

**Group Short Term Disability  
Insurance Certificate**

**OSI Restaurant Partners, LLC**



## **IMPORTANT NOTICES**

If you reside in one of the following states, please read the important notices below:

**Arizona, Florida and Maryland residents:**

**The group policy is issued in the state of Florida and will be governed by its laws. If you reside in a state other than Florida, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.**



## **IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call the Life Insurance Company of North America, Group Insurance Division's toll-free telephone number for information or to make a complaint at **1-800-441-1832**.



## **FOREWORD**

Disability insurance provides individuals and their families with financial protection. The Disability Insurance Benefit described in this booklet will help secure your family's financial security in the event of your disability.

The need for disability insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the disability insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.





**LIFE INSURANCE COMPANY OF NORTH AMERICA**

1601 CHESTNUT STREET  
PHILADELPHIA, PA 19192-2235  
(800) 732-1603 TDD (800) 336-2485  
**A STOCK INSURANCE COMPANY**

**GROUP INSURANCE  
CERTIFICATE**

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, certify that we have issued a Group Policy, FLK-980130, to OSI Restaurant Partners, LLC.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

A handwritten signature in cursive script that reads "Scott Berlin". The signature is written in black ink on a light-colored background.

Scott Berlin, President



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## SCHEDULE OF BENEFITS

**Policy Effective Date:** January 1, 2013

**Certificate Effective Date:** January 1, 2024

**Policy Anniversary Date:** January 1

**Policy Number:** FLK-980130

**Eligible Class Definition:**

All active, Full-time salaried Employees and hourly Employees of the Employer who are eligible for salaried benefits.

**Eligibility Waiting Period**

If you were hired on or before the Policy Effective Date:

For Core Benefits:	No Waiting Period
For Optional Benefits:	First of the month coinciding with or following the date of hire

If you were hired after the Policy Effective Date:

For Core Benefits:	No Waiting Period
For Optional Benefits:	First of the month coinciding with or following the date of hire

For Employees from the Moss acquisition: No Waiting Period

**Benefit Waiting Period**

Core Benefit	For Accident: 7 days
	For Sickness: 7 days
Optional Benefit	For Accident: 7 days
	For Sickness: 7 days

Paid Time Off (PTO)/Vacation time can be used to complete the Benefit Waiting Period, however you do not need to exhaust PTO/Vacation time during the Benefit Waiting Period.

**Disability Benefit**

Core Benefit:	40%
Optional Benefit:	60%

The lesser of the percent of your weekly Covered Earnings listed above, rounded to the nearest dollar, or the Maximum Disability Benefit, reduced by any Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for your dependents, or which your dependents receive because of your entitlement to Other Income Benefits.

**Maximum Disability Benefit**

Core Benefit: \$750 per week  
Optional Benefit: \$2,000 per week

**Minimum Disability Benefit**

10% of Weekly Benefit

**Maximum Benefit Period**

Core Benefit:  
For Accident: The date the 26th Disability Benefit is payable.  
For Sickness: The date the 26th Disability Benefit is payable.  
Optional Benefit:  
For Accident: The date the 26th Disability Benefit is payable.  
For Sickness: The date the 26th Disability Benefit is payable.

Inclusive of the 7 days Benefit Waiting Period.

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## **WHO IS ELIGIBLE**

If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date, or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. Your Eligibility Waiting Period will be extended by the number of days you are not in Active Service.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former Employee who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you no longer qualify under your Class Definition, but you continue to be employed, and within one year you qualify again.

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## **WHEN COVERAGE BEGINS**

If you are required to contribute to the cost of your insurance you may elect to be insured only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of your insurance depends on the date coverage is elected

If you elect coverage within 45 days after you become eligible or during an Annual Enrollment Period, your insurance is effective on the latest of the following dates.

1. The Policy Effective Date.
2. The date you authorized payroll deduction.
3. The date the completed enrollment form is received by the Employer or us.

