UNIVERSITY OF SOUTHERN CALIFORNIA

LONG-TERM DISABILITY (LTD) INCOME PLAN

PLAN DOCUMENT

(AMENDED AND RESTATING FOR DISABILITIES COMMENCING ON OR AFTER JANUARY 1, 2003)
The principal purpose of the University of Southern California Long-Term Disability LTD income Plan (the "Plan") is to financially aid Participants in the event of a Total Disability, as defined in the Plan. This Plan does not replace other disability benefit sources which may be available to Participants, such as Social Security, State Disability, or Workers’ Compensation. This Plan provides a benefit supplement to such other benefit sources.

The Plan’s original effective date is January 1, 2000. Effective January 1, 2001, the University of Southern California Long-Term Disability Benefit Plan (Plan No. 523) was merged into this Plan (Plan No. 527). This amendment and restatement is effective for Disabilities commencing on or after January 1, 2003.
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UNIVERSITY OF SOUTHERN CALIFORNIA
LONG-TERM DISABILITY (LTD) INCOME PLAN

ARTICLE I
DEFINITIONS

General

Wherever the following terms are used in this Plan, they shall have the meaning specified below unless the context clearly indicates to the contrary.

1.01 Claims Administrator

"Claims Administrator", as used herein, shall mean the administrative services organization with which the University contracts for performance of claims administration services relating to the Plan.

1.02 Disability/Total Disability

During the first twelve (12) months following the commencement of a Participant’s disability, total disability means that, as a result of a sickness or bodily injury, the Participant is unable to perform his usual and customary work at USC.

After the first twelve (12) months of disability, total disability means that the Claims Administrator has determined that the condition for which the Participant is claiming benefits is disabling within the meaning of Title II of the Federal Social Security Act as now or hereafter in effect.

1.03 Effective Date

"Effective Date of the Plan", as used herein, shall mean January 1, 2003.

1.04 Employee

"Employee", as used herein, shall mean a person who on or after the Effective Date, is working as a "benefits eligible" employee. A benefits eligible employee shall mean an employee working 50% time or more for the Employer.

1.05 Employer

"Employer", as used herein, shall mean the University of Southern California and any other employer that is authorized by USC to participate herein and that adopts the plan for the exclusive benefit of its employees in accordance with any conditions required by USC.

1.06 Hospital

"Hospital", as used herein, shall mean an institution that is licensed and operated pursuant to law and that is primarily engaged in providing on an in-patient basis for the medical care and treatment of sick and
injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises, under the supervision of a staff of physicians and with twenty-four (24) hour a day nursing service.

1.07 Hospital Confinement

"Hospital Confinement", as used herein, shall mean any twenty-four (24) hour period of time, or any part thereof, for which a claimant is charged a full day's rate for room and board as a registered bed patient in a hospital, or in a nursing home as defined in subsection (i) of Section 1395X of Title 42 of the United States Code, or in a nursing home conducted by and for adherents of any well recognized church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend upon prayer or spiritual means for healing in the practice of such church or denomination.

1.08 Participant

"Participant", as used herein, shall mean an Employee who satisfies the eligibility requirements of Article II and who participates in the Plan.

1.09 Physician

"Physician", as used herein, shall mean a legally qualified and licensed doctor of medicine or, to the extent required by applicable law, another practitioner practicing within the scope of his license. The Plan Administrator may require, in its sole discretion, that any physician have training as a specialist or be a practicing specialist in a field of medicine. A physician must be someone other than the Employee or a member of the Employee's immediate family.

1.10 Plan

"Plan", as used herein, shall mean the University of Southern California Long-Term Disability (LTD) Income Plan, as amended from time to time.

1.11 Plan Administrator

"Plan Administrator", as used herein, shall mean the University. The Plan Administrator shall also serve as the "Named Fiduciary" for purposes of satisfying the requirements of Section 402 of the Employee Retirement Income Security Act of 1974.

1.12 Plan Year

"Plan Year", as used herein, shall mean a calendar year, which is from January 1 through December 31 of each year.

1.13 University

"University" or "USC" as used herein, shall mean the University of Southern California.
"Gross Wages" or "Regular Wages" as used herein, for the purposes of benefit determination, shall mean basic (regular) weekly compensation paid to the Employee by the Employer (excluding for example overtime, shift differential pay, bonuses, commission, monies paid in which the University is acting solely as the common paymaster and not as an employer, etc), during the last completed payroll period immediately prior to the date of commencement of the disability.
ARTICLE II
PARTICIPATION

2.01 Eligibility for Participation

All benefits eligible Employees (50% time or more), who enroll for “Optional Supplemental Coverage” in the USC Short Term Disability Plan, are eligible to participate in this plan.

