An Overview Guide: Your Health and Welfare Benefits

This Brochure is your guide to:

- **Your eligibility for medical, dental, vision, flexible spending, and health savings account Benefit Programs.**
- **How you enroll in medical, dental, vision, flexible spending, and health savings account Benefit Programs.**
- **Important legal information regarding health and welfare Benefit Programs at Sherwin-Williams, including your rights under ERISA, COBRA, and HIPAA, and Benefit Program administration.**

Separate Brochures and summaries provide you with:

- **Specific information on individual Benefit Programs (such as your medical program options, copays, etc.).**
- **Information on program specific policies and procedures.**

Effective: January 1, 2021

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INTRODUCTION

The Sherwin-Williams Company (the "Company" or "Sherwin-Williams") provides a wide range of benefits designed to help keep you and your family healthy and financially secure. Sherwin-Williams has established the Group Health and Welfare Benefits Plan for The Sherwin-Williams Company (the "Plan") in order to provide eligible employees with the opportunity to choose the health and welfare benefits that best suit each individual's needs. Various benefit programs are available under the Plan depending on your eligibility for the individual programs. These include medical, dental, vision, health and dependent care flexible spending accounts, disability benefits, life insurance, and other programs ("Benefit Programs").

This brochure provides an overview of the Plan, including the medical, dental, vision, flexible spending, and health savings account Benefit Programs that might be available to you, when you can enroll, and when your coverage will start and end. Additional brochures and other overview documents provide information about the individual Benefit Programs.

Information in this Brochure

This brochure is designed to help you understand:

- The different Benefit Programs you have to choose from;
- When you can enroll in Benefit Programs;
- Your coverage beginning and ending dates;
- Your eligibility for coverage;
- Where to get more information about your benefits and options;
- How the Plan pays benefits; and
- Your rights and responsibilities as a participant under the Plan.

This brochure also includes important information about the administration of the Plan and Benefit Programs and your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other important laws. This brochure, accompanying Benefit Program brochures, and other incorporated documents together comprise a summary plan description ("SPD") prepared in compliance with ERISA.

Benefit Programs Available to You

You can find a list of many of the Benefit Programs offered under the Plan, and where to find more information about these Benefit Programs, in the next section of this brochure (**Health Coverage Benefit Program Options**).

Depending on your eligibility, you can choose different medical (including prescription drug), health savings account, dental and vision benefits, as well as participate in health care and dependent care flexible spending accounts. The Company's "cafeteria plan" will also allow you to pay for certain benefits on a pre-tax basis.

Individual Benefit Program Brochures

Individual brochures and other incorporated documents summarize the highlights of the individual Benefit Programs offered under the Plan. The brochures do not cover every detail of the

Benefit Programs. Complete information regarding the Benefit Programs and Plan can only be collectively found in the formal Plan documents, contracts and certificates of insurance. If there is a conflict between the information in these brochures and the Plan documents, contracts or certificates, the Plan documents, contracts and certificates will be the controlling documents. Brochures, summaries and other governing documents are available to you on www.myswbenefits.com.

Special Note: Collective Bargaining Agreements, Union Employees and Participating Employers

Certain Benefit Programs under the Plan are maintained pursuant to collective bargaining agreements. If you are a union employee subject to a collective bargaining agreement, you can obtain a copy of your collective bargaining agreement by contacting your local HR representative, or by requesting the document in writing from Sherwin-Williams. In addition, pursuant to ERISA, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

Temporary extension of deadlines due to COVID-19 National Emergency

Due to the COVID-19 National Emergency, the Department of Labor (DOL) temporarily extended certain otherwise-applicable deadlines. The extension period is the ***shorter*** of:

1. the Outbreak Period (the period between March 1, 2020 and the 60th day after the end of the COVID-19 National Emergency or other date set by the DOL); or
2. a 12-month period starting on the first day of the regular (unextended) period for taking action.

The extension period will not count against the following deadlines:

<u>COBRA</u>

- 60-day period to make a COBRA election
- 45-day grace period to pay the first COBRA premium
- 30-day grace period to pay monthly COBRA premiums
- 60-day period to give notice of a qualifying event or disability for purposes of COBRA

<u>Special enrollment</u>

- 31 day period to enroll in medical coverage after marriage, birth, adoption, placement for adoption or loss of other employment-based medical coverage
- 60-day period to enroll in medical coverage after a loss of Medicaid or CHIP (or new availability of state Medicaid or CHIP subsidies for employment-based medical coverage

<u>Periods for filing claims, appeals and requests for external review</u>

This gives you a longer time to take action. However, it is strongly recommended that you take action as soon as possible because the last day of the Outbreak Period is not known and/or guidance may change. Please contact the Sherwin-Williams Benefits Service Center at 1-844-358-0604 if you have questions.

HEALTH COVERAGE BENEFIT PROGRAM OPTIONS

Below is a chart providing an overview of Sherwin-Williams' health coverage Benefit Programs and where you can find more information regarding the programs. Information about eligibility for and enrollment in these programs can be found in the **Eligibility For Health Coverage** and **Enrollment in Health Coverage** sections of this brochure. Information on other Benefit Programs that may be available to you, such as disability and life insurance, is also available on myswbenefits.com.

Type of Program	What Are the Options?	Where Can You Find More Information?
Medical	• Anthem Standard Plan • Anthem Prime Plan • Anthem Advantage Plan • Anthem Out-of-Area Plans • CVS/Caremark Prescription Drug Program	More plan information, including vendor contact information, is available on www.myswbenefits.com,in the ***Anthem Medical Options Brochure*** and other documents available on that site**.**
	• HMOs (availability varies by location)	Certain employees are eligible for HMOs. More plan information, including vendor contact information, is available on www.myswbenefits.com.
Health Savings Accounts (HSAs)	• HSAs are only available if you select the Anthem Prime or Advantage medical coverage options.	More plan information, including vendor contact information, is available on www.myswbenefits.com, in the ***Anthem Medical Options Brochure*** and other documents available on that site**.**
Dental	• Sherwin-Williams Dental Plan (Aetna Dental PPO)	More plan information, including vendor contact information, is available on www.myswbenefits.com, in the ***Aetna Dental PPO Brochure*** and other documents available on that site**.**
	• Aetna Dental DMO Plan (availability varies by location)	Certain employees are eligible for the DMO. More plan information, including vendor contact information, is available on www.myswbenefits.com.
Flexible Spending Accounts (FSAs)	• Health and Dependent Care Flexible Spending Accounts	More plan information, including vendor contact information, is available on www.myswbenefits.com, in the ***Flexible Spending Accounts Brochure*** and other documents available on that site.

Type of Program	What Are the Options?	Where Can You Find More Information?
Vision	• Sherwin-Williams EyeMed Vision Plan	More plan information, including vendor contact information, is available on www.myswbenefits.com, in the ***Vision Plan Brochure*** and other documents available on that site.
Cafeteria Plan (allows you to pay for certain other Benefit Programs on a pre-tax basis)	• Sherwin-Williams Cafeteria Plan	***Appendix A of this Brochure, "Cafeteria Plan".***

ELIGIBILITY FOR HEALTH COVERAGE

Your Eligibility

You are eligible for coverage under medical (including health savings account), dental, vision, and health and dependent care flexible spending account Benefit Programs under the Plan if you are:

- an active full-time non-union employee of Sherwin-Williams or a wholly-owned domestic subsidiary of Sherwin-Williams residing in the U.S. or the U.S. Virgin Islands; or
- in an applicable collective bargaining unit that has bargained for benefits under the Plan (refer to your collective bargaining agreement for any other applicable eligibility requirements).

An active full-time employee is an employee who averages 30 or more hours of service per week (as defined in the Patient Protection and Affordable Care Act ("PPACA")). Temporary employees, seasonal employees, leased employees and independent contractors are generally excluded from coverage unless they otherwise qualify as full-time employees eligible under the PPACA. A full explanation of how eligibility is measured under PPACA can be found in **Appendix B: PPACA Policy**. The PPACA policy only applies to health coverage. An employee who is classified as full-time under the PPACA policy does not become eligible for other benefits (such as basic and voluntary disability and life insurance).

If you are eligible for a particular option, it will be shown on your MySWBenefits account. **More information regarding eligibility for a particular benefit program can be found at www.myswbenefits.com or by contacting the Sherwin-Williams Benefits Service Center at 1-844-358-0604 .** Special eligibility rules for Health and Dependent Care Flexible Spending Account Programs are addressed in the **Flexible Spending Accounts Brochure.**

If you terminate employment with the Company, medical, dental and vision benefits generally end on the last day of the month of your last day worked. If your last day worked is the last day of the month, your benefits end that day. You will automatically receive information about COBRA coverage if you are enrolled in qualifying programs at the time of your termination of employment.

Eligibility for HMO and DMO Benefit Programs

HMO and DMO Benefit Programs may have slightly different requirements for participant eligibility, based on your location and other factors. Please consult the plan documents related to those Benefit Programs for more information. **If you are eligible for a particular option, it will be shown on your MySWBenefits account.** You can contact the Sherwin-Williams Benefits Service Center at 1-844-358-0604 if you have any questions about your eligibility for any HMO or the DMO.

Special note for union employees

Your eligibility for the below programs and other Benefit Programs may vary based on your location and the terms of your collective bargaining agreement. Please consult your collective bargaining agreement, Sherwin-Williams Benefits Service Center, or your Human Resources Representative if you have any questions about your eligibility for particular Benefit Programs.

Dependent Eligibility for Health Coverage

Your eligible dependents for purposes of **medical**, **dental** and **vision** coverage are:

- Your legal spouse;
- Your common law spouse as defined by applicable state law and subject to a verification process;
- Your same- or opposite-gender Domestic Partner subject to the verification process. (Refer to www.myswbenefits.com or contact the Sherwin-Williams Benefits Service Center at 1-844-358-0604 for all required procedures and documents, and see below for a definition of "Domestic Partner");
- Your children to age 26. (Eligibility ends on the last day of the month of the child's 26th birthday.) Your children are:
  - Your children by birth, adoption, and placement for adoption;
  - Your stepchildren, including children of your Domestic Partner;
  - Foster children or dependent children for whom you are the legal guardian who are primarily dependent on you for support;
  - Children you support under a Qualified Medical Child Support Order or administrative order (Sherwin-Williams will determine whether or not an order meets the criteria of a Qualified Medical Child Support Order); and/or
  - Your unmarried child of any age who is permanently and totally incapacitated, provided that the handicap began before the child reached age 19, who is primarily dependent on you for support.

