OSI Restaurant Partners, LLC
Employee Benefit Plan

This document incorporates by reference the Summary Plan Description (see Appendix C) and one or more specific contracts or documents that describe in more detail certain provisions governing the OSI Restaurant Partners, LLC Employee Benefit Plan, which are listed in Addendum A to the Summary Plan Description.

PREAMBLE AND EXECUTION

WHEREAS, OSI Restaurant Partners, LLC ("the Company") maintains the OSI Restaurant Partners, LLC Employee Benefit Plan; and

WHEREAS, the Company desires to amend and restate the plan;

NOW, THEREFORE by virtue and in exercise of the amending power reserved to the Company as the authorized representative of the Board of Directors and pursuant to the authority delegated to the undersigned agent of the Company by resolutions adopted by its Board of Directors, the OSI Restaurant Partners, LLC Employee Benefit Plan (the "Plan") is hereby amended and restated in its entirety, which amendment and restatement shall be effective January 1, 2022.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 9th **day of** September**, 2022.**

OSI Restaurant Partners, LLC

By: DocuSigned by: Dave Deno 5DBAB852C611441...

Title: Chief Executive Officer

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ARTICLE I
ESTABLISHMENT OF PLAN

1.1 Effective Date

The Effective Date of the OSI Restaurant Partners, LLC Employee Benefit Plan, as restated, is January 1, 2022.

1.2 Purpose

The Plan is created to provide specified health and welfare benefits for the exclusive benefit of Covered Persons, as defined in Section 2.5; this document is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended.

1.3 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, OSI Restaurant Partners, LLC, or any successor, in its sole discretion and in accordance with the provisions of Article X may amend or terminate the Plan or any provision of the Plan including, but not limited to, the existence and duration of coverage for Employees and/or Dependents of Employees, eligibility and requirements for coverage, the availability, nature and extent of benefits, and the conditions for and method of payment of benefits.

1.4 Cafeteria Program

The Plan includes the Cafeteria Program which is intended to qualify under section 125 of the Internal Revenue Code of 1986, as amended. Under the Cafeteria Program, the benefits which an Employee elects to receive under the Plan are excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE II
DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Article II shall have the meaning set forth in an applicable Incorporated Document, and if not defined in an applicable Incorporated Document, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

2.1 Board of Directors

Board of Directors means the persons, and their successors, appointed or elected to manage and direct the affairs of the Company.

2.2 Claim Administrator

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals. The current Claims Administrators are set out in the "Claims and Appeal Process" Section of the Summary Plan Description.

2.3 Code

Code means the Internal Revenue Code of 1986, as amended, and its regulations.

2.4 Company

Company means OSI Restaurant Partners, LLC, a corporation, and any successor, by merger or otherwise.

2.5 Covered Person

Covered Person means an Employee or Dependent who has satisfied the eligibility provisions of Article III or, if applicable, has coverage under the Consolidated Omnibus Budget Reconciliation Act as explained under the "COBRA" Section of the Summary Plan Description.

A Covered Person may have Plan coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.6 Dependent

Dependent means a lawful Spouse or child of an Employee who is a Covered Person as determined under the applicable Incorporated Document. For health care spending account plans, Dependent must also be the Employee's dependent as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) or, the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the Plan Year.

A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.7 Eligible Employee

Eligible Employee means an Employee that meets the eligibility provisions under the "Eligibility" section of the Summary Plan Description

2.8 Employee

Employee means a common law employee of an Employer. The term Employee does not mean any of the following persons:

a. a self-employed individual, as defined in Code section 401(c)(1)(A),

b. a member of the Board of Directors who is not otherwise an Employee,

c. a person the Plan Administrator determines is an Employer's independent contractor, or

d. a person the Plan Administrator determines an Employer engages as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

2.9 Employer

Employer means the Company, a Participating Employer and any subsidiary and any successor which, with the approval of the Plan Administrator, and subject to such conditions as the Plan Administrator may impose, adopts the Plan.

2.10 ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and its regulations.

2.11 HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

2.12 Incorporated Document

Incorporated Document means an insurance policy, plan, certificate of coverage, evidence of coverage, summary plan description or other document incorporated by reference in, together with any exhibits, supplements, addendums or amendments thereto. The Incorporated Documents are listed in Addendum A to the Summary Plan Description.