If your enrollment form is received more than 45 days after you are eligible for insurance, you must satisfy the Insurability Requirement before your insurance is effective. If approved, your insurance is effective on the date we agree in writing to insure you.

If you are not in Active Service on the date your insurance would otherwise be effective, it will be effective on the date you return to any occupation for your Employer on a Full-time basis.

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## **WHEN COVERAGE ENDS**

Your insurance ends on the earliest of the dates below.

1. The date you are eligible for coverage under a plan intended to replace this coverage.
2. The date the Policy is terminated.
3. The date you no longer qualify under your Class Definition.
4. The day after the period for which premiums are paid.
5. The date you are no longer in Active Service.

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## WHEN COVERAGE CONTINUES

This provision modifies the When Coverage Ends provision to allow insurance to continue under certain circumstances if you are no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the When Coverage Ends provisions.

Your Disability Insurance will continue if your Active Service ends because of a Disability for which benefits under the Policy are or may become payable. If you do not return to Active Service, this insurance ends when your Disability ends or when benefits are no longer payable, whichever occurs first.

If your Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of your approved FMLA leave or the leave period required by law in the state in which you are employed. Premiums are required for this coverage.

If your Active Service ends due to military leave approved timely by the Employer, insurance will continue for you through the duration of the leave, if the required premium is paid when due.

If your Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date you cease work, insurance will continue for you for up to 12 weeks. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If your Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, your insurance will continue until the earlier of:

- a. the date your employment relationship with the Employer terminates;
- b. the date premiums are not paid when due;
- c. the end of the 30 day period that begins with the first day of such excused absence;
- d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if your Active Service ends due to layoff, termination of employment or any other termination of the employment relationship, insurance will terminate and continuation of insurance under this provision will not apply.

If your insurance is continued pursuant to this When Coverage Continues provision, and you become Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Benefit Waiting Period is satisfied or the date you are scheduled to return to Active Service.

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## **DESCRIPTION OF BENEFITS WHAT IS COVERED**

### **Disability Benefits**

If you become Disabled, as we define the term in the Definitions section, while you are covered under the Policy, we will pay you Disability Benefits. After you are Disabled, you must satisfy the Benefit Waiting Period and be under the Appropriate Care of a Physician. Also, we ask you to provide us with satisfactory proof of your Disability, at your expense, before benefits will be paid.

We will require continued proof of your Disability for benefits to continue.

### **Benefit Waiting Period**

The Benefit Waiting Period is the period of time you must be continuously Disabled before Disability Benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.

We will not require you to satisfy the Benefit Waiting Period if benefits were payable to you under a Prior Plan on the Policy Effective Date and you return to Active Service within 14 days after this date. Your return to Active Service must be for more than one day but less than 14 consecutive days. Your later period of Disability must be caused by the same or related causes for your Benefit Waiting Period to be waived.

### **Termination of Your Disability Benefits**

Your Disability Benefits will end on the earliest of the dates listed below.

1. The date we determine you are no longer Disabled
2. The date the Maximum Benefit Period ends
3. The date you die
4. The date you refuse to participate in rehabilitation efforts as required by us
5. The date you are no longer receiving Appropriate Care

### **Successive Periods of Disability**

Once you are eligible to receive Disability Benefits under the Policy, separate periods of Disability resulting from the same or related causes are a continuous period of Disability unless you return to Active Service for more than 14 consecutive days.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes, or your later Disability occurs after your coverage under the Policy ends.

The Successive Periods of Disability provision will not apply if you are eligible for coverage under a plan that replaces the Policy.

