OSI Restaurant Partners, LLC
Employee Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2022

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INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Addendum A (collectively, Incorporated Documents), is intended to serve as the Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by the OSI Restaurant Partners, LLC Employee Benefit Plan (the Plan) for eligible employees and their eligible dependents.

One of the Incorporated Documents is the OSI Restaurant Partners Cafeteria Program which is intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide eligible employees Health Care and Dependent Care Flexible Spending Accounts and the opportunity to make pre-tax contributions toward certain benefits.

OSI Restaurant Partners, LLC also offers employees enrolled in one of the medical high deductible health plan options, the opportunity to make pre-tax contributions to a Health Savings Account (HSA). It is the employee's responsibility to enroll in and open their HSA through the Company's preferred third party vendor in order for the Company to deposit the employee's pre-tax contributions and any applicable employer contributions into their HSA. Special COVID-19 provisions and coverages are explained in Addendum B.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as Health Care Reform), as each may be amended from time to time. Any relevant notices related to these Acts are provided to you in the time and manner required by law and are also available at https://www.bloominbrandsbenefits.com/keyword/legal-plan-documents/ .

Medical, Prescription Drug, Dental and Vision benefits offered to eligible employees in Hawaii are provided under insurance contracts. This means the benefits are insured by a third party. All other benefits (including Medical, Prescription Drug, Dental and Vision benefits offered to eligible employees who are not in Hawaii and Wellness, Health Reimbursement Arrangement, Medical Savings Account and Flexible Spending Accounts coverage is self-insured, or funded, by the Company and administered by a third party. All benefits are summarized in this document and in the Incorporated Documents (as defined above).

This summary should be read in connection with the Incorporated Documents (see Addendum A for a list of Incorporated Documents). The Incorporated Documents are prepared and provided by the insurance companies and third party service providers. If there is ever a conflict or a difference between what is written in this SPD and the Incorporated Documents with respect to **the specific benefits provided**, the Incorporated Documents shall govern unless otherwise provided by any federal and

state law. If there is a conflict between the Incorporated Documents and this SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, this SPD will control.

The applicable Incorporated Documents for the medical, dental and vision benefits describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverage will be provided for out-of-network services. A directory of participating network providers will be provided upon request at no cost to you. You may also access provider directories on the applicable vendor's website or you can call the applicable program's third party administrator at the phone number indicated in the Incorporated Documents. Any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan are outlined in the Incorporated Documents.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on page 48.

OSI Restaurant Partners, LLC reserves the right to change, amend, suspend, or terminate any or all of the benefits under the Plan, in whole or in part, at any time and for any reason at its sole discretion. If a benefit is paid in error, that error does not amend the Plan nor obligate the Plan to continue to pay the same service(s) in the future.

Note that by adopting and maintaining these benefits, OSI Restaurant Partners, LLC has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by OSI Restaurant Partners, LLC or to interfere with OSI Restaurant Partners, LLC's right to discharge any employee at any time.

ELIGIBILITY

ELIGIBLE EMPLOYEES

Generally, you are considered an "eligible employee" and are eligible to participate in the Plan as follows:

- If you are a salaried employee or hourly employee with salaried benefits (i.e., Sous Chef, Manager in Training), hereinafter referred to collectively as "salaried," you are eligible effective the first day of the month coincident with or immediately following your date of hire.
  - If you move from being a salaried employee or hourly employee of the Company with salaried benefits to a Variable Hourly Employee (see below), you will continue to be eligible for benefits for the remainder of the Plan Year in which the move occurred. You will then be measured in the following Plan Year for eligibility, as explained below.

- An hourly employee whose primary job is not one that, regardless of location, is regularly scheduled to work at least 30 hours per week is considered a "Variable Hour Employee".
  - A Variable Hour Employees not working at a Hawaii location first becomes eligible if they have one year of continuous service and earn 1,560 hours of service (hours for which you worked or are entitled for payment such as paid time off) (an average of 30 Hours of Service per week) within their initial measurement period.
  - An hourly employee's initial measurement period begins on the first day of the pay period following the pay period in which the employee first has hours and ends twelve months later, provided the employee has not had a Break in Service (i.e., separated from employment at least 14 weeks). Eligibility will be checked on the anniversary of the Employee's second paycheck in which they accrued an hour of service.
  - For continued eligibility in future stability periods, a Variable Hour Employee not working at a Hawaii location must earn 1,560 hours of service (average of 30 hours per week) during a measurement period of 52 weeks generally beginning the first day of the payroll period that includes October 1 and ending on the last day of the payroll period preceding the payroll period that includes September 30.
  - If you were determined to be eligible under initial eligibility but not annual eligibility, you will be able to continue on your benefits for 12 months from your initial eligibility effective date ("stability period").
  - Notwithstanding the forgoing, a Variable Hour Employee who was considered full time for benefit purposes for the 2020 and 2021 Plan years and who had no break in service since 2020 will not lose eligibility for the 2022 Plan Year for those benefits if hours worked during 2020 and 2021 by the Variable Hour Employee averaged less than 30 hours per week. This waiver of the 30 hour rule for eligibility is based on the current COVID-19 situation, and will therefore be in effect for the 2021 and 2022 Plan Years only.
  - If you are promoted from a Variable Hour Employee to a salaried employee or hourly employee with salaried benefits, you are eligible the first day of the month coincident with or immediately following the effective date of your promotion.
  - A Variable Hour Employee working at a Hawaii location shall be eligible on the first of the month if he or she works 80 hours in the prior month. If the Employee becomes eligible and then fails to meet the 80-hour requirement in a subsequent month, coverage will be terminated.

  Provided they meet the preceding eligibility requirements, Variable Hour Employees are eligible for Medical, Dental, Vision, Basic Life, Basic AD&D, Health Reimbursement Arrangement (or, if applicable, Health Savings Account), Wellness and EAP benefits under the Plan. Variable Hour

Employees are not eligible for Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, Supplemental AD&D, Short-Term Disability, Long-Term Disability, Health Care Flexible Spending Account or Dependent Care Flexible Spending Account benefits under the Plan. Only employees in qualifying jobs are eligible for Business Travel Accident benefits. See the Business Travel Accident policy for the list of covered qualifying jobs.

For purposes of determining eligibility, Hours of Service means all hours for which you are paid for the performance of duties and for periods when no duties are performed such as vacation, holiday, and sick. In addition, you will be credited with 30 hours for each full or partial week you are absent due to a period of unpaid leave under the Family and Medical Leave Act and State family or medical leave, unpaid jury duty and unpaid military leave under the Uniformed Services Employment and Reemployment Rights Act.

For additional eligibility information, visit **MyBBI.com > BBI Benefits > Enroll > Eligibility**.

INDIVIDUALS NOT ELIGIBLE

You are not eligible to participate in the Plan if you are:

- regularly scheduled to work less than the minimum number of hours per week as listed above;
- a Variable Hour seasonal or temporary employee who the Plan Administrator determines was not a full-time employee working 30 hours per week during the most recent standard measurement period;
- a leased employee;
- non-resident aliens;
- an independent contractor; or
- a member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

A person the Plan Administrator determines is not an employee (as defined in the Plan) will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

ELIGIBLE DEPENDENTS

Medical, Dental and Vision

The following dependents are eligible for Medical, Dental and Vision coverage offered under the Plan:

- Your legal Spouse;
- Your children until the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and regardless of whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26.