2.02 Commencement of Participation

Eligible Employees are covered following twelve (12) active months of employment (they need not be consecutive). Employees who are off work due to occupational or non-occupational injury or illness, or under the auspices of state (CFRA) or federal (FMLA) versions of the University’s Family Medical Care Leave (FMCL), or for any other leave of absence, for more than 7 working days do not accrue time toward eligibility during this period away from work; however, nor do they lose time accrued toward eligibility before the onset of such leave of absence.

If an Employee has satisfied the eligibility requirements above, but because of sickness or injury was not at work on the day his coverage under this Plan would normally become effective, coverage will be effective following the day he returns to active work at all the duties of his occupation for one (1) full day. This requirement is also applicable to any subsequent Plan changes.

If an Employee is not an active (50% time or more) Employee on the day or during the period he would otherwise become eligible to be covered by the Plan, coverage will not become effective until he has returned to active employment status at his usual and customary schedule for one (1) full day as an eligible Employee.

2.03 Cessation of Participation

An Employee shall cease to participate in the Plan upon the earliest of the following dates:

A. On the date of termination of employment.

B. On the date the Employee ceases to be an eligible Employee.

C. On the date of termination of the Plan.
ARTICLE III
DISABILITY BENEFIT

3.01 Eligibility for Benefit

A Participant who sustains a Disability within the meaning of Section 1.04 shall, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 3.05.

3.02 Commencement of Disability Benefits

Benefits shall commence after a covered Employee has been disabled for a qualifying period of fifty two (52) weeks of continuous Disability.

3.03 Maximum Duration of Benefit

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<td>1 year and 6 months</td>
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<tr>
<td>69 or older</td>
<td>1 year</td>
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3.04 Limitations and Exclusions

A. No person shall be entitled to a Long-Term Disability benefit for any Total Disability that arises out of, relates to, is caused by or results from or to which the following conditions apply:

1. An intentionally self-inflicted injury while sane or insane.

2. An illness or injury caused by participation in a violent disorder, assault, criminal act or occupation. Additionally, no benefits are payable during any period while a Participant is in prison or any other correctional institution.

3. An illness or injury resulting from any act of war, military or international police action, or arising out of active temporary, or reserve duty in the armed forces.
4. An illness or injury for which the Participant is not under the continuous care and treatment of a duly qualified Physician, unless such continuous care and treatment are not medically indicated given the nature of the disability as determined by the Claims Administrator.

5. Any condition or symptoms for which the Participant received medical consultation, or a recommendation for care or treatment (including tests or taking prescribed Medicines or drugs) during the six (6) month period immediately prior to the most recent date of Plan participation. This exclusion ceases to apply at the end of a period of twelve (12) months of continuous Plan participation.

6. Alcoholism, drug addiction, or abuse, unless the Participant is in an approved treatment program. If the Participant is in such an approved treatment program, he will be entitled to benefits for a maximum period of twelve (12) months. This twelve (12) month maximum is an overall maximum which applies to all periods of Disability due to any one (1) or more of the above conditions. It is not a separate maximum for each of the conditions. (Drug abuse includes the taking of a prescription or controlled drug in a manner not prescribed by a Physician.)

B. Benefits Due To A Mental Illness

Monthly benefits for Disability due to mental or nervous disorders will not be payable beyond twenty-four (24) months of disability, unless the Participant is in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits (see Section 3.03).

An illness shall be considered a mental or nervous disorder if:

(1) The illness has psychologic or behavioral manifestations or results in impairment of mental functioning due to any causes including, but not limited to, social, psychological, genetic, physical, chemical or biological; and

(2) The illness has a primary diagnosis that either is listed in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Third Edition – Revised, or falls within diagnostic codes 290 through 319 in the International Classification of Diseases, 9th Revision.

This limitation shall not apply to a Total Disability due to Alzheimer’s disease, multiple sclerosis, amyotrophic lateral sclerosis, traumatic brain injuries, or other organic, degenerative, progressive diseases as determined by the Claims Administrator.
Monthly benefits for conditions diagnosed as or without regard to their designation, equivalent to, attention deficit disorder (ADD), chronic fatigue syndrome, Epstein-Barr Virus, infectious mononucleosis or fibromyalgia will not be payable beyond twenty-four (24) months.

