UNIVERSITY OF SOUTHERN CALIFORNIA

SHORT-TERM DISABILITY PLAN

PLAN DOCUMENT

(AMENDED AND RESTATED FOR DISABILITIES COMMENCING ON OR AFTER JANUARY 1, 2003)

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(AMENDED AND RESTATED EFFECTIVE FOR DISABILITIES COMMENCING ON OR AFTER JANUARY 1, 2003)

The principal purpose of the University of Southern California Short-Term Disability Plan ("Plan") is to provide financial assistance to Participants in the event of Disability. 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 is integrated with other disability benefit sources and only provides a benefit supplement to such other benefit sources, where appropriate.

The Plan became effective on January 1, 2000. Effective December 31, 2000, the University of Southern California Short-Term Disability Benefit Plan I (Plan No. 522) was merged into this Plan. The assets of the University of Southern California Short-Term Disability Benefit I are to be used to pay benefits under the Plan before any other assets of the Plan or contributions made after December 31, 2000 are used to pay benefits under the Plan. Effective January 1, 2001 The University of Southern California Short-Term Disability Plan II (Plan no. 524) was merged into this Plan (Plan no. 526). Effective for Disabilities commencing on or after January 1, 2003, this plan is amended and restated.

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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 University of Southern California contracts for performance of certain claims administration services relating to the Plan.

1.02 Disability

"Disability", as used herein, shall mean (i) the continuous inability of a Participant, due to physical or mental illness or injury, to perform the material duties pertaining to his or her usual and customary work at the Employer, and (ii) during which the Participant is under the regular and continuous care of a licensed Physician.

A Participant shall not be considered to have a Disability if (i) he is performing work of any kind for remuneration or profit unless he or she receives the prior written approval of the Plan Administrator to perform such work, or (ii) he or she declines alternative employment by the Employer which is within the Participant's capabilities, and as determined by the Plan Administrator, in its sole discretion, has status and compensation comparable to the Participant's previous occupation.

The Claims Administrator shall make a determination as to whether a Disability exists with respect to a Participant on the basis of objective medical evidence. It shall be the obligation of the Participant to provide the Claims Administrator with objective medical evidence of disability.

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 50% time or more for the Employer in the United States.

1.05 Employer

"Employer", as used herein, shall mean University of Southern California ("USC"), 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 the laws of the state in which it operates 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 (1) 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 Short-Term Disability Plan, as amended from time to time.

1.11 Plan Administrator

"Plan Administrator", as used herein, shall mean University of Southern California. The Plan Administrator shall also serve as the "Named Fiduciary" for purposes of satisfying the requirements of Section 402(a)(2) or ERISA.

1.12 Plan Year

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

1.13 Surgical Clinic

"Surgical Clinic", as used herein, shall mean a clinic which is not part of and not operating under the license of a Hospital, which is duly licensed, and which provides treatment for patients who remain less than twenty-four (24) hours. A surgical clinic does not include the offices of private Physicians in individual or group practice or Emergency Room treatment.

1.14 Surgical Unit

"Surgical Unit", as used herein, shall mean a surgical unit located in or operating under the license of a Hospital and providing treatment for patients who remain less than twenty-four (24) hours. A surgical unit does not include emergency room facilities.

1.15 University

"University" or "USC" as used herein, shall mean University of Southern California.

1.16 Wages or Regular Wages

"Wages" or "Regular Wages", as used herein, for the purposes of benefit determination, shall mean basic compensation paid to the Employee by the Employer (excluding for example overtime, shift differential pay, bonuses, commission), during the last completed payroll period immediately prior to the date of commencement of the disability. For purposes of calculating a benefit payment (or any portion of a benefit payment) equal to 70% of an Employee's Regular Wages (to a maximum of $766.00 per week), Wages and Regular Wages shall include compensation paid to an Employee by a physician practice entity through the University, acting as common paymaster. For purposes of calculating any portion of a benefit payment in excess of 70% of Regular Wages (to a maximum of $766.00 per week), such compensation shall be excluded from the Employee's Wages or Regular Wages.

ARTICLE II
PARTICIPATION

2.01 Eligibility for Participation

An Employee is eligible for participation in this Plan on the later of January 1, 2003 or the date he becomes an employee. Employees working in California must participate in USC's California Voluntary Disability Plan (The Voluntary Plan) in order to be eligible for participation in this Plan, provided that an Employee who ceases to participate in the Voluntary Plan during the calendar year will not be ineligible to participate in this Plan for the remainder of the year.

