OSI Restaurant Partners, LLC
Employee Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2015

Contents

INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, Benefit Booklets), 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.

OSI Restaurant Partners, LLC (the Company) also offers its employees the OSI Restaurant Partners Cafeteria Plan 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 the high deductible health plan option, the opportunity to make pre-tax contributions to a Health Savings Account (HSA). It is the employee's responsibility to open their HSA through the Company's preferred third party vendor in order for the Company to deposit the employee's pre-tax contributions into their HSA.

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 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).

All benefits (except for non-Hawaii Medical, Prescription Drug, Dental, Vision, Wellness, Health Reimbursement Arrangement coverage and the Flexible Spending Accounts) are provided under insurance contracts. This means the benefits are insured by a third party. In addition, the Medical, Prescription Drug, Dental, Vision, Wellness, Health Reimbursement Arrangement coverage and the Flexible Spending Accounts are provided under other contracts with service providers. This means these benefits are self-insured, or funded, by the Company and administered by a third party. All benefits are summarized in this document and in the Benefit Booklets (as defined above).

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). The Benefit Booklets are provided by the insurance companies and service providers. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will rule.

The applicable Benefit Booklets 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 vendor's websites or you can call our administrators at the phone numbers indicated in the Benefit Booklets. 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 benefit booklets..

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on page 42.

OSI Restaurant Partners, LLC reserves the right to change, amend, suspend, or terminate any or all of the benefits under this 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.
- 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. Variable Hour Employees become eligible if they average 30 Hours of Service (hours for which you worked or are entitled for payment such as paid time off) per week. Eligibility is checked on their first anniversary.
  - In 2015, eligibility is checked on the anniversary of the Employee's first pay check in which they accrued an hour of service. The hours credited on the first pay check will be the greater of the hours accrued or an average of 30 hours per week.
  - Beginning in 2016, eligibility will be checked on the anniversary of the Employee's second pay check in which they accrued an hour of service.
- 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 and Wellness benefits under the Plan. Variable Hour Employees are not eligible for Supplemental Life, Dependent 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.

  In 2015, Variable Hour Employees are not eligible for EAP coverage. In 2016, Variable Hour Employees will be eligible for EAP coverage, subject, in some circumstances to approval by their Managing Partner or Joint Venture Partner.

  For additional eligibility information, visit **MyBBI.com > BBI Benefits > Benefit Basics > 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;
- prior to January 1, 2015, a seasonal or temporary employee;
- 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 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 legally married spouse as defined under the law of the state in which you were married;
- In 2015, your same-sex domestic partner (as defined below);
  - In 2016, same-sex domestic partners will not be eligible;
- In 2015, your children or your same-sex domestic partner's children who are under age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
  - In 2016, your same-sex domestic partner's children will not be eligible unless they meet the definition of a Dependent under the plan (such as being the employee's adopted child);
- 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. For years prior to 2016, any adult child of your domestic partner who satisfies this definition prior to 2016 will also be eligible.

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 or, for 2015 only, in a same-sex domestic partnership with 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 Benefit Booklets and benefits website (**MyBBI.com > BBI Benefits > Benefits Basics > Eligibility**) for additional special rules that apply to eligibility requirements.

Dependent Life

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

- Your legally married spouse as defined under the law of the state in which you were married;
- For 2015, your same-sex domestic partner (as defined below);
  - In 2016, your same-sex domestic partner will not be eligible for Dependent Life;
- In 2015, your, your spouse's or your same-sex domestic partner's unmarried natural child or stepchild, or legally adopted child under age 26 if primarily dependent on you for support;
  - In 2016, your same-sex domestic partner's children will not be eligible for Dependent Life.

Please see the applicable Benefit Booklets and benefits website (**MyBBI.com > BBI Benefits > Benefits Basics > Eligibility**) for additional eligibility requirements.

Health Care Flexible Spending Account

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

- Your legal spouse as defined under the laws of the state in which you were married,
- 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 (including a domestic partner) 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. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

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.

Dependents Not Eligible

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

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

Domestic Partner Eligibility – For 2015

Your "domestic partner" means a same-sex domestic partner of a Company eligible employee where you both meet all of the following requirements:

- You may not be so closely related that marriage would otherwise be prohibited;
- Neither of you may be legally married to, or in a domestic partnership with another person;
- Both of you must be at least 18 years old;
- Both of you must be mentally competent to enter into a contract;
- You must be financially interdependent; and
- You must jointly sign an affidavit of domestic partnership.