C. Successive Periods of Disability

If a Participant receives monthly LTD benefits under this Plan, recovers and while he is still eligible and the Plan is still in force, returns to work and resumes his regular occupation and performs all the duties of his occupation on a full-time basis for less than six (6) months and then is disabled again, then the Participant’s recurrent Disability will be treated as part of the prior Disability if it is caused by a related illness or injury and after receiving Disability benefits. Benefit payments will be subject to the terms of this Plan for the prior Disability.

If the Participant returns to his regular occupation on a full-time basis for six (6) months or more, or if the recurrent Disability is not caused by a related illness or injury, a recurrent Disability will be treated as a new period of Disability. The Participant must then complete another elimination period.

In order to prevent duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to the Participant under any other group Long-Term Plan.

D. If a Participant is unable to perform his usual or customary work, but is not wholly disabled and is offered alternative employment by the Employer that is of comparable status and compensation to the Participant’s previous occupation, as determined by the Plan Administrator in its sole discretion, and the Participant declines the alternative employment offer, benefits cease.

E. No benefits are payable unless or until the Claims Administrator has received objective medical evidence in support of disability. Objective medical evidence includes but is not limited to, data and records from the Participant’s attending physician, narrative reports, x-ray and other laboratory findings, and consulting physician reports. This information is required at the initiation of a claim and periodically thereafter when requested by the Claims Administrator.

3.05 Amount of Plan Benefits

If a Participant is Totally Disabled, he may be eligible to receive payments under this Plan equal to 70% of his Wages.

For each day of any period of Disability for which benefits are payable and which is less than a full month, the amount of benefit payable shall be one-thirtieth (1/30th) of the monthly benefit.
Such benefits as described in Section 3.05 above shall be reduced by the amount of any of the following "other benefits" (converted to comparable monthly or daily equivalents, as appropriate) which the Plan Administrator determines are available to the Participant (whether or not such benefits are applied for) for the same period of Disability for which benefits are payable hereunder:

A. Any salary, wages, commissions, severance pay (except as otherwise provided in a written severance agreement between USC and the Participant) or other remuneration the Participant receives, or is entitled to receive from any Employer, while eligible for benefits under this Plan (excluding vacation pay cash-outs and tuition remission).

B. Any federal Social Security benefits for which the Participant and his dependents are eligible because of the Participant's Disability or retirement under Social Security (Old Age, Survivors, Disability and Health Insurance (OASDHI) Act of the United States. For purposes of computing this offset, any statutory cost of living increases awarded after the initial Social Security Award date, will not be used. However, if the initial award is subsequently adjusted to give credit for additional earnings or for any other reason, other than a statutory cost of living increase, the new award will be offset.

C. Benefits paid or claimed pursuant to any occupational disease law, any state or federal workers' compensation or Disability law, or other law of similar purpose; such benefits shall include, but shall not be limited to, temporary Disability payments (whether total or partial), vocational rehabilitation payments. Any amount awarded or paid in a lump sum, in accordance with any one of the workers' compensation plans as mentioned above, whether voluntarily or by operation of law, shall be deducted from the Plan benefit payable commencing from the date of the claim, award, or settlement, and continuing for as many future months as is necessary to equal the amount of such lump sum. (However, before computing the reduction to the Employee's Plan benefit on single sum awards or settlements, the Administrator will subtract any approved medical expenses and attorney fees which were incurred prior to the award.)

D. Disability benefits under a State Disability Insurance plan or a Company plan established in lieu thereof.

E. The amount of any award or settlement the Participant receives, directly or indirectly, from a third party if the Participant's Disability is the result of the acts or omissions of such third party, and the amount of any payments the Participant receives under any no fault or wage loss provisions of an insurance contract with respect to any injury which results in the Participant's disability.

F. Any Employer funded program which provides for a periodic Disability benefit or a
lump sum benefit payable (only the portion of these benefits attributable to contributions made by the employer will be integrated with the Plan benefits).

G. Any Government Retirement or Disability Plan that is initiated or increased (including benefits payable to his dependents) as a result of the Employee’s Disability.

H. Any retirement or pension benefits or similar remuneration the Participant receives, at or after attainment of age 65, or is entitled to receive, while eligible for benefits under this Plan, excluding amounts attributable to loans, hardship withdrawals, or distributions of voluntary contributions.