If Your Child Is Disabled

Coverage for your unmarried disabled child may be continued past age 26 for dependents if the following criteria are met. Your dependent:

- Is unable to earn a living because of a mental or physical disability that began before age 19;
- Depends mainly on you for support and maintenance; and
- Meets all other eligibility requirements of the plan outlined earlier in this section.

You must provide proof of your child's disability no later than 31 days after your child reaches the age of 26 for medical, dental and vision. Your plan may continue to ask you for a physician's statement certifying that the child continues to meet these conditions of incapacity and dependency and is approved by the Plan's administrator. The child's coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the dependent age limit.

Definition of Domestic Partner

A "Domestic Partner" means a person (of the same or opposite gender) with whom an eligible employee has a current, valid domestic partnership registration, civil union certificate, or similar document from any state or local government agency. If no valid domestic partnership registration, civil union certificate, or similar document exists from any state, your same- or opposite-gender domestic partner may be considered a dependent if you have satisfied all of the following criteria:

- Have lived together for at least one year;
- Are both age 18 years or older and mentally competent to enter into a legal contract;
- Are both in an exclusive relationship;
- Are both not married to anyone else;
- Are both not related by blood closer than would bar marriage in the state;
- Share the same regular and permanent residence with the current intent of doing so indefinitely; and
- Are financially interdependent on each other and have attested to such interdependence on an "Affidavit of Domestic Partnership" (Additional information and the Affidavit are located on www.myswbenefits.com. When completing the form, it is recommended that you consult your personal tax advisor.)

An employee who does not meet all eligibility criteria is not eligible to apply for Domestic Partnership. If your Domestic Partner is not your tax dependent, you may be taxed on the value of your Domestic Partner's coverage.

Dependent Verification Documentation and No Duplicate Coverage

At any time, you may be asked by the Plan to provide documentation that proves your dependent's eligibility for the Plan or their status as a tax dependent, including but not limited to marriage certificates, evidence establishing Domestic Partnership criteria, or certifications of federal tax dependent status. If you fail to provide timely, proper documentation when it is requested, or if your dependent does not meet the requirements, your dependent will be dropped from all coverage.

If you enroll ineligible dependents in the Plan or fail to remove dependents who have become ineligible, you will be in violation of Sherwin-Williams' policy. Failure to provide accurate information will be treated in accordance with Sherwin-Williams' rules, which may result in discipline up to and including discharge.

If your spouse, Domestic Partner or child is an eligible employee, he or she may have employee coverage or dependent coverage but not both. If both parents are eligible employees, your children may be covered as dependents of either (but not both) of you.

ENROLLMENT IN HEALTH COVERAGE

There are generally two opportunities to enroll in medical (including health savings account), dental, vision, and health and dependent care flexible spending account coverage under the Plan:

- Initial Enrollment (after you initially become eligible); and
- Annual Open Enrollment (an annual open enrollment period that generally takes place in October of each year).

Generally, these are the only opportunities to enroll, and your elections during these enrollment opportunities are effective until December 31. In certain special circumstances discussed below (such as marriage and birth of a child, or the loss of other medical coverage), you may have a special opportunity to enroll yourself or dependents at another time within the time limit specified below.

Your Initial Enrollment

You must enroll in your medical, dental, vision, and flexible spending benefits under the Plan ***within 30 days of becoming eligible*** (this is often the period beginning the date you begin employment with Sherwin-Williams). If you would like dependent coverage, you must enroll your eligible dependents at this time. You must be enrolled in order to enroll your eligible dependents. You will be required to obtain and provide Sherwin-Williams with a Social Security Number for each covered dependent. A Social Security Number is not required to enroll but should be updated on MySWBenefits when received. If you do not enroll during this initial enrollment or within 30 days of a qualified status change, you can only enroll during annual open enrollment or during a special enrollment event under the Health Insurance Portability and Accountability Act (HIPAA) (discussed below).

When Your Coverage Begins After Initial Enrollment

When the enrollment requirements are met, your coverage will become effective on the 1st of the month following your date of hire. If you are hired on the first of the month, enrollment requirements are met, and you are eligible for coverage upon hire, your coverage begins on that day.

Your Required Contributions

You are required to make payroll deduction contributions to help cover the cost of medical, dental, and vision benefits. Before the beginning of each plan year, the Company will inform you of the amount of the required contributions. By enrolling, you are agreeing to pay the required contributions. When you enroll in HSA and FSA programs, you select the dollar level at which you would like to participate. The FSA Accounts have a minimum annual contribution of $150. There is no minimum contribution for the HSA. There is a limit on the amount you can contribute every year for the plans. These programs are funded through your contributions, which are deducted from your paycheck.

Working Spouse/Domestic Partner Surcharge

If you elect medical coverage and enroll a spouse or Domestic Partner who has access to medical coverage through their employer, a surcharge will be added to the amount of your medical

plan contribution. The Company will inform you of the amount of the surcharge annually. This does not apply if your spouse or Domestic Partner works for the Company.

Pre-Tax Contributions

An important feature of the Plan is that you may have your contributions made with "pre-tax" dollars, as specified by the IRS. This means that your share of the cost of these Benefit Programs is deducted from your paycheck before federal income and social security taxes are applied. However, your pre-tax contributions will reduce the amount of your gross taxable income. Therefore, there could be a decrease in your social security benefits by reducing the total taxable income used to calculate your social security benefit and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation. For more information on how you can make pre-tax contributions, see the "**Appendix A: Cafeteria Plan**" section of this brochure.

Annual Open Enrollment

You must also enroll yourself and/or your eligible dependents during the annual open enrollment period, which is scheduled by the Company and is generally in October of *each* year. If you do not enroll during annual enrollment (or initial enrollment), you can only enroll during the next annual open enrollment or during a special enrollment event under the Health Insurance Portability and Accountability Act ("HIPAA"), or within 30 days of a qualifying status change (see below for more information).

When Your Coverage Begins After Annual Open Enrollment

If you enroll during the annual open enrollment period, coverage begins on January 1st of the next plan year.

HIPAA Special Enrollment Rights and Qualifying Status Changes

Your enrollment elections are effective the entire calendar year. Generally, outside the annual open enrollment period, you can only change your coverage during the calendar year if you have a qualifying status change, such as getting married or having a baby, or are eligible for another special enrollment right, such as an enrollment right due to a loss of other medical coverage. If your status changes, you have 30 days (or 60 in limited cases involving Medicaid/CHIP losses of coverage) from the date the change occurs to make any coverage change.

If you do not submit changes online at www.myswbenefits.com or notify the Sherwin-Williams Benefit Service Center at 1-844-358-0604 within 30 days (or 60, where applicable) of the qualifying event, you must wait until open enrollment to make changes. More information regarding status changes and special enrollment rights is available in the next section, Health Coverage Special Enrollment and Change in Status Information.

HEALTH COVERAGE SPECIAL ENROLLMENT AND CHANGE IN STATUS INFORMATION

This section addresses special enrollment opportunities and qualified status changes, which are opportunities outside of initial and annual enrollment to enroll yourself and your dependents, including new dependents.

Effective Date of Changes

If properly enrolled, the effective date of changes covered by this section will be the first day of the month following the date the change took place with the exception of newborns, adopted children and children placed for adoption. Newborns adopted children and children placed for adoption are covered retroactive to the date of birth, adoption or placement for adoption.

Important Note: If you do not submit changes covered by this section through www.myswbenefits.com or notify the Sherwin-Williams Benefit Service Center within 30 days (60 days for Medicaid/CHIP special enrollment changes) of the qualifying event, you must wait until open enrollment to make changes.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act ("HIPAA"), special enrollment rights are available to certain individuals who previously declined medical coverage under the Plan and wish to enroll themselves and/or one or more of their dependents. If one of the special enrollment events occurs, you will have a special enrollment right regardless of when you would otherwise be eligible to enroll under the Plan. Therefore, these provisions supplement any other enrollment period otherwise available to you.

You will be entitled to special enrollment, if <u>all</u> of the following conditions are met:

1) You did not elect health coverage when you were first eligible to do so, because at that time:

- you were covered under a group health plan or had insurance at the time coverage was previously offered; and
- if required to do so, you stated in writing at the time you declined coverage that the reason you were declining was because you had other similar coverage; and
- you (or a dependent) lost coverage because of a loss of eligibility for that coverage due to:
  - termination of employment in a class eligible for such coverage;
  - reduction in hours of employment;
  - death;
  - divorce or legal separation;
  - the exhaustion of COBRA continuation coverage;
  - the other employer is no longer contributing toward the cost of such coverage;
  - the exhaustion of applicable lifetime benefits under the coverage;
  - an individual ceases to be a dependent under the plan;
  - the plan terminates a benefit option;

- if your coverage is provided through an HMO, you no longer live or work in the HMO's service area (and there is no other coverage available under the plan); or
- the plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees); and

2) You elect coverage no later than 30 days after the date of the loss of coverage for one of the reasons stated above.

If you are a special enrollee, your coverage will become effective no later than the first day of the month following the date of your election.

Special Medical Enrollment for New Dependents

These special enrollment provisions also apply with respect to the medical program coverage if you acquire a dependent through marriage, birth, adoption or placement for adoption, or entering into a Domestic Partner relationship and provided that you elect coverage no later than 30 days after such event. You will be entitled to special enrollment if you meet one of the following conditions:

Non-Enrolled Employee: If you are eligible but have not enrolled, you may enroll upon your marriage, upon the birth, adoption, or placement for adoption of your child, or upon entering into a Domestic Partner relationship.