2.13 Participating Employer

Participating Employer means an Employer as listed in Appendix A.

2.14 Plan

Plan means the OSI Restaurant Partners, LLC Employee Benefit Plan as herein set forth and as amended from time to time.

2.15 Plan Administrator

Plan Administrator means OSI Restaurant Partners, LLC or any other person(s) or entity(ies) delegated by OSI Restaurant Partners, LLC to perform the duties of the Plan Administrator.

2.16 Plan Year

Plan Year means the 12-month period beginning January 1 and ending December 31.

2.17 Spouse

Spouse means, for purposes of this Plan only, a person of the same or opposite sex who, as determined by the Plan Administrator, is legally married to the Covered Employee under applicable state law, without regard to the state in which you reside.

2.18 Summary Plan Description

Summary Plan Description means the summary plan description for the OSI Restaurant Partners, LLC Employee Benefit Plan, which is incorporated into the Plan by reference and attached as Appendix C.

ARTICLE III
ELIGIBILITY, PARTICIPATION, AND COVERAGE

3.1 Eligibility

See the eligibility provisions under the "Eligibility" section of the Summary Plan Description. Specific additional eligibility requirements, if any, for certain benefits, shall be set forth in Article IV or in the applicable Incorporated Documents.

3.2 Participation

The provisions and requirements describing how and when Employees become participants in the Plan and any conditions and limitations to participation in the Plan shall be as set forth in the applicable Incorporated Document.

3.3 Coverage

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances under which coverage terminates shall be as set forth in the applicable Incorporated Document.

ARTICLE IV
BENEFITS

4.1 Medical Benefits

Covered Persons shall have the right to elect the medical (including prescription drug) benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents. Medical benefits are self-insured by the Company other than medical benefits for employees in Hawaii which are fully-insured.

4.2 Dental Benefits

Covered Persons shall have the right to elect the dental benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents. Dental benefits are self-insured by the Company other than dental benefits for employees in Hawaii which are fully-insured.

4.3 Vision Benefits

Covered Persons shall have the right to elect the vision benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents. Vision benefits are self-insured by the Company other than vision benefits for employees in Hawaii which are fully-insured.

4.4 Group-Term Basic Life Insurance Benefits

Covered Persons who are Employees shall have the right to elect the fully-insured group-term basic life insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.5 Supplemental Life Insurance Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured supplemental life insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.6 Dependent Life Insurance Benefits (Spousal Supplemental Life and Child Supplemental Life)

Covered Persons who are Dependents of salaried Employees or Dependents of hourly Employees with salaried benefits shall have the right , through the Employee, to elect, as applicable, the fully-insured Spousal supplemental life insurance benefits or the child supplemental life insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.7 Basic Accidental Death and Dismemberment Benefits

Covered Persons who are Employees shall have the right to elect the fully-insured basic accidental death and dismemberment insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.8 Supplemental Accidental Death and Dismemberment Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured supplemental accidental death and dismemberment insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.9 Spousal Accidental Death and Dismemberment Benefits

Covered Persons who are Spouses of salaried Employees or Spouses of hourly Employees with salaried benefits shall have the right, through the employee, to elect the fully-insured accidental death and dismemberment insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.10 Core Short Term Disability Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured core short term disability insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, minimums, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.11 Buy-Up Short Term Disability Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured buy-up short term disability insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, minimums, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.12 Core Long Term Disability Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured core long term disability insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, minimums, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.13 Buy-Up Long Term Disability Benefits

Covered Persons who are salaried Employees or hourly Employees with salaried benefits shall have the right to elect the fully-insured buy-up long term disability insurance benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents.

A description of such benefits, including the amount payable, minimums, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.14 Health Care Spending Account Plan Benefits

Covered Persons who are salaried Employees or Dependents of salaried Employees or hourly Employees with salaried benefits or Dependents of hourly Employees with salaried benefits shall have the right to elect the health care spending account plan benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

4.15 Employee Assistance Plan Benefits

Covered Persons who are Employees and their household members shall have the right to participate in the employee assistance plan benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.16 Business Travel Accident Benefits

Covered Persons who are Employees in an eligible position as defined in the Business Travel Accident policy shall have the right to the fully-insured business travel accident insurance described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and the result when a beneficiary is not named, shall be as set forth in the applicable Incorporated Documents.