I. Benefits paid under any Unemployment Compensation Act of the United States or any state.

In the event that an overpayment exists because the Participant’s Plan benefits were not sufficiently reduced by any of the above mentioned reductions at the time they were paid, the Plan Administrator will recalculate the claim and inform the Participant of its findings. Any overpayment will become payable by the Participant, immediately upon request.

If the Participant either chooses not to apply for, elects to defer or fails to request any of the above benefits, for which he may be eligible, the Plan Administrator will reduce such benefits on the basis that the Participant had received the benefit on the earliest date he was eligible.

If, however, the Participant does apply for and/or requests any of the above benefits for which he may be eligible and provides the Plan Administrator with written evidence of these applications and/or requests, the Plan Administrator shall have the option of having the Participant sign a "Promise To Repay" form agreeing to pay the plan the appropriate amount of the "other benefits" payable. If the Participant signs the "Promise To Repay" form, the Plan Administrator will pay the Participant the full plan benefits while he or she is waiting for "other benefits" payments. Failure to sign the "Promise To Repay" form will result in a delay or denial in the payment of all or some of the Participants benefits payable under this Plan.

3.07 Duration and Frequency of Plan Benefits

Plan benefits shall be payable as of the first day that a Participant becomes eligible and applies thereafter shall be payable monthly, so long as such eligibility continues. Eligibility for Plan benefits shall continue until the earliest of the following events:

A. The date following the exhaustion of the maximum benefit period payable under Section 3.03.

B. The death of the Participant.
C. A determination by the Plan Administrator that the participant's Disability no longer exists (i.e., recovery, no longer disabled) Such determination shall be based upon objective medical evidence.

D. A failure by the Participant to cooperate in any examination by one (1) or more Physicians, vocational specialists, or other experts of the Plan Administrator's choice within thirty (30) days following a written request by the Claims Administrator.

E. A refusal by the Participant to provide information (including but not limited to objective medical evidence) requested in writing by the Plan Administrator for the purpose of determining whether the Participant is entitled to benefits under the Plan; failure to provide such information within thirty (30) days following such request shall be considered to constitute a refusal.

F. The date the Participant is no longer under the regular and continuous care of a Physician, or refuses to follow or rejects the treatment plan recommended by his attending Physician, unless the Participant disputes such treatment on the advice of another Physician. "Regular Care" means a planned program of observation and treatment by a licensed Physician, as required by applicable medical standards.

G. For periods following the first twelve (12) months of payments under this Plan, the date following a period of Disability if either (a) a determination is made by Social Security that the Participant's condition is not disabling within the meaning of Social Security Law; or (b) if the Participant does not qualify for Social Security benefits due solely to a lack of qualifying quarters of earnings and a determination is made by the Claims Administrator that the Participant's condition does not meet all of the required medical and vocational criteria listed in the U.S. Social Security Regulations.

H. During any period that the Participant works for himself or another employer for wage, remuneration or profit except in a rehabilitation program approved by the Claims Administrator (see below).

I. The date a Participant is confined in a penal or correctional institution

No benefit shall be due or payable under the Plan for any month prior to the month of January 1, 2000.

3.08 Rehabilitation Employment

As an incentive to return to work, the Plan will allow an eligible Employee even though he is disabled, to engage in an occupation or employment for Wage or profit for a period of up to twelve (12) months, during which he is eligible for benefit payments, without complete forfeiture of eligibility for benefits under the Plan as long as he does so with prior written approval of the Claims Administrator and as long as the Claims Administrator finds that rehabilitation or therapy...
is the primary purpose of employment and the rehabilitative employment is performed during a period he is unable to fully perform his regular occupation, with the following requirements:

A. The Participant must be reasonably able to do the job, because of his education, training or experience.

B. The Participant must be under the care and attendance of a qualified Physician (other than himself) during the employment.

C. The employment must be part of a rehabilitation program recommended and supervised by the Participant's Physician and/or the Claims Administrator.

D. The employment must occur during the course of a single period of Disability.

E. The Participant must not be in his regular job after more than twelve (12) months of eligibility for benefit payments under this Plan.

In the event an Employee receives income from rehabilitation or employment, engaged in with the prior approval of the Claims Administrator, the disability benefit shall only be reduced by 50% of the monthly income derived from that occupation or employment.