Non-Enrolled Spouse or Domestic Partner: If you are already enrolled, you may enroll your spouse / Domestic Partner at the time of your marriage or upon entering into a Domestic Partner relationship. You may also enroll your spouse / Domestic Partner if you acquire a child through birth, adoption, or placement for adoption.

New Dependents of an Enrolled Employee: If you are already enrolled, you may enroll a child who becomes your eligible dependent as a result of marriage, birth, adoption, or placement for adoption, or upon entering a Domestic Partner relationship.

New Dependents / Spouse / Domestic Partner of a Non-Enrolled Employee: If you are eligible but not enrolled, you may enroll a spouse, Domestic Partner or child, as applicable, who becomes your eligible dependent as a result of marriage, birth, adoption, or placement for adoption, or upon entering a Domestic Partner relationship. However, you (the non-enrolled employee) must also be eligible to enroll, and actually enroll at the same time.

To enroll yourself and/or your new eligible dependent(s), you must enroll on www.myswbenefits.com no later than 30 days after the date of the event that entitles you and/or your eligible dependent(s) to the special enrollment period. If you are entitled to special enrollment and you enroll on www.myswbenefits.com within 30 days of the date of the event, coverage will become effective (i) as of the date of the event if the event is the birth, adoption or placement for adoption of your child (as noted above, newborns, adopted children and children placed for adoption are covered retroactively to the date of birth, adoption or placement for adoption); and (ii) no later than the first day of the first calendar month beginning after the date of the event if the event is your marriage. If enrollment is not completed on www.myswbenefits.comwithin 30 days from the date of the event, your enrollment must wait until the next annual enrollment period. This enrollment will then be effective at the beginning of the next Plan Year (the "Plan Year" being the calendar year), unless

another event occurs which would allow you to enroll yourself and/or your new Eligible Dependent(s) prior to such time.

Loss of Medicaid or CHIP Coverage or Medicaid/CHIP Premiums Assistance

HIPAA special enrollment rights also apply if (1) you and/or your eligible dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage due to no longer being eligible for those benefits, or (2) you and/or your eligible dependents become eligible for premium assistance in the Plan under Medicaid or CHIP. You must request special enrollment due to one of these reasons by enrolling no later than 60 days after the date of the event that entitles you and/or your eligible dependents to the special enrollment period in accordance with the procedures established by the Company. If you are entitled to special enrollment and you enroll within 60 days after the date of the event, coverage will become effective no later than the first day of the first calendar month beginning after the date of the event. If you do not timely enroll, you must wait until the next annual enrollment period to enroll (to be effective at the beginning of the next Plan Year) unless another event occurs which would allow you to enroll yourself and/or your new eligible dependents prior to such time.

Qualified Changes in Status and Irrevocable Elections

Once you make your election for a Plan Year (or in your initial year of eligibility, for the remaining portion of the Plan Year), you cannot change or revoke your election until the beginning of the next Plan Year unless you have a qualified change in status (defined in the next paragraph). However, in addition to the HIPAA special enrollment rights described above, an eligible employee may enroll in the Plan within 30 days after a qualified change in status event if such enrollment is necessary as a result of and is consistent with the qualified change in status event. If proper enrollment is not completed during this time, your enrollment must wait until the next annual enrollment period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow enrollment prior to such time).

This rule does not apply to your election to contribute to your Health Savings Account, which you may change or revoke at any time (with changes to apply to future contributions only).

A "**qualified change in status**" includes the following events that may impact you or your dependent's eligibility (including dependent Domestic Partners and their dependents), for coverage under the Plan:

Marital Status - An event that changes your legal marital status, meaning your:

- marriage;
- divorce;
- legal separation;
- annulment; or
- the death of your spouse.

Number of Dependents - An event that changes the number of your dependents, meaning a:

- birth;
- death;

- adoption;
- placement for adoption;
- a change in the number of qualifying dependents under the Dependent Care Flexible Spending Account Program; or
- entering into or terminating a Domestic Partner relationship.

Employment Status - An event that changes the employment status of you, your spouse or Domestic Partner, or dependent and that causes you, your spouse or Domestic Partner, or dependent to either gain or lose eligibility for an employer's Benefit Program, meaning:

- the commencement or termination of employment;
- a strike or lockout;
- the commencement or termination of an unpaid leave of absence;
- a change in work site location that removes the affected individual from a benefit plan's service provider area; or
- any employment status change that affects the eligibility of the individual to participate in a Benefit Program or plan of an employer, including a change from full-time to part-time, hourly to salaried, union to non-union status, or the reverse of any such change.

Special Note Regarding Full-Time to Part-Time Status Changes

Under PPACA or applicable state or local law, every individual must obtain medical coverage or be subject to a potential penalty. Please note that, as of 2021, PPACA penalties have been suspended, however penalties may still apply in certain locations under state or local law. Penalties may also or be reinstated under PPACA. Where any such penalties apply, if you waive medical coverage under the Plan due to a special enrollment right stemming from a qualifying change from full-time to part-time status, you do so with the intent to enroll in another plan providing minimum essential coverage (whether through an exchange or another employer) or be subject to a potential penalty.

Residence - A change in your residence or the residence of your spouse, Domestic Partner or dependent that removes the affected individual from a benefit plan's service provider area (such a change entitles you to make a new plan election selecting another coverage option, but generally does not permit you to opt out of coverage entirely unless no other relevant coverage is available).

Dependent Eligibility - A change that causes your dependent(s) to satisfy or cease to satisfy the eligibility requirements to participate in an employer's benefit plan, including:

- the attainment of a particular age;
- gaining or losing student status (if applicable); or
- a change in plan eligibility requirements.

Cost or Coverage - A significant change in the cost or coverage of a benefit plan offered to you, your spouse or Domestic Partner, or dependent, meaning:

- a new benefit option being added;
- a benefit option being eliminated or significantly curtailed;
- a coverage change made under a plan offered by the Company or the employer of your spouse, Domestic Partner, former spouse or dependent;
- a significant increase in the cost of a benefit (such qualified change in status permits you to make a new benefit selection, but does not allow you to revoke coverage entirely, unless no other similar coverage is available); further, in the case of the Dependent Care Flexible Spending Account Program, where the provider is your relative, no election change is permitted for this change in status reason; or
- a change in dependent care provider (for purposes of elections made under the Dependent Care Flexible Spending Account Program).

Medicare/Medicaid - You, your spouse, Domestic Partner, or dependent become covered or lose benefit coverage under Medicare or Medicaid, other than for pediatric vaccines.

Court Order - A duly executed judgment, decree or order (including a QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for your child (including your adopted or foster child) who is your dependent (for the purpose of any elections made under any available accident or health plan - coverage previously elected by you may be dropped only if the other individual actually provides coverage for the child).

HIPAA - A special enrollment right you may be entitled to under the provisions of HIPAA, as described above (for the purpose of any elections made under any available accident or health plan, or the Health Care Flexible Spending Account Program if the Health Care Flexible Spending Account Program is subject to the provisions of HIPAA).

COBRA - You, your spouse or dependent (including Domestic Partners and their dependents) becoming eligible for COBRA continuation coverage but only for the purpose of allowing an election to increase any pre-tax contributions to pay for the COBRA premium.

Family and Medical Leave Act ("FMLA") - You commence or return from an unpaid leave of absence as permitted and regulated by the FMLA.

Open Enrollment - An election of coverage by your spouse, Domestic Partner, or dependent during an open enrollment period that differs in time from the open enrollment period offered by the Company.

Medicaid/CHIP – A special enrollment right in the event you and/or your dependent: (1) lose coverage under Medicaid or the State Children's Health Insurance Program; or (2) become eligible for certain health plan premium assistance offered by the State, as described above.

Any election change or revocation you make must be consistent with the qualified change in status. You must change or revoke your election within 30 days after the change in status (or within 60 days after a Medicaid/CHIP change in status). Changes in elections due to a qualified change in

status will only be effective as to contributions and benefits under any Benefit Program on and after the effective date of such change. However, election changes made due to a special enrollment right as provided by HIPAA may result in coverage being made available retroactively to the date of the qualified change in status. The terms of certain Benefit Programs may either not permit you or limit your right to change or revoke your election due to a qualified change in status.

You are not permitted to reduce your election for the Health Care Flexible Spending Account Program or the Dependent Care Flexible Spending Account Program to an amount where your annualized contributions for such program is less than the amount already reimbursed. In addition, any change you make in your election which affects contributions to the Health Care Flexible Spending Account Program or the Dependent Care Flexible Spending Account Program also will change the maximum reimbursement benefit available for the remaining portion of the Plan Year.

Changing Elections to HSA Contributions

If you are a participant in the HSA you may elect to increase, decrease, or revoke your election to make contributions to your HSA through the Plan on a prospective basis at any time in accordance with the procedures established by the Company. Any such election will be effective following the date you make such an election in accordance with the procedures established by the Company.

YOUR BENEFITS DURING LEAVE OF ABSENCE OR AFTER REHIRE

Participation in Benefit Programs During Leave of Absence

If you are not at work due to an unpaid, Company-approved leave of absence, a period of military service lasting more than 31 days, or any other reason that creates a legal obligation for the Company to extend certain benefits, you may, at your option, continue during the period of your absence, any or all benefits under the Plan that you were receiving at the date your absence commenced. However, such continued coverage is subject to specific limitations of the applicable leave of absence. In addition, you must pay any required premiums or contributions for such coverage. During the absence, you may make contributions or pay premiums by remitting payment to the Company or the Company administrator on or before the first of each month, provided that any delinquent payment must be made within 30 days of its due date.

If you are absent from work for any paid leave of absence you must continue any and all benefits elected under the Plan, and your contributions (if any) for those benefits will continue to be deducted from your paychecks during the absence.

