounts of one to seven times eligible pay. Certain levels of optional life insurance require you to provide Evidence of Insurability (EOI). Details can be found in your enrollment materials and the Life Insurance Benefits booklet.

Spouse/Domestic Partner and Child Life Insurance Benefits
The Plan provides optional life insurance coverage for the spouse/domestic partner and/or children of full-time and RSP employees. This benefit is not available to part-time employees. You may elect to cover one or all of your eligible family members. Certain levels of optional life insurance for your spouse/domestic partner require you to provide Evidence of Insurability (EOI).

Details can be found in your enrollment materials and the Life Insurance Benefits booklet.

Business Travel/Criminal Acts Insurance Benefits
The Plan provides business travel/criminal acts insurance coverage for eligible employees at no cost. No enrollment is required. This benefit offers financial protection against losses incurred while traveling on company business or resulting from the criminal acts of others while you travel and/or are functioning in your capacity as a PNC employee. Details can be found in the Life Insurance Benefits booklet.

Personal Accident Insurance Benefits
The Plan provides personal accident insurance coverage for eligible full-time and RSP employees. You may elect coverage for yourself and your eligible family members. This benefit is not available to part-time employees. Personal accident insurance pays a benefit if the covered individual is severely injured or dies as a result of an accident. Details can be found in your enrollment materials and the Personal Accident Insurance Benefits booklet.

Dependent Care Reimbursement Account (DCRA)
The Plan provides a Dependent Care Reimbursement Account (DCRA) for eligible full-time and RSP employees. This benefit is not available to part-time employees. The DCRA allows you to contribute pretax dollars to cover eligible child or elder care expenses. Details can be found in your enrollment materials and the Dependent Care Reimbursement Account booklet. The DCRA complies with Code Section 129 and is not subject to ERISA.

Supplemental Disability Insurance Benefits
The Plan provides a limited group of eligible employees with a supplemental disability insurance benefit. This benefit is available to highly compensated employees as defined in Code Section 414(q). Details can be found in the enrollment materials provided to the employees eligible for the benefit.

Vacation Buy
The Plan allows eligible full-time and RSP employees to buy up to five vacation days for the following year, if they meet the service requirement and have supervisor approval. This benefit is not available to part-time employees. Details on the vacation buy program and PNC's vacation policy are available on Pathfinder (link from the PNC Intranet or go directly to **www.pncpathfinder.com**) and in your enrollment materials.

Adoption Assistance
The Plan provides eligible full-time, part-time and RSP employees with an adoption assistance benefit that includes financial assistance for eligible expenses and paid time off. Details can be found in the Adoption Assistance Benefits booklet. The adoption assistance benefit complies with Code Section 137 and is not subject to ERISA.

Privacy of Health Information
The receipt, use and disclosure of protected health information by the health care benefits under the Plan are governed by regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). In accordance with these regulations, the Plan Administrator, medical coverage insurer, certain employees of the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out payment, treatment and health care operations under the Plan. These entities and individuals may use protected health information for such purposes without your consent or written authorization.

In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes. In the normal course, if your protected health information is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. Access a copy of the Plan's privacy notice on the websites listed under Online Access on Page 2, or call the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m ET weekdays, if you have questions or believe the privacy of your health information has been compromised.

CLAIMS AND APPEALS PROCEDURES

A benefits claim must be filed according to the Plan's claim filing procedures and submitted in writing to the applicable claims administrator in Appendix B on Pages 22-23. References to the claims administrator in this document include any claims administrator listed in Appendix B or any individual benefit booklet, as well as the Plan Administrator. To be considered for payment, claims must be for services received while an individual is covered under the Plan.

Claims and appeals procedures are explained in each individual benefit booklet and in this section, as applicable. For other inquiries, for example about general eligibility or mid-year election change rules, call the HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m ET weekdays. A request for prior authorization or predetermination of benefits, if not required under the Plan, is not considered a claim.

For purposes of filing a claim under the Plan, you may designate an authorized representative to act on your behalf. You must provide written notice of the designation and identify this representative to the appropriate claims administrator. For an urgent benefits claim, a health care professional with knowledge of your condition may act as your authorized representative with or without prior notice. However, this authorized representative is not considered a Plan beneficiary.

You must follow the relevant administrative claims and appeals procedures described in this document or any applicable individual benefit booklet to preserve any rights you may have to:

- a Plan benefit; and
- any claim against the Plan, any fiduciary or other party associated with the Plan (including your right to pursue the claim in court or seek a ruling or judgment of any kind).