Effective January 1, 2014, a same-sex domestic partner will be an eligible dependent only when you live in a state that does not provide for same-sex marriage. If you live in a state that allows same-sex marriage, you need to be married in order to have your partner be eligible for coverage under the Plan.

Effective January 1, 2016, domestic partners will no longer be benefits eligible.

Tax Consequences of Domestic Partner Benefits – For 2015 and prior tax years

Unless your same-sex domestic partner or his or her dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner and his or her dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic partner (or his or her child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child of a domestic partner being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify the Resource Center at OSI Restaurant Partners, LLC immediately in writing of this special state income tax status.

If you have enrolled your same-sex spouse, depending on the laws of the state in which you live, there may be state tax consequences for covering your same-sex spouse. Please speak to your tax advisor.

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 Benefit Booklets provided by the applicable insurance companies and/or service providers.

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. You may obtain a copy of OSI Restaurant Partners, LLC's procedures governing QMCSO determinations, free of charge, by contacting the Resource Center 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.

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 in writing and contain the change in status event, the date of the event, and your requested change and must be sent to the Resource Center at the address in the following paragraph.

In order to preserve your dependent's COBRA rights, you must notify the Resource Center at OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607 in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage (see section Eligible Dependents above for a description of these requirements). You may also notify the Resource Center via email at bbiconnect@bloominbrands.com. 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 Plan (salaried only in 2015, includes hourly beginning in 2016)
- 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)

- Wellness
- Dental
- Vision
- Supplemental Life (salaried only)
- Dependent Life (salaried only)
- Supplemental AD&D (salaried only)
- Buy-Up Short-Term Disability (salaried only)
- Buy-Up Long-Term Disability (salaried only)
- Health Care Flexible Spending Account (salaried only)
- Dependent Care Flexible Spending Account (salaried 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 defined by the health plan. 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 towards 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 Benefit Booklets 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, Dependent Life, 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 Dependent Life 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, Vision, 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 or adoption of a child, your election change will be effective as of the date of the birth or adoption (or placement for adoption).

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 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 (including domestic partners in 2015 only) 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 after your or your eligible dependents' other coverage ends (or 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. The Plan is not required to extend all of the HIPAA special rules for a newly acquired domestic partner, however, you may still be able to add them to the Plan as described in the Change in Status section.

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, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your timely request for enrollment.

The Plan also provides a HIPAA special enrollment for employees and dependents (including, for 2015, domestic partners) 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 OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607, bbiconnect@bloominbrands.com or at 1-813-282-1225 (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, unless your enrolled eligible dependents do not qualify for tax-free coverage. If your enrolled eligible dependents are not eligible for tax-free coverage, you will pay your contributions for their coverage on an after-tax basis. The level of contribution is determined by the Company.

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

If you are enrolled in Supplemental Life, Dependent Life, 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. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution. 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

Bloomin' Brands 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 and flexible spending account coverage. Bloomin' Brands funds the full cost of basic life and AD&D and core long and short term disability coverage.

CONTRIBUTIONS FOR NON-TAX DEPENDENTS

In 2015, if you elect Medical, Dental and Vision coverage for your eligible same-sex domestic partner and his or her eligible children, you will be asked if they are your federal tax dependents when confirming your dependent's eligibility status. If you do not indicate that they are your federal tax dependents, you will be required to pay contributions for your domestic partner and his or her children's coverage on an after-tax basis and the amount OSI Restaurant Partners, LLC contributes toward your domestic partner's and their dependents' coverage will be treated as imputed income. The amount of your imputed income will be added to your paycheck each payroll period and will be subject to income tax withholding. In addition, OSI Restaurant Partners, LLC will include the annual amount of this imputed income on your Form W-2 at the end of each year. Before enrolling your domestic partner and his or her eligible children, you should talk to your tax advisor about the tax implications for you.

In 2016, same-sex domestic partners and their children will not be eligible for coverage under the plan.

SECTION 125 PLAN – PREMIUM CONVERSION

OSI Restaurant Partners, LLC has established a premium conversion plan under Internal Revenue Code Section 125 in order for you to be able to pay your contributions for the Medical, Dental, Vision and Buy-Up STD coverages provided under the Plan on a pre-tax basis.