2.02 Commencement of Participation

Each eligible Employee is covered as of the date of his or her employment, unless coverage is rejected by the Employee in writing. An Employee who has rejected coverage, or has withdrawn from the Plan, and subsequently elects to be covered by the Plan, may participate by enrolling during the Open Enrollment period (held in November of each year). Coverage will begin on January 1st of each year or as determined by the Employer. However, if an eligible Employee enrolls in the Plan pursuant to the second sentence of this paragraph, he or she will not receive benefits under the Plan for any Disability that begins in the first twelve (12) months after the effective date of coverage, if the Disability is caused by or contributed to or results from the Employee's pre-existing condition. For purposes of this Section 2.02, an Employee has a "pre-existing condition" if he or she received medical treatment, consultation, care or services (including diagnostic measures) or took prescribed drugs or medicines with respect to the condition in the six (6) months just prior to the effective date of his or her coverage.

If an Employee is not working in accordance with his normal work schedule on the day he would ordinarily become covered by the Plan, coverage will go into effect on the date he returns to his normal work schedule.

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 (including permanent layoff or reduction in force where no definite rehire date is given); or at 12:00 midnight on the 15th day following the commencement of a personal leave of absence without pay (excluding such a leave of absence qualified and approved in accordance with the Family Medical Leave Act of 1993 or the California Family Rights Act) or a temporary layoff (definite rehire date given) without pay.

B. On the date the Employee ceases to be an eligible Employee (as defined in Section 2.0 1);

C. On the date of termination of the Plan;

D. On the January 1 following the Open Enrollment period in which the Employee rejects coverage under the Plan.

E. On the effective date of an election to cease participation in the Plan that is made in accordance with the University of Southern California Code Section 125 Plan.

ARTICLE III
DISABILITY BENEFIT

3.01 Eligibility for Benefit

A Participant who sustains a Disability within the meaning of Section 1.02 shall, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 3.04.

3.02 Commencement of Disability Benefits

Benefits will commence on the eighth (8th) calendar day of disability.

3.03 Limitations and Exclusions

Participants are eligible to receive Plan benefits only if their Disability commences while they are an eligible Employee and are participating in the Plan. Benefits are subject to the following exclusions and limitations:

A. Alcohol/Drug

Payment for disabilities resulting from alcohol or drug abuse are limited:

1. If a Participant has been referred or recommended by competent medical authority to participate as a resident of an approved alcoholism recovery home, and in the absence of any other disabling condition, benefits while receiving alcoholism recovery treatment, while a full time resident in an approved recovery program, will be paid for a period not to exceed thirty (30) days, and shall be eligible for disability benefits for an additional period not in excess of sixty (60) days, if the referring physician certifies to the need for continuing resident services; or

2. If a Participant has been referred or recommended by competent medical authority to participate in an approved drug-free residential facility, and in the absence of any other disabling condition, benefits while receiving such drug recovery treatment will be paid for a period not to exceed forty-five (45) days, and shall be eligible for Disability benefits for an additional period not to exceed forty-five (45) days if the referring physician certifies to the need for continuing resident services.

B. No Benefits Are Payable:

1. If the Employee is confined, pursuant to commitment or court order, or certification, in an institution, or other place, as a dipsomaniac, drug addict, or sexual psychopath.

2. For any period of Disability for which benefits are paid or payable under any Unemployment Compensation Act of the United States or of any state.

3. For any day for which the Employee receives wages from his Employer except that benefits will be paid for any day in an amount not to exceed benefits provided by this Plan which, together with the wages received, does not exceed for such day one-seventh ($1/7^{th}$)of the wages earned in the last full week of work immediately prior to the commencement of the Employee's Disability.

4. If the Employee is unable to perform his regular or customary work with the employer, is not wholly disabled, and he was offered alternative employment by the Employer that is, as determined by the Plan Administrator, in its sole discretion, of comparable status and compensation to his previous occupation and he declined the alternative employment offer.

5. Any Employee who a) is incarcerated, in any Federal, State, or municipal penal institution, jail, medical facility, public or private hospital, or in any other place because of a criminal conviction of a federal, state, or municipal law or ordinance or b) commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.

6. Unless and until the Claims Administrator has received objective medical evidence in support of Disability. Such objective medical evidence includes, but is not limited to, data and records from the Employee's attending Physician, narrative reports, x-rays and other laboratory findings, and consulting Physician reports. This information is required at the initiation of the Employee's claim and periodically thereafter as reasonably requested by the Claims Administrator or the Plan Administrator.

7. During any period in which the Participant would not otherwise have been scheduled to perform services.

8. For any Disability described in Section 2.02.

C. No person shall be entitled to a Disability benefit for any Disability that arises out of, relates to, is caused by or results from:

1. An illness or injury caused by participation in a violent disorder, assault, felony or an illegal occupation or other act in violation of any law, order or regulation;

2. An illness or injury due to war or any act of war, declared or undeclared, or insurrection if Employee is a member of the armed services, except during any period of up to thirty (30) days while traveling overseas on University business.