Any argument or evidence not presented during the administrative claims and appeals procedures described in this document or individual benefit booklet is waived.

For the Claims Administrator Contact List, see Appendix B on Pages 22-23.

After exhausting the Plan's administrative claims and appeals procedures (but not before), you may file a lawsuit regarding your claim as described under the Legal Actions section on Page 13.

Claims and Appeals Procedures: Supplemental Disability Insurance Benefits

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 Process

You must submit a written claim to the claims administrator within 31 days after you become disabled.

The completed claim form, along with any supporting evidence that is requested, should be returned as instructed. Benefits are paid immediately upon receipt of due written or authorized electronic proof of loss.

The claims administrator will notify you in writing within 45 days if a claim is denied in whole or in part. That written notice will explain the reasons for the denial and provide information about the appeal process.

If the claims administrator determines that an extension is necessary due to matters beyond the control of the Plan, the claims administrator will notify you within the initial 45-day period that up to an additional 45 days is needed to review your claim. If you do not agree with the reasons given, you may request an appeal of the claim.

Appeal Procedure

If your supplemental disability claim is denied, you may appeal the decision by submitting a written appeal to the claims administrator. This appeal must be received by the claims administrator within 31 days of the date of the letter notifying you of the claim determination. Your written appeal should include your comments and views of the issues, as

well as any new documentation you would like the claims administrator to consider.

Separate independent review may be completed at the request of the claims administrator. You will receive a decision on your appeal from the claims administrator within 45 days, unless there are special circumstances, in which case an extension of an additional 45 days may be taken by the claims administrator. The claims administrator will keep you informed of the status of the appeal by phone or in writing.

In deciding an appeal, the claims administrator has the exclusive right and the discretionary authority:

- to interpret the Plan terms and provisions;
- to resolve all questions, without limitation;
- to determine eligibility for benefits; and
- to resolve and remedy Plan ambiguities, inconsistencies or omissions.

Such action is final and binding.

Claims and Appeals Procedures: All Other Benefits
You should follow the claims procedures described in the individual benefit booklet or other descriptive material provided to you by PNC or the claims administrator. For more information, contact the claims administrator for the benefit listed in Appendix B on Pages 22-23.

Legal Actions, Venue and Statute of Limitations
The information provided in this section applies to all benefits listed in Appendix A, excluding the Dependent Care Reimbursement Account (DCRA) and Adoption Assistance Benefit.

If you wish to bring a claim-related legal action against the Plan with regard to your 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
- earliest date you knew or should have known the material facts on which your lawsuit is based (the 24-month claims period).

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.

CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and/or your spouse and family member children may be eligible to continue health coverage if your or their coverage ends because of certain qualifying events. You may have additional rights to continued benefits under state law. Appendix C on Pages 24-26 contains a general notice outlining the continuation of coverage available under COBRA.

ADMINISTRATIVE INFORMATION

Plan Information
The official plan name, plan identification number, plan year and other important administrative information for the Plan are as follows:

Plan Name:	The PNC Financial Services Group, Inc. Group Benefit Plan
Employer and Plan Sponsor:	The PNC Financial Services Group, Inc. The Tower at PNC Plaza 300 Fifth Avenue Pittsburgh, PA 15222
Plan Number:	530
Plan Year:	Jan. 1–Dec. 31
Plan Sponsor EIN:	25-1435979
Type of Plan:	The Plan is a welfare benefit plan. The Plan is also a Section 125 cafeteria plan with pretax premium and a Dependent Care Reimbursement Account (DCRA). The following benefits are described in this Summary Plan Description for information purposes only and are not subject to ERISA: adoption assistance and DCRA.
Plan Funding:	The benefits provided under the Plan are paid from the general assets of the Company to the extent not provided through one or more insurance contracts.
Plan Administrator:	The Plan Sponsor is the Plan Administrator under the Plan. The Plan Administrator has delegated certain administrative functions to insurers and other third-party service providers.
Service of Process:	Service of legal process with respect to the Plan may be made upon the Plan Sponsor.
Vendor/Claims Administrator:	Contact information for the third-party providers with which the Plan has entered into contracts is provided in Appendix B on Pages 22-23.