3.09 Overpayments

The Claims Administrator shall take such steps as it deems necessary to obtain prompt repayment of any overpayments made under the Plan. Toward this end, the Claims Administrator shall require that an agreement by the Participant to repay overpayments shall be included as part of an application for benefits whenever, in its discretion, this might contribute to safeguarding the Plan. Such agreement may provide for direct repayment by the Participant, assignment of rights to receive income or payments, and transfers of liquid assets. The failure of the Claims Administrator to obtain an agreement, however, shall not limit the Claims Administrator's right to recover an overpayment out of the income or resources of a Participant. In addition, current LTD benefits may be reduced (in whole or in part) at any time to recover any overpayment. Any amount that is reimbursable under the third party provisions in Section 3.06 E of the Plan shall be deemed an overpayment to the extent not already reimbursed. If a Participant fails to repay an overpayment, the Participant shall be liable for any attorneys fees or costs incurred by the Plan Administrator or the Claims Administrator in recovering such overpayment.
ARTICLE IV
PAYMENT OF BENEFITS

4.01 Application for Benefits

To be entitled to any Plan benefits for which a Participant is otherwise eligible, a Participant must be in compliance with such procedures and requirements as the Plan Administrator may have prescribed with respect to the completion and filing of an application for such benefits and submission of evidence that such Participant is entitled to such benefits.

The Plan Administrator shall have the right to:

A. Require continued proof of Disability at the Participant's expense during the pendency of a claim.

B. Require the Participant's written authorization for medical records and other information needed to document properly the Participant's file.

C. Require information with respect to the Participant's age, address, marital status, dependents, employment record and medical history.

D. Require any other information reasonably relevant to a determination of whether such Participant is eligible to receive Plan benefits, including, but not limited to, Federal and State tax returns.

E. Personally contact and interview the Participant, the Participant's Physician, Employer or any other persons who can provide relevant information regarding the Participant's Disability. Failure to cooperate with the Plan Administrator in a reasonable investigation or processing of a claim will result in benefits being denied, suspended or terminated.

4.02 Medical or Other Expert Examinations

The Plan Administrator may require that a Participant applying for Plan benefits submit to an examination by one or more Physicians, vocational specialists, or other experts designated by the Plan Administrator. Re-examinations of a Participant receiving Plan benefits may be required by the Plan Administrator from time to time for the purpose of determining whether a Disability continues to exist subject to Article I, Section 1.02. The fees of such Physician, vocational specialist, or other experts and the expenses of such examination shall be paid by the Plan.
The interest and property rights of any person in the Plan or in any payment to be made under the Plan shall not be subject to option nor be assignable either by voluntary or involuntary assignment or by operation of law, including (without limitation) bankruptcy, garnishment, attachment or other creditor's process, and any act in violation of this Section 4.03 shall be void.

4.04 Payment to Representative

In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made, in good faith, to the legal representative making claim therefore, and any such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Plan Administrator, i.e., the University.

4.05 Acts of Third Parties

If the Plan pays benefits when it appears that a third party may be liable, the Plan has the following rights:

A. The right of reimbursement to recover 100% of the amount of benefits paid by the Plan to or on behalf of the Participant from the Participant, or from an insurer or plan or other third party.

B. Subrogation right to bring an action against the other party if the Participant does not bring an action against the other party within a reasonable period of time.

The Plan may withhold payment of benefits when it appears that a party other than the Participant or the Plan may be liable until such liability is legally determined. As a pre-condition to paying benefits when it appears that the disability was a direct or indirect result of acts or omissions of a third party, the Plan may withhold the payment of benefits until the Participant signs an agreement furnished by the Plan Administrator setting forth the Plan’s right to reimbursement and subrogation right.

The Plan has a first priority right of reimbursement and subrogation right to recover 100% of the amount of benefits paid by the Plan to or on behalf of a Participant from another party if the following conditions are satisfied:

A. The Plan pays benefits to or on behalf of the Participant; and

B. The Participant has a right to claim or a right to recover damages from another party for causing the need for benefits from the Plan.

If the two conditions listed above are met, the Plan will have a first priority lien on 100% of the proceeds of any full or partial recovery the Participant receives or is entitled to receive from the third party, whether by judgment, settlement, or otherwise. The Plan’s lien applies:
Not only to any recovery the Participant receives or is entitled to receive from the other party, but also to any recovery the Participant receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.

To any recovery from the Participant's own uninsured or underinsured policy if that is the source of payment.