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, Buy-Up STD and LTD Mid-Year Changes

If you do not enroll for Supplemental Life, Dependent Life, Supplemental 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. You may request to increase your election or request enrollment in Supplemental Life, Dependent Life or Supplemental 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 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 Plan Administrator within 31 days of the event, or 60 days to add a newborn and for certain events as described under HIPAA Special Enrollments in this booklet. 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 notify OSI Restaurant Partners, LLC, you can submit your notification via mail at OSI Restaurant Partners, LLC, 2202 N. West Shore Blvd, Suite 500, Tampa, FL 33607, by email at bbiconnect@bloominbrands.com or call for more information 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 notify OSI Restaurant Partners, LLC within 60 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 may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, 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;
- **Change in domestic partnership status:** Registration or dissolution of a domestic partnership. This applies for 2015 only;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, 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 or dental option's network service area;
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA);
- **FMLA leave:** Beginning or returning from an FMLA leave.

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 may 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, 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.

Coverage Changes

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

- 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 CHANGES IN STATUS

The changes you make to your coverage 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.

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 Plan, and Health Care Flexible Spending Account or Health Reimbursement Arrangement 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 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, 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 Plan, and Health Care Flexible Spending Account or Health Reimbursement Arrangement 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 Plan, and Health Care Flexible Spending Account or Health Reimbursement Arrangement 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).

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 Plan and Health Care Flexible Spending Account or Health Reimbursement Arrangement 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 are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA Plan Year.

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 Plan, 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 Benefit Booklets.

Coverage for your spouse and other dependents (including your domestic partner, as eligible in 2015 and prior years) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. 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 Dependent 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 legally married spouse, domestic partner 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 your Benefit Booklets for more information on conversion.

Except as otherwise stated in this document, the Benefit Booklets 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 participatory. This 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 similarly situated individuals, regardless of health status and without the need for engaging in a specific outcome-based physical activity.

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.

In connection with the Wellness benefit program, such program complies with the Americans with Disabilities Act (ADA), which generally prohibits disability-related inquiries or requiring medical examinations of employees. Moreover, to the extent any voluntary medical examinations are conducted, or information from medical histories are obtained, as part of the Wellness benefit program, medical information from these is kept confidential and separate from personnel records. To the extent required under applicable law, if the Wellness benefit program conditions a reward on a health factor constituting a disability under the ADA, there will be compliance with the ADA's reasonable accommodation rules.

Also, the Genetic Information Nondiscrimination Act (GINA) prohibits group health plans from adjusting premiums or contribution amounts based on genetic information, from requiring an individual to undergo a genetic test, and from collecting genetic information prior to or in connection with enrollment or underwriting purposes. However, GINA allows the acquisition of genetic information about employees when offering voluntary health or genetic services, including Wellness benefit programs.

Where required by applicable law, the information subject to GINA will be in aggregate form and will not disclose the identities of specific employees. In addition, the release of such information will be pursuant to a prior voluntary, knowing and written authorization by each employee. In connection with the Wellness benefit program, financial inducements offered to employees for completing a health risk assessment or questionnaires containing questions about family medical history or other genetic information is permissible only if it complies with the requirements of consent and authorization and also clearly states that the financial inducement is available regardless of whether the employee answers questions regarding genetic information. Lastly, health care providers will not to collect (including use of questionnaires) information subject to GINA as part of an employment-related medical exam.

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.

For domestic partners in 2015 and prior years, federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. As such, a domestic partner has no independent right to continue group health coverage after the dissolution of a domestic partnership or the employee's death. But a former employee has a COBRA right to retain a domestic partner's coverage and to elect domestic partner coverage during open enrollment if similarly situated active employees can do so.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse (including your same-sex spouse) and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, Wellness, 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 Life, STD, LTD, or AD&D benefits). 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.

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 (including a same-sex 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 the employee does 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 notify OSI Restaurant Partners, LLC (see contact information below) in writing within 60 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 providing the required notice.**

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the 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 qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license or marriage license.

You must mail or hand deliver this notice to OSI Restaurant Partners, LLC at the address listed below under Contact Information. **If the above procedures are not followed or if the notice is not**

provided to OSI Restaurant Partners, LLC within the 60-day 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.

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. 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 who have underspent accounts. 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 beneficiaries to carry-over a limited amount of funds from one year to the next. Also, the plan requires beneficiaries to spend their HCFSA dollars by the end of the calendar year and allows 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 your employment with the Company ended.

