UNIVERSITY OF SOUTHERN CALIFORNIA

HEALTH CARE REIMBURSEMENT PLAN

Effective as of January 1, 2023

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University of Southern California

Health Care Reimbursement Plan

ARTICLE 1

INTRODUCTION

This Plan document amends, restates and renames the University of Southern California Health Care Reimbursement Plan, effective as of January 1, 2023. This Plan is intended to qualify as a Health Care Reimbursement Plan under section 105(b) of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with all relevant provisions of the Code and ERISA including, but not limited to, sections 601 through 609 of ERISA and section 4980B of the Code. The purpose of the Plan is to provide Participants with reimbursements of Qualifying Health Care Expenses that are excludable from the Participant's gross income under section 105(b) of the Code.

ARTICLE 2

DEFINITIONS

Wherever used herein, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

"Administrator" means the University or such other person or committee as may be appointed from time to time by the University to supervise the administration of the Plan.

"Benefit Eligible Employee" means a regular Employee who is regularly scheduled to work at least 50-percent full-time equivalent hours. The term "Benefit Eligible Employee" shall not include an Employee classified as a temporary, per diem, relief, temporary agency or contract Employee, or any other individual who is in a division, department, unit, or job classification designated by the University as not benefit eligible, regardless of the individual's work schedule or number of hours worked, or any individual covered by a collective bargaining agreement with a Participating Employer that does not provide for participation in this Plan.

"Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

"Coverage Amount" means the amount of health care reimbursement coverage elected by the Participant for the Plan Year under Section 4.2.

"Dependent" means any person who is a dependent of the Participant within the meaning of section 152 of the Code, determined without regard to Code section 152(b)(1), (b)(2), and (d)(1)(B), including any child (as defined in Section 152(f) of the Code) of the Participant who as of the end of the Plan Year has not reached age 27. For this purpose, any child to whom section 152(e) of the Code applies shall be treated as a Dependent of both parents.

"Employee" means any individual who is employed by a Participating Employer.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

"Flexible Benefit Plan" means the University of Southern California Flexible Benefits Plan, as amended from time to time.

"Health Care Expense Reimbursement Account" means the account described in Article 5 hereof.

"Participant" means each Benefit Eligible Employee who participates in the Plan in accordance with Article 3 hereof.

"Participating Employer" means the University and any affiliate of the University listed on the attached Appendix A whose participation in this Plan has been approved by the University.

"Plan" means the University of Southern California Health Care Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto.

"Plan Year" means the calendar year.

"Qualifying Health Care Expense" means an expense incurred by the Participant, or by the spouse or Dependent of such Participant, for medical care as defined in section 213(d) of the Code including, without limitation, amounts paid for hospital bills, doctor and dental bills, prescription drugs and insulin, over-the-counter medicine, and menstrual care products, and personal protective equipment, such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of the Coronavirus Disease 2019, but only to the extent that the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under the Plan). "Qualifying Health Care Expense" does not include any premium paid for coverage under any plan maintained by a Participating Employer or any other employer or any expense incurred for qualified long-term care services as defined in section 7702B(c) of the Code. Qualifying Health Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

"Required Premium" means the Participant's Coverage Amount for the Plan Year divided by 24 (or, if different than 24, the number of regular compensation payments, if any, currently received by the Participant per year). In the case of a Benefit Eligible Employee who first becomes a Participant in the middle of the Plan Year, the Required Premium shall be the Participant's Coverage Amount divided by the number of regular compensation payments remaining in the Plan Year. If the Participant changes his election under the Flexible Benefit Plan to increase or decrease his Coverage Amount during the Plan Year, his Required Premium shall likewise be increased or decreased by the amount of such change divided by the number of regular compensation payments remaining in the Plan Year.

"University" means the University of Southern California, or any successor to all or a major portion of its assets or business which assumes the obligations of the University under the Plan.

ARTICLE 3

PARTICIPATION

3.1. Date of participation. Each Benefit Eligible Employee will become a Participant upon the effective date of an election under the Flexible Benefit Plan to receive Qualifying Health Care Expense reimbursements under this Plan.

