SHERWIN-WILLIAMS

BRIGHTER. BETTER. **BENEFITS.**

SUMMARY PLAN DESCRIPTION: 2021 EDITION

THE SHERWIN-WILLIAMS COMPANY

SHORT TERM DISABILITY PLAN

FOR SALARIED EMPLOYEES

SW 7048
Urbane Bronze

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Introduction

The Sherwin-Williams Company Short-Term Disability Plan ("Plan") provides benefits to eligible employees of The Sherwin-Williams Company or its subsidiaries (together, the "Company"). The Plan provides up to 25 weeks of full or partial short-term disability income payments to eligible employees when they are unable to work because of a qualifying Disability. The Company delegates much of the day-to-day administration of the Plan to a third-party administrator, The Hartford. The Hartford has discretionary authority to make determinations for the Plan, including determinations on eligibility for benefits, factual disputes, and interpretation and enforcement of Plan terms.

This Summary Plan Description ("SPD") provides a summary of the Plan's available coverage, as well as limitations, exclusions, and requirements that apply to the Plan. This SPD replaces and supersedes prior SPDs. We urge you to read this SPD in its entirety.

Plan Eligibility

You are eligible to participate in the Plan if you:

- are a regular, full-time employee of the Company (full-time means that you are regularly scheduled to work 35 hours or more per week, or that you are otherwise formally classified as full-time by your Division or department);
- have completed 30 calendar days of active, continuous full-time service;
- are *not* a temporary employee, seasonal employee, or independent contractor;
- are *not* covered by a collective bargaining agreement; and
- work and reside in the U.S. or participating U.S. territory and are either a U.S. citizen or otherwise legally authorized to work in the U.S.

Participating U.S. territories for the purposes of this Plan include the U.S. Virgin Islands but do not include Puerto Rico. Puerto Rico employees participate in a separate program. Participants who may become eligible for medical benefits based on their average hours worked per week under the company's medical benefit eligibility policies shall not become eligible for this Plan due solely to their eligibility for medical benefits.

Plan Eligibility for Rehires and Transfers

If you terminate employment with the Company and are later rehired, you will still be required to complete 30 calendar days of active, continuous full-time service with the Company before participating in the Plan after your rehire date. If you transfer within the Company directly from an ineligible position to an eligible position – for example, if you transfer from a part-time to an eligible full-time position – you will still be required to complete 30 days of active, continuous full-time service with the Company before participating in the Plan after your transfer date.

Waiting Period

The Plan begins to pay benefits if you are unable to work due to a continuing Disability (as defined in the Definition of Disability section of this Plan), after a seven calendar day waiting period (the "Waiting Period"). This means that, for the Plan to pay benefits, you must be unable to work for more than seven consecutive calendar days due to the Disability. The Waiting Period begins on the date of your first full day of absence from work due to the Disability, so if you leave work during a workday after starting a shift,

the waiting period will begin the following day. The Plan will not pay benefits during the Waiting Period; however, you may be able to, or in some cases you may be required to, use other paid leave available to you during this period according to the policies and procedures applying to that leave. Please consult the Company's leave of absence policy for situations where you may be required to use paid leave.

Length and Amount of Benefits

After the Waiting Period, the Plan will continue a percentage of your regular base pay (see below for what is included in regular base pay) for up to twenty-five (25) weeks if you continue to be unable to work due to the continuing Disability. Benefits are first provided at full regular base pay for up to the first eight (8) weeks of your continuing Disability, and then partial regular base pay for up to seventeen (17) weeks of your continuing Disability.

Maximum Benefit Amount	
Full Pay (100%)	**Partial Pay (60%)**
8 weeks	17 weeks

Special note for employees with nine (9) or more years of service on January 1, 2021: The above benefit does not increase with additional years of service. However, employees with nine (9) or more years of service as of January 1, 2021 will receive additional benefits under the Plan due to their length of service on that date. Employees with nine (9) or more years of service as of January 1, 2021 should consult the Appendix – Additional Benefits for Long-Service Employees (last page of this document) for their benefit schedule.