**Pre-Existing Condition Limitation (Applicable for Optional Benefit Only)**

We will not pay Disability Benefits if your Disability is caused or contributed to by, or results from, a Pre-Existing Condition. A "pre-existing condition" is any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within 6 months before your most recent effective date of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. It will not apply to a period of Disability that begins after you are in Active Service for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

We will not apply the Pre-Existing Condition Limitation to your Disability if you were covered under your Employer's Prior Plan and satisfied the pre-existing condition of that plan. This is true only for the amount of benefit covered under that prior plan. If you were covered under your Employer's Prior Plan, but did not fully satisfy the pre-existing condition limitation of that plan, we will credit you for any time you did satisfy. If you are now covered for benefits in excess of your Prior Plan coverage, the Pre-Existing Condition Limitation will apply to the excess amount.

**Disability Benefit Calculation**

Your Disability Benefit for any week Disability Benefits are payable to you is shown in the Schedule of Benefits. We base our calculation of Disability Benefits on the number of days in your normally scheduled work week immediately prior to the date your Disability begins. Benefits will be prorated if payable for any period less than a week.

**Work Incentive Benefit**

If you return to your regular occupation on a part-time basis, or any other occupation on a Full-time or part-time basis, your Disability Benefits may be reduced. For any week, if the sum of your Disability Benefit, current earnings and any additional Other Income Benefits exceed 100% of your weekly Covered Earnings, the Disability Benefit will be reduced by the excess amount.

No Disability Benefits will be paid if we determine you are able to work under a Transitional Work Arrangement or other modified work arrangement, and you refuse to do so.

Current earnings include any wage or salary you earn for work performed while Disability Benefits are payable. If you are working for another employer on a regular basis when your Disability begins, your current earnings will include any increase in the amount you earn from this work during the period for which Disability Benefits are payable.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

## **Other Income Benefits**

While you are Disabled, you may be eligible to receive benefits from other income sources. If so, we may reduce the Disability Benefits payable to you under the Policy by the amount of these Other Income Benefits. The extent to which Other Income Benefits will reduce your Disability Benefits is shown in the Amounts of Insurance section of the Schedule of Benefits.

Other Income Benefits include:

1. any amounts you or your dependents, if applicable, receive (or are assumed to receive\*) under:
  - a. the Canada and Quebec Pension Plans;
  - b. the Railroad Retirement Act;
  - c. any local, state, provincial or federal government disability or retirement plan or law as it pertains to your Employer;
  - d. any sick leave or salary continuation plan of your Employer;
  - e. any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive\*) either on your behalf or for your dependents; or, if applicable, which your dependents receive (or are assumed to receive\*) because of your entitlement to such benefits.
3. any retirement plan benefits funded by your Employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by your Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any Employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
6. any wage or salary for work performed. If Work Incentive Benefits apply to you, we will only reduce your Disability Benefits to the extent provided under your Work Incentive Benefit.

Dependents include any person who receives (or is assumed to receive\*) benefits under any applicable law on account of your entitlement to benefits.

\*See the Assumed Receipt of Benefits provision.

### *Increases in Other Income Benefits*

After we make the first deduction for any Other Income Benefit (except wage or salary), we will not reduce your Disability Benefits further during that period of Disability due to any cost of living increase in the Other Income Benefit.

### *Lump Sum Payments*

Other Income Benefits or earnings that are paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated monthly over a five-year period.

If no specific allocation of a lump sum payment is made, we will assume the total payment is an Other Income Benefit.

### *Assumed Receipt of Benefits*

We will assume you or your dependents, if applicable, are receiving Other Income Benefits if you may be eligible for them. We will estimate the amount of these assumed benefits on the basis of what you may be eligible to receive and reduce your Disability Benefits as if you actually received them.

Except for any wage or salary for work performed while Disability Benefits are payable, we will not assume your receipt of Other Income Benefits if you give us proof of the following events.

1. Application was made for these benefits.
2. Reimbursement Agreement is signed by you.
3. Any and all appeals were made for these benefits, or we have determined further appeals will not be successful.
4. Payments were denied.

We will not assume you have received, nor will we reduce your Disability Benefits by, any elective, actuarially reduced, or early retirement benefits under such laws until you actually receive them.