Your eligible dependents can be enrolled in the Medical, Dental and Vision coverage under the Plan only if you (the employee) are enrolled. If you are married to another Company eligible employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one eligible employee’s coverage only under the Plan.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (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. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

With the exception of continuation coverage under COBRA, former spouses are not eligible for benefits under this Plan even if you have a divorce decree stipulating you must provide health coverage.

Your dependent children are:
- Your natural children,
- Stepchildren,
- Legally adopted children,
- Children who are placed in your home for adoption, and
- Children for whom you are appointed as legal guardian and who are chiefly dependent on you for support and maintenance.

Please see the applicable Incorporated Documents and benefits website (**MyBBI.com > BBI Benefits > Enroll > Eligibility**) for additional special rules that apply to eligibility requirements.

Dependent Life (Spousal Supplemental Life and Child Supplemental Life)

The following dependents are eligible for Dependent Life offered under the Plan:

- Your legal Spouse, provided you have enrolled for Supplemental Life;
- Your or your spouse's unmarried natural child or stepchild, or legally adopted child under age 26 if primarily dependent on you for support, provided you have enrolled for Supplemental Life.

Please see the applicable Incorporated Documents and benefits website (**MyBBI.com > BBI Benefits > Enroll > Eligibility**) for additional eligibility requirements.

Spousal Supplemental Accidental Death & Dismemberment (AD&D)

The following dependents are eligible for Spousal Supplemental AD&D offered under the Plan:

- Your legal Spouse, provided you have enrolled for Supplemental AD&D.

Please see the applicable Incorporated Documents and benefits website (**MyBBI.com > BBI Benefits > Enroll > Eligibility**) for additional eligibility requirements.

Health Care Flexible Spending Account

For purposes of the Health Care FSA, your dependents include:

- Your legal Spouse,
- Your children until the end of the month in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as

a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes.)

Dependent Care Flexible Spending Account

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code),
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

Employee Assistance Program (EAP)

The following are eligible for the Employee Assistance Program (EAP) offered under the Plan:

- Your household members, whether or not they are related to you.

Please see the applicable Incorporated Documents and benefits website (**MyBBI.com > BBI Benefits > Wellness > EAP**) for additional eligibility requirements.

Dependents Not Eligible

The following individuals are not eligible for Medical, Dental, Vision, Dependent Life Insurance, or Spousal Supplemental Accidental Death & Dismemberment Insurance coverage, regardless of whether they are your tax dependents:

- Your parent or spouse's parent;
- Your grandparent or spouse's grandparent;
- Foster children.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Incorporated Document provided by the applicable insurance companies and/or service providers and attached in Addendum A.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child, or even if you have not previously enrolled in medical coverage. You may obtain a copy of OSI Restaurant Partners, LLC's procedures governing QMCSO determinations, free of charge, by contacting the Benefits Department at OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't

reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

If the Plan receives a QMCSO for an eligible dependent(s), both you and the referenced child(ren) will be enrolled in coverage. The Plan does not allow for a dependent to be enrolled in the Plan without also enrolling the employee. Any coverage provided under a QMCSO is conditioned upon your payment of applicable contributions.

Notification

If you experience a change in status (see page 10), you must notify the Resource Center at OSI Restaurant Partners, LLC within 31 days (60 days for newborns) in order to make a change in your election during the year. The notice must be made either online through BBI Connect (MyBBI.com > Digital Resources > BBI Connect > Menu > Myself > Life Events) or by calling the Resource Center at 800-555-5808, Option 3.

In addition, if you dependent is losing coverage, in order to preserve your dependent's COBRA rights, you must process a life event with the Resource Center either online through BBI Connect (MyBBI.com > Digital Resources > BBI Connect > Menu > Myself > Life Events) or by calling the Resource Center at 800-555-5808, Option 3 within 31 days of the date you dependent is losing coverage. Specifically, in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage, you must provide documented proof of the event to the Resource Center via email at bbiconnect@bloominbrands.com within 31 days of the date the dependent would lose coverage on account of the qualifying event (see section Eligible Dependents above for a description of these eligibility requirements). For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

ENROLLMENT

NEW EMPLOYEES

When you begin working at OSI Restaurant Partners, LLC, you will receive the information necessary to enroll in the Plan. You are eligible for and will automatically be enrolled in the following:

- Core Life
- Core AD&D
- Employee Assistance Program
- Business Travel Accident, if working in a qualifying job. See the Business Travel Accident policy for the list of covered qualifying jobs.
- Core Short-Term Disability (salaried only)
- Core Long-Term Disability (salaried only)

If you want to enroll in coverage, you must affirmatively enroll yourself and your eligible dependents within 45 days of your eligibility date for:

- Medical (includes prescription drug)
- Dental
- Vision
- Supplemental Life (salaried/ hourly with salaried benefits only)
- Spouse Supplemental Life (salaried/ hourly with salaried benefits only)
- Child Supplemental Life (salaried/ hourly with salaried benefits only)
- Supplemental AD&D (salaried/ hourly with salaried benefits only)
- Spouse Supplemental AD&D (salaried/ hourly with salaried benefits only)
- Buy-Up Short-Term Disability (salaried/ hourly with salaried benefits only)

- Buy-Up Long-Term Disability (salaried/ hourly with salaried benefits only)
- Health Care Flexible Spending Account (salaried/ hourly with salaried benefits only)
- Dependent Care Flexible Spending Account (salaried/ hourly with salaried benefits only)

If you elect medical coverage, the Company will make a contribution to a Health Reimbursement Arrangement or Health Savings Account for you. This contribution may be contingent upon your completion of certain steps within certain time limits, as set out in the Incorporated Documents in Addendum A. In addition, if you elect medical coverage under a high deductible health plan and are otherwise eligible, OSI Restaurant Partners, LLC allows you to make pre-tax contributions to a Health Savings Account.

If you and your eligible dependents do not enroll in Medical, Dental, Vision, Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverage within 45 days of your eligibility date, you will have to wait until the next Open Enrollment period to enroll, unless you experience a qualified change in status, which is defined and explained more below in this document, under "Qualified Changes in Status."

Please refer to the applicable Incorporated Documents in Addendum A for additional details on eligibility including any requirements for you to be actively at work prior to coverage becoming effective. Although enrollment may be automatic, coverage may not be automatic.

If you do not enroll for Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, Supplemental AD&D, Spouse Supplemental AD&D, Buy-Up Short Term Disability (STD), or Buy-Up Long Term Disability (LTD) coverage when you are first eligible, you will have to wait until the next open enrollment period. If you marry or acquire a child and were already enrolled in Employee Supplemental Life or Employee Supplemental AD&D, you may request enrollment in Spouse or Child Supplemental Life and Spouse AD&D, as applicable, mid-year. You will have to provide evidence of insurability for amounts over the guaranteed issue amount at that time and coverage is not in effect until approved by the insurance company.

Your coverage under the Plan will begin as of your eligibility date, except that Supplemental Life, Buy-Up STD and Buy-Up LTD are not effective until you enroll, have completed any applicable waiting period, have completed and submitted evidence of insurability information to the insurance company and received their approval and you are actively at work. Amounts elected under Supplemental Life that are over the guaranteed issue amount will not go into effect until you have provided evidence of insurability and have been approved by the insurance company. Your eligible dependents' coverage under the Plan will begin on the same date as your coverage if you make the necessary elections and provide evidence of insurability information for them and received insurance company approval as well within the time period required.

If you enroll yourself or a dependent in the Medical, Dental, and/or Vision benefits, or if you elect Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account benefits mid-year due to a qualified change in status, coverage will be effective as of the first of the month following the date we receive your timely request for enrollment due to a change in status. However, if you have made a change to your medical coverage due to the birth of a child, your election change will be effective as of the date of the birth.