3. An illness or injury for which the Participant is not under the continuous care and treatment of a duly qualified Physician, and in compliance with his treatment program.

4. An intentionally self-inflicted injury, while sane or insane.

D. Successive Periods of Disability

Two (2) consecutive periods of Disability due to the same or related cause or condition and separated by a period of not more than fourteen (14) days shall be considered as one (1) Disability benefit period.

3.04 Classification and Amount of Plan Benefits

A. Benefit Class 1 - Employees who have completed less than 52 weeks of active employment will receive the "Basic" STD Plan level of benefits, as follows:

Commencing with the first (1st) compensable day (See Section 3.02) of Disability, Benefit Class 1 Employees will receive a weekly benefit equal to 70% of his or her Regular Wages subject to a maximum weekly benefit of $766.00 and minimum weekly benefit of $64.

B. Benefit Class 2 - Benefits eligible Employees who have completed 52 weeks or more of active employment and have not elected "Optional Supplemental Coverage" will receive the "Basic" STD Plan level of benefits, as follows:

Commencing with the first (1st) compensable day (See Section 3.02) of Disability, Benefit Class 2 Employees will receive a weekly benefit equal to 70% of their Regular Wages subject to a maximum weekly benefit of $766.00 and minimum weekly benefit of $64.

C. Benefit Class 3 - Benefits eligible Employees who have completed 52 weeks or more of active employment and who have elected "Optional Supplemental Coverage" will receive benefits as follows:

Commencing with the first (1st) compensable day (See Section 3.02) of Disability, Benefit Class 3 Employees will receive a weekly benefit in accordance with their length of service, as set forth in the table below:

If Length of Service is:	**Maximum Duration of Benefits at 100% of Regular Wages**	**Maximum Duration of Benefits at 80% of Regular Wages**
1 year but less than 2 years	1 Week	51 Weeks
2 years but less than 3 years	2 Weeks	50 Weeks
3 years but less than 4 years	3 Weeks	49 Weeks
4 years but less than 5 years	4 Weeks	48 Weeks

5 years but less than 6 years	5 Weeks	47 Weeks
6 years but less than 7 years	6 Weeks	46 Weeks
7 years but less than 8 years	7 Weeks	45 Weeks
8 years but less than 9 years	8 Weeks	44 Weeks
9 years but less than 10 years	9 Weeks	43 Weeks
10 years or more	10 Weeks	42 Weeks

D. Benefit Class 4 - Benefits eligible Employees who have completed 52 weeks or more of active employment and who have withdrawn from the USC's California Voluntary Disability Plan will receive the "Basic" STD Plan level of benefits.

Commencing with the first (1st) compensable day (See Section 3.02) of Disability, Benefit Class 4 Employees will receive a weekly benefit equal to 70% of their Regular Wages subject to a maximum weekly benefit of $766.00 and minimum weekly benefit of $64.

For each day of any period of Disability for which benefits are paid and which is less than a full week, the amount of benefits payable shall be divided by seven (7) in order to determine the weekly benefit to which the Employee would otherwise be entitled.

3.05 Reductions Because of Other Benefits Payable

Such benefits as described in Section 3.04 above shall be reduced by the amount of any of the following "other benefits" (converted to comparable weekly or daily equivalents, as appropriate) which the Plan Administrator determines, in its sole discretion, 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 Federal Social Security 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.

B. Benefits paid 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 or permanent Disability payments (whether total or partial) and vocational rehabilitation payments. Any amount awarded or paid in a lump sum, in accordance with any one (1) 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 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 Plan Administrator will subtract any approved medical expenses and attorney fees which were incurred prior to the award.

C. Disability benefits under a State Disability Insurance plan or a University plan established in lieu thereof, including the University of Southern California Self-Insured Voluntary Plan of Short-Term Disability Benefits for California Employees.

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

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 provision of an insurance contract with respect to any injury which results in the Participant's disability.

F. Any benefits under any disability benefits program for which the University or any other employer makes contributions or direct payment to covered employees.

G. Any wages or remuneration payable from the Employer, (including severance pay, except as otherwise provided in a written severance agreement between USC and the Participant), or other employment, or self-employment, excluding vacation pay cash-outs and tuition remission. Employees who elect to receive wages for a nine (9) month period will be determined to receive wage payments during the twelve (12) months covered by their contract.

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

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. Determination of the amount of such benefit shall be made by the Plan Administrator, in its sole discretion.

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 may, at the Plan Administrator's sole discretion, result in a delay or denial in the payment of all or some of the Participants benefits payable under this Plan.

3.06 Duration and Frequency of Plan Benefits

Plan benefits shall be payable as of the first day that a Participant becomes eligible and applies therefore and thereafter shall be payable, so long as such eligibility continues (or such other period, as established from time to time by the Plan Administrator). Eligibility for Plan benefits shall continue until the earliest of the following events:

A. The date following fifty-two (52) weeks of Disability.

B. A determination by the Claims Administrator, that the Participant's Disability no longer exists (for example, recovery, no longer disabled). This determination shall be based upon objective medical evidence.