Regular Base Pay – Amount of Benefit

The benefit amounts paid under the Plan are calculated as a percentage of your regular base pay and are paid according to your regular payroll cycle. The Plan pays for partial pay periods of Disability on a pro-rata basis based on the number of days of that pay period that you were Disabled. Your regular base pay means your wages and compensation before any payroll deductions, salary reduction contributions or other pre-tax contributions are deducted from your pay, based on your regular work schedule. Basic Earnings does not include any overtime, bonus, incentive pay or additional types of compensation, except scheduled overtime, if any.

When Benefits End

Your benefits under the Plan end on the earliest of the following:

- You are no longer Disabled, as determined by The Hartford;
- You have received the maximum benefit under the Plan for the Disability;
- You return to active service with the Company;
- Your employment with the Company is terminated for any reason, including retirement;
- The Hartford determines that you refused to follow your Physician's treatment plan or that you have ceased to be under the care of a Physician;
- You fail to submit proof of your continuing Disability or otherwise adhere to plan administrative requirements, as determined by The Hartford;
- Your refusal to participate in a medical exam required by the Company or The Hartford;
- Your employment with another employer;

- Your death;
- The Plan is terminated or amended to eliminate benefits by the Company; or
- You are otherwise no longer an eligible participant in the Plan.

Return to Work

If you have been absent from work due to a Disability you will be required to present to The Hartford a Fitness For Duty Certificate or other documentation to show that you are able to return to work or follow other return to work procedures.

Long-Term Disability Benefits

If you are still Disabled after exhausting any benefits under the Plan, you may qualify for any long-term disability program benefits that may be offered to you by the Company under the terms of such program. If you believe you will still be Disabled after exhausting your benefits under the Plan, you can begin your application process for any long-term disability benefits while receiving benefits under this Plan – you should contact The Hartford for more information on this process. Qualification for benefits under this Plan does not guarantee eligibility for or approval of any long-term disability or other benefits.

Disability Definition

You have a "Disability" or are "Disabled" under this Plan when The Hartford determines that you are unable to perform the essential duties of your regular occupation with the Company due to your non-occupational illness, disease or injury, including mental illness.

For the purposes of the Plan, including the above definition of Disability, please note the definitions of the bolded terms below:

- Your **regular occupation** includes any comparable position offered to you by the Company as a reasonable accommodation in accordance with the Americans with Disabilities Act or any similar laws.
- A **comparable position** is any occupation or employment which the Company determines is substantially similar in terms of compensation or wages or the particulars of the position's responsibilities.
- An **essential duty** means a duty that is substantial, not incidental; is fundamental or inherent to your occupation; and cannot be reasonably omitted or changed.
- **Mental illness** refers to a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders, published by the American Psychiatric Association (most current as of the start of your Disability) and which requires treatment by a: 1) Psychiatrist; 2) Clinical or counseling psychologist; or Clinical Social Worker (Master's level). Mental illness does not include any non-medically-based functional impairment which is due to your reaction to employment-related stress, as determined by your treating Physician.
- A **Physician** means a licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery in the state or locality where the services are rendered. This includes those licensed as a Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine (D.O.) and Doctor of Chiropractic, if the chiropractor is referred by an M.D. or D.O. In addition, Physician Assistants and Nurse Practitioners under the supervision of an M.D. or D.O. will satisfy the licensed medical practitioner requirement; however, the term "Physician" does not include nurse midwives or any member of the Participant's family.