Additional Plan Administration Information

Plan Administrator

Benefits under the Plan are administered by the Plan Administrator in accordance with the Plan document, which includes contracts and/or policies PNC has entered into with various insurance companies and other providers or administrators of health benefits. All matters relating to the administration of the Plan, including the duties imposed upon the Plan Administrator by law and the interpretation of the Plan provisions, are the responsibility of the Plan Administrator, and the Plan Administrator will have all duties and powers necessary to carry out the terms of the Plan. By way of example, and not limitation, the Plan Administrator or its delegate has the authority:

- to interpret the terms and provisions of the Plan and to resolve all questions arising under the Plan, 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, which is an exclusive right and sole discretionary authority, will 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 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, including, but not limited to, requiring the submission of proof of a claim (either directly to the Plan Administrator or to any person delegated by it) as a condition of receiving benefits under the Plan;
- to adopt such rules as it deems necessary, desirable or appropriate for the administration of the Plan. All rules and decisions of the Plan Administrator or its delegate will be uniformly and consistently applied to all participants in similar circumstances. When making a determination or calculation, the Plan Administrator or its delegate will be entitled to rely upon information furnished by a participant or the legal counsel of the Company;
- to direct an insurer as to the payment of benefits;
- to prepare and distribute, in such manner as the Plan Administrator or its delegate determines is appropriate, information explaining the Plan;
- to receive information from participants that is necessary or appropriate 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 individuals to assist in the administration of the Plan and any other agents it deems desirable, including legal counsel.

The Plan Administrator or its delegate is not entitled to compensation for its services, as such. All fees, salaries and other costs of providing services to the Plan will be paid by PNC or with forfeitures under the Plan, if any.

The Plan Administrator is the named fiduciary (within the meaning of Section 402(a)(2) of ERISA) with the authority to control and manage the operation of the Plan. The named fiduciary may allocate or delegate fiduciary responsibilities to other individuals (including insurance companies and third-party administrators). The Plan Administrator has delegated certain administrative and claim review functions under the Plan to the Claims Administrators. As the Plan Administrator's delegate, the benefit providers have the authority to make all decisions under the Plan relating to benefit claims, including, where applicable, determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or their delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

Amendment or Termination of Plan

PNC expects that the Plan will continue indefinitely; however, PNC reserves the right to amend or modify the Plan at any time and for any reason, with respect to both current and former employees and their

Contact information for the Plan Administrator for each benefit can be found in the individual books listed in Appendix A.

family members and beneficiaries. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease cost-sharing between PNC and participants, (3) increase or decrease deductibles and/or coinsurance, (4) change the class(es) of employees and/or family members covered by the Plan and (5) change benefit claims administrators. PNC also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason.

A committee appointed by the Board of Directors of PNC or its duly appointed delegate may make all technical, administrative, regulatory and compliance amendments to the Plan and any other amendment that will not significantly increase the cost of the Plan to PNC, as such committee or delegate will deem necessary or appropriate without prior Board approval. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination or partial termination. Participants will be notified in due course concerning substantial changes.

Benefits for claims occurring after the effective date of plan modification or termination are payable in accordance with the revised plan documents.

All statements in this document and all representations by PNC or its designated benefits planning and administration department are subject to this right of amendment, modification, suspension or termination. These rights apply without limitation, even after an individual's circumstances have changed by retirement or otherwise.

Plan benefits do not become vested. In the event the Plan is terminated, assets held in trust, if any, for the Plan will be used to provide benefits for employees of PNC or a successor, or they may be used in other ways not prohibited by Internal Revenue Service regulations.

Nondiscrimination

Contributions and benefits under the Plan will not discriminate in favor of highly compensated employees or key employees. PNC may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and PNC that you will be employed for any specific period of time.

Loss of Benefits

Except as might otherwise be described in the separate descriptive booklets, your coverage generally ends on the day of employment termination or loss of eligibility. There are also circumstances that may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of medical benefits that a participant otherwise expected the Plan to provide. These circumstances include, but are not limited to:

- subrogation, recovery and third-party recovery rights of the Plan;
- coordination of benefits when a Participant is enrolled in more than one plan and the Plan is not the primary plan;
- possible reductions when private hospital rooms are used and for certain multiple surgical procedures;
- reductions due to charges that exceed usual and customary allowances;
- reductions or denials due to services that are not generally accepted as appropriate, and/or that are not medically necessary and/or that are considered as over-utilization;
- treatment, services or supplies that are excluded from coverage by the Plan, whether or not medically necessary;
- non-compliance with the Plan's precertification requirements; or
- non-compliance with a claims filing deadline of a benefit under the Plan.