### *Social Security Assistance*

We will, at our own discretion, assist you in applying for Social Security Disability Income (SSDI) benefits. Disability Benefits will not be reduced by your assumed receipt of SSDI benefits while you participate in the Social Security Assistance Program.

We may require you to file an appeal if we believe a reversal of a prior decision is possible. If you refuse to participate in, or cooperate with, the Social Security Assistance Program, we will assume receipt of SSDI benefits until you give us proof that you have exhausted all the administrative remedies available to you.

### **Minimum Benefit**

We will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

### **Recovery of Overpayment**

If we overpay your benefits, we have the right to recover the amount overpaid by either requesting you to pay the overpaid amount in a lump sum or by reducing any amounts payable to you by the amount due. If there is an overpayment due when you die, we will reduce any benefits payable under the Policy to recover the overpayment.

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## **ADDITIONAL BENEFITS**

### **Rehabilitation During A Period of Disability**

If you are Disabled and we determine that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. We must agree on the terms and conditions of the Rehabilitation Plan.

We may require you to participate in a rehabilitation assessment, at our expense, and/or Rehabilitation Plan. We will work with you, your Employer, your Physician and others as appropriate, to develop a Rehabilitation Plan. If you refuse to participate in the rehabilitation efforts, Disability Benefits will not be payable.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

A "Rehabilitation Plan" is a written agreement between you and us in which we agree to provide, arrange or authorize vocational or physical rehabilitation services.

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## **WHAT IS NOT COVERED**

We will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or whenever you injure yourself on purpose.
2. war or any act of war, whether or not declared.
3. an Injury or Sickness that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. An Injury or Sickness that occurs while engaged in Reserve or National Guard training is not excluded until training extends beyond 31 days.
4. active participation in a riot.
5. commission of a felony.
6. revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
7. any cosmetic surgery or surgical procedure that is not Medically Necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. (We will pay benefits if your disability is caused by your donating an organ in a non-experimental organ transplant procedure.)
8. Injury or Sickness for which benefits are paid or payable to you from Workers' Compensation or occupational disease law.

We will not pay Disability Benefits for any period of Disability during which you:

9. are incarcerated in a penal or corrections institution.
10. are not receiving Appropriate Care.
11. fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit due.
12. refuse to participate in rehabilitation efforts as required by us.
13. refuse to participate in a Transitional Work Arrangement or other modified work arrangement.

“Transitional Work Arrangement” means any work offered to you by the Employer, or an affiliated company while you are Disabled and which may be your own occupation or any occupation. The term includes but is not limited to reassigned duties, work site modification, flexible work arrangements, job adaptation, or special equipment.

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## **CLAIM PROVISIONS**

### **Notice of Claim**

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

### **Claim Forms**

When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

### **Claimant Cooperation Provision**

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

### **Insurance Data**

The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

**Proof of Loss**

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

**Time of Payment**

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

**To Whom Payable**

Disability Benefits will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to any of your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

**Physical Examination and Autopsy**

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

**Legal Actions**

No legal action may be brought to recover on the Policy within 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, is given as required by the Policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time proof of loss is required to be given.

**Time Limitations**

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

**Physician/Patient Relationship**

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

## ADMINISTRATIVE PROVISIONS

### **Premiums**

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

### **Your Grace Period**

If your required premium is not paid on the Premium Due Date, there is a 45 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

### **Reinstatement of Insurance**

Your insurance may be reinstated if it ends because you are on an unpaid leave of absence. If your Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, your insurance may be reinstated at the conclusion of the FMLA leave.

If your Active Service ends due to an Employer approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. If the reinstatement occurs within 6 months from the date insurance ends, or
2. When returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For insurance to be reinstated the following conditions must be met:

1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. We must receive a written request for reinstatement within 31 days from the date you return to Active Service.

Reinstated insurance will be effective on the date you return to Active Service. If you did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence, credit will be given for any time that was satisfied.