Current Employees

Open enrollment is held every fall, generally in November. This is your opportunity to enroll, change, or drop coverage. Changes are effective on the January 1 following open enrollment. You'll receive information, including instructions on how to enroll, before open enrollment each year.

HIPAA Special Enrollment Events

If you decline enrollment for Medical, Dental or Vision benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical, Dental and Vision benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days of the date that your or your eligible dependents' other coverage ends (or 31 days after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 31 days after the marriage, adoption, or placement for adoption and 60 days after birth.

If you request a change due to a special enrollment event within the 31 day timeframe (60 days for birth), coverage will be effective the date of birth. For all other events, coverage will be effective the first of the month following your timely request for enrollment. In order for a request to be timely, you must provide proof of the dependent relationship to the verification vendor within the relevant time period.

The Plan also provides a HIPAA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change in time, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact the Resource Center at bbiconnect@bloominbrands.com or at 1-800-555-5808 (Option 3).

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

You pay your share of the cost of Medical, Dental, Vision, and Buy-Up STD coverage on a pre-tax basis through the Cafeteria Program. The level of contribution, either as a fixed dollar or percentage basis, is determined by the Company. The amount of such contribution shall be as set forth in any election or enrollment materials, whether paper or electronic as part of a web-based enrollment process, issued or posted in conjunction with the Plan or the Cafeteria Program, as such materials may be changed from time to time.

Contributions to the Health Care and Dependent Care Flexible Spending Accounts are also on a pre-tax basis through the Cafeteria Program. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. As an alternative to the Health Care Flexible Spending Account, if you are enrolled in the high deductible health plan option, you may make pre-tax contributions to a Health Savings Account through the Cafeteria Program.

If you are enrolled in Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, Supplemental AD&D, Spouse Supplemental AD&D, or Buy-Up LTD coverage, you pay the cost for

coverage on an after-tax basis. Contributions are deducted from your paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution monthly in arrears. Refer to the Section later in the SPD on FMLA and USERRA leave rules. An invoice will be sent to your address listed in BBI Connect for these contributions. If you do not make your required contribution, coverage will be cancelled.

EMPLOYER CONTRIBUTIONS

The Company will pay towards the cost of coverage through general assets. For medical and prescription drug, the amount the Company contributes towards the cost of coverage is determined each year as a percentage of overall estimated costs. It is intended that Employees will fund all or substantially all of the cost for dental, vision, supplemental life and AD&D, buy up long and short term disability, contributions to a Health Savings Account, and flexible spending account coverage. The Company funds the full cost of basic life and AD&D, core long and short term disability coverage and any HRA contributions. The Company reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit options and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at open enrollment generally remain in effect for the following Plan Year (January 1 through December 31).

QUALIFIED CHANGES IN STATUS

Supplemental Life, Dependent Life, Supplemental AD&D, Spousal Supplemental AD&D, Buy-Up STD and LTD Mid-Year Changes

Generally, if you do not enroll for Supplemental Life, Dependent Life, Supplemental AD&D, Spousal AD&D, Buy-Up Short Term Disability or Buy-Up Long Term Disability coverage when you are first eligible, you will have to wait until the next open enrollment period to do so. However, you may request to increase your election or request enrollment in Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, Supplemental AD&D or Spousal AD&D mid-year if you marry or acquire a child if you were already enrolled in Employee Supplemental Life or Employee Supplemental AD&D. You will have to provide evidence of insurability (proof of good health) at that time to the insurance company and coverage will not be effective until approved by the insurance company. You may also drop coverage mid-year if you terminate employment or you or your dependents become ineligible for benefits under the Plan.

Medical, Dental, Vision and Flexible Spending Account Mid-Year Changes

You may be able to change your Medical, Dental, Vision and Health Care Flexible Spending Account or Dependent Care Flexible Spending Account elections during the Plan Year if you experience a qualified change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify the Plan Administrator within 31 days of the event, or 60 days to add a newborn and for certain events as described above under HIPAA Special Enrollments in this SPD. If you do not notify OSI Restaurant Partners, LLC within the 31-day period (60 days for a newborn), you will not be able to make any changes to your coverage until the next open enrollment period. To make a change, you can submit your elections online at **MyBBI.com > BBI Connect > Myself > Life Events** or call the Resource Center at 1-800-555-5808 (Option 3). If a dependent becomes ineligible to participate in the Plan (such as due to a divorce) and you do not or your dependent does not submit notice of the qualifying event within 31 days of when they should have lost coverage, the dependent will not be offered COBRA coverage and will be immediately terminated from coverage.

Please note that in order to change your benefit elections due to a change in status, you will be required to submit proof verifying that these events have occurred and the date of the event (e.g., copy of marriage or birth certificate, or divorce decree, loss of coverage notice, etc.) These rules apply to elections you make for your Medical, Dental and Vision coverage and Health Care Flexible Spending Account and Dependent Care Flexible Spending Account. The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, and placement for adoption;
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependent children (regardless of financial dependency status) to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical, dental, or vision option's network service area;

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental and Vision coverage and Health Care Flexible Spending Account elections.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the

QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

COST OR COVERAGE CHANGE EVENTS

In some instances, you can make elections if the type of coverage or cost of coverage changes. These rules do not apply for purposes of a Health Care Flexible Spending Account. Please note that if the change occurs to another employer's plan, you will be required to show proof verifying these events have occurred.

Cost Changes

If the Plan Administrator determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverage for its employees, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage and there is a significant decrease in cost, you may also make a corresponding new election.

Any change in the cost of your benefit option that the Plan Administrator determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Company.

Coverage Changes

The following are additional situations in which you may change your current coverage.

HIPAA Special Enrollment Events — If you or a dependent have an event, such as the loss of other coverage, that qualifies as a special enrollment event under the Health Insurance Portability and Accountability Act (HIPAA), you may change your coverage.

FMLA leave: If you are beginning or returning from an FMLA leave, you may change your coverage.

Restriction or Loss of Coverage — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election. Restriction or change in a provider network generally does not qualify as a restriction or loss of coverage.

Addition to or Improvement in Coverage — If OSI Restaurant Partners, LLC adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

Changes in Coverage under Another Employer Plan — If your spouse or dependent child(ren) is employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer's open enrollment period, you may request to end your coverage under this Plan.

Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events and provide timely documentation to prove the event and effective date:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or
- You make a change to you or your spouse's regular work schedule, including changing to or from full time student status, which increases or decreases your need for dependent care.

CONSISTENCY REQUIREMENTS FOR QUALIFIED CHANGES IN STATUS

The changes you make to your coverage as a result of a qualified change in status must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health program, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

Regardless of the consistency requirement, if you, your Spouse, or your Dependent becomes eligible for continuation coverage under the Company's medical, dental or vision plan as provided in Code Section 4980B or any similar state law, then you may elect to increase payments under the Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Resource Center at OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607, bbiconnect@bloominbrands.com or at 1-800-555-5808, Option 3.

FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the

Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact the Resource Center at OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607, bbiconnect@bloominbrands.com or at 1-800-555-5808, Option 3.

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, Employee Assistance Program, and/or Health Care Flexible Spending Account coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave (for any coverage requiring a contribution). If you take a leave of absence that is paid through PTO or vacation time, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid or partially paid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by paying for coverage in arrears during your leave on an after-tax basis. You will receive monthly invoices and must send in any required contributions in order to continue your coverage. You also have the option to suspend your health coverage during the leave. If you would like to suspend your benefits, please request to do so when you are requesting your FMLA leave. It is your responsibility to request your benefits be reinstated when you return to work.