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, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. 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 or hand deliver 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 it 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:
Discovery Benefits
www.discoverybenefits.com
1-866-451-3399
PO Box 2926
Fargo, ND 58108-2926

Plan Administrator:
OSI Restaurant Partners, LLC
2202 N. West Shore Blvd, Suite 500
Tampa, FL 33607
1-813-282-1225
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 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 Benefit Booklets 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 the Medical Health Reimbursement Arrangement option (UHC Choice Plus HRA in 2015 and the UHC Choice HRA in 2016, collectively referred to as the UHC HRA), 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 UHC summary plan description.

The UHC HRA option is your combined medical and prescription drug benefit. This option includes an employer-provided Health Reimbursement Arrangement (HRA). In 2015, OSI will credit your HRA account with funds you use to help pay for eligible out-of-pocket medical and prescription drug expenses. Beginning in 2016, you will need to complete certain activities as outlined in the benefits communication materials 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.

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 UHC summary plan description). Below is the coinsurance, and minimum and maximum amounts you pay for 2015. Each year during open enrollment OSI will communicate if there is a change to the prescription drug coverage.

	At a Retail Pharmacy Up to a 30-day supply	**Through Express Scripts Pharmacy mail-order service** Up to a 90-day supply
Generic Drugs	20% ($20 max)	20% ($60 max)
Preferred Brand-Name Drugs	20% ($35 min/$100 max)	20% ($105 min/$300 max)
Nonpreferred Brand-Name Drugs	40%	40%

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, including your deductible, your Plan pays 100 percent of eligible medical and prescription drug expenses for the remainder of the Plan Year.

HSA MEDICAL PLAN PRESCRIPTION DRUG COVERAGE

If you are covered under the Medical Health Savings Account option (My 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 benefits booklet which is the UHC summary plan description.

The UHC My Health Savings option is your combined medical and prescription drug benefit. In 2015, if you are eligible for, and open, a health savings account with OSI Restaurant Partners, LLC's preferred HSA vendor, OSI Restaurant Partners, LLC will deposit funds each year that you may use to help pay for eligible out-of-pocket medical and prescription drug expenses. Beginning in 2016, you will need to complete certain activities as outlined in the benefits communication materials 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 (outlined in the UHC summary plan description). Below is the coinsurance, and minimum and maximum amounts you pay for 2015 and 2016. Each year during open enrollment OSI Restaurant Partners, LLC will communicate if there is a change to the prescription drug coverage.

	At a Retail Pharmacy Up to a 30-day supply	**Through Express Scripts Pharmacy mail-order service** Up to a 90-day supply
Eligible Preventive Drugs	Covered in Full	Covered in Full
Generic Drugs	20% ($20 max)	20% ($60 max)
Preferred Brand-Name Drugs	20% ($35 min/$100 max)	20% ($105 min/$300 max)
Nonpreferred Brand-Name Drugs	40%	40%

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:

Under the HSA plan only, preventive drugs, as defined by Express Scripts, Inc., are covered in full and are not subject to the deductible. Contact Express Scripts 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 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 Food and Drug Administration 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

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. 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 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 Benefit Booklets.

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, Dependent Life, AD&D, Business Travel, EAP, STD and LTD benefits of the Plan are guaranteed 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 & Dependent Life, Core and Supplemental Accidental Death and Dismemberment (AD&D),	CIGNA www.mycigna.com 1-800-238-2125
Core and Buy-Up Short-Term Disability	CIGNA www.mycigna.com 1-800-352-0661
Core and Buy-Up Long-Term Disability	CIGNA www.mycigna.com 1-800-352-0661
Business Travel Accident	Chubb www.chubb.com 15 Mountain View Road PO Box 1615 Warren, NJ 07061-1615