Information on Pregnancy and Childbirth

Absences due to childbirth are considered to be a Disability due to illness and are subject to all of the requirements under the Plan and this SPD. A vaginal delivery will result in a Disability for a minimum period of six (6) weeks, beginning on the date of birth, unless you are released by your Physician to return to work on an earlier date. A Cesarean delivery will result in a Disability for a minimum period of eight (8) weeks, beginning on the date of birth, unless you are released by your Physician to return to work on an earlier date. Pre-birth complications that may arise to the level of a Disability will be determined as such by your treating Physician. If you are eligible for the Company's paid parental leave program, that leave does *not* run concurrently leave under this Plan, meaning that paid parental leave is in addition to Short Term Disability leave under this Plan. Paid parental leave, however, will run concurrently with any unpaid bonding leave you may take under the Family Medical Leave Act. More details on the interaction of the Plan with the Company's paid parental leave program or other leave programs is outlined in the materials describing those programs.

Benefit Limitations

Exclusions

No benefits will be paid under the Plan for any of the following circumstances:

- Disability resulting from intentionally self-inflicted illness or injury;
- Disability resulting from acts of war, declared or undeclared;
- Your disability results from any occupational illness or injury, including one obtained through outside employment, contracting, or self-employment;
- Disability resulting from you committing or attempting to commit a felony;
- Time off taken for elective surgery and recovery from elective surgery; for the avoidance of doubt, benefits are payable if the Disability is (a) caused by your donation of an organ in a non-experimental organ transplant procedure or (b) due to any other procedure that would be covered under the Company's then current active employee medical coverage, regardless of whether you have enrolled in such medical coverage; or
- Any Disability during which you are not under the regular care of a Physician.

Recurring Disabilities

If you return to work after receiving benefits under the Plan and then become Disabled again from the same or a related cause within thirty (30) days of returning to work, this second Disability period will be considered a continuation of your first Disability period. In addition, each subsequent absence due to the same or a related Disability resets the thirty (30) day period. This means that your intermittent absences will remain covered under the Plan as long as each absence occurs within thirty (30) days of a previously covered absence and is due to the same or a related Disability. However, if your Disability recurs more than thirty (30) days after you return to work or if you become Disabled from an unrelated cause or otherwise distinct Disability, you must again qualify for benefits under the Plan.

Physical Exams

The Company, including your specific division or site, and The Hartford have the right to require that, during your period of Disability, you must submit to a physical exam performed by a Physician of the Company's or The Hartford's choice, at the Company's expense. If the Physician selected by the Company

or The Hartford determines that you are no longer Disabled, as defined by the Plan, your benefits under the Plan will stop. If you refuse to be examined by the Physician chosen by the Company or The Hartford, your benefits under the Plan will stop.

Additional Employment

If you are receiving benefits under the Plan and you are gainfully-employed by another employer, or you are working as a self-employed individual, an independent contractor or a consultant during your period of Disability, your benefits under the Plan will stop. In addition, you are not eligible to file for Disability benefits under the Plan for a Disability caused by your additional employment occupation.

Workers' Compensation

The Plan does not provide benefits for any Disability for which you are entitled to benefits under any state Workers' Compensation program or similar law. This exclusion applies regardless of whether your Disability was a result of your employment with the Company, another employer, or self-employment.

Family and Medical Leave Act and Other Leave Laws

Benefits under the Plan are administered concurrently with the Company's applicable leave of absence policies or leaves. This includes leave under the Family and Medical Leave Act of 1993 ("FMLA") or any related state or local leave laws permitting the Plan to run concurrently.

Offsets, Reductions and Excess Benefit Recovery

All benefits under the Plan are subject to offset and reduction against any other types of disability income that you are eligible to receive, including federal or state disability insurance income. If the Company and/or The Hartford determine that you were paid excess benefits under the Plan, the Plan has the right to use all reasonable methods to recover the excess benefit amounts owed to the Plan.

Filing an Application for Short-Term Disability Benefits

To request Plan benefits, you should contact The Hartford to begin the Disability claim process. Please note that in addition to contacting The Hartford, you must continue to follow your department or Division call-in or other absence notification procedures, including any required call-ins or notifications to your site or manager.