4.17 Health Reimbursement Arrangement Plan Benefits

Covered Persons who are Employees shall have the right to the health reimbursement arrangement plan benefits described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Documents.

4.18 Wellness Benefits

Covered Persons who are Employees that participate in the Medical benefits described in Section 4.1 or the Spouses of such Employees shall have the right to the wellness benefits

described in the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, shall be as set forth in the applicable Incorporated Documents.

ARTICLE V
COORDINATION OF BENEFITS

5.1 Applicability

Except as provided in Section 5.10, the following Coordination of Benefits ("COB") provisions apply to this Plan, as outlined in this Article V, when a Covered Person has health care coverage (such as medical, dental or vision) under more than one Health Care Arrangement.

5.2 COB Definitions

a. "Health Care Arrangement" means any of the following coverages which provides benefits or services to the Covered Person for, or because of, medical, surgical or hospital care treatment:

1. group, blanket or franchise coverage, whether insured or uninsured;

2. any prepayment coverage on a group basis, including health maintenance organizations;

3. coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;

4. coverage under government programs and any other coverage required or provided by law other than Medicare or a State plan under Medicaid;

5. group or individual automobile no-fault coverage; or

6. other arrangements of insured or self-insured group coverage.

The term Health Care Arrangement shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Health Care Arrangements into consideration in determining its benefits and that portion which does not.

b. "Allowable Expense" means a usual and customary item of expense for health care, when the item of expense is covered at least in part by one or more Health Care Arrangements covering the individual for whom the claim is made.

When a Health Care Arrangement provides benefits in the form of services instead of cash payments, the reasonable cash value of each rendered service will be considered both an Allowable Expense and a benefit paid.

c. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Plan.

5.3 Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

a. COB/Non-COB Provision

The benefits of a Health Care Arrangement which does not contain a COB provision always shall be determined before the benefits of a Health Care Arrangement which does contain a COB provision.

b. No Fault Auto Insurance

The benefits of the Health Care Arrangement which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.

c. Non-Dependent/Dependent

The benefits of the Health Care Arrangement which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the Health Care Arrangement which covers the person as a dependent.

d. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph (e) below, when this Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called "parents":

1. the benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year; but

2. if both parents have the same birthday, the benefits of the Health Care Arrangement which covered the parent longer are determined before those of the Health Care Arrangement which covered the other parent for a shorter period of time.

However, if the other Health Care Arrangement does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

e. Dependent Child/Separated or Divorced Parents

If two or more Health Care Arrangements cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Health Care Arrangement of the parent with custody of the child;

2. then, the Health Care Arrangement of the spouse of the parent with custody of the child; and

3. finally, the Health Care Arrangement of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangements of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

This Plan will not cover the expenses of any child who does not meet the definition of Dependent as defined in Section 2.6, except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

f. Active/Inactive Employee

The benefits of a Health Care Arrangement which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Care Arrangement which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Health Care Arrangement does not have this rule, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, this rule is ignored.

g. Continuation Coverage

If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or State law, and also under another group plan, the following shall be the order of benefit determination:

1. first, the benefits of a plan covering the person as an employee (or as that employee's dependent); and

2. second, the benefits of coverage under the continuation plan.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

h. Longer-Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement which covered an employee, member or subscriber longer are determined before those of the Health Care Arrangement which covered that person for the shorter time.

i. Medicare Coordination

1. Employees and/or Spouses Age 65 or Older

   Unless an active Employee age 65 or older gives the Plan written notice waiving his or her right to Plan benefits, the Plan is primary. With respect to the Spouse who is age 65 or older of an active Employee, unless the Employee gives the Plan written notice waiving Plan benefits, the Plan is primary.