Liabilities

To the extent permitted by law, neither the Plan Administrator, nor any director, officer or employee of PNC or its affiliates, will be liable for any action or failure to act under or in connection with the Plan, except for their own gross misconduct or bad faith. The Plan Administrator or a director, officer or employee of PNC or its affiliate will be indemnified and held harmless by PNC 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 PNC's written approval) or paid in satisfaction of a judgment in any such action, suit or proceeding, except judgment based on a finding of bad faith.

However, any such indemnification is subject to the condition that, upon the assertion or institution of any such claim, action, suit or proceeding against such person, he/she will give PNC written notice and the opportunity, at PNC's expense, to handle and defend the action, suit or proceeding. This right of indemnification is not exclusive of any other right to which such person may be entitled as a matter of law or otherwise, or any power that PNC may have to indemnify or hold harmless.

Third-Party Liability/Subrogation

General Principle

When you or your family member receive benefits under the Plan that are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no-fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your family member will reimburse the Plan for the related benefits received out of any funds or monies you or your family member recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan will be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your family member may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your family member have not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed, unless the Plan agrees in writing to a reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the make whole doctrine, the fund doctrine, the common fund doctrine, comparative/contributory negligence, collateral source rule, attorney's fund doctrine, regulatory diligence or any other equitable defenses that may be raised against the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your family member to assert a claim for any recovery from a third party to which you or your family member may be entitled. The Plan will not pay attorney fees or costs associated with the claim or lawsuit without express written authorization from PNC.

If the Plan should become aware that you or your eligible family members have received a third-party payment, amount or recovery and not reported that amount, the Plan, at its sole discretion, may suspend all further benefits payments related to you or any of your eligible family members until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your eligible family members.

Participant Duties and Actions

By participating in the Plan, you and your eligible family members consent and agree that a constructive trust, lien or equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your family members agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your eligible family member have any reason to believe that you or he/she may be entitled to recovery from any third party, you or your eligible family member must notify the Plan. At that time, you and your family member (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your family member to any payment, amount or recovery from a third party.

If you or your eligible family member fail or refuse to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any

benefits to you and any of your eligible family members until the agreement is signed. Alternatively, if you or your eligible family member fail or refuse to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your eligible family member, you or your eligible family member's acceptance of those benefits will constitute agreement to the Plan's right to subrogation or reimbursement.

You and your eligible family member consent and agree that you or they will not assign your or their rights to settlement or recovery against a third person or party to any other party, including your or their attorneys, without the Plan's consent. Accordingly, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from PNC.

Coordination of Medical Benefits

The Plan has a coordination of benefits feature with respect to medical benefits. This prevents duplication of benefits if you or your eligible family members are covered by more than one medical plan. When a claim is made, the primary plan pays benefits first, without regard to the other plan. When your PNC plan is secondary, the Plan calculates what it would have paid if it were primary and reduces those benefits by what the other plan has paid. This describes the more common coordination scenarios. Refer to the plan document or call the HR Service Center if you have a specific coordination question that is not addressed.

The Plan will not supplement the other plan to bring reimbursement up to 100%, but will coordinate with the other plan to bring your reimbursement up to the Plan's benefit level. Generally, the plan covering a person as an employee is the primary plan, while the plan covering the same person as a family member is the secondary plan. A plan that does not coordinate with other plans is always the primary plan.

Coordination of benefits rules apply whenever you or a family member are covered by more than one insurance plan. Group plans include any other type of coverage for individuals in a group—whether the plan is fully insured or self insured. No-fault auto insurance that is required by law is also included, even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with Other Group Plans

Primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a family member is the secondary plan.
- For eligible children, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (i.e., male's plan pays first) instead of the birthday rule to determine order of benefits, the other plan's provision will apply.

In the case of separated or divorced parents, primary and secondary plans are determined as follows:

- If a court decree awards joint custody but does not specify which parent is responsible for health care expenses, the rules above apply.
- If a court decree has given financial responsibility for medical care for eligible family member children to one parent, the plan of this parent is primary.
- If there is not a court decree establishing financial responsibility for medical care for eligible children:
  - the plan that covers the parent with custody pays first; and
  - if the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.

If none of these rules apply, the plan that has covered the individual for the longest period of time is primary.