Even if the other party is not found to be legally at fault for causing the Participant to become entitled to Plan benefits.

Even if the damages recovered or recoverable from the other party, its insurer or plan or the Participant’s uninsured or underinsured policy are not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.

To any full or partial recovery, regardless of whether the recovery fully compensates the Participant for his injuries.

The only limitation on the Plan’s reimbursement and subrogation rights is that the Plan’s lien may not exceed 100% of the amount of benefits paid by the Plan. However, if the 100% recovery exceeds the amount recovered less legal fees and attorney fees incurred in obtaining the recovery (the “Net Recovery”), the Plan’s recovery will equal 100% of the Net Recovery.

If the Participant does not bring an action against the other party who directly or indirectly caused the disability within a reasonable period of time after the claim arises, the Plan will have the right to bring an action against the other party under the Plan’s subrogation right. The Plan will be responsible for its own attorney fees.

The Participant must do whatever is necessary and cooperate fully to secure the rights of the Plan. This includes assigning his rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

The Participant must give the Plan Administrator written notice of any claim against another party within 90 days after the claim arises. The Participant will not compromise or settle any claim against another party without the prior written consent of the Plan Administrator.
ARTICLE V
PLAN FINANCING

5.01 Participant Contributions

Participants are not required to make financial contributions to the Plan, but the University reserves the right to require employees to contribute financially to the plan. The cost of the benefits is entirely funded by the University and will be fully taxable to the Employee, until such time in its sole discretion it requires employees to contribute under the plan.

5.02 Limitation of Liability

No liability for the payment of benefits under the Plan shall be imposed upon the University's officers, trustees, agents or employees.

5.03 The University's Liability in the Event of Amendment, Termination, or Suspension of the Plan

The University may amend or terminate the Plan by a written instrument signed by a duly authorized officer of the university at any time. There are no vested benefits under the plan. Nothing in the Plan shall give any Employee the right to continued employment. The Plan shall not prevent discharge of any Employee at any time for any reason. All benefits under the Plan shall be unfunded and shall be payable only from the general assets of the University.
ARTICLE VI
ADMINISTRATION OF THE PLAN

6.01 Appointment of Plan Administrator

The University is the Plan sponsor and the Plan Administrator, as such terms are used in ERISA, and the named fiduciary with respect to control over and management of the operation and administration of the Plan. Any insurance carrier or other entity issuing an administrative services contract shall be solely responsible with respect to the matters for which it is made responsible under such administrative services contract, and to the extent required by ERISA, shall acknowledge in writing that it is a fiduciary with respect to the Plan.

6.02 Duties of Plan Administrator

The University shall be the named fiduciary with the discretion and authority to control and manage the operation and administration of the Plan. The University shall make such rules, interpretations and computations and take such other actions to administer the Plan as it may deem appropriate. The rules, interpretations, computations and actions of the University shall be binding and conclusive on all persons. In administering the Plan, the University shall at all times discharge its duties with respect to the Plan in accordance with the standard set forth in Section 404(a)(1) of ERISA.

6.03 Performance of Duties and Responsibilities

The University shall carry out its duties and responsibilities under the Plan through its directors, officers, and Employees, acting on behalf of and in the name of the University in their capacities as trustees, officers, agents and employees and not as individual fiduciaries. The University may engage such attorneys, actuaries, accountants, consultants or other persons to render advice or to perform services with regard to any of its responsibilities under the Plan as it shall determine to be necessary or appropriate. The University may designate by written instrument (signed by both parties) one (1) or more actuaries, accountants or consultants as fiduciaries to carry out, where appropriate, fiduciary responsibilities of the University. The University may rely on the actions of the Claims Administrator or the written opinion or advice of counsel or any actuary prudently retained by the University.

Any person or group of persons may serve in more than one (1) fiduciary capacity with respect to the Plan.

6.04 Claims Procedure

A Participant who submits a claim for Plan benefits shall submit such claim by following the claim procedures established from time to time by the Plan Administrator, in its sole discretion. The Participant’s Physician must also verify the Disability by complying with such procedures established from time to time by the Plan Administrator, in its sole discretion. Except for good
cause, written notice of cl. ... must be given to the Claims Administrator no later than sixty (60)
days after the first day of a Disability.

A claim may be submitted by a representative of the Participant if the Participant is not reasonably
able to do so.