C. A failure by the Participant to cooperate in any examination by one (1) or more Physicians or vocational specialists, or other experts, of the Claims Administrator's (or Plan Administrator's) choice.

D. A refusal by the Participant to provide information (including, but not limited to, objective medical evidence of disability) requested in writing by the Claims or 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 a refusal.

E. 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.

F. The death of the Participant.

G. Termination of the Plan.

3.07 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 STD 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 Article III, Section 3.05 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 attorneys fees or costs incurred by the Plan Administrator or the Claims Administrator in recovering such overpayments.

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 prescribe from time to time 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 and Other Expert Examinations

The Plan Administrator may require that a Participant applying for Plan benefits submit to an examination by one or more Physicians or 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 or vocational specialist, or other expert, and the expenses of such examination shall be paid by the Plan.

4.03 Non-Alienation of Benefits

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 therefore and the obligations of the Plan Administrator and the Employer.

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 or 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:

A. 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.

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

C. Even if the other party is not found to be legally at fault for causing the Participant to

become entitled to Plan benefits.

D. 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

E. 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

Covered Employees will be required to make contributions to the Plan in such amount and manner as the University may from time to time require. Employees will be notified of the contribution rate no later than December 31st of each year.

If a California Employee withdraws from the USC California Voluntary Plan of Short Term Disability Benefits for California Employees, the Employee will continue to make contributions to this Plan until the end of the calendar year subject to Section 2.03. Those contributions will be used to pay for the Employee's participation in the California State Disability Insurance Plan (SDI).

5.02 Limitation of Financial Liability

No liability for the payment of benefits under the Plan shall be imposed upon the University or its officers, trustees, directors 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 at any time by a written instrument signed by a duly authorized officer of the university. 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 USC.

ARTICLE VI
ADMINISTRATION OF THE PLAN

6.01 Appointment of Plan Administrator

The University is the Plan sponsor and the Plan Administrator, and the named fiduciary, as such terms are used in ERISA, with respect to control over and management of the operation, administration, and interpretation 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 such 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, from time to time, in its sole discretion.

The rules, interpretations, computations and actions of the University shall be binding and conclusive on all persons, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. 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. As the Plan Administrator, the University has sole discretionary authority to administer and interpret the Plan, including (without limitation) discretionary authority to determine eligibility for participation and for benefits under the Plan, the amount of benefits (if any) payable per participant, granting or denial of benefit claims and the review of claim denials, and to interpret ambiguous terms.

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 directors, officers 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 from time to time, in its sole discretion. 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 claim 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 also 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 Administrator 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 Short 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, guideline, 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 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; 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 such 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, terminate the Plan in accordance with its provisions, at any time, without any liability whatsoever for such termination. No Employee Participant or other person shall be entitled a vested right to any benefits under this Plan.

7.02 Right to Amend

The University shall have the full power and authority to amend at any time or times the provisions of the Plan, either prospectively or retroactively, to such extent and in such manner as the University shall deem advisable, in accordance with its normally established procedures. The University may delegate such power, in whole or in part, to one or more committees (comprised of officers or other managerial personnel or the University) to whom administrative responsibilities may be delegated under the Plan.

7.03 No Right to Employment

No provision of this Plan is intended to provide any Employee with any right to continue employment with the Employer or affect the Employer's right, which is hereby expressly reserved, to terminate the employment of any individual at any time.

ARTICLE VIII
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 Employer'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 Plan Administrator with his current address (and all such other information reasonably requested by the Plan Administrator). 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 (nor the Employer) 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 Plan 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 hereunder shall be governed by ERISA and, to the extent not preempted by ERISA, by the internal substantive laws (but not the conflict of laws) of the State of California or any other state.

8.06 Severability

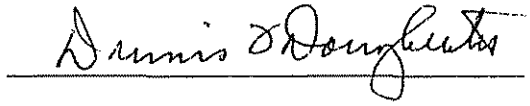
If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan shall continue in full force and effect.

UNIVERSITY OF SOUTHERN CALIFORNIA

EFFECTIVE FOR DISABILITIES

COMMENCING ON OR AFTER

JANUARY 1, 2003

BY 

TITLE Senior Vice President, Administration

DATE 1/15/2003

UNIVERSITY OF SOUTHERN CALIFORNIA

EFFECTIVE FOR DISABILITIES

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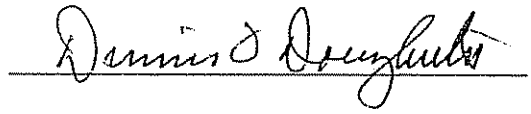
BY 

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