Your Health Care Flexible Spending Account coverage continues during your leave and when you return, you have the option to increase your contributions to "make up" for contributions you missed during your leave period.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to enroll the child) within the appropriate time limits from the date of the event.

Your Employer paid (also known as Core) Life, AD&D, Business Travel Accident, STD and LTD coverages will continue during an FMLA leave. Your Supplemental Life, Dependent Life, Supplemental AD&D, Spousal Supplemental AD&D, Buy-Up STD and Buy-Up LTD coverage will continue during FMLA leave and missed contributions are collected upon your return to work. Your contributions to the Dependent Care Flexible Spending Account will continue during a leave that is paid through PTO or vacation pay, but will be suspended once the leave is unpaid and missed contributions collected upon your return.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any Medical, Dental, Vision, Employee Assistance Program, and/or Health Care Flexible Spending Account coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave assuming you are still eligible for coverage. Your Medical, Dental, Vision, Employee Assistance Program, and/or Health Care Flexible Spending Account coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave, you may be entitled to purchase COBRA continuation coverage (see When Coverage Ends) if you continued paying for your coverages during your FMLA leave.

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Employee Assistance Program and/or Health Care Flexible Spending Account

coverage for up to 24 months as long as you give OSI Restaurant Partners, LLC advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from OSI Restaurant Partners, LLC, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

As long as you have not been terminated from the Company's system and you remain benefits eligible, you will not be required to pay any more than the contributions required for active employees. If you are terminated from the Company's system or lose benefits eligibility, you will be eligible for COBRA and will be subject to COBRA cost requirements.

You may continue your Life, AD&D, Short-Term Disability and Long-Term Disability for up to five years during your military leave as long as you pay required premiums. This coverage will remain subject to the exclusions listed in the policies. However, Business Travel Accident coverage and participation in the Dependent Care Flexible Spending Account will terminate.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at OSI Restaurant Partners, LLC, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to Medical, Dental, Vision, Employee Assistance Program, and Health Care Flexible Spending Account or Health Reimbursement Arrangement coverage. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see When Coverage Ends). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible (see COBRA section). Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by OSI Restaurant Partners, LLC;

- The end of the month in which you cease to be employed in one of the eligible classes. This includes your death, reduction in hours, or termination of active employment;
- The end of the month in which you change from salaried employee to Variable Hour employee (applicable only for any coverage that is not offered to Variable Hour employees);
- The end of the grace period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The end of the month in which you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to pre-existing conditions, and exclusions for certain medical procedures) are described in the Incorporated Documents.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Incorporated Documents. In addition, their coverage will terminate:

- For your dependent child, for Medical, Dental and Vision coverage, the end of month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- For your dependent child, for Child Supplemental Life, the end of the month in which he or she attains age 26, marries or is no longer primarily dependent on you for support;
- The end of the month in which your Spouse or child is no longer considered an eligible dependent;
- The end of the grace period for which you stop making contributions required for dependent coverage; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit program. Refer to the applicable Incorporated Documents for more information on conversion.

Except as otherwise stated in this SPD, the Incorporated Documents or other materials for each benefit program, your or your covered Dependent's benefits generally will not be rescinded (which means terminated) retroactively. The Plan reserves the right to terminate benefits (including retroactively) for individuals (and any other individuals who have coverage along with them) who are discovered to have engaged in an act, practice, or omission that constitutes fraud with respect to the Plan, or who have made an intentional misrepresentation of material fact. In such cases and before coverage is rescinded retroactively, the Plan will provide reasonable advance written notice (usually thirty days) to you or your covered Dependents who would be affected and, among other things, will explain the retroactive termination of benefit coverage. The Plan also reserves the right to retroactively terminate benefits if you do not pay your required contributions towards the cost of coverage on a timely basis.

The foregoing Plan provisions satisfy the requirements of the Affordable Care Act, and applicable regulations, that restrict retroactive rescission for group health programs. The Plan reserves the right to rescind coverage to the full extent, including retroactively, as may be allowed under these regulations or any future regulations meant to update or replace these regulations.

WELLNESS BENEFIT PROGRAM

The Wellness benefits program offered under the Plan are voluntary and participatory. Participatory means the conditions for obtaining a reward (an incentive) under the Wellness benefit program do not require satisfaction of a standard related to a health factor. Participation in the Wellness benefit program is made available to all Participants and Spouses of Participants who participate in the Plan, regardless of health status and without the need for engaging in a specific outcome-based physical activity.

The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary Health Survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Lipid Profile (TC, HDL, TC/HDL ratio, LDL, Triglycerides), Blood Glucose, Hemoglobin A1c, Height, Weight, Blood Pressure, BMI, Waist Circumference). You are not required to complete the Health Survey or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive as set forth in relevant summary in Addendum A. Although you are not required to complete the Health Survey or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives, as explained in the relevant summary in Addendum A, may be available for Participants and Spouses who participate in certain health-related activities. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Resource Center at 1-800-555-5808, Option 3.

The information from your Health Survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Company may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of

participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the ones you voluntarily provide it to such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under coaching programs in the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding the above, or about protections against discrimination and retaliation, please contact [Employee Relations at 1-800-806-1133.

In the event that the Wellness benefit program is, or becomes, a health-contingent wellness program (whether activity-only or outcome-based), then the Wellness benefit program will meet additional criteria to be compliant. These additional criteria include: at least an annual opportunity to qualify; a reward that is limited in value relative to the cost of employee only medical coverage; a benefit structure and design that is reasonably focused on promoting health or preventing disease; and, uniform availability to all similarly situated and, when needed, availability of a legitimate and reasonable alternative standard that is communicated to employees.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

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

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, Wellness, Employee Assistance Program, Health Reimbursement Arrangement and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by OSI Restaurant Partners, LLC (such as any Core or Supplemental Life, AD&D, STD, LTD, or the Dependent Care Flexible Spending Account). The

Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

When the provisions for COBRA continuation coverage are set forth in an applicable Incorporated Document, such applicable Incorporated Document shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the following provisions shall govern.

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event." After a qualifying event occurs and any required notice of that event is properly provided to OSI Restaurant Partners, LLC, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost plus 2% for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of OSI Restaurant Partners, LLC, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of service with the Company that impacts your eligibility for benefits as described under the Eligibility section. If you are a variable hour employee, the reduction in hours may not impact your eligibility for coverage until the beginning of the following stability period; or
- The termination of your employment with the Company (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of OSI Restaurant Partners, LLC, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse (the employee);
- The termination of your spouse's employment with OSI Restaurant Partners, LLC (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of service with OSI Restaurant Partners, LLC; or
- Divorce, annulment or legal separation from your spouse. Also, if your spouse reduces or eliminates your group health coverage in anticipation of a divorce, annulment or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Spouses have the same right and ability to notify OSI Restaurant Partners, LLC timely of a qualifying event. If notification is not made timely, OSI Restaurant Partners, LLC is not required to make an offer of COBRA to you.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with OSI Restaurant Partners, LLC (for reasons other than the employee's gross misconduct) or reduction in the parent-employee's hours of service;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

Dependent Children have the same right and ability to notify OSI Restaurant Partners, LLC timely of a qualifying event. If notification is not made timely, OSI Restaurant Partners, LLC are not required to make an offer of COBRA to you.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because you do not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform OSI Restaurant Partners, LLC that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the employee or former employee of OSI Restaurant Partners, LLC, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the COBRA Administrator (see contact information below) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 60 days of birth and within 31 days of adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the COBRA administrator within the 60 days (or 31, if applicable), you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be

considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) during the covered employee's period of employment with OSI Restaurant Partners, LLC is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of service or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify OSI Restaurant Partners, LLC of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you submit your qualifying event online at MyBBI.com> Digital Resources> BBI Connect> Myself> Life Event or call the Resource Center at 1-800-555-5808, option 3 within 31 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. **You or a representative acting on your behalf (such as a family member) are responsible for timely notification of the qualifying event.**

In addition, you must provide documentation supporting the occurrence of the qualifying event. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license or marriage license, or official notice detailing the commencement or end of coverage(s) and effective dates.