If the Claims Administrator or Plan Administrator determines that the Participant is entitled to Plan
benefits, the Claims Administrator shall so advise the claimant in writing. Such written notice shall
set forth the amount of the Plan benefits to which the Participant is entitled and the method by
which the Claims Administrator computed the amount of such benefits.

If a claim is wholly or partially denied, the Claims Administrator shall provide the claimant with a
notice of denial, written in a manner calculated to be understood by the claimant and setting forth:

A. The specific reason(s) for such denial.

B. Specific references to the pertinent Plan provisions on which the denial is based.

C. A description of any additional material or information necessary for the claimant
to perfect the claim with an explanation of why such material or information is
necessary.

D. Appropriate information as to the steps to be taken to appeal the Claims
Administrator’s determination, including the right to submit written comments and
have them considered, the right to review (on request and at no charge) relevant
documents and other information, and the right to file suit under ERISA with
respect to any adverse determination after appeal of the claim. To the extent that
the Claims Administrator relied on an internal rule, guideline protocol, or other
similar criterion in making its decision, a description of the specific rule, guideline,
protocol, or other similar criterion, or a statement that such a rule, guideline,
protocol or similar criterion was relied on and that a copy of such rule, guideline,
protocol, or other criterion will be provided free of charge to the claimant upon
request,”

A decision regarding a claim for benefits will be rendered within a reasonable time
not longer than 45 days after it is received. This time period may be extended for
two additional 30-day periods for a maximum of 105 days for matters beyond the
control of the Claims Administrator, including cases where a claim is incomplete.
The claimant will receive written notice of any extension, including the reasons for
the extension, and the date as of which the Plan expects to render a decision, prior
to the expiration of the 45-day period (or, if applicable, the expiration of the first
30-day extension). The notice will set forth the standards on which entitlement to a
benefit is based, the unresolved issues that prevent a decision on the claim, and the
additional information needed to resolve those issues. The claimant shall be
afforded at least 45 days within which to provide the specified information. The
Claims Ad. ...istrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide any claim.

All appeals of an adverse decision on a claim for benefits must be submitted in writing within 180 days of the initial notice of adverse benefit determination. There shall be no right to submit an appeal after such 180 days and no right to file suit in court as a result of the failure to exhaust administrative remedies.

6.05 Claims Appeal Procedure

A. First Level Appeal. The Claims Administrator is responsible for rendering decisions on appeal following a denial of a claim for benefits. Requests for review should be sent to VPA, Inc. Attn: Manager Long Term Disability, P.O. Box 9830, Calabasas, CA 91372-0830.

The Claims Administrator will review and decide an appeal within a reasonable time not longer than 45 days after it is submitted and will notify the claimant of its decision in writing. If additional information is required to complete its review of any appeal, the Claims Administrator may, with prior notice, extend the review period for up to an additional forty-five (45) days for a maximum of ninety (90) days.

The individual who decides an appeal will not be the same individual who decided the initial claim denial and will not be that individual’s subordinate.

The Claims Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide any appeal, except that any medical expert consulted in connection with an appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with an appeal will be provided to the claimant.)

If the decision on appeal affirms the initial denial of a claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

The specific reason(s) for the denial,

The specific Plan provision(s) on which the decision is based,

A statement of the claimant’s right to review (on request and at no charge) relevant documents and other information,

To the extent that the Claims Administrator relied on an internal rule, guideline protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or similar criterion was relied on and that a copy of such
rule, guide, protocol, or other criterion will be provided free of charge to the claimant upon request."

A statement of the right to bring suit under ERISA § 502(a),

Any claim referenced in this section that is reviewed by a court, arbitrator, or any other tribunal shall be reviewed solely on the basis of the record before the Claims Administrator at the time it made its determination. In addition, any such review shall be conditioned on the claimant having fully exhausted all rights under this section,

The review process described above is intended to be the minimum required process and may be modified in any way by the Plan Administrator or Claims Administrator, but only with the Plan Administrator’s permission.

The claimant’s right to appeal to the Plan Administrator.

B. Second Level Appeal. Any person whose appeal pursuant to subsection (A) is not satisfactory, or such person’s duly authorized representative, may further appeal such denial by submitting to the Plan Administrator a written request for a review of the application within 180 days after receiving written notice of such denial.

The review request should be sent to: University of Southern California Disability Office, Denny Research Building 376, Los Angeles, CA 90089-1114, attention: Doug Moore.