2. Medicare Disabled Covered Persons

   If required by law, the Plan is primary with respect to a Covered Person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

3. Covered Persons with End-Stage Renal Disease

   For the period required by law, if any, the Plan is primary with respect to a Covered Person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

5.4 Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person or a beneficiary of the Covered Person as required by any State Medicaid program, as provided in section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law

that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

5.5 Effect on the Benefits of this Plan

a. When this Section Applies

This Section 5.5 applies when, in accordance with Section 5.3, "Order of Benefit Determination Rules," this Plan is a secondary payor of benefits to one or more other Health Care Arrangements. In that event, the benefits of this Plan may be reduced under this Section. Such other Health Care Arrangement or Arrangements are referred to as "the other Arrangements" in (b) immediately below.

b. Reduction in this Plan's Benefits

The benefits that would be payable under this Plan in the absence of the COB provisions specified in this Article V will be reduced by the benefits payable under the other Arrangements for the expenses covered in whole or in part under this Plan. This applies whether or not a claim is made under a Health Care Arrangement.

When a Health Care Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

5.6 Limitation of Benefits

In applying this Article V's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary.

5.7 Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this Article V. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of this Plan or any other Health Care Arrangement. The Company need not tell, or get the consent of, any person prior to obtaining that information. Each person claiming benefits under this Plan must give the Company any information it needs to process the claim.

5.8 Facility of Payment

A payment made under another Health Care Arrangement may include an amount which should have been paid under this Plan. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which

case "payment made" means reasonable cash value of the benefits provided in the form of services.

5.9 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under the COB provisions specified in this Article V, it may recover the excess from one or more of:

a. the persons it has paid or for whom it has paid;

b. insurance companies; or

c. other Health Care Arrangements, including Workers' Compensation.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.10 Governing Provisions

When the provisions describing coordination of benefits are set forth in an applicable Incorporated Document, such Incorporated Document shall govern except to the extent the provisions fail to establish order of responsibility, in which case the provisions of this Article V shall govern.

ARTICLE VI
FUNDING AND PLAN ASSETS

6.1 Funding

a. Funding Policy

The Company shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

b. Funding Mechanism

Contributions from the Employer and/or Eligible Employees may be held under or paid to insurance policies or other arrangements established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer. Further, neither the Company nor the Employer is obligated to separately fund the Plan or establish a trust for such purpose.

c. Benefits shall be deemed to be paid first from amounts contributed by Eligible Employees and then from amounts contributed by the Employer.

6.2 Plan Assets

Subject, in all cases, to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s) provided for herein, to the extent not:

a. provided for by Employee contributions; or

b. payable from an insurance policy held under the Plan.

Where an insurance policy provides for payment of premiums directly from the Company, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, rebates or experience refunds are not Plan assets. These dividends, retroactive rate adjustments, rebates or experience refunds are Company property, which the Company may retain to the extent they do not exceed the Company's aggregate contributions to Plan cost made from its own funds, except as required by law.

ARTICLE VII
ADMINISTRATION

7.1 Plan Administrator

The Company shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

7.2 Plan Administrator's Duties

Except as to those functions reserved within the Plan to the Board of Directors, the Company, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall cause to be maintained such records as may be reasonably necessary or desirable for the proper management and administration of the Plan. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of the document governing the Plan; the latest annual report, summary annual report, and summary plan description; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

7.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Board of Directors, the Company or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

a. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

b. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

c. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

d. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

e. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

f. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

g. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

h. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

i. pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

7.4 Finality of Decisions

The Plan Administrator or its delegate(s) shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator or its delegate(s) with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties, except where expressly prohibited by applicable laws or regulations.

7.5 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Company or unless required by federal or State law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

7.6 Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

7.7 Reserved Powers

The Company reserves the powers, among others:

a. to adopt the Plan;

b. to amend and terminate the Plan according to Article X; and

c. to appoint and remove any Claim Administrator or Plan Administrator.

ARTICLE VIII
PAYMENT PROCEDURES

8.1 Payment of Claim

Subject to Section 9.4, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Plan Administrator deems appropriate.

8.2 Facility of Payment

If a claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Plan Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

8.3 Forfeiture

The Plan Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

ARTICLE IX
MISCELLANEOUS

9.1 No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company, or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

9.2 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

9.3 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

9.4 No Assignment of Benefits

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

9.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

9.6 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

9.7 Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis. An Employee may be asked to provide proof of eligibility for his or her Dependents. False or misrepresented eligibility information could cause both the Employee's and his or her Dependents' coverage to terminate irrevocably (retroactively to the extent permitted by law), and could be grounds for Employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

The Plan Administrator will not rescind a Covered Person's coverage under the Plan's benefits subject to the PPACA except in the case of fraud or intentional misrepresentation of a material fact as described above. In the event of fraud or intentional misrepresentation or a material fact, the Plan will provide at least 30 days' advance notice to a Covered Person before coverage is rescinded.