If you anticipate being absent from work due to a foreseeable Disability, you should notify The Hartford by giving at least 30-days advance notice or as much advance notice as practicable under the circumstances. If your absence due to Disability is unforeseeable, you must provide The Hartford with notice of your absence due to Disability within three (3) calendar days or as soon as practicable under the circumstances. Failure to provide notice may result in delay or denial of Plan benefits as determined by the Company, including by The Hartford as the Company's administrator, in the Company's sole discretion.

After you contact The Hartford, The Hartford will supply you with an information packet outlining what is needed for your Disability claim. The Hartford will verify certain information with the Company, potentially including your manager or human resources representative, such as your last day worked and job responsibilities. Your physician(s) will be asked to provide proof of disability to substantiate the disability condition. This information could include office treatment notes, test results, prescription histories, specific restrictions or limitations, and treatment plans from all treating physicians.

You may be required to complete a medical authorization that authorizes the release of your medical information to The Hartford. You may also be required by The Hartford to undergo an independent medical exam due to conflicting medical information. If you deny permission or refuse to undergo an independent medical exam, your claim may be denied and you may not receive Plan benefits.

The Hartford may also request that you provide proof of continuing disability and that you are under the regular care of a physician who is qualified to treat the type of injury or illness under which your claim is made. This proof, provided at your expense, must be received as soon as possible, and no later than fifteen (15) business days after the request is made, to avoid an interruption in Plan benefits. Failure to provide adequate supporting information within fifteen (15) business days may result in the denial of Plan benefits and may subject any absences to the Company's attendance policies and standards.

Claims and Appeals

Written Claims for Benefits

If you believe that you are being denied benefits under the Plan, you, or your authorized representative can file a written claim with The Hartford at P.O. Box 14869, Lexington, KY 40512. You must file your written claim within sixty (60) days of when you become entitled, or believe you became entitled, to benefits under the Plan. The Hartford will review your claim and notify you of its decision under the process outlined in this Claims for Benefits section.

The Hartford will respond to your claim within forty-five (45) days. This time period can be extended for up to thirty (30) days if The Hartford determines that an extension is necessary due to matters beyond its control and The Hartford notifies you of the extension and the date that The Hartford expects to make its decision before the end of the initial thirty (30) day review period. If, before the end of the first thirty (30) day extension, The Hartford decides that it needs more time, an additional extension of thirty (30) days is possible. The Hartford would again notify you of the extension prior to the end of the first thirty (30) day extension, telling you the circumstances for the second extension and the date on which The Hartford expects to make its decision. Any notice to you from The Hartford under this section will include: (a) an explanation of the Plan's eligibility requirements; (b) the unresolved issues that prevent The Hartford from making a decision and (c) any information necessary to resolve the outstanding issues. If you are asked to provide additional information for your claim, you will be provided at least forty-five (45) days to respond.

If your claim is denied, in whole or in part, you will receive a written notice from The Hartford. If, for some reason, a notice of denial is not provided to you within the required timeframe, your claim will be deemed denied and you can appeal that decision as outlined below. The denial notice will contain the following information, if applicable to you:

- a detailed explanation of why your claim was denied, including, if applicable, an explanation of why the Plan disagreed with the views of a medical professional or vocational expert (including those who treated the claimant and those whose advice was obtained by the Plan) or a disability determination made by the Social Security Administration;
- a specific reference to the provisions of the Plan upon which the denial was based;
- a statement that you are entitled to receive, upon request and at no cost to you, reasonable access to and/or copies of all documents relevant to your claim for benefits;
- a description of any additional information necessary for you to complete your claim and an

explanation of why such additional information is needed;
- the Plan rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that none exist; and
- a description of the Plan's appeal process, including the time limits involved and a statement of your right to pursue your claim in court if your claim is denied on appeal. In addition, if an internal rule, guideline, protocol or other similar criteria was relied on in denying your claim, the notice will either contain the specific rule, guideline, protocol or other similar criteria, or a statement that this information will be provided to you free of charge upon your written request.