Employee Assistance Plan	Magellan www.MagellanHealth.com/member 1-800-327-6754

Claims Administrators – Self-Insured

Medical, Dental, Vision, Wellness, Health Reimbursement Arrangement and Health Care Flexible Spending Account and Dependent Care Flexible Spending Account benefits are self-insured. The Employer 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: United Healthcare www.myuhc.com 1-800-985-3290 185 Asylum Street Hartford, CT 06103-3408 Prescription Drugs: Express Scripts www.express-scripts.com 1-866-544-7943 8111 Royal Ridge Parkway Irving, TX 75063
Dental	CIGNA Dental www.mycigna.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	UnitedHealthcare www.myuhc.com 1-800-985-3290 9900 Bren Road East Minnetonka, MN 55343 For Employees with grandfathered HRA coverage relating to the San Francisco Health Care Ordinance, (a closed group with no new enrollments) the Claims Administrator is: Discovery Benefits www.discoverybenefits.com 1-866-451-3399 PO Box 2926 Fargo, ND 58108-2926 Note, the HRA plan used to comply with the San Francisco Health Care Ordinance ended in April 2015.
Flexible Spending Accounts (Health and Dependent Care)	Discovery Benefits www.discoverybenefits.com 1-866-451-3399 PO Box 2926 Fargo, ND 58108-2926

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and, if so, those rules will apply. See the Benefit Booklets for more information.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules do not apply to claims incurred under standalone dental or vision programs or health care flexible spending account plans.

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.

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 and HRA 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	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	

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The appeals processes for fully insured health program options may vary somewhat. Please see your Benefit Booklets for more information on fully insured health benefits.

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 minimus, 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.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 39. 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
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

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.

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 Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, 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. The Plan can require two levels of mandatory appeal review.

	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. If two levels of appeal review are allowed, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of appeal review are allowed, notice must be provided within 30 days of each appeal.	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.

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.

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.
- 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.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

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 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 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 Plan ▪ Core Short-Term Disability ▪ Core Long-Term Disability ▪ Buy-Up Short-Term Disability ▪ Buy-Up Long-Term Disability ▪ Core Life Insurance ▪ Supplemental Life Insurance ▪ Dependent Life Insurance ▪ Accidental Death and Dismemberment (AD&D) ▪ 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, Dental and Vision coverage 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 Supplemental Life, Dependent Life, Buy-Up Short-Term Disability, Buy-Up Long-Term Disability, 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 a Benefit Booklet. OSI Restaurant Partners, LLC 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, Dependent 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 Benefit Booklets 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, Benefit Booklets, 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 Benefit Booklets, 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.

APPENDIX A — BENEFIT BOOKLETS

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

The Benefit Booklets 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 Benefit Booklets for details of Plan benefits.

For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

Coverage	Benefit Booklet Name
Medical	2015 only: OSI Restaurant Partners, LLC Choice Plus HRA Plan Summary Plan Description 2015 only: OSI Restaurant Partners, LLC Choice Plus HRA Out-of-Area Plan Summary Plan Description Beginning 2016: OSI Restaurant Partners, LLC Choice HRA Plan Summary Plan Description Beginning 2016: OSI Restaurant Partners, LLC Choice HRA Out-of-Area Plan Summary Plan Description OSI Restaurant Partners, LLC My Health Savings Plan Summary Plan Description OSI Restaurant Partners, LLC My Health Savings Out-of-Area Plan Summary Plan Description Hawaii Medical Assurance Association Certificate of Coverage
Dental	CIGNA Dental Preferred Provider Insurance CIGNA Dental Preferred Provider Insurance Out-of-Area Plan
Vision	Group Vision Care Plan Evidence of Coverage
Employee Assistance Plan	EAP pamphlets
Core and Supplemental Life Insurance, including Dependent Life Insurance, if applicable	Group Life Insurance Certificate • Class 1: Salaried Employees, Vice Presidents and above • Class 2: Salaried Employees and Hourly Employees eligible for salaried benefits

	excluding Vice Presidents or above • Class 3: Hourly Employees
Short-Term Disability	Group Short Term Disability Insurance Certificate
Long-Term Disability	Group Long Term Disability Insurance Certificate • Class 1: Employees classified as Executives • Class 2: Salaried Employees and Hourly Employees eligible for salaried benefits
Core and Supplemental Accidental Death and Dismemberment	Group Accident Insurance Certificate • Class 1: Salaried Employees, Vice Presidents and above • Class 2: Salaried Employees and Hourly Employees eligible for salaried benefits excluding Vice Presidents or above • Class 3: Hourly Employees • Class 4: Pilots (terminated 12/31/2015)
Business Travel Accident Insurance	Business Travel Accident Insurance Program
Health Care and Dependent Care Flexible Spending Accounts	OSI Restaurant Partners Cafeteria Plan Summary Plan Description