You must submit the documentation online to BBIConnect@bloominbrands.com. **If the above procedures are not followed or if the notice is not provided to OSI Restaurant Partners, LLC within the required notice period, you will lose your right to elect COBRA.** In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to the COBRA administrator. You may also elect coverage by calling the COBRA administrator, currently Wex Benefits, at 1-866-451-3399.

An election notice will be provided to qualified beneficiaries at the time (following timely notification where required) of the qualifying event. The notice will be mailed to the home address you have listed in BBI Connect for yourself and, if different, the home address you have listed in BBI Connect for your dependents. It is your responsibility to keep your contact information up to date in BBI Connect so you receive your notifications timely.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to “similarly situated” employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated eligible employees or family members, your coverage will be modified as well. “Similarly situated” refers to a current eligible employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active eligible employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary’s COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care FSA COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account (HCFSA) will be offered only to qualified beneficiaries losing coverage. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care Flexible Spending Account by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. The plan does not allow for qualified beneficiaries to carry-over a limited amount of funds from one year to the next. Also, the Plan requires qualified beneficiaries to spend their HCFSA dollars by the end of the calendar year and allows qualified beneficiaries until the following March 31st to substantiate their claim to prove the dollars used were for eligible expenses. All qualified beneficiaries who were covered under the Health Care Flexible

Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage, but generally no more often than every 12 months, and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan and your benefits will remain terminated as of the end of the month in which your employment with the Company ended. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan and your benefits will remain terminated as of the end of the month in which you made your last COBRA payment.

All COBRA premiums must be paid by check or money order, ACH, debit or credit card, as permitted by the COBRA Administrator. Please refer to the COBRA Administrator for details on payment methods and any potential convenience fees for on-line payments. Your first payment and all monthly payments for COBRA coverage must be sent to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Once you elect COBRA coverage and make the required payment, your coverage is effective retroactively to the first day of your COBRA eligibility period. Until both election and payment has been made, coverage is suspended and claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose group health coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA

coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months measured from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare in the 18 months BEFORE his or her termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year (December 31) in which the qualifying event occurred. COBRA coverage for the Health Care Flexible Spending Account cannot be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months under the disability extension, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination on a date that is both: (i) within 60 days of the date of the Social Security Administration's disability determination; and (ii) within 18 months after the covered employee's termination or reduction of hours. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event.
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date this determination is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice

must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the Plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license or marriage license.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- OSI Restaurant Partners, LLC no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled.

Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, OSI Restaurant Partners, LLC reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. OSI Restaurant Partners, LLC, and/or the insurance carriers may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact

COBRA Administrator:
WEX Benefits
www.wexinc.com
1-866-451-3399
cobraadmin@wexhealth.com
PO Box 2926
Fargo, ND 58108-2926

Plan Administrator:
OSI Restaurant Partners, LLC
Attn: Benefits Department
2202 N. West Shore Blvd, Suite 500
Tampa, FL 33607
1-813-282-1225
BBIConnect@bloominbrands.com
Resource Center 1-800-555-5808, option 3

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep OSI Restaurant Partners, LLC informed of any changes in your and your family members' addresses. You can do so by updating your contact information in BBI Connect at MyBBI.com> Digital Resources> BBI Connect > Menu> Myself or by calling the Resource Center at 1-800-555-5808, option 3. You should also keep a copy, for your records, of any notices you send to OSI Restaurant Partners, LLC or the COBRA Administrator.

COVERED AND NON-COVERED SERVICES

Refer to the applicable Incorporated Documents provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

PRESCRIPTION DRUG BENEFITS (EXCLUDING HAWAII)

HRA MEDICAL PLAN PRESCRIPTION DRUG COVERAGE

If you are covered under one of the Medical Health Reimbursement Arrangement options (Choice HRA Plan or Value HRA Plan), this section describes your prescription drug benefits through Express Scripts.

Coinsurance at a Glance

Deductible Phase

You pay 100 percent of your medical and prescription drug expenses until you meet your calendar year deductible which is detailed in the Incorporated Document in Addendum A.

The HRA option is your combined medical and prescription drug benefit. This option includes an employer-provided Health Reimbursement Arrangement (HRA). You will need to complete certain activities as outlined in the Wellness Program communication materials in Addendum A in order to receive a company contribution towards your HRA. Each year during open enrollment, OSI will communicate if there is a change to the amount funded and how to earn those funds.

Note: if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the applicable coinsurance, plus the difference in cost between the brand and the generic.

Coinsurance Phase

Once you've met your deductible, you pay the coinsurance until you reach your calendar year out-of-pocket maximum (outlined in the booklet in Addendum A).

100 Percent Coverage Phase

Once you've reached your out-of-pocket maximum, including your deductible, your Plan pays 100 percent of eligible medical and prescription drug expenses for the remainder of the Plan Year.

Preventive Medications:

Preventive drugs, as defined by Express Scripts, Inc., are covered in full and are not subject to the deductible. Contact Express Scripts at 866-544-7943 for additional information on preventive drugs as well as a preventive drug listing.

HSA Medical Plan Prescription Drug Coverage

If you are covered under one of the Medical Health Savings Account option (Choice Health Savings Plan or Value Health Savings Plan), this section describes your prescription drug benefits through Express Scripts.

Coinsurance at a glance

Deductible Phase:

You pay 100 percent of your medical and prescription drug expenses until you meet your calendar year deductible which is detailed in the Incorporated Document in Addendum A.

The HSA Medical Plan option is your combined medical and prescription drug benefit. You will need to complete certain activities as outlined in the Wellness Program communication materials in Addendum A in order to receive a company contribution in your HSA Account. Each year during open enrollment, OSI will communicate if there is a change to the amount funded.

Coinsurance Phase:

Once you've met your annual deductible, you pay the coinsurance amounts listed in the chart below until you reach your calendar year out-of-pocket maximum. (Each year during open enrollment OSI Restaurant Partners, LLC will communicate if there is a change to the prescription drug coverage. Note: if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the applicable coinsurance, plus the difference in cost between the brand and the generic.

100 Percent Coverage Phase:

Once you've reached your out-of-pocket maximum for the year, including your deductible, your Plan pays 100 percent of eligible medical and prescription drug expenses for the remainder of the Plan Year.

Preventive Medications:

Preventive drugs, as defined by Express Scripts, Inc., are covered in full and are not subject to the deductible. Contact Express Scripts at 866-544-7943 for additional information on preventive drugs as well as a preventive drug listing.

PROVISIONS APPLICABLE TO BOTH HRA AND HSA PRESCRIPTION PLANS

For short-term prescriptions, such as antibiotics, use a retail pharmacy.

As a member, you can go to any retail pharmacy in the Express Scripts' network. Just ask your retail pharmacy if it's in the network. You can also log into Express-Scripts.com and click "locate a pharmacy" or call Member Services toll-free at 866-544-7943.