If You Go on Disability – Medical, Dental, Vision and All Health and Welfare Benefits

If you go on disability, the following happens to your medical, dental, and vision benefits:

- If you are on paid short-term disability, coverage continues and employee contributions will be deducted from your pay.
- If you are on unpaid short-term disability, coverage continues as long as you make the required monthly employee contribution payment before the beginning of the month and until your approved paid leave of absence ends.
- If you are on long-term disability, coverage continues as long as you make the required monthly employee contribution payment before the beginning of the month and until your approved paid leave of absence ends.
- If you are on workers' compensation wage replacement indemnity benefits, coverage continues for the first six months as long as required employee contributions are made before the beginning of the covered month.
- As soon as you start receiving wage indemnity benefits under workers compensation, coverage continues as long as the required employee monthly contribution payments are made before the beginning of the covered month.

You are required to enroll in Medicare Part B when you go on disability and are Medicare-eligible. If you do not enroll in Medicare Part B once you are on disability and are Medicare-eligible, the plan will not cover any of your medical benefits as a primary payer.

FSAs and Cafeteria Plan Participation During Leave

More specific information regarding your FSA and Cafeteria Plan participation during leave can be found in **Appendix A: Cafeteria Plan** and the **Flexible Spending Accounts Brochure**.

Coverage During FMLA Leave

Regardless of any provision to the contrary in the Plan, if you are on a qualifying unpaid leave under the FMLA, to the extent required by FMLA, the Company will continue to maintain your benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though you were still an active Employee (i.e., the Company will continue to pay its share of the premium to the extent you elect to continue your coverage). If you elect to continue your coverage, you may pay your share of the premium with after-tax dollars while on leave (or pre-tax dollars if you receive compensation during the leave), through prepayment of the premium for the anticipated duration of the leave by a special-election to reduce pre-leave compensation (if permitted, and provided that your pre-tax dollars may not be used to fund coverage in any subsequent Plan Year), or through other arrangements agreed upon by you and the Company (e.g., the Company may fund coverage during the leave and withhold amounts upon your return). Upon return from such leave, if you elected to discontinue coverage, you will be permitted to re-enter the Plan on the same basis as you were participating prior to taking leave, or as otherwise required by the FMLA.

Rehired Employees

If you terminate employment and you are subsequently reemployed by the Company, you will become a participant as provided in the document(s) for each Benefit Program. If a benefit document does not contain any rules for participation on reemployment, the following rules will apply:

- If you terminate employment prior to becoming a participant and you are subsequently reemployed by the Company, you must satisfy the eligibility requirements in order to participate in the Plan without regard to any prior period of employment with the Company.
- If you terminate employment after becoming a participant and you are subsequently reemployed by the Company within 30 or fewer days from the date you terminated employment and meet eligibility requirements, after you re-enroll through MySWBenefits, you may participate in the Plan beginning the first of the month following your rehire (or, if your first day of employment is the first of the month, as of the date of your rehire).
- If you terminate employment after becoming a participant and you subsequently become reemployed with the Company more than 30 days from the date you terminated employment, you may participate in the Plan again upon reemployment when you again meet the Plan's eligibility requirements.

CONTINUING HEALTH COVERAGE UNDER COBRA

This section explains your right to "COBRA continuation coverage," when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage is a temporary extension of health coverage, available to you and to other members of your family (including Domestic Partners and their dependents) who are covered under the Plan, at group rates, in certain instances where coverage under the Plan would otherwise end. For more information about your COBRA rights and obligations under the Plan and under federal law, please see the additional incorporated documents prepared for each Benefit Program to which COBRA applies.

You and other members of your family may have other options available when you lose coverage under the Plan. 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 mid-year enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or Domestic Partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse or Domestic Partner of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason; or
- You become divorced or legally separated from your spouse, or your Domestic Partnership ends.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason;
- The parents become divorced or legally separated, or their Domestic Partnership ends; or
- The child stops being eligible for coverage under the Plan as a dependent child.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's administrator has been notified that a qualifying event has occurred. The employer must notify the Plan's administrator of the following qualifying events:

- The end of employment or reduction of hours of employment; or
- Death of the employee.

For all other qualifying events (divorce or legal separation of the employee and spouse, termination of a Domestic Partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan's administrator within 60 days after the qualifying event occurs.

For how long is COBRA continuation coverage available?

Once the Plan's administrator 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. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

18-Month Continuation Period

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for **18 months** due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan's administrator in a timely fashion, you and your entire family may be entitled to get up to an additional **11 months** of COBRA continuation coverage, for a maximum **of 29 months**. You will be required to pay up to 150% of the group rate during the 11-month extension. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Also, you or a family member must provide the written determination of disability from the Social Security Administration to the Plan's administrator (1) within 60 days of the latest of (a) the date of the disability determination by the Social Security Administration, or (b) the

date of the qualifying event, and (2) prior to the end of the 18-month COBRA continuation period. If you fail to provide timely notice, you will lose the right to the 11-month extension.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the **18 months** of COBRA continuation coverage, the spouse or Domestic Partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if the Plan is properly notified about the second qualifying event. The notice must be provided within 60 days of the event. This extension may be available to the spouse or Domestic Partner and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or legally separated; the Domestic Partnership ends; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or Domestic Partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You Must Give Notice of Some Qualifying Events

You must notify the Plan's administrator of a divorce, legal separation, or termination of a Domestic Partnership or a child's losing eligibility within 60 days of the event. You must also notify the Plan's administrator of a determination of disability by the Social Security Administration by the deadline explained above. The employee or dependent can provide notice on behalf of themselves as well as other family members affected by the qualifying event. The notice of the qualifying event should be submitted according to Plan administrative directions and policies, which can be obtained by calling the Sherwin-Williams Benefit Service Center at 1-844-358-0604. Notice should include the following information:

- Date of notice (month/day/year)
- Employee's name and SSN/ID#
- Spouse's/Domestic Partner's and children's:
  - Names
  - SSNs
  - Address(es)
  - Dates of birth (month/day/year)
- Relationship to the Employee
- Date of event (month/day/year)
- Type of event

If you need help acting on behalf of an incompetent beneficiary, please contact the Plan's administrator at 1-844-358-0604 for assistance. If you fail to provide timely notice, you will lose all rights to COBRA continuation coverage.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can you enroll in Medicare instead of COBRA continuation coverage?

In general, if you don't enroll in Medicare Part A or B when you are first eligible (during the Medicare initial enrollment period) because you are still employed, you will have an 8-month special enrollment period to sign up for Medicare Part A or B beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods and https://www.medicare.gov/medicare-and-you.

If you have questions:

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, PPACA, 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 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.

Keep your Plan informed of address changes

To protect your family's rights, let the Company know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Company or the Plan's administrator.

Plan contact information:

For more information about your COBRA rights and obligations under the Plan and under federal law, please see the additional incorporated summaries prepared for each Benefit Program to which COBRA applies, or contact the Plan's administrator at 1-844-358-0604.

Continuation Coverage – Health Care Flexible Spending Account Program

For information regarding continuation of the Health Care Flexible Spending Account Program under COBRA, please see the **Flexible Spending Accounts Brochure**.

USERRA Continuation of Coverage

If you perform service in the uniformed services and are called to active duty for more than 30 days, you may elect continuation of coverage for any benefit under the Plan that is considered to be a "health plan", for up to 24 months as required by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), concurrent with COBRA continuation coverage.

ADDITIONAL HEALTH COVERAGE ELIGIBILITY INFORMATION

This section provides additional information regarding special rules and circumstances surrounding health plan eligibility.

Qualified Medical Child Support Order (QMSCO)

If Sherwin-Williams determines that your separated or divorced spouse or any state child support or Medicaid agency has obtained a legal qualified medical child support order ("QMCSO"), through a court order or an administrative process established under state law, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. Contact the Sherwin-Williams Benefit Service Center at 1-844-358-0604 for information and Plan administrative directions and policies on how to provide the Plan administrator notice of a QMSCO.

If a QMCSO requires that you provide medical coverage for your child(ren) and you do not enroll the child(ren), Sherwin-Williams must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence from the court to Sherwin-Williams that the child support order is no longer in effect.

The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). If you are not enrolled for coverage, you will be required to enroll or a default medical, dental, or vision election will be made for you along with the child and your share of the cost of such coverage will be withheld from your pay.

Important Information Regarding Health Insurance Marketplaces

Under the Patient Protection and Affordable Care Act, you can buy health insurance through the Health Insurance Marketplace. To assist you as you evaluate the options for you and your family, this brochure provides some basic information about the new Marketplace and its interaction with the Benefit Programs provided by Sherwin-Williams.

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium (however, your eligibility for Sherwin-Williams' Benefit Programs will affect this eligibility).

You may qualify to save money and lower your monthly premium, but only if Sherwin-Williams does not offer you medical coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

If you are eligible for health coverage through Sherwin-Williams' Benefit Programs, you will likely not be eligible for a tax credit through the Marketplace and may wish to enroll in Sherwin-Williams' health coverage. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if Sherwin-Williams does not offer coverage to you at

all or does offer coverage that is more than 9.5% (as indexed) of your household income for the year. ***If Sherwin-Williams does offer you coverage (if you are eligible for Sherwin-Williams coverage), it is likely that the coverage offered will prevent you from being eligible for tax credits or other assistance through the Marketplace.*** The Marketplace can help you to evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

If you purchase a health plan through the Marketplace instead of accepting employer-offered health coverage offered by Sherwin-Williams, then you will lose Sherwin-Williams' contribution to the employer-offered coverage. Also, this Sherwin-Williams contribution –as well as your employee contribution to the employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Medical Loss Ratio Rebates

With respect to any insurance company rebate received by the plan sponsor that are subject to the Medical Loss Ratio ("MLR") provisions of PPACA, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of participants; which participants need not be the same participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated among one or more of participating employer(s) as the plan sponsor in its sole discretion determines appropriate.

Rescission of Benefits Due to Fraud or Misrepresentation

Coverage may be retroactively terminated if you or a family member commits fraud or makes an intentional misrepresentation of a material fact. Thirty days advance notice and an opportunity to appeal will be provided prior to retroactive termination for fraud or an intentional misrepresentation of a material fact.