Appeal Process

If your claim is denied, or deemed denied, you may file a written appeal with the Company within one hundred eighty (180) days after you receive the denial notice or the date your claim was deemed to be denied. Upon receiving your appeal, the Company will conduct a full and fair review of your appeal. A notice of the Company's decision will be mailed to you within forty-five (45) days after your appeal is received, unless the Company determines that special circumstances (such as the need to hold a hearing) require additional time. If the Company decides that additional time is necessary, it will advise you of the extension before the expiration of the initial forty-five (45) day review period. The notice will describe the special circumstances and the date by which the Company expects to make its decision. During the appeal of your claim, you, or your personal representative, will be given the opportunity to review documents related to your appeal and to submit issues and comments in writing to be considered by the Company. You may also request a hearing at which you or your representative can present information relevant to your appeal. Once the Company makes its decision on your appeal, you will receive a written notice with the Company's decision. The notice will include, as applicable:

- a detailed explanation of why your claim was denied, including, if applicable, an explanation of why the Plan disagreed with the views of a medical professional or vocational expert (including those who treated the claimant and those whose advice was obtained by the Plan) or a disability determination made by the Social Security Administration;
- a specific reference to the provisions of the Plan upon which the denial was based;
- information on any additional voluntary levels of appeal;
- a statement that you are entitled to receive, upon request and at no cost to you, reasonable access to and/or copies of all documents relevant to your claim for benefits;
- the Plan rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that none exist; and
- a description of your rights to seek judicial review of the Plan's decision, including a description of any contractual limitations period that applies to the right to bring an action, and the calendar date on which the claim's contractual limitations period expires.

If your application for benefits under the Plan has not been resolved, and after you have exhausted the Plan's claims and appeals process, you may file a civil lawsuit against the Plan. Any legal action must be initiated no later than one year from the date of the completion of the Plan's claims and appeals process.

Additional Legal and Administrative Information

No Enlargement of Employment Rights

Nothing contained in the Plan is to be construed as a contract of employment between the Company and you. The Plan does not give you the right to be retained in the employ of the Company, nor does it limit the right of the Company to employ or discharge you or to discipline you, for any reason or for no reason.

Interpretation, Amendment and Termination of the Plan

This Summary Plan Description describes the Plan. It does not interpret, extend or change the Plan in any way. The full provisions of the Plan can only be determined precisely by consulting the applicable governing Plan documents. In the event of any discrepancy between this summary and the provisions of any Plan documents, the Plan documents will govern.

The Company reserves the right to change, modify or discontinue the Plan at its discretion at any time. Such amendments or modifications which affect covered participants or employees will be communicated to the covered Participants and employees. Any amendment to the Plan shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications and shall be signed by an authorized officer of the Company.

Plan Administrator and Claims Administrator

The Company is the Plan's administrator and sponsor and is responsible for paying all Disability claims and for interpreting the provisions under the Plan. The Company may appoint one or more committees to assist with the Plan's administration. In addition, the Company may use the services of an insurance company or third-party administrator to assist with the Plan's administration. You can contact the Plan administrator as follows: via mail at The Sherwin-Williams Company, Attn: Total Rewards Department, 101 Prospect Avenue, N.W., Cleveland, OH 44115 or via phone at 216-566-2000. The Hartford is the Plan's Claims Administrator, and is responsible for maintaining all individual and Plan records, filing required reports, authorizing payments and assisting with resolving questions of Plan interpretation. You can contact the Claims Administrator, The Hartford, as follows: via mail at: P.O. Box 14869, Lexington, Kentucky 40512-4869 or via phone at: 877-627-3702.

Type of Plan, Funding Medium and Type of Administration

The Plan is a self-insured welfare benefit plan providing short-term disability benefits, as described in greater detail in this SPD. Plan benefits are paid from the general assets of the Company. The Plan is administered by the Company. There is no cost to you for these benefits.