Drug conversion programs at mail

If you are prescribed a drug that is not on the Plan's preferred list, yet an alternative Plan-preferred drug exists, Express-Scripts may contact your doctor to ask whether the alternative drug would be appropriate for you. If your doctor agrees to use a Plan-preferred drug, you will usually pay less.

For long-term prescriptions, use the Express Scripts Mail Order Pharmacy to avoid paying more

You may pay more for your long-term drugs (such as those used to treat high blood pressure or high cholesterol) unless you order your prescriptions through the mail from the Express Scripts Pharmacy. The first two times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail coinsurance. After the second purchase, you'll pay the entire cost of the drug if you continue to purchase it at retail. To avoid paying more, use the Express Scripts Pharmacy and pay your mail-order coinsurance for up to a 90-day supply.

If the cost of a medication at a retail pharmacy is lower than your Plan's retail coinsurance, you will not pay more than the retail pharmacy's cash price, regardless of the number of times you purchase the medication. In some cases, this price may be less than either your standard retail or mail coinsurance.

If you are obtaining a 90-day supply and are unable to pay your mail-order coinsurance for the 90-days, you may enroll in the Express Scripts Extended Payment Program. When you enroll, instead of paying in full for your mail order medication up front, you'll be billed for the cost of your medications over three installments. You can enroll online at Express-Scripts.com or by calling Member Services using the phone number on your ID card.

Specialty Medications: Get individualized service through Accredo:

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Accredo Health Group, Inc., an Express Scripts specialty pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Counseling, scheduled delivery, and safety checks are just a few of the services that Accredo provides.

If you are taking a specialty medication, please contact Express Scripts Member Services to make sure that there is no interruption in your therapy. There is no coverage for specialty medications at retail pharmacies.

Step Therapy

If you use medications in certain drug classifications, you will be identified for the step therapy program. When you are first prescribed a medication on the Step Therapy list, your pharmacist will advise you that you need to try a different drug prior to filling the one prescribed to you. If the alternative drug isn't as effective as needed, you may use the medication originally prescribed to you.

Prior Authorization

Certain medication classes require pre-authorization to fill. In addition, prior authorization will be required for certain medication classes when your dosage exceeds Food and Drug Administration (FDA)-approved levels.

Dispensing Quantity Management

Certain medications will be limited in the amount of the medication dispensed at a time. This is due, in part, to dosage safety information and guidelines from the FDA along with supporting medical studies. It is also to help manage, control and lower overall drug costs by reducing drug waste.

CLAIMS AND APPEAL PROCESS

FILING A CLAIM

Generally, the claims filing procedures are set forth in the relevant Incorporated Documents, which are listed in Addendum A. The following provisions apply when there are no claims filing procedures in the relevant Incorporated Documents or when the claims filing procedures in the relevant Incorporated Documents fail to comply with requirements of applicable law, in which case the provisions of this Section shall govern. However, the provisions of this Section shall not be interpreted so as to override applicable State laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such State laws are not preempted by ERISA.

Before pursuing a legal remedy, you shall first exhaust all claims, review, and appeals procedures required under the Plan.

In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms by requesting them from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the relevant Incorporated Document.

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

Claims Administrators – Fully Insured

OSI Restaurant Partners, LLC provides the following benefits under the Plan through contracts with the insurance companies listed below. The Hawaii Medical, Hawaii Dental, Hawaii Vision, Life, Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, AD&D, Supplemental AD&D, Spouse Supplemental AD&D, Business Travel, EAP, STD (Core and Buy-up) and LTD (Core and Buy-up) benefits of the Plan are provided under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Hawaii Medical, Dental and Vision	HMAA 737 Bishop Street, Suite 1200 Honolulu, HI 96813 1-800-621-6998
Core Life, Supplemental Employee, Spouse & Child Life, Core and Supplemental Accidental Death and Dismemberment (AD&D), Spouse AD&D	New York Life Group Benefit Solutions www.mynylgbs.com 1-888-842-4462
Core and Buy-Up Short-Term Disability	New York Life Group Benefit Solutions www.mynylgbs.com 1-888-842-4462
Core and Buy-Up Long-Term Disability	New York Life Group Benefit Solutions www.mynylgbs.com 1-888-842-4462
Business Travel Accident	OSI RESTAURANT PARTNERS, LLC 2202 N. WESTSHORE BLVD. TAMPA, FL 33607
Employee Assistance Program	Magellan www.magellanascend.com 1-800-327-6754

Claims Administrators – Self-Insured (Non-Hawaii)

Medical, Dental, Vision, Wellness, Health Reimbursement Arrangement, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account benefits are self-insured. The Company or its delegate has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment under the Medical, Dental, Vision, Wellness, Health Reimbursement Arrangement and Health Care Flexible Spending Account and Dependent Care Flexible Spending Account. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Medical (including Prescription Drugs)	Medical: Blue Cross Blue Shield 1-833-578-1132 P.O. Box 100121 Columbia, SC 29202 Prescription Drugs: Express Scripts www.express-scripts.com 1-866-725-2520 8111 Royal Ridge Parkway Irving, TX 75063
Dental	CIGNA Dental www.my.cigna.com 1-800-244-6224 PO Box 188037 Chattanooga, TN 37422
Vision	Vision Service Plan www.vsp.com 1-800-877-7195 PO Box 997105 Sacramento, CA 95899-7105
Health Reimbursement Arrangement	Accrue Health member.accrue-health.com 1-844-643-3099 P.O. Box 100237 Columbia, SC 29202
Flexible Spending Accounts (Health and Dependent Care)	WEX Benefits www.wexinc.com 1-866-451-3399 PO Box 2926 Fargo, ND 58108-2926

CLAIM-RELATED DEFINITIONS

Claim

Any request for Plan benefits made in accordance with the Plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain

that could not be adequately managed otherwise. The Medical claims administrator must defer to an attending provider to determine if a claim is urgent.

Pre-Service Claims

“Pre-service claims” are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

“Post-service claims” are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

“Concurrent care claims” are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an “urgent care claim,” “pre-service claim,” or “post-service claim,” depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

INITIAL CLAIM DETERMINATION

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific Plan provisions 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 review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For Medical claims, the notice will also include information sufficient to identify the claim involved. This includes:

- the date of service;
- the health care provider;
- the claim amount (if applicable);
- the denial code;
- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For STD and LTD benefit claims, the notice will also include:

- a discussion of the determination, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating you and vocational professionals who evaluated you (if you presented these to the Claims Administrator as part of your claim materials),
  - the views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - a disability determination regarding you made by the Social Security Administration (if you presented this to the Claims Administrator as part of your claim materials);
- a statement describing any applicable limitations time period that is imposed by the Plan that applies to your right to bring an action under Section 502(a) ERISA, including the calendar date on which the limitations time period expires for such claim;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits; and

- a statement clearly indicating how to access the language services provided by the Claims Administrator. (This statement must be prominently displayed in any applicable non-English language.)

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health care Flexible Spending Account, HRA and Wellness Program claims are considered non-urgent “post-service” claims.