Wellness program discounts

If you complete or update a health assessment and/or certify your family's tobacco-free status as detailed in your enrollment materials, you may be eligible to save on your contributions for medical coverage during the following year. More information on health assessments and tobacco-cessation, including potential annual savings, is available on myswbenefits.com and in your enrollment materials and other communications.

Your medical plan is committed to helping you achieve your best health. Savings on contributions for participating in the wellness program are available to all employees. If you currently use tobacco, we offer the Quit for Life tobacco cessation program. If you complete the program, you can save on your contributions for medical coverage. Enroll at www.quitnow.net/sherwinwilliams or by calling 1-866-784-8454.

HEALTH COVERAGE – OTHER IMPORTANT LEGAL INFORMATION

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, in the event of a cesarean birth).

The Women's Health and Cancer Rights Act

If you are a participant or covered dependent receiving benefits under the Plan in connection with a mastectomy and you elect breast reconstruction, the Plan will cover benefits consistent with the Women's Health and Cancer Rights Act. These benefits are coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.

These benefits are subject to the deductibles and coinsurance limitations, if any, applicable to the medical coverage available under the medical program option that you choose under the Plan.

HIPAA Privacy Compliance

The medical, dental, vision, employee assistance program and health care flexible spending account portions of the Plan (the identified "health care components") may have access to certain health information about you and your covered dependents. This information is necessary to administer claims and provide benefits under the Plan. The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures.

As required by HIPAA, the Plan has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information ("PHI"). You will receive a copy of the Plan's Notice of Privacy Practices (the "Notice") that outlines how and when the Plan can use or disclose your PHI as well as your rights and protections under the law. If there are material changes made to the Plan's practices and procedures regarding the use and protection of your PHI, you will receive a revised Notice. In addition, you may receive a copy of the Notice at any time by contacting the Plan's Privacy Officer listed in the Notice.

The Plan has appointed one or more individuals to oversee the Plan's compliance with the HIPAA privacy rules and to address complaints. If you have any questions about how the Plan protects your PHI and your question is

not answered by reviewing the information in the Notice, if you would like more information about the Plan's privacy practices or if you want to make a complaint about the Plan's privacy activities, contact the individual(s) identified in the Notice.

Genetic Information Non-discrimination Act of 2008 (GINA)

GINA prohibits health coverage and employment discrimination against a plan participant based on his or her genetic information. Genetic information generally includes family medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Neither the plan nor the Company can use the information obtained as a result of genetic testing as a basis for employment or benefit determinations. In addition, you will not be asked to provide personal or family history or genetic data, except under circumstances as permitted by law. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential as required by GINA and HIPAA.

PLAN ADMINISTRATION AND FUNDING

Plan Administration and Funding

The Plan is a welfare benefits plan providing medical (including prescription drug), dental, vision, disability, life and accidental death and dismemberment benefits and employee assistance benefits, as well as health care and dependent care flexible spending accounts. The Plan also includes a "cafeteria plan" under Section 125 of the Internal Revenue Code which allows you to pay for certain benefits on a pre-tax basis, including pre-tax contributions to health savings accounts. These individual Benefit Programs are the Benefit Programs offered under the Plan.

Some benefits under the Plan are fully-insured and others are self-funded. Except for the HMO, the medical, prescription drug, and dental and programs are self-funded by the Company. The Company may hire certain providers (such as Anthem, Caremark and The Hartford) to process claims and provide services for the self-funded programs under the Plan. These companies do not serve as insurers. If applicable, these companies process claims and request and receive funds from the Company to pay the claims, and then make payment on the claims to applicable providers. The Company and covered employees share the cost of the medical, prescription drug, and dental programs. You must make any required contributions for these benefits.

The medical HMO, dental DMO, employee assistance, vision, life, accidental death and dismemberment and long-term disability programs are fully-insured. These fully-insured benefits are provided under insurance contracts entered into between the Company and a separate provider, such as Aetna DMO (dental DMO), CuraLinc (employee assistance), EyeMed Vision Care Program (vision), The Hartford (long-term disability), and The Prudential Insurance Company of America (life and accidental death and dismemberment). Claims for the fully-insured benefits are sent to the respective insurance company who is responsible for paying claims, not the Company. Insurance premiums are generally paid by the Company from its general assets, although the Company and covered employees may share the cost of the Benefit Programs, or covered employees may be responsible for the entire cost of certain Benefit Programs. For instance, you may be required to contribute toward the cost of coverage under the Benefit Programs you select. The Company will inform you of any required contributions toward the cost of your coverage under the Benefit Programs.

The Health Care Flexible Spending Account Program and the Dependent Care Flexible Spending Account Program are self-funded by the Company through employee pre-tax contributions. Your claims under the reimbursement programs are processed through a third-party administrator, which assists in administering each reimbursement account. In addition, if you are eligible for and elect to participate in the high-deductible health plan, you may be able to establish a health savings account ("HSA"). Although you may establish an HSA wherever you like, if you establish an HSA with a vendor selected by the Company, you may elect to make pre-tax payroll deduction contributions to your HSA.

Amendment and Termination of the Plan

The Company may with its sole discretion modify or amend the Plan at any time or for any reason as it relates to any active or former employee or any beneficiary, including adding or removing Benefit Programs available under the Plan. Anyone claiming an interest under the Plan will be bound

by any such amendment. Such amendments or modifications which affect covered persons will be communicated to the covered persons.

While the Company expects the Plan to be continued, future conditions affecting the Company cannot be anticipated. Therefore, the Company has reserved the right to terminate the Plan or to discontinue permanently paying benefits under the Plan or any portion thereof. Moreover, the Company has the specific discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.

CLAIMS AND APPEALS PROCEDURES

You should follow the procedures under each Benefit Program to request your benefits under such program. If your request is denied, you may appeal your claim under the claims procedures provided under the specific Benefit Program. If a Benefit Program does not include specific claims and appeals procedures, the procedures in this section apply. EyeMed, Aetna Dental DMO and Aetna Dental PPO specific appeal procedures are included at the end of this section.

Note, for example, that Anthem's plans have specific claims procedures outlined in the booklets for those plans. For the plans Anthem administrates, Anthem is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the Plan. In exercising such fiduciary responsibility, Anthem will have discretionary authority to determine entitlement to Plan benefits as determined by the respective Plan documents for each claim received and to construe the terms of the Plan. Anthem's decision on any claim is final unless your claim is eligible for an external review.

The Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims and appeals, such as an insurance company) shall be referred to as the "Claims Administrator.".

You may designate a representative to represent you in the claims and appeals process. However, you cannot assign your benefits (or Plan payments for benefits) to anyone else without written permission from the Claims Administrator except as required by a Qualified Medical Child Support Order.

You have 12 months after the date the service was provided or the loss or event occurred to file a claim. Claims filed after that time are not payable unless you were unable to file because you were legally incapacitated.

Claims Notification

If your claim is wholly or partially denied, the Claims Administrator will notify you of its decision in a written or electronic communication pursuant to Department of Labor Regulation Section 2520.104b-1(c)(1). In the event of such an adverse benefit determination, you will receive notice of the determination, which will include:

- the specific reason(s) for the adverse determination;
- the specific Plan provision(s) on which the determination is based;
- a request for any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the Plan's appeal procedures, information on initiating an appeal and the time limits applicable to such procedures (a denial of an urgent care claim will contain a description of the expedited review process);
- a statement of your right to bring a civil action under section 502(a) of ERISA following exhaustion of the internal appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon, either (a) a copy of the specific rule, guideline, protocol or other similar criterion, or (b) a statement

that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to a claimant upon request;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided free of charge upon request.

A denial of an urgent care claim will contain a description of the expedited review process. Furthermore, a notice of adverse determination from one of the Benefit Programs that is a medical plan (e.g., the Anthem Standard, Prime and Advantage Plans, or an HMO plan, along with prescription drug benefits) should also include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings);
- the denial code and its meaning, along with a description of the Plan's standard, if any, used in denying the claim;
- a description of external review procedures; and;
- for insured medical and prescription drug benefits, the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under health care reform to assist individuals with the internal claims and appeals and external review procedures.

This notification will be given within the following timeframes, depending on the type of claim:

Urgent Care Claims – as soon as possible, but no later than 72 hours after receipt of your claim, unless you do not provide enough information for the Claims Administrator to determine what benefits are payable under the Plan. If this occurs, the Claims Administrator will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Claims Administrator will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An "**urgent care claim**" is a pre-service claim for medical care or treatment where a delay in making a determination could jeopardize the life or health of you or your dependent or the ability of you or your dependent to regain maximum function, or, in the opinion of your or your dependent's physician, would subject you or your dependent to severe pain that cannot be adequately managed without the requested treatment.

Pre-Service Claims *(non-urgent)*– within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Claims Administrator, but only if the Claims Administrator notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the Claims Administrator expects to make a decision. If the extension is due to your failure to submit necessary

information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "**pre-service claim**" is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include pre-authorization for hospital stays, second surgical opinions, etc.

Post-Service Claims – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Claims Administrator's control if the Claims Administrator notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the Claims Administrator expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "**post-service claim**" is any claim for medical benefits that is not a pre-service claim.

Ongoing treatment – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care treatment beyond the approved period of time or number of treatments, the Claims Administrator will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

Disability claims – within 45 days after receipt of your claim. The review period may be extended for up to two 30-day periods due to matters beyond the Claims Administrator's control if the Claims Administrator notifies you of the extension before the end of the applicable period, the circumstances requiring the extension and the date by which the Claims Administrator expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

Other claims – for other claims where applicable, such as certain life insurance claims, the Plan Administrator will notify you within 90 days. An extension of an additional 90 days is available if written notice is given to you before the initial 90-day period ends.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period.

ANTHEM PROGRAM CLAIMS & APPEAL PROCEDURES

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- Your are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

Notice of Adverse Benefit Determination
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the appeal decision if You submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,
- information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

Appeals
You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought, and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054

You must include Your Member identification number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or

- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Appeal Denial

If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to

minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

Voluntary Second Level Appeals
If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, or if it pertained to a rescission of coverage, You may be eligible for an independent External Review pursuant to Federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by Your or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054

You must include Your Member identification number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent

External Review. The External Review decision is final and binding on all parties except for any relief ERISA.