Method of Coordination

Coordination depends on whether you or your eligible family members obtain care on an in-network or out-of-network basis, and on which plan is primary.

For example, assume your spouse is covered under their employer's plan (which is, therefore, primary) and as your eligible family member under this Plan. Let's also assume deductibles under the two plans have been met. If your spouse received medical care that was not provided by an in-network provider, this Plan will pay benefits using the reasonable and customary cost as the basis for calculating

coordination of benefits. Likewise, when an in-network provider is used, this Plan will pay benefits using the negotiated rate as the basis for calculating coordination of benefits.

Coordination with Medicare

If you or a covered eligible family member become eligible for Medicare, Plan coverage will be your primary source of coverage (with Medicare secondary). If, as an active employee, you choose to be covered under both plans, the Plan will be primary and Medicare secondary. If you also cover your spouse (and they are not covered as an employee under another employer's plan), the Plan is primary for your spouse as well, regardless of whether your spouse is under or over age 65.

Recoupment

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plan under the Third-Party Liability/Subrogation section on Page 17. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover those amounts, or use any other lawful remedy to recoup any such amounts.

No Alienation or Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, will be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

Incapacity

Whenever, in the Plan Administrator's or its delegate's opinion, a person entitled to receive any payment of a benefit or installment hereunder is under a legal disability or incapacitated in any way, so as to be unable to manage their financial affairs, the Plan Administrator may make payments, or direct payment, to such person or to the person's legal representative, to a relative or friend of such person for such person's benefit, or to such other person as the Plan Administrator considers advisable, at its sole discretion. Any such payment of a benefit or installment will be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

Forfeitures

If the total benefits paid or reimbursed to an eligible employee for expenses incurred during the plan year are less than the amounts allocated to the provision of benefits to the eligible employee, the unused portion will be immediately forfeited after the end of the plan year. An eligible employee is not entitled to carry over any unused portion of their benefits to the succeeding plan year, or to reallocate the unused portion to any other benefit. An eligible employee is not entitled to receive any unused benefits in the form of additional cash. Forfeited amounts will be used by PNC, at its sole discretion, to offset administrative or other costs of providing the benefits to which the forfeitures relate, or for any other purpose permitted under applicable regulations.

Applicable Law

The Plan will be construed and enforced according to the laws of the Commonwealth of Pennsylvania, to the extent not preempted by any federal law.

Severability

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

Heirs and Assigns

This Plan will be binding upon the heirs, executors, administrators, successors and assigns of all parties.

Headings and Captions; Gender

The headings and captions set forth in the Plan are provided for convenience only, will not be considered part of the Plan and will not be employed in construction of the Plan.

The feminine whenever used herein will include the masculine and vice versa.

Examination of Records

As a condition of receiving benefits under the Plan, the claimant for such benefits (or their parent or guardian, as the case may be) will grant the Plan Administrator or its delegate the right to examine any medical or hospital or other records that are relevant to any case for which benefits are claimed under the Plan.

Amounts Received from Insurers

Any rebates, dividends, demutualization proceeds or other such amounts received from an insurer may be retained by PNC, at its sole discretion, to the extent permitted by applicable law.

PNC's Protective Clause

In the event of a failure of either the participant or PNC to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the participant's benefit will be limited to the insurance premium, if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by PNC or the participant as a result of the participant's claim.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all 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 insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial reports. 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, or a family member, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this summary plan description and documents governing the Plan on the rules about your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to act 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 a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 qualified status of a 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 questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or 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 by calling the publications hotline of the Employee Benefits Security Administration at 866-444-EBSA (3272). You can view available publications on the website at **www.dol.gov/ebsa**.

APPENDIX A–MATERIALS INCORPORATED BY REFERENCE

Medical
PNC Medical Benefits Booklet–Part of the Group Benefit Plan Summary Plan Description

Expatriate Benefits
For purposes of clarity, the provision of health care benefits to eligible employees who are classified by PNC as expatriate employees will be governed solely by the terms of the applicable global benefit contract.

Dental
PNC Dental Benefits Booklet–Part of the Group Benefit Plan Summary Plan Description

Vision
PNC Vision Benefits Booklet–Part of the Group Benefit Plan Summary Plan Description

Employee Assistance Program
GuidanceResources is the EAP provider. Information is available on **www.pncpathfinder.com**.