	Medical, Dental, Vision, EAP, HRA, Wellness & Health Care FSA				Short-Term & Long-Term Disability	Life, AD&D & Business Travel
	Urgent Care Claims	Non-Urgent “Pre-Service” Claims	Non-Urgent “Post-Service” Claims	“Concurrent Care” Decision to Reduce Benefits		
Time frame for Providing Notice of Benefit Determination	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Dental, Vision, EAP, HRA, Wellness & Health Care FSA				Short-Term & Long-Term Disability	Life, AD&D & Business Travel
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	N/A

APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The following provisions apply when there are no claims and appeals procedures in the relevant Incorporated Documents or when the claims and appeals procedures in the relevant Incorporated Documents fail to comply with requirements of applicable law, in which case the provisions of this Section shall govern. However, the provisions of this Section shall not be interpreted so as to override applicable State laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such State laws are not preempted by ERISA.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed under the Claims and Appeals Process section of this document. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the

Plan) in connection with the claim. This evidence will be provided at no cost to you and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review, and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

If the Plan fails to strictly adhere to all of the requirements of ERISA with respect to such a STD benefit or LTD benefit claim (or appeal of a denied claim), you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions that are explained below. Accordingly, you are entitled to bring a civil action to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim for benefits that relates to the determination of disability.

If you choose to bring a civil action to pursue remedies under Section 502(a) of ERISA under such circumstances, your claim (or appeal) is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted for such claims based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Plan or Claims Administrator demonstrates that such violation(s) was for good cause or due to matters beyond the control of the Plan or Claims Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or Claims Administrator and you. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or Claims Administrator. Before filing a civil action, you may request a written explanation of any such violation(s) from the Plan or Claims Administrator and the Plan or Claims Administrator must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

If a court rejects your request for immediate review, and expressly does so on the basis that the Plan or Claims Administrator met the standards for the exception, your claim will be considered as re-filed on appeal upon the Plan or Claims Administrator's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan or Claims Administrator will provide you with notice of the resubmission and, thereafter, will process the claim / appeal according to the administrative procedures herein.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 41. For urgent care claims, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims), and
- If requested by you, the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan or Claims Administrator, without regard to whether the advice was relied upon in making the determination.

For medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The health care provider;
- The claim amount (if applicable); and
- The denial code.

For medical claims, the notice will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determination related to STD and LTD benefits, the notice will also include:

- a statement describing any applicable limitations time period that is imposed by the Plan (including any applicable insurance contract issued thereunder) and that applies to your right to bring an action under ERISA §502(a), including the calendar date on which the limitations time period expires for such claim;
- discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating you and vocational professionals who evaluated you (if presented by you to the appeals reviewer as part of your appeal materials),
  - the views of medical or vocational experts whose advice was obtained on behalf of the appeals reviewer in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - a disability determination regarding you made by the Social Security Administration (if presented by you to the appeals reviewer as part of your appeals materials); and

- if applicable, a statement clearly indicating how to access the language services provided by the appeals reviewer. (This statement must be prominently displayed in any applicable non-English language.)

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the relevant Incorporated Document for that benefit. Please consult the relevant Incorporated Document for the specific benefit involved. Where not otherwise covered by the relevant Incorporated Document, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of an adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days.

	Medical, Dental, Vision, EAP, HRA, Wellness & Health Care FSA			Short-Term & Long-Term Disability	Life, AD&D & Business Travel
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have 180 days.	You have 180 days.	You have 180 days.	You have 180 days.	You have 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review	Within a reasonable period of time, but not later than 60 days after receipt of request for review.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

External Review

The following rules shall apply only to claims filed for medical or prescription drug benefits. This Section shall not be interpreted to give you any rights to external review beyond what is expressly required under law.

If you and/or your provider are dissatisfied with the written formal appeals decision by the Claims Administrator, you, your representative, or your provider may file with the Claims Administrator a request for an external review (subject to certain conditions being followed). A request for an external review must be filed within four (4) months of receipt of the written formal appeal denial by the Claims Administrator. External review is performed by Independent Review Organizations (IRO). External review should involve a question of rescission of coverage, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or whether a treatment or service is experimental or investigational. If your provider is filing the request for an external review, your provider must submit a copy of your written consent. The request must contain any materials, supporting information, or necessary justification for the external review. If a timely request for an external review is received, the Claims Administrator will complete a preliminary review of the request within five (5) business days. The purpose of the preliminary review is to determine whether 1) you are or were covered at the time the service/item was requested; 2) the adverse benefit determination relates to your failure to meet the requirements for coverage; 3) you exhausted internal claims and appeals; and 4) you provided all information and forms necessary to process the external review. Within one business day after completion of the preliminary review, the Claims Administrator will issue a notification to you in writing as to whether your appeal is eligible for an external review. The Claims Administrator will tell you if additional information is needed to determine eligibility for an external review

If additional information is needed, you will be advised what is needed and you will be allowed to submit the additional information within the 4-month filing period or within the 48-hour period following your receipt of notification, whichever is later. If your appeal is eligible for external review, you will be notified of the IRO name, address and phone number. You, your representative, or your provider may supply additional information to the IRO to consider in the external review within five (5) business days of notification that your appeal is eligible for external review. The IRO will then provide this information to the Claims Administrator within one (1) business day so that the Claims Administrator has an opportunity to consider the additional information as well. Within five (5) days of determining that your appeal is eligible for external review, the Claims Administrator will forward a copy of all written documentation regarding the adverse benefit determination to an IRO. Documentation will include the correspondence concerning the claims and appeals decision, all reasonable supporting documentation, and a summary of the clinical rationale for the adverse determination. At the same time, the Claims Administrator will provide you, your representative, or your provider with the list of documents that are being forwarded to the IRO for the external review. The IRO will review all information provided by the Claims Administrator and you, your representative, or your provider. The IRO will make a determination under the terms of the Plan. The IRO will issue a decision within 45 days of receipt of the external review request. The decision will be issued in writing to you or your representative and the Claims Administrator. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision. You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your claim, including the benefit provision, guideline, diagnosis codes, or treatment codes on which the decision was based. If your claim is an urgent care claim that is being reviewed as an internal appeal, you can also request an expedited external review during that

same time. You can contact the Claims Administrator for information on requesting an expedited external review.

The external review decision is binding on you and the Plan, except to the extent that other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

ACTS OF THIRD PARTIES

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery when there are no subrogation and right of recovery provisions in the applicable Incorporated Document.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the Plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary Plan Description.
- Provide proof, satisfactory to the Claim Administrator or Plan Administrator, that no right, claim, interest or cause of action against a third party has been, or will be, discharged or released without the written consent of the Claim Administrator or Plan Administrator.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Authorize the Plan, in writing, to sue, compromise or settle, in your name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid by the Plan and shall do nothing to prejudice the rights given to the Plan under this section.
- Agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against a third party, including, if requested by the Claim Administrator or Plan Administrator, the institution of a formal proceeding against a third party.
- Execute a written agreement assigning to the Plan all rights, claims, interests, and causes of action that you have against a third party in connection with the expenses paid by the Plan.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

Should it be necessary for the Plan to institute proceedings against you for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section, you will be liable for the costs of collection relating to such failure, including reasonable attorney's fees.

The Plan's rights under this Section shall be enforceable regardless of whether the third party admits liability for the injury or illness to you, and shall remain enforceable against the heirs and estate of you.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing insured benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing insured benefits at issue, the right of recovery provisions in the insurance contract will govern.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the

insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and OSI Restaurant Partners, LLC to the extent of such payment.