Requirement to file an Appeal before filing a lawsuit.
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision. Actions brought against the Plan must be brought in the United State District Court for the Northern District of Ohio, Eastern Division – Cleveland.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

EyeMed Vision Program Claims & Appeal Procedures

EyeMed is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the vision program. In exercising such fiduciary responsibility, EyeMed will have discretionary authority to determine entitlement to Benefit Program benefits as determined by the respective Benefit Program documents for each claim received and to construe the terms of the Plan. EyeMed's decision on any claim is final.

Written notification of any denied claim will be provided to you on an explanation of benefit or explanation of payment statement (EOB) by EyeMed explaining the denial. Your EOB will include instructions regarding appeal rights specific to your state and type of insurance. You or your authorized representative may choose to file a written appeal with EyeMed of a denied claim. To appoint an authorized representative, you must submit a completed appointment of representative form to EyeMed. You can get this form on the EyeMed member website, or by calling the customer care center number on your ID card. A copy of the specific rule, guideline or protocol relied upon in the decision will be provided free of charge upon request by you or your authorized representative. You or your authorized representative may also review the documents relevant to your claim.

You or your authorized representative must appeal within 180 days of the date of a denial by submitting a written letter of appeal to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040
Fax: 1-513-492-3259

You or your representative should include the information specified on your EOB when requesting an appeal, which generally includes your Plan/Group Name and/or ID Number, Claim ID Number, Claim Service Date, name, member ID number, date of birth, and any comments, documents, records or other information you would like EyeMed to consider. Each level of appeal is reviewed by a qualified independent reviewer who was not involved in the previous decision and not involved with your plan.

Written notification of EyeMed's decision on the appeal will be delivered to you within a reasonable period of time, but not later than 30 days after the appeal is received unless otherwise dictated by your EOB, plan benefits and/or federal or state law. If your vision care provider believes that a delayed decision could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited review. If EyeMed deems the request should be expedited, EyeMed will make a decision within 72 hours.

Any further appeal rights and instructions for procedures to exercise those rights will be detailed within the resolution letter you receive for the appeal.

If you do not receive notice of the decision on the appeal within the prescribed time period, the appeal is deemed denied. Following the denial of an appeal, you may bring a legal action no later than one year from the date of completion of the appeal process, or if earlier, one year from the time proof of loss is required by the EyeMed program. You must complete the appeal process prior to bringing a legal action. You may also contact your state insurance regulatory agency to find out if additional dispute resolution resources are available to you through that agency.

Additional information regarding your rights and responsibilities under your EyeMed plan can be found in the EyeMed Member Bill of Rights, accessible on the EyeMed website, currently at the following URL: https://eyemed.com/en-us/member-bill-of-rights.

Aetna Dental DMO Program Claims & Appeal Procedures

Aetna Dental ("Aetna") is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the Dental DMO program. In exercising such fiduciary responsibility, Aetna will have discretionary authority to determine entitlement to Benefit Program benefits as determined by the respective Benefit Program documents for each claim received and to construe the terms of the Plan. Aetna's decision on any claim is final.

You or your dental provider are required to send Aetna a claim in writing. You can request a claim form from Aetna. Aetna will review that claim for payment to the provider or to you as appropriate. The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	• You should get a claim form from Aetna's self-service website or call Aetna. • The claim form will provide instructions on how to complete and where to send the forms.	• You must send Aetna notice and proof as soon as reasonably possible • If you are unable to complete a claim form, you may send Aetna: – A description of services – Bill of charges – Any dental documentation you received from your provider
Proof of claim When you have received a service from an eligible dental provider, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by Aetna.	• You must send Aetna notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits • If Aetna challenges any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

Communicating claim decisions. The amount of time that Aetna has to tell you about the decision on a claim is shown below.

Post-service claim
A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial decision by Aetna	30 days
Extensions	15 days
If Aetna requests more information	30 days
Time you have to send Aetna additional information	45 days

Adverse benefit determinations
Aetna pay many claims at the full rate negotiated charge with an in-network provider and the recognized charge with an out-of-network provider, except for your share of the costs. But sometimes

Aetna will pay only some of the claim. And sometimes Aetna does not pay at all. Any time Aetna does not pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision."

If Aetna makes an adverse benefit determination, Aetna will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write Aetna. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna will review the information and provide you with a written response within 30 calendar days of receiving the complaint. Aetna will let you know if they need more information to make a decision.

An appeal

You can ask Aetna to review an adverse benefit determination. This is called an appeal. You can appeal by calling Aetna.

Appeals of adverse benefit determinations

You can appeal Aetna's adverse benefit determination. Aetna will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Aetna. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like Aetna to consider

Another person may submit an appeal for you, including a dental provider. That person is called an authorized representative. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your dental provider). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form on Aetna's website or by contacting us. The form will tell you where to send it. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The amount of time that Aetna has to tell you about their decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time Aetna has to tell you about our decision.

Type of notice	Post-service appeal
Initial decision by Aetna	30 days
Extensions	15 days
If Aetna requests more information	30 days
Time you have to send Aetna additional information	45 days

Exhaustion of appeals process

You must complete the appeal process with us before you can take these actions:

- Contact the Connecticut Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Connecticut Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

You may contact the Connecticut Department of Insurance for assistance regarding any complaint, grievance or appeal at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O.Box 816
Hartford, CT 06142-0816
860-297-3900 or 800-203-3447
cid.ca@ct.gov

You may also contact the Office of Healthcare Advocate at:

State of Connecticut
Office of the Healthcare Advocate
P.O.Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review only if:

- Aetna's claim decision involved medical judgment.
- Aetna decided the service or supply is not medically necessary or not appropriate.
- Aetna decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If Aetna's claim decision is one for which you can seek external review, Aetna will say that in the notice of adverse benefit determination or final adverse benefit determination Aetna sends you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review form:

- To the Connecticut Insurance Department;

- Within 4 months of the date you received the decision from Aetna;
- And you must include a copy of the notice from Aetna and all other important information that supports your request

You will need to mail your application for External Review to:
Connecticut Insurance Department
Attention: External Review
P.O. Box 816
Hartford, CT 06142-0816

If you are using an overnight delivery service, mail to:
Connecticut Insurance Department
Attention: External Review
153 Market Street, 7th floor
Hartford, CT 06103

You will pay for any information that you send and want reviewed by the ERO. Aetna will pay for information Aetna sends to the ERO plus the cost of the review.

The Connecticut Insurance Commissioner will forward the appeal to Aetna.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date Aetna receives your request form and all the necessary information

Aetna will stand by the decision that the ERO makes, unless Aetna can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

Aetna will tell you of the ERO decision not more than 45 calendar days after Aetna receives your Notice of External Review Form with all the information you need to send in.

Recordkeeping

Aetna will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

Aetna does not pay any fees or expenses incurred by you when you submit a complaint or appeal. Aetna will pay for information we send to the ERO plus the cost of the review.

Aetna Dental PPO Program Claims & Appeal Procedures

Aetna Dental ("Aetna") is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the Dental PPO program. In exercising such fiduciary responsibility, Aetna will have discretionary authority to determine entitlement to Benefit Program benefits as determined by the respective Benefit Program documents for each claim received and to construe the terms of the Plan. Aetna's decision on any claim is final.

You or your dental provider are required to send Aetna a claim in writing. You can request a claim form from Aetna. Aetna will review that claim for payment to the provider or to you as appropriate. The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	• You should get a claim form from Aetna's self-service website or call Aetna. • The claim form will provide instructions on how to complete and where to send the forms.	• You must send Aetna notice and proof as soon as reasonably possible • If you are unable to complete a claim form, you may send Aetna: – A description of services – Bill of charges – Any dental documentation you received from your provider
Proof of claim When you have received a service from an eligible dental provider, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required	• You must send Aetna notice and proof as soon as reasonably possible.

Benefit payment	• Written proof must be provided for all benefits • If Aetna challenges any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

Communicating claim decisions

The amount of time that Aetna has to tell you about the decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial decision by Aetna	30 days
Extensions	15 days
If Aetna requests more information	30 days
Time you have to send Aetna additional information	45 days

Adverse benefit determinations

Aetna pay many claims at the full rate negotiated charge with an in-network provider and the recognized charge with an out-of-network provider, except for your share of the costs. But sometimes Aetna will pay only some of the claim. And sometimes Aetna does not pay at all. Any time Aetna does not pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision."

If Aetna makes an adverse benefit determination, Aetna will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write Aetna. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna will review the information and provide you with a written response within 30 calendar days of receiving the complaint. Aetna will let you know if they need more information to make a decision.

An appeal

You can ask Aetna to review an adverse benefit determination. This is called an appeal. You can appeal by calling Aetna.

Appeals of adverse benefit determinations

You can appeal Aetna's adverse benefit determination. Aetna will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Aetna. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like Aetna to consider

Another person may submit an appeal for you, including a dental provider. That person is called an authorized representative. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your dental provider). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form on Aetna's website or by contacting us. The form will tell you where to send it. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The amount of time that Aetna has to tell you about their decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time Aetna has to tell you about our decision.

Type of notice	Post-service appeal
Initial decision by Aetna	30 days

Exhaustion of appeals process

You must complete the appeal process with us before you can take these actions:

- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review only if:

- Aetna's claim decision involved medical judgment.
- Aetna decided the service or supply is not medically necessary or not appropriate.
- Aetna decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If Aetna's claim decision is one for which you can seek external review, Aetna will say that in the notice of adverse benefit determination or final adverse benefit determination Aetna sends you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review form:

- To Aetna;
- Within 4 months of the date you received the decision from Aetna;
- And you must include a copy of the notice from Aetna and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. Aetna will pay for information Aetna sends to the ERO plus the cost of the review.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date Aetna receives your request form and all the necessary information

Aetna will stand by the decision that the ERO makes, unless Aetna can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

Aetna will tell you of the ERO decision not more than 45 calendar days after Aetna receives your Notice of External Review Form with all the information you need to send in.