Upon receipt of a request for review, pursuant to its discretionary authority to administer and interpret the Plan and to determine eligibility for participation and for benefits under the Plan, the Plan Administrator shall provide review of the Claims Administrator’s decision in accordance with the review process outlined in Article VI Section 6.05 A.

C. No legal action for benefits under the Plan shall be brought unless and until the claimant (i) has submitted a written application for benefits in accordance with Section 6.04, (ii) has been notified by the Plan Administrator that the application is denied in whole or in part, (iii) has filed a written request for a review of the application in accordance with Section 6.05 (A) and 6.05 (B) and (iv) has been notified in writing that the Plan Administrator has affirmed the denial of the application; provided, however, that legal action may be brought after the Plan Administrator has failed to take any action on the claim within the time limits prescribed by Sections 6.04 and 6.05, respectively. If a claimant who has been determined to be eligible for benefits under the Plan believes that the Plan Administrator has incorrectly calculated the amount of such benefits resulting in the underpayment of benefits under the Plan or that the Plan Administrator has incorrectly determined that the claimant is no longer eligible for benefits under the Plan, the claimant is required to file a separate claim for such additional benefits,
and any claim for additional benefits shall be subject to the requirements of this paragraph.

6.06 Limitation of Liability

The Plan Administrator and any representative thereof shall be entitled to rely upon any information from any source assumed in good faith to be correct. Neither the Plan Administrator nor any of its representatives, nor the University or any officer or other representative of the University, shall be liable because of any act or failure to act on the part of the Plan Administrator or any of its employees, to any person whomsoever, except that nothing herein shall be deemed to relieve any individual from liability for his own fraud, bad faith or gross negligence. The University may acquire such insurance coverage for the Plan Administrator and its representatives as is permitted by law.

6.07 Time Limits on Legal Actions and Certain Defenses

No action at law or in equity may be brought more than three (3) years after the time within which proof of loss is required to be furnished.
ARTICLE VII
DURATION AND AMENDMENT OF THE PLAN

7.01 Permanence of the Plan

The Plan shall continue in full force and effect unless terminated, modified, altered, or amended by the University, as provided in this Article.

Although the University has established the Plan with the bona fide intention and expectation that it will be able to continue the Plan indefinitely, nevertheless, the University is not, and shall not be, under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time.

The University may, in its sole and absolute discretion, amend or terminate the Plan in accordance with its provisions, at any time, without any liability whatsoever for such termination.

7.02 Right to Amend

The Plan Administrator, acting through the Board of Trustees of the University (the "Board"), shall have the full power and authority to amend or terminate at any time or times the provisions of the Plan, either prospectively or retroactively, to such extent and in such manner as the Board of Trustees shall deem advisable, in accordance with its normally established procedures. The Board of Trustees may delegate such power, in whole or in part, to one or more committees (comprised of officers or other managerial personnel or the Employer) to whom administrative responsibilities may be delegated under the Plan. There are no vested benefits under the plan.

Any modification, alteration or amendment of the Plan may be made retroactive to the Effective Date.
ARTICLE V111
GENERAL PROVISIONS

8.01 No Limitation of Management Rights

Participation in the Plan shall not lessen or otherwise affect the responsibility of an Employee to perform fully his duties in a satisfactory and efficient manner, nor shall it affect the University's right, which right is hereby expressly reserved, to discipline, discharge (with or without cause), or take any other action with respect to an Employee.

8.02 Participant's Responsibilities

Each Participant shall be responsible for providing the Administrator with his current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the University shall have any obligation or duty to locate a Participant. In the event a Participant becomes entitled to a payment under the Plan and such payment cannot then be made (a) because the current address referred to above is incorrect, (b) because such Participant fails to respond to the notice sent to the current address referred to above, (c) because of conflicting claims to such payment, or (d) because of any other reason, the amount of such payment, if and when made, shall be that determined under the provisions of Article III hereof without interest thereon.

8.03 Missing Persons

If, within one (1) year after any amount becomes payable hereunder to a Participant, the same shall not have been claimed, provided due and proper care shall have been exercised by the Administrator in attempting to make such payment, the amount thereof shall be forfeited, and shall cease to be a liability of the Plan.

8.04 Gender and Number

The masculine pronoun shall include the feminine pronoun and the singular the plural, where the context so indicates.

8.05 Governing Law

The Plan and all matters arising thereunder shall be governed by ERISA and, to the extent not preempted by ERISA, by the laws of the State of California.