Life Insurance and Business Travel/Criminal Acts Insurance
PNC Life Insurance Benefits Booklet–Part of the Group Benefit Plan Summary Plan Description

Personal Accident Insurance
PNC Personal Accident Insurance Benefits Booklet–Part of the Group Benefit Plan Summary Plan Description

Dependent Care Reimbursement Account
PNC Dependent Care Reimbursement Account Booklet–Part of the Group Benefit Plan Summary Plan Description

Supplemental Disability Insurance
If eligible, you will receive information directly from MassMutual.

Vacation Buy
The PNC vacation buy policy is available on **www.pncpathfinder.com**.

Adoption Assistance Benefit
PNC Adoption Assistance Benefit Booklet–Part of the Group Benefit Plan Summary Plan Description

APPENDIX B–CLAIMS ADMINISTRATOR CONTACT LIST

Provider	Claims	Appeals	Member Services
Medical Benefits (Health Choice 1 and Health Choice 2)			
Highmark Blue Cross Blue Shield	Highmark Blue Shield P.O. Box 3355 Pittsburgh, PA 15253-5095	Highmark Member Grievances and Appeals P.O. Box 535095 Pittsburgh, PA 15230 Attn: Review Committee	Phone: 800-241-5703 or **www.highmarkbcbs.com**
Aetna	Aetna P.O. Box 981110 El Paso, TX 79998-1110	Aetna P.O. Box 981110 El Paso, TX 79998-1110	Phone: 800-248-9977 or **www.aetna.com**
UnitedHealthcare	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 Fax: 801-938-2100	UnitedHealthcare P.O. Box 30432 Salt Lake City, UT 84130-0432 Fax: 801-938-2100	Phone: 888-510-9566 or **www.uhc.com**
Prescription Drug Benefits			
CVS/caremark	CVS/caremark P.O. Box 52196 Phoenix, AZ 85072-2196	CVS Caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866-689-3092 or 866-443-1172	Phone: 800-268-5104 or **www.caremark.com**
Expatriate Benefits			
Aetna	Aetna Attn: Aetna Global Benefits 151 Farmington Avenue Hartford, CT 06156	Aetna Attn: Aetna Global Benefits 151 Farmington Avenue Hartford, CT 06156	**Plan Insurer** Aetna 4630 Woodland Corporate Blvd. Tampa, FL 33614 Phone: 813-775-0217
Dental (PDO, PPDO and DMO)			
Aetna	Aetna P.O. Box 91110 El Paso, TX 79998-1110	Aetna P.O. Box 14080 Lexington, KY 40512	Phone: 877-238-6200 or **www.aetna.com**
Vision			
Davis Vision	Davis Vision P.O. Box 1525 Latham, NY 12110	Davis Vision Quality Assurance P.O. Box 791 Latham, NY 12110	Phone: 877-923-2847 or **www.davisvision.com**
Employee Assistance Program (EAP)			
GuidanceResources			Phone: 888-999-6768 **www.guidanceresources.com** (web ID: PNC)
Life Insurance			
MetLife	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 570-558-8645	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays
Business Travel/Criminal Acts Insurance			
MetLife	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 570-558-8645	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays

THE PNC FINANCIAL SERVICES GROUP, INC. GROUP BENEFIT PLAN

Provider	Claims	Appeals	Member Services
Personal Accident Insurance			
MetLife	To initiate a claim, contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays. For questions and correspondence regarding open claims, contact MetLife at the address in this chart.	MetLife Group Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 570-558-8645	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays
Dependent Care Reimbursement Account			
YSA Member Services	YSA Member Services PNC HR Service Center P.O. Box 661147 Dallas, TX 75266-1147	YSA Member Services PNC HR Service Center P.O. Box 661147 Dallas, TX 75266-1147	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays
Supplemental Disability Benefits			
Massachusetts Mutual Life Insurance Company	Massachusetts Mutual Life Insurance Company Disability Income Benefits Department M125 1295 State Street Springfield, MA 01111-0001	Massachusetts Mutual Life Insurance Company Disability Income Benefits Department M125 1295 State Street Springfield, MA 01111-0001	**Plan Insurer** **MassMutual Financial** 7300 W. 110th, Ste. 560 Overland Park, KS 66210 Phone: 913-234-6045
Adoption Assistance Benefit			
YSA Member Services	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays	YSA Member Services Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays	Contact the HR Service Center 877-YOUR-PNC (968-7762), option 1; 9 a.m. to 5 p.m. ET weekdays

DEPENDENT VERIFICATION VENDOR CONTACT INFORMATION

HMS Phone: 866-868-8991

www.VerifyOS.com

APPENDIX C–GENERAL COBRA RIGHTS NOTICE

You are receiving this notice because you have recently become eligible under the PNC Financial Services Group, Inc., Group Benefit Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible family members and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description or contact the PNC HR Service Center at 877-YOUR-PNC (968-7762).