Recordkeeping

Aetna will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

Aetna does not pay any fees or expenses incurred by you when you submit a complaint or appeal. Aetna will pay for information we send to the ERO plus the cost of the review.

COORDINATION OF BENEFITS

This section outlines basic coordination of benefits procedures under the Plan. ***Specific Benefit Programs may provide separate coordination of benefits procedures. Please consult the documents related to your specific Benefit Program for more information.*** Certain types of plans coordinate the payment of benefits. Benefits for medical and health-care related expenses paid by this Plan will be coordinated with benefits payable under other plans, including plans provided by an employer, union, trust or similar plan; other group health plans that cover you or your dependents; and governmental programs or coverage required by law (*i.e.*, Medicare and no-fault automobile insurance). The Plan does not coordinate benefits within individual, privately-paid coverage except no-fault automobile insurance.

If you are covered by more than one plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a benefit (if any). When benefits are coordinated, the plans decide which plan pays first (*i.e.*, primary), which pays second (*i.e.*, secondary), etc. Below are the guidelines the Plan uses to determine which plan is primary.

1. A plan is considered primary if the plan: (a) has no coordination-of-benefits provision; (b) coordinates benefits according to different rules; (c) is a plan required by law (*i.e.*, Workers' Compensation); or (d) constitutes a no-fault motor vehicle insurance or third party liability policy.
2. The plan covering the person as an employee, rather than as a dependent, is primary and pays benefits first. The plan covering an active employee pays first before the plan covering a laid-off or retired employee.
3. If both parents' plans cover a dependent (and the parents are not divorced or separated), the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the birthday rule, then the rules of that plan determine the order of benefits. If the other plan uses the gender rule, the father's plan is primary.
4. In the case of a divorce or separation, the plan of the parent (who hasn't remarried) with custody of the dependent child usually pays benefits first. However, if there's a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.
5. If the parent with custody remarries, his or her plan pays benefits first, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if there's a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.
6. If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

Coordination of Benefits with Medicare

When you or your dependents are eligible for Medicare, the Plan's health coverage is primary for each of you only:

- while you are actively employed; or
- during a covered person's first 30 months of end stage renal disease treatment.

In these cases, Medicare is secondary, however, you may elect to end coverage and have Medicare coverage alone. When your active employment ends, Medicare coverage becomes primary for you and any Medicare-eligible dependents. For purposes of coordinating benefits with Medicare, your active employment ends when you retire, terminate employment or have been disabled for more than six months. Medicare is also primary after 30 months of end-stage renal disease treatment.

When Medicare is primary and the Plan is secondary, the Plan's benefits are coordinated with Medicare Part A and Part B benefits that the covered person is eligible to receive (even if the covered person fails to enroll in Medicare or a part of Medicare). This applies whether or not the benefits are actually paid by Medicare.

SUBROGATION AND REIMBURSEMENT

This section outlines basic subrogation and reimbursement procedures under the Plan.

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to an injury, sickness or other loss. Regardless of any other subrogation or right of reimbursement provision contained in any Benefit Program or applicable incorporated document, if you or your dependent or your or your dependent's heir, legatee, administrator, executor, personal representative, beneficiary, or assignee (collectively, the "Claimant"), has any claim, right, or cause of action against any other person for payment of expenses covered under this Plan other than:

- another benefit plan, as described in the Coordination of Benefits Section of this Summary; or
- in the case of an employee, one or more of his or her dependents; or
- in the case of a dependent, the employee upon which he or she is dependent and any other dependents of such employee;

benefits may be withheld under the Plan when a party other than the participant may be liable for such expenses until such liability is legally determined.

In certain circumstances, you, your dependent, or another Claimant may have an obligation to reimburse the Plan for payments made to or on behalf of you or your dependent. In particular, if you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant (such as under a policy of insurance), then payments made by the Plan are only made on the condition that the Plan will be reimbursed by you, your dependent, and/or other Claimant to the extent of any amounts received from the third party. It does not matter whether the amounts received from the third party are as a result of a judgment rendered in a lawsuit, as a settlement of a claim, or otherwise.

We will treat any funds received by you, your dependent, or another Claimant as being held in a constructive trust on behalf of the Plan. No portion of such funds may be distributed to you, your dependent, or another Claimant until you have fully paid the Plan's claim for subrogation/reimbursement. The Plan will neither pay any attorneys' fees nor pay any portion of the expenses which have been incurred as a result of the injury case.

If you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant, the Plan will, to the extent of its payment of benefits, be subrogated to all of your, your dependent's, any other Claimant's rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. As a result, if a Claimant does not pursue recovery from a liable third party, the Plan may pursue the claim on the Claimant's behalf. In addition, a Claimant agrees to reimburse the Plan for any benefits paid under the Plan, and any out-of-pocket expenses incurred by the Plan, the Plan Administrator, the Company, or any Employer in pursuing such recovery, out of any monies recovered from a third party as the result of judgment, settlement or otherwise.

The subrogation and reimbursement obligation applies to any full or partial recovery from a third party, even if the Claimant has not been "made whole" for the loss accruing because of the alleged negligent, willful or other conduct of the third party. Further, the Plan's right of reimbursement applies on a first-dollar basis. In other words, the reimbursement right will be in first priority over you, your dependent, and any other Claimant to the extent of any benefits paid hereunder. The reimbursement obligation applies to any amounts paid by a third party, is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement or judgment, and is not subject to offset or reduction by reason of any legal fees or other expenses incurred by the Claimant in securing such recovery.

By filing a claim for and accepting benefits under this Plan, any Claimant will be deemed to have consented to the Plan's rights of subrogation and reimbursement and to have agreed to cooperate with the Company and/or Plan Administrator in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, regardless of whether the Claimant chooses to pursue such claim, right or cause of action. A Claimant may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your dependents may be delayed, withheld, or denied unless the Claimant cooperates fully and, upon the request of the Company or Plan Administrator, enters into a subrogation and reimbursement agreement with the Plan. The Plan's right to subrogation and reimbursement do not apply, however, to a recovery obtained by you or your dependent from an insurance company on a policy under which you or your dependent is entitled to indemnity as a named insured person.

The Plan will have an equitable lien against any right the Claimant may have to recover any payments made by the Plan from any other party. Recovery will be limited to the amount of payments made from this Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment, settlement or otherwise, where the Plan has paid expenses otherwise eligible as covered expenses under the Plan prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or programs or the Employer will be deemed to mean that such a determination has been made. This equitable lien will also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery. The Plan will also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties.

Whenever payment has been made in error, the Plan has the right to recover such payment from you or the person to whom such payment was made. At the discretion of the Plan Administrator, the Plan may reduce any future benefit payments otherwise available to the Claimant (and all individuals enrolled as part of the same family unit) under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien. The Plan's provisions regarding subrogation, reimbursement, equitable liens or other equitable remedies are intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

ADMINISTRATIVE AND LEGAL OVERVIEW

Administrative Information

About the Plan

The official name of the Plan is the "**Group Health and Welfare Benefits Plan for The Sherwin-Williams Company**." The Plan's designation for reporting purposes is plan number 656.

The health savings accounts and dependent care flexible spending accounts are referenced in this Overview Guide for your convenience but are not subject to ERISA and are not components of the Group Health and Welfare Benefits Plan for The Sherwin-Williams Company.

Plan Administrator

The Senior Vice President – Human Resources is the Plan Administrator of the Plan, and delegates the day-to-day responsibility to the Company's Total Rewards Department. The Plan Administrator is responsible for maintaining all individual and Plan records, filing Plan tax returns and reports, authorizing payments, and resolving questions of Plan interpretation. The Plan Administrator has wide and absolute discretion to interpret and apply Plan provisions and determine facts, benefits, and eligibility. All interpretations, decisions, and determinations of the Plan Administrator are intended to be final, conclusive, and binding on all parties having an interest in the Plan. The Company may appoint one or more Committees to assist with the Plan's administration. In addition, the Company may utilize the services of insurance companies and/or professional third-party administrators to assist with administration of the Plan.

For the self-insured plans administered by a third-party administrator, the third-party administrator is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the Plan. For insured benefits, the insurer is the "appropriate named fiduciary" with respect to Section 503 of ERISA for the purpose of reviewing denied claims under the Plan. The Plan Administrator has the right to delegate its discretionary authority and responsibilities for administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. The Plan Administrator has, through this document, delegated discretionary authority for the administration of claims and appeals to the third-party administrators and insurers. As a fiduciary responsible for deciding appeals, the third-party administrators and insurers will have discretionary authority to determine entitlement to Plan benefits as determined by the respective Plan documents for each claim received and to construe the terms of the Plan. The third-party administrators' and insurers' decisions on any claim is final.

You can contact the Plan Administrator as follows:

The Sherwin-Williams Company
Attention: Senior Vice President – Human Resources
101 Prospect Avenue, NW
Cleveland, OH 44115
Phone: 216.566.2000

Type of Plan

The Plan is a welfare benefit plan as described in the Introduction to this Summary.

Funding Medium and Type of Administration

See the description provided in the Plan Administration and Funding section of this Summary.

Plan Year

The Plan maintains a Plan Year of January 1 through December 31.

Required Participant Information

You must provide the Plan Administrator with the information that is requested of you from time to time for the purpose of the Plan's administration. The Plan Administrator will rely on the information you provide.

Source of Financing

Except for the HSA Program, all of the benefits provided under this Plan will be paid from the general assets of the Company and by any insurance policies purchased by the Company. Participants may be required to make contributions to the Plan based on the Benefit Programs elected. To the extent permitted by applicable law, the Company is not obligated to establish a separate trust or fund under the Plan; however, the Company may elect, in its discretion, to fund Benefits through a voluntary employees' beneficiary association.

Legal 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 will not be deemed to give you the right to be retained in the employ of the Company, nor will it limit the right of the Company to employ or discharge you or to discipline you, for any reason or for no reason.