9.8 Legal Action

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth under the "Claims and Appeal Process" section of the Summary Plan Description, nor shall an action be brought at all unless within 36 months after the date a claim is incurred under the Plan.

9.9 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Florida.

9.10 Governing Instrument

This document, together with the Incorporate Documents, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence including the Incorporated Documents, the terms of the Incorporated Documents shall govern.

For purposes of clarification, in the event of a conflict between the terms of this Plan and the terms of an insurance contract of an independent third party insurer whose product is then being used in conjunction with this Plan, the terms of the insurance contract shall control as to those Participants receiving coverage under such insurance contract. For this purpose, the insurance contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.11 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

9.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

9.13 Notices

No notice or communication in connection with the Plan made by a claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

9.14 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing wavier unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

9.15 Parties' Reliance

The Board of Directors, the Company, the Employer, the Claim Administrator, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated

may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Board of Directors, the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

9.16 Disclaimer

The Company makes no assertion or warranty about:

a. health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or

b. whether Plan benefits will be excludable from a Covered Person's gross income for federal or State income tax purposes. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

9.17 Expenses

All expenses of the Plan shall be paid from Employer general assets. The Employer may advance expenses on behalf of the Plan, subject to reimbursement, without obligating itself to pay such expenses.

9.18 Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless the Board of Directors and any employee, officer, or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

9.19 Rescission

Notwithstanding any provision of the Plan to the contrary, the Plan may rescind your medical coverage (or your Dependent's medical coverage if they are on your same coverage) if you engage in fraud with respect to the Plan, or you make an intentional misrepresentation of material fact. Except as otherwise prohibited by law or as set forth below for medical coverage, the Plan may rescind coverage for other reasons in accordance with the terms of the applicable coverage.

The Plan will not rescind your medical coverage unless you (or a person seeking coverage on behalf of you) performs an act, practice, or omission that constitutes fraud

with respect to the Plan, or unless you make an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty (30) days advance written notice to you or your Dependent who would be affected before coverage will be rescinded under this Section 9.18. This paragraph is included in the Plan to comply with the requirements of the Affordable Care Act and applicable regulations, including Treasury Regulations Section 54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

A rescission is a cancellation or discontinuance of medical coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively only to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage.

ARTICLE X
AMENDMENT, TERMINATION OR MERGER OF PLAN

10.1 Right to Amend the Plan

Except as provided in Section 10.3, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Board of Directors or its authorized representative(s) in accordance with its normal procedures, except that the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulations, or to comply with the Company's intent.

10.2 Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company reserves the unlimited right to terminate or merge the Plan. Any decision to terminate or merge the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures.

10.3 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

10.4 Change in Funding Mechanism

The Company reserves the unlimited right to change, modify, cancel or otherwise terminate any of the funding arrangements under the Plan, including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously insured benefits on a partially insured or fully uninsured basis.

ARTICLE XI
HIPAA PRIVACY AND SECURITY

11.1 Introduction

The Plan recognizes that it is, in part, a single group health plan it is subject to the Health Insurance Portability and Accountability Act of 1996. However, the Plan includes programs that do not meet the definition of a group health plan. As a result, the Plan has been designated by the Plan Administrator as a Hybrid Entity. This means that for purposes of this Article XI, the term "Plan" refers only to the Medical, Dental, Vision, Wellness, Health Care Spending Account, Employee Assistance Plan and Health Reimbursement Arrangement benefits. The Hybrid Entity designation may be changed or modified at any time, including without limitation, by adding or deleting programs of the Plan that are part of the Hybrid Entity.