MISSTATEMENT OF FACT

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit Plan:

Plan Name	OSI Restaurant Partners, LLC Employee Benefit Plan
Plan Number	501
Plan Sponsor	OSI Restaurant Partners, LLC 2202 N. West Shore Blvd, Suite 500 Tampa, FL 33607
Employer Identification Number	59-3061413
Plan Administrator	OSI Restaurant Partners, LLC 2202 N. West Shore Blvd, Suite 500 Tampa, FL 33607 1-813-282-1225
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the following types of benefits: ▪ Medical ▪ Health Reimbursement Arrangement ▪ Wellness ▪ Dental ▪ Vision ▪ Employee Assistance Program ▪ Core Short-Term Disability ▪ Core Long-Term Disability ▪ Buy-Up Short-Term Disability ▪ Buy-Up Long-Term Disability ▪ Core Life Insurance ▪ Supplemental Life Insurance ▪ Spouse Supplemental Life Insurance ▪ Child Supplemental Life Insurance ▪ Accidental Death and Dismemberment (AD&D) ▪ Supplemental AD&D ▪ Spouse Supplemental AD&D ▪ Health Care Flexible Spending Account ▪ Business Travel Accident Although the Dependent Care Flexible Spending Account and Health Savings Account are described in this SPD, they are not ERISA plans.

Source of Contributions	Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from OSI Restaurant Partners, LLC, contributions by the employee, or will be shared by OSI Restaurant Partners, LLC and the employee. The cost of Medical, including Prescription Drug, is shared by OSI Restaurant Partners, LLC and its employees enrolled in those coverages. OSI Restaurant Partners, LLC pays 100% of the cost of the EAP, Health Reimbursement Arrangement, Business Travel Accident, Core Life and AD&D, Core Short-Term Disability and Core Long-Term Disability coverages. Employees pay 100% of the Dental, Vision, Supplemental Life, Spouse Supplemental Life, Child Supplemental Life, Buy-Up Short-Term Disability, Buy-Up Long-Term Disability, Supplemental AD&D, Spouse Supplemental AD&D, and contributions to the Health Care and Dependent Care Flexible Spending Accounts. Where OSI Restaurant Partners, LLC and employees share the cost of coverage, OSI Restaurant Partners, LLC shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. OSI Restaurant Partners, LLC, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse OSI Restaurant Partners, LLC for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

OSI Restaurant Partners, LLC reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, OSI Restaurant Partners, LLC reserves the right to amend or terminate benefits, covered expenses, benefit copays, or lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. OSI Restaurant Partners, LLC also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by OSI Restaurant Partners, LLC will be done in accordance with OSI Restaurant Partners, LLC's normal operating procedures and the governing Plan documents. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of OSI Restaurant Partners, LLC, the Plan shall terminate unless the Plan is continued by a successor to OSI Restaurant Partners, LLC.

PLAN ADMINISTRATION

OSI Restaurant Partners, LLC is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an Incorporated Document. OSI Restaurant Partners, LLC or its delegate has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and OSI Restaurant Partners, LLC will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor OSI Restaurant Partners, LLC will be liable in any manner for any determination made in good faith.

OSI Restaurant Partners, LLC may designate other organizations or persons to carry out specific fiduciary responsibilities for OSI Restaurant Partners, LLC in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan or any of its benefits programs, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as claims administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

OSI Restaurant Partners, LLC will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

POWER AND AUTHORITY OF THE INSURANCE COMPANY

The Hawaii Medical, Hawaii Dental, Hawaii Vision, Life, Spouse Supplemental Life, Child Supplemental Life, Supplemental Life, AD&D, Supplemental AD&D, EAP, Business Travel Accident, STD and LTD benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between OSI Restaurant Partners, LLC and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not OSI Restaurant Partners, LLC.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan; and

- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan and the requirements of ERISA.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your relevant Incorporated Document or contact the applicable insurance company or Claims Administrator. If you have an ID card for a benefit option under the Plan, you may also use the contact information on the back of that card.

ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Incorporated Documents, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents and insurance contracts governing the operation of the Plan, including Incorporated Documents, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) 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 denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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:

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.

ADDENDUM A — INCORPORATED DOCUMENTS

This summary should be read in combination with the insurance contracts, member handbooks, program documents, benefit booklets, certificates of coverage, or evidence of coverage or other summary documents (together and individually referred to as "Incorporated Documents") provided by the insurance companies and service providers.

The Incorporated Documents are intended to describe the OSI Restaurant Partners, LLC benefits available to you as an employee of OSI Restaurant Partners, LLC, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the relevant Incorporated Documents for details of Plan benefits.

For additional information or for copies of the Incorporated Documents, please contact the Plan Administrator.

Coverage	Incorporated Document Name
Medical	Preferred Provider Plan of Benefits Choice HRA Plan Preferred Provider Plan of Benefits Choice HSA Plan Preferred Provider Plan of Benefits Value HRA Plan Preferred Provider Plan of Benefits Value HSA Plan Hawai'i Medical Assurance Association (HMAA) Comprehensive Plus Medical Plan Summary Hawai'i Medical Assurance Association (HMAA) Option Plus Medical Plan Summary Hawai'i Medical Assurance Association (HMAA) Prescription Drug Summary
Dental	CIGNA Dental Preferred Provider Organization (DPPO) In-Network Area Plan Certificate (self-insured) CIGNA Dental Preferred Provider Organization (DPPO) Out-of-Area Plan Certificate (self-insured) CIGNA Dental Health Maintenance Organization (DHMO) Patient Charge Schedule CIGNA Dental Health Maintenance Organization (DHMO) Plan Certificate (fully-insured) Hawai'i Medical Assurance Association (HMAA) Dental Summary

Vision	Vision Service Plan (VSP) Vision Certificate of Coverage Hawai'i Medical Assurance Association (HMAA) Vision Summary
Employee Assistance Program	EAP Overview
Core and Supplemental Life Insurance, including Spouse Supplemental Life Insurance and Child Supplemental Life Insurance, if applicable	Life Insurance Certificate of Coverage (VP and above) Life Insurance Certificate of Coverage (all other Salaried, Flex Managers, GEDMs, Sous Chefs, MITs, PDDs) Life Insurance ERISA Amendment New York Life Insurance Company Name Change Endorsement
Short-Term Disability	Salaried Short-Term Disability Coverage Certificate Short-Term Disability ERISA Amendment New York Life Insurance Company Name Change Endorsement New York Life Summary on How to file your disability claim New York Paid Family Leave Plan Document New York Paid Family Leave Statement of Rights
Long-Term Disability	Salaried Long-Term Disability Coverage Certificate Executive (VP and above) Long-Term Disability Certificate New York Life Insurance Company Name Change Endorsement Long-Term Disability ERISA Amendment
Core and Supplemental Accidental Death and Dismemberment	AD&D Certificate of Coverage (VP and above) AD&D Certificate of Coverage (all other Salaried, Flex Managers, GEDMs, Sous Chefs, MITs, PDDs) New York Life Insurance Company Name Change Endorsement
Business Travel Accident Insurance	Business Travel Accident

Health Care and Dependent Care Flexible Spending Accounts and Pre-tax contributions for Medical, Dental and Vision Benefits	OSI Restaurant Partners Cafeteria Program
Wellness Program	Health Rewards Overview

This Addendum A shall be subject to modification without formal amendment of the Plan.

ADDENDUM B

COVID-19 SPECIAL PROVISIONS AND COVERAGES

1. The Plan will be administered to cover testing needed to detect or diagnose COVID-19, and the administration of that testing, without cost-sharing until the end of the COVID-19 public health emergency.

2. The Plan will be administered to cover COVID-19 preventive services, vaccines, medications, and related treatment that are required to be covered under the Coronavirus Aid, Relief and Economic Security (CARES) Act and subsequent related legislation.

3. The Plan will be administered in accordance with the joint guidance of the DOL and the IRS published on May 4, 2020, in the Federal Register, (Final Rule 85 FR 26351), as further explained in EBSA Disaster Relief Notice 2021-01, regarding certain extended deadlines imposed by ERISA COBRA and HIPAA contained in such Final Rule.