3.2. Cessation of participation. A Participant will cease to be a Participant as of the earliest of:

(a) the date on which the Plan terminates;

(b) the date on which his or her election to receive health care expense reimbursements under the Plan expires or is terminated under the Flexible Benefit Plan (unless a new such election is effective immediately thereafter);

(c) the date on which the individual ceases to be a Benefit Eligible Employee (including, without limitation, cessation due to a Plan amendment by the University in accordance with Article 9 hereof); or

(d) the date on which the individual fails to pay any Required Premium (including payment by salary reduction).

3.3. Reinstatement of former Participant. If a former Participant who is eligible under Section 3.1 elects again under the Flexible Benefit Plan to receive benefits under this Plan for any Plan Year, or if such an election is reinstated under the Flexible Benefit Plan, the Participant will again become a Participant in this Plan on the effective date of such election or reinstatement.

3.4. Participation of spouses or dependents. If and to the extent required by law (including, without limitation, section 4980B of the Code and regulations thereunder), coverage under this Plan shall be made available to the spouse or a dependent of a Participant or former Participant in lieu of (or in addition to) the Participant. In that event, such spouse or dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No salary reduction agreement shall be required for such a spouse or dependent, but Required Premiums must be paid to the Administrator on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such Required Premium.

ARTICLE 4

ELECTION TO RECEIVE MEDICAL REIMBURSEMENTS

4.1. Election procedure. A Participant may elect to receive reimbursements of his or her Qualifying Health Care Expenses under this Plan by filing an election and compensation

reduction agreement in accordance with the procedures established under the Flexible Benefit Plan. An election to receive reimbursements of Qualifying Health Care Expenses may not be changed or revoked by the Participant during the Plan Year, except as provided in the Flexible Benefit Plan. However, such an election may automatically terminate or may be terminated or modified by action of the Flexible Benefits Plan Administrator, in accordance with the terms of the Flexible Benefit Plan.

4.2. Coverage amount. A Participant may elect to receive payments or reimbursements of Qualifying Health Care Expenses incurred in any Plan Year up to $3,050 in 2023, as that amount may be adjusted for inflation from time to time, in accordance with Code section 125(i), in the sole discretion of the Administrator. A Participant may, to the extent permitted under the Flexible Benefit Plan, change his or her election by increasing or decreasing his or her Coverage Amount during the Plan Year, provided that any Coverage Amount, as so increased, does not exceed the limit set forth in the preceding sentence.

4.3. Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election to receive reimbursements of Qualifying Health Care Expenses during the Plan Year, and (b) adjust a Participant's Coverage Amount and Required Premium as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulations pertaining thereto.

ARTICLE 5

HEALTH CARE EXPENSE REIMBURSEMENT ACCOUNTS

5.1. Establishment of accounts. Each Participating Employer will cause to be established and maintained a Health Care Expense Reimbursement Account for each Plan Year with respect to each Participant employed by such Participating Employer who has elected to receive reimbursement of Qualifying Health Care Expenses incurred during the Plan Year.

5.2. Crediting of accounts. There shall be credited to a Participant's Health Care Expense Reimbursement Account for each Plan Year, as of the beginning of such Plan Year (or, if later, as of the date the individual became a Participant during the Plan Year), an amount equal to the Participant's Coverage Amount for such Plan Year. Any increase in the Participant's Coverage Amount during the Plan Year shall be credited to the Participant's Health Care Expense Reimbursement Account for such Plan Year, as of the effective date of such increase. Except as otherwise required by law, the amount credited for each Plan Year shall be the property of the Participating Employer until paid out pursuant to Article 6.

5.3. Debiting of accounts. A Participant's Health Care Expense Reimbursement Account for each Plan Year shall be debited from time to time in the amount of any payment under Article 6 to or for the benefit of the Participant for Qualifying Health Care Expenses incurred during such Plan Year. Any decrease in the Participant's Coverage Amount during the Plan Year shall be debited from the Participant's Health Care Expense Reimbursement Account for such Plan Year, as of the effective date of such decrease.