11.2 Definitions

For purposes of this Article XI, the following terms have the following meanings:

a. "HIPAA Privacy Provisions" or "HIPAA" means the federal law commonly known as the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160 through 164, as amended.

b. "Plan Administration Functions" means the activities listed under the definitions of Payment or Health Care Operations as defined by HIPAA § 164.501, but does not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan Administration Functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans. Plan Administration Functions do not include any employment-related functions or functions in connection with any other benefits or benefit plans, and the Plan may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by the Employer are not considered Plan Administration Functions.

c. "Protected Health Information or PHI" means information that is created or received by a health plan, employer, health care provider, or health care clearinghouse and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, either the information must identify the individual, or there must be a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.

d. "Summary Health Information" means information that may be individually identifiable health information, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer or a Participating Employer has provided health benefits under the Plan; and from

which the following information has been deleted, except that the geographic information described in subsection 2 below need only be aggregated to the level of a five digit zip code:

1. Names;

2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

    b. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people are changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

4. Telephone numbers;

5. Fax numbers;

6. Electronic mail addresses;

7. Social security numbers;

8. Medical record numbers;

9. Health plan beneficiary numbers;

10. Account numbers;

11. Certificate/license numbers;

12. Vehicle identifiers and serial numbers, including license plate numbers;

13. Device identifiers and serial numbers;

14. Web Universal Resource Locators (URLs);

15. Internet Protocol (IP) address numbers;

16. Biometric identifiers, including finger and voice prints;

17. Full face photographic images and any comparable images; and

18. Any other unique identifying number, characteristic or code.

11.3 Disclosure of Summary Health Information to the Employer

In accordance with the HIPAA Privacy Provisions, the Plan may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

a. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

b. Modifying, amending or terminating the Plan.

11.4 Disclosure of Certain Enrollment Information to the Employer

Pursuant to HIPAA §164.504(f)(1)(iii) the Plan may disclose to the Employer information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan to the individual.

11.5 Disclosure Pursuant to Participant's Authorization

The Plan may disclose an Individual's PHI to the Employer pursuant to the Individual's authorization.

11.6 Other Disclosures of PHI to the Employer for Plan Administration Functions

In order that the Employer may receive and use PHI for Plan Administration Functions, the Employer certifies that it will:

a. not use or further disclose such PHI other than as permitted or required by the Plan or HIPAA or as required by law;

b. ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Employer with respect to such information and agree to implement reasonable and appropriate security measures to protect electronic PHI;

c. not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer, except pursuant to an authorization which meets the requirements of HIPAA;

d. report to the Plan any security incident, or any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware, including, reporting any breach of "unsecured" PHI as required under Health Information Technology for Economic and Clinical Health Act;

e. make available PHI to the appropriate individual where approved by the Plan and requested by a Participant for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

f. make available PHI to the appropriate individual where approved by the Plan and requested by a Participant for purposes of required accounting of disclosures by the Employer pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR 164.528;

g. make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

h. if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

i. ensure that there is adequate separation between the Plan and the Employer by implementing the terms of subparagraphs i through iv below:

1. Employees with Access to PHI: The employees, classes of former employees or other individuals under the control of the Employer listed on Appendix B are the only individuals that may access PHI received from the Plan.

2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in i, above, is limited to plan administration functions as defined in HIPAA regulation 45 CFR § 164.504(a) that are performed by the Employer for the Plan.

3. Mechanism for Resolving Noncompliance: If the Employer or the persons listed on Appendix B determine that any person described in i above, has violated any of the restrictions of this Article XI, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy and security compliance, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

4. Adequate Security Measures: The adequate separation will be supported by reasonable and appropriate security measures;

j. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan as required by HIPAA §164.302 et.al.

11.7 Certification of Amendment.

The Plan shall disclose PHI to the Employer only upon receipt of a certification by the Employer that:

a. the Plan's documents have been amended to incorporate the above provisions; and

b. the Employer agrees to comply with such provisions.

APPENDIX A

PARTICIPATING EMPLOYERS

In addition to OSI Restaurant Partners, LLC, the following entities are Participating Employers in this Plan:

Outback Steakhouse of Florida
Outback Steakhouse Management
Outback Steakhouse Restaurant Services

The list of Participating Employers shall be subject to modification without formal amendment of the Plan.

APPENDIX B

EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

HR Operations department staff

HR Technology department staff

IT department staff

Benefits department staff

Director of Benefits and Wellness

HR Directors

Legal department staff

Vice President, Human Resources

Vice President, Total Rewards

APPENDIX C

SUMMARY PLAN DESCRIPTION AND OTHER INCORPORATED DOCUMENTS