No Guarantee of Tax Consequences

Neither the Company nor the Plan Administrator 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, the Plan Administrator and their designees under the terms of the Plan will have the discretionary authority to:

- construe any uncertain or disputed term or provision in Plan and its Benefit Programs;
- decide all questions of law and fact concerning the Plan (including, but not limited to, determining questions concerning eligibility and benefits).

The exercise of this discretionary authority will be binding upon all interested parties, including, but not limited to, you, your estate and your beneficiaries, and will be 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 will be based only on such evidence presented to or considered by the Company, Plan Administrator, or its designees at the time it made 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 made in their 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 or the Company's General Counsel.

Plan Identification Information

Name of Plan	Group Health and Welfare Plan for The Sherwin-Williams Company
Employer/Plan Sponsor/ Plan Administrator	The Sherwin-Williams Company Attention: Senior Vice President – Human Resources 101 Prospect Avenue, NW Cleveland, OH 44115 Phone: 216.566.2000
Name and Address of Plan Agent for Service of Legal Process	The Sherwin-Williams Company Attn: General Counsel 101 Prospect Ave. NW Cleveland, Ohio 44115
Employer Identification Number	34-0526850
Effective Date of Plan Summary	January 1, 2021
Plan Number	656
Type of Plan	The Plan is a welfare benefit plan and a cafeteria plan under Section 125 of the Internal Revenue Code.
Plan Year	January 1 to December 31

YOUR RIGHTS UNDER ERISA

Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents, 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 Plan documents, 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 report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your covered dependents may have to pay for such coverage. Review this Summary and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The fiduciaries of the Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including 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.

Enforce Your Rights

If your claim for an ERISA 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 a copy of Plan documents or the latest annual report 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 administrator. If you have a claim for benefits which is ignored or appeal which is denied or ignored, in whole or in part, you may file suit in 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 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.

INCORPORATED PROGRAMS AND MATERIALS

The following programs and materials (including related Certificates of Coverage, Evidence of Coverages, Group Agreements, Summary Plan Descriptions, and Summaries of Benefits Coverage) are hereby incorporated by reference to form and constitute the following Benefit Programs, as may change or be offered from time to time at the Company's discretion:

1. **MEDICAL PROGRAMS, INCLUDING PRESCRIPTION DRUG PROGRAM**
    - Prime and Advantage Plans with Health Savings Accounts
    - Standard Plan
    - Out-of-Area Medical Programs
    - Passive Programs
    - Prescription Drug Program
    - HMO Plans (available based on location)
2. **VISION PROGRAM**
3. **DENTAL PROGRAMS**
4. **LIFE INSURANCE PROGRAMS**
5. **ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PROGRAMS**
6. **VOLUNTARY INSURANCE PROGRAMS**
7. **LONG TERM DISABILITY INSURANCE PROGRAM**
8. **EMPLOYEE ASSISTANCE PROGRAM**
9. **HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROGRAM**
10. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PROGRAM**
11. **HEALTH SAVINGS ACCOUNT PROGRAM**

*Note: This list of incorporated documents and materials may be modified and communicated to Plan participants without requiring a formal Plan amendment.

MEDICAID/CHIP NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX A: CAFETERIA PLAN

What is the "Cafeteria Plan"?

Sherwin-Williams sponsors a "cafeteria plan" under Section 125 of the Internal Revenue Code that allows eligible employees to choose from a selection of different Benefit Program options and to pay for those benefits will pre-tax dollars. That means that your share of the cost of these Benefit Programs is deducted from your compensation before federal income and social security taxes are applied. Because your share of the benefit cost is deducted first, you do not pay taxes on that portion of your compensation. This results in a tax savings to you that can help offset your share of the costs for the Benefit Programs you selected.

Are you eligible to participate in the Cafeteria Plan?

You are eligible to participate in the cafeteria plan if you are an employee who is eligible to participate in any of the Benefit Programs offered by Sherwin-Williams which require employee contributions, if those contributions are made using pre-tax dollars. For example, this would include your employee contributions for Sherwin-Williams' health coverage.

How and when do you enroll?

You can elect to participate in the cafeteria plan when you make your benefit enrollment elections – either your Initial Enrollment upon hire or eligibility, or at Annual Open Enrollment. Special enrollment periods may also be available based on certain circumstances outlined in the summary plan description. Enrollment must be completed within 30 days of your initial eligibility, a qualified change of status or the occurrence of a special enrollment right. (For more information on special enrollment rights and qualified changes of status, see the "**Enrollment in Health Coverage**" section.) If enrollment is not completed within 30 days of one of these events, you must wait until Annual Open Enrollment. To enroll in the cafeteria plan, you need to log on to www.myswbenefits.com and authorize pre-tax deductions from your compensation for the Benefit Programs you elected.

How and when can you change your elections?

After you make your election under the cafeteria plan for the plan year, you generally cannot change or revoke your election until the next Annual Open Enrollment. However, if you or an eligible dependent have a "qualifying family status change" which impacts your eligibility for benefits under the plan, you may be able to make a change in your election if you do so within 30 days of the status change. See the list of qualifying family status change events contained in the "**Enrollment in Health Coverage**" section for more information.

NOTE: Changes can be made to contribution elections for the health savings account on a prospective basis, even if you do not have a qualifying family status change, in accordance with procedures established by the Company.

Contribution Amounts

The contribution amounts that you may elect on a pre-tax basis will be determined by Sherwin-Williams for each eligible Benefit Program on an annual basis and included with the enrollment

materials for each Benefit Program. Your contributions may represent only a portion of the total cost of providing the Benefit Program. Sherwin-Williams will also make contributions to the cost of your Benefit Programs. In some cases, your pre-tax contributions may be considered as "employer" contributions.

Participation During a Leave of Absence or FMLA

If you are on a paid leave of absence, your contributions under the cafeteria plan will continue. If your leave is unpaid, or due to military service for a period of more than 30 days, you may be able to continue your benefits coverage, per the terms of the specific Benefit Program, but your pre-tax contributions will stop. You will need to make other arrangements to make your employee contributions for coverage during your unpaid leave. You should contact the HR Services or consult individual Benefit Program Information with more detailed questions regarding what happens to your coverage on various types of leave of absence and disability.

If you are on a leave under the FMLA, you may be able to pre-pay your contributions with pre-tax dollars for the period of your expected leave in the current year. Other payments arrangements may also be available as approved by Sherwin-Williams. Upon return from your leave, if you elected to discontinue coverage while you were out, you will be permitted to re-enter the plan on the same basis as you were participating prior to taking leave, or as otherwise required by the FMLA.

Termination of Coverage

Your participation in the cafeteria plan will end when you are no longer eligible to participate in any of the Benefit Programs under the plan or the specific Benefit Program is terminated. Under certain circumstances, you may be able to continue to make contributions for COBRA continuation coverage with pre-tax dollars.

APPENDIX B: PPACA POLICY

SHERWIN-WILLIAMS.

Patient Protection and Affordable Care Act
Eligibility Determination Policy

1. Purpose

The purpose of this Patient Protection and Affordable Care Act Eligibility Determination Policy ("PPACA Policy") is to describe how the company determines Health Benefits eligibility.

2. Regular Full-Time Employees

Employees who are classified by the company as regular full-time will be eligible for Health Benefits as of the first day of their employment with the company. The eligibility of all other Employees will be determined using the measurement procedures outlined in this policy.

3. Determining Eligibility for Ongoing Employees

If an Ongoing Employee is credited with 1560 or more PPACA Hours of Service in a Standard Measurement Period, the Ongoing Employee will be eligible for Health Benefits for the following Standard Stability Period.

4. Determining Eligibility for New Employees

If a New Employee is credited with 1560 or more PPACA Hours of Service in the New Employee's Initial Measurement Period, that Employee will be eligible for Health Benefits in the New Employee's Initial Stability Period.

Each New Employee's Initial Stability Period shall end during a Standard Stability Period. The New Employee's eligibility for this first Standard Stability Period shall be determined by the measurement method for Ongoing Employees described in Section 3 of this PPACA Policy, using the first fully completed Standard Measurement Period of employment. However, for the avoidance of doubt, if a New Employee has 1560 or more PPACA Hours of Service in the Initial Measurement Period and less than 1560 PPACA Hours of Service in the Standard Measurement Period, such New Employee may remain eligible during the balance of the Initial Stability Period (provided he or she remains employed). The Employee will continue to be measured as an Ongoing Employee unless terminated and rehired as described in Section 5 of this PPACA Policy.

5. Rehired Employees

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an PPACA Hour of Service with the company for a period of at least 13 consecutive weeks immediately preceding the date of rehire. Otherwise, the Employee will be treated as an Ongoing Employee.

6. Definitions

"PPACA Hour of Service" means: (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the company; (2) each hour for which an Employee is paid, or entitled to payment, by the company for a period of time during which no duties are performed (for example, any paid vacation, holiday, illness, disability, layoff, jury duty, military leave, or paid leave of absence); and (3) each hour of unpaid leave that is subject to FMLA, USERRA, or on account of jury duty.

"Employee" has the meaning set forth in the Plan.

"Health Benefits" means medical, dental, vision, and flexible spending account benefits, as offered through the Plan.

"Initial Measurement Period" means the 12-month period beginning with the first day of a New Employee's employment and ending on the first anniversary of that date.

"Initial Stability Period" means the 12-month period beginning on the first day of the second calendar month after the end of the Initial Measurement Period.

"New Employee" means an Employee who has been employed for less than one complete Standard Measurement Period.

"Ongoing Employees" are Employees who have been employed for at least one complete Standard Measurement Period (in other words, one full calendar year). If an Employee has not been employed for a full Standard Measurement Period, see Section 4 of this policy, for New Employees.

"Plan" means The Sherwin-Williams Company Group Health and Welfare Benefits Plan.

"Standard Measurement Period" means the pay period beginning approximately November 1 of each year through the pay period ending approximately October 31 of the next year, as dictated by the Company's payroll cycles.

"Standard Stability Period" means the calendar year (January 1-December 31) after each Standard Measurement Period.