Subrogation

Subrogation allows the Company or The Hartford to bring a legal action against a Third Party to recover benefits. Not all states permit subrogation. Third Party as used in this provision means any person or legal entity whose act or omission, in full or in part, causes you to suffer a Disability for which benefits are paid or payable under the Plan.

If you (1) suffer a Disability because of the act or omission of a Third Party; (2) become entitled to and are paid benefits under the Plan; and (3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time; then the Company will be subrogated to any rights you may have against the Third Party and may, at the Company's sole discretion, bring or direct The Hartford or other applicable agent to bring on its behalf a legal action against the Third Party to recover any payments of Plan benefits made in connection with the Disability.

No Guarantee of Tax Consequences

Neither the Company nor The Hartford makes any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes.

Authority to Construe and Apply Plan Documents

To the full extent permitted by law, the Company and its designee(s) under the terms of the Plan shall have the discretionary authority to construe any uncertain or disputed term or provision in Plan and related documents, and this Summary (collectively, "Plan Documents**"**), and decide all questions of law and fact concerning the Plan Documents and their application (including, but not limited to, determining questions concerning eligibility and benefits). The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate and your beneficiaries, and is subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law.

Standard of Judicial Review

Any review of an exercise of this discretionary authority shall be based only on such evidence presented to or considered at the time of the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Company and its designee(s) makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described in this section and in the Plan.

Agent for Service of Legal Process

Any legal process against the Plan in the event of an unresolved dispute over the Plan provisions may be made on the Plan Administrator at the address listed above.

Discrimination

The Company will not discriminate against any employee or Participant with regard to benefits available under the Plan as prohibited by the Internal Revenue Code, ERISA, the FMLA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Genetic Information Nondiscrimination Act of 2008 ("GINA") or any other applicable law, statute or regulation.

Your Rights Under ERISA

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall 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, if any, 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, if any, 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 report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The Senior Vice President – Human Resources is the "Fiduciary" of the Plan, and has a duty to operate the Plan prudently and in the interest of you and other Plan participants. To the extent permitted by applicable law, the Fiduciary has the power and authority to allocate or delegate any responsibility or power reserved to it hereunder to any person (or persons) as the Fiduciary may, in the exercise of their sole discretion, deem appropriate.

Enforce Your Rights

No one, including the Company 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. If your claim for an ERISA 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 a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT PLAN INFORMATION	
Name of Plan	The Sherwin-Williams Company Short-Term Disability Plan
Employer/Plan Sponsor/ Plan Administrator	The Sherwin-Williams Company 101 Prospect Avenue, N.W. Cleveland, OH 44115 (216) 566-2000
Employer Identification Number	34-0526850
Effective Date of Plan	January 1, 2021
Plan Number	656
Type of Plan	Welfare benefit plan providing short-term disability benefits.
Plan Year	January 1 to December 31

Appendix – Additional Benefits for Long Service Employees

If you have more nine (9) or more years of service under the Plan as of January 1, 2021 you will receive benefits according to the below schedule under the Plan.

You will not receive any additional benefits for additional years of service earned after January 1, 2021. Your maximum benefit in the below chart on January 1, 2021 is your maximum benefit under the Plan for all future years.

Your years of service are determined by your adjusted service date as of January 1, 2021 as reflected in the Company's HR information systems of record.

Employee's Years of Service as of January 1, 2021	Maximum Benefit Amount	
	Full Pay (100%)	Partial Pay (60%)
Less than 9 years	This appendix and chart does not apply.	
9 years but less than 10	10 weeks	15 weeks
10 years but less than 20	13 weeks	12 weeks
20 years but less than 25	20 weeks	5 weeks
25 years or more	25 weeks	0 weeks

Rehire for Long-Service Employees

Employees whose benefits are greater under this Appendix because they have nine (9) or more years of service as of January 1, 2021 **will be treated as new hires if they terminate employment for any reason. This means that any employee who terminates employment and is rehired will be treated as a new hire and eligible only for the new hire maximum benefit under the Plan, not the additional benefits in this Appendix.**