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## GENERAL PROVISIONS

### **Incontestability**

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

### **Misstatement of Age**

If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

### **Workers' Compensation Insurance**

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

### **Assignment of Benefits**

We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

### **Clerical Error**

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

### **Ownership of Records**

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

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## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

### **Accident**

The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

### **Active Service**

If you are an Employee, you are in Active Service on a day which is one of your Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

### **Annual Enrollment Period**

The period in each calendar year agreed upon by your Employer and us when you may enroll for, or change benefit elections, under the Policy.

### **Appropriate Care**

Appropriate Care means you:

1. Have received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
2. Continue to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
3. Adhere to the treatment plan prescribed by the Physician, including the taking of medications.

### **Covered Earnings**

Covered Earnings means your annual wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

### **Disability/Disabled**

For purposes of coverage under the Policy, you are Disabled if, because of Injury or Sickness, you are unable to perform the material and substantial duties of your regular occupation, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Covered Earnings.

**Employee**

For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

**Employer**

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

**Full-time**

Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

**Furlough**

Furlough means a temporary suspension or alteration of Active Service initiated by the Employer, for a period of time specified in advance not to exceed 30 days at a time.

**Injury**

Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

**Insurability Requirement**

An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

**Insurance Company**

The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

**Insured**

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

**Life Status Change**

A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

If the Employer does not sponsor a Flexible Benefits Plan or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of your spouse
5. Termination of your spouse's employment
6. A change in the benefit plan available to your spouse
7. A change in employment status for you or your spouse that affects your eligibility for benefits

**Physician**

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

**Prior Plan**

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date.

**Sickness**

The term Sickness means a physical or mental illness.

**Temporary Layoff**

Temporary Layoff means a temporary suspension of Active Service for a period of time determined in advance by the Employer, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as termination of employment.

TL-004708 (FL) as modified by TL-009980

**SUPPLEMENTAL INFORMATION  
for**

**Weekly Disability Income Insurance for Employees of OSI Restaurant Partners, LLC  
required by the Employee Retirement  
Income Security Act of 1974**

As a Plan participant in OSI Restaurant Partners, LLC's Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

**IMPORTANT INFORMATION ABOUT THE PLAN**

- The Plan is established and maintained by OSI Restaurant Partners, LLC, the Plan Sponsor.
- The Employer Identification Number (EIN) is 59-3061413.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLK-980130, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.
- The Plan Administrator is:     OSI Restaurant Partners, LLC  
  2202 North Westshore Blvd.  
  Suite 500  
  Tampa, FL 33607  
  813-282-1225
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer and Employees.
- The date of the end of the Plan Year is December 31.

## **WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM**

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

## **Appeal Procedure for Denied Claims**

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

## **YOUR RIGHTS AS SET FORTH BY ERISA**

As a participant in OSI Restaurant Partners, LLC's Insurance Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, 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. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.



## IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state, and only when the underlying provision is included in the certificate.

### **Louisiana residents:**

The percentage of Covered Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

### **Massachusetts residents:**

#### **Continuation of Insurance after leaving the group**

If you leave the group covered under the Policy, insurance for you will be continued until the earliest of the following dates:

1. 31 days from the date you leave the group;
2. The date you become eligible for similar benefits.

#### **Continuation of Insurance due to a Plant Closing or Partial Closing**

If you leave the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for you will be continued until the earliest of the following dates:

1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date you become eligible for similar benefits.

**Definitions** : For purposes of this provision:

**Plant Closing** means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

**Partial Closing** means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

### **Minnesota residents:**

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

### **Texas residents:**

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

### **Washington residents:**

The following definition of "Children" as stated under the Survivor Benefit is applicable to Washington residents.

"Children" means as Employee's children under age 26 who are chiefly dependent upon the Employee for support and maintenance.





**UNDERWRITTEN BY:  
LIFE INSURANCE COMPANY OF NORTH AMERICA  
a New York Life Insurance company**

Class 1  
11/2023