Although an employee's Domestic Partner and their children (see Page 5 for definition) are not considered qualified beneficiaries under federal law, PNC provides the same coverage continuation opportunity to those individuals as provided to qualified beneficiaries, including spouses, under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if he/she loses coverage under the Plan because any of the following qualifying events happens:

- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- your death;
- your entitlement to Medicare benefits (under Part A, Part B or both); or
- you become divorced or legally separated.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- your death;
- your entitlement to Medicare benefits (under Part A, Part B or both);
- your divorce or legal separation; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The PNC Financial Services Group, Inc., (PNC) will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, PNC will notify the PNC HR Service Center of the qualifying event:

- your hours of employment are reduced;

- your employment ends;
- your death;
- your entitlement to Medicare benefits (under Part A, Part B or both); or
- PNC commences Chapter 11 bankruptcy proceedings.

You Must Give Notice of Some Qualifying Events
For the following qualifying events, you or a family member must notify the PNC HR Service Center within 60 days after the qualifying event occurs:

- your divorce or legal separation;
- your eligibility for Medicare; or
- your dependent's loss of eligibility for coverage as a dependent child.

You must notify the PNC HR Service Center of the qualifying event by accessing PNC Pathfinder at **www.pncpathfinder.com** or calling 877-YOUR-PNC (968-7762).

How Is COBRA Coverage Provided?
Once the PNC HR Service Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- your death;
- your divorce or legal separation; or
- your dependent stops being eligible for coverage under the Plan as a "dependent child."

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare eight months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months prior to the qualifying event).

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

- **Disability Extension of 18-Month Period of Continuation Coverage:** COBRA coverage may be available for you and your family for up to a total of 29 months at a higher premium if:
  - you, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage;
  - the Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
  - the disability must last at least until the end of the 18-month period of continuation coverage; and
  - the PNC HR Service Center is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify the PNC HR Service Center within the first 60 days of COBRA coverage.

You, your covered spouse or your covered dependents must notify the PNC HR Service Center within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify the PNC HR Service Center of the disability determination event, call 877-YOUR-PNC (968-7762).

You, your covered spouse or your covered dependents must notify the PNC HR Service Center within 30 days of the date the disability ends by calling 877-YOUR-PNC (968-7762).

- **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage:** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan, had the first qualifying event not occurred. These events include:
  - your death;
  - your divorce or legal separation; or
  - your dependent stops being eligible for coverage under the Plan as a "dependent child."

You, your covered spouse or your covered dependents must notify the PNC HR Service Center within 60 days after the event occurs in order to receive this additional coverage. To notify the PNC HR Service Center of the additional qualifying event, call 877-YOUR-PNC (968-7762).

Events That May Change Continued Coverage
Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualified change in status. You, your covered spouse or your covered dependents must notify the PNC HR Service Center by calling 877-YOUR-PNC (968-7762) within 30 days of the qualified change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29- or 36-month continuation period. In such case, you must notify the PNC HR Service Center by calling 877-YOUR-PNC (968-7762) within 30 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage
COBRA coverage will end automatically upon the expiration of the 18-, 29- or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- PNC stops providing group health benefits;
- premiums are not paid within 30 days of the due date (with the exception of the initial premium, which is due within 45 days of your election date); or
- a person eligible for continued benefits becomes covered under any other group health plan or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29- or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

Other Coverage Options
When you lose group health coverage, there may be other, more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Address Information
Be sure to keep your current address information up to date with PNC. Doing so is the only way to ensure that important benefit information will reach you.

Your Rights Under ERISA
For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

For More Information

If you need additional information, access PNC Pathfinder at **www.pncpathfinder.com** or call the PNC HR Service Center at 877-YOUR-PNC (968-7762), option 1, between 9 a.m. and 5 p.m. ET weekdays.

The PNC HR Service Center is providing COBRA administration services on behalf of PNC, the Plan Administrator. Please address any written correspondence to:

PNC HR Service Center
P.O. Box 661147
Dallas, TX 75266-1147