5.4. Carryover and Forfeiture of accounts. The amount credited to a Participant's Health Care Reimbursement Account for any Plan Year shall be used to reimburse the Participant for Qualifying Health Care Expenses incurred during such Plan Year and only if the Participant applies for reimbursement on or before the March 31 following the close of the Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day). Any balance up to $610, as that amount may be adjusted for inflation from time to time, remaining in the Participant's Health Care Reimbursement Account for any Plan Year, after all reimbursements hereunder, shall be carried over to reimburse the Participant for Qualifying Health Care Expenses incurred in the subsequent Plan Year. Any amounts carried over shall be in addition to the Coverage Amount elected in accordance with Section 4.2. Any balance remaining in the Participant's Health Care Reimbursement Account in excess of $610 shall not be carried over to reimburse the Participant for Qualifying Health Care Expenses incurred after such Plan Year, and shall not be available to the Participant in any other form or manner but shall remain the property of his or her Participating Employer, and the Participant shall forfeit all rights with respect to such balance.

ARTICLE 6

PAYMENT OF HEALTH CARE EXPENSE REIMBURSEMENTS

6.1. Claims for reimbursement. A Participant who has elected to receive health care reimbursements for a Plan Year may apply to the Administrator for reimbursement of Qualifying Health Care Expenses incurred while a Participant during the Plan Year by making application in writing to the Administrator, in such form as the Administrator may prescribe, setting forth:

(a) the amount, date and nature of each expense;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;

(d) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense;

(e) such other information as the Administrator shall from time to time require; and

(f) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and that the Participant will not seek reimbursement under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Administrator may request. Such

application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

6.2. Reimbursement or payment of expenses. The Administrator shall reimburse the Participant from the Participant's Health Care Expense Reimbursement Account, at such time and in such manner as the Administrator may prescribe, for Qualifying Health Care Expenses incurred during the Plan Year while a Participant, for which the Participant applies for reimbursement and submits documentation in accordance with Section 6.1. No reimbursement or payment under this Section 6.2 of expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Health Care Expense Reimbursement Account for the Plan Year at the time of the reimbursement or payment, nor shall any reimbursement or payment be made if the Participant's claim is for an amount less than the minimum reimbursable amount, if any, established by the Administrator. The amount of any Qualifying Health Care Expenses not reimbursed or paid as a result of the minimum reimbursable amount shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement during the last month of the Plan Year or on or before the March 31 following the close of the Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day) shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided they do not exceed the remaining balance of the Participant's Health Care Expense Reimbursement Account for the Plan Year.

6.3. Limitation on reimbursements or payments with respect to certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code section 105(h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 5.4.

ARTICLE 7

CESSATION OF COVERAGE

7.1. Cessation of participation. In the event that a Participant ceases to be a Participant in this Plan for any reason during the Plan Year, the Participant's election and compensation reduction (if any) relating to this Plan shall terminate. Except as provided in Section 7.2, the Participant shall be entitled to reimbursement only for Qualifying Health Care Expenses incurred within the same Plan Year and while the individual was a Participant.

7.2. Continuation of coverage. If and to the extent required by law (including, without limitation, sections 105, 125, and 4980B of the Code and regulations thereunder), in the event a Participant ceases to be an Employee and undertakes to pay Required Premiums to the Administrator on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and

shall be entitled to reimbursement for Qualifying Health Care Expenses incurred during such period of continued coverage, subject to Section 7.3.

7.3. Limits on time and amount of reimbursement. Reimbursements shall be made for any Plan Year under this Article 7 only if the Participant applies for such reimbursement in accordance with Section 6.1 on or before the March 31 following the close of the Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day). In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article 7. No reimbursement under this Article 7 shall exceed the remaining balance, if any, in the Participant's Health Care Expense Reimbursement Account for the Plan Year in which the expenses were incurred.

ARTICLE 8

ADMINISTRATION

8.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details subject, however, to the requirements of ERISA. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(e) To authorize the payment of benefits;

(f) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

(g) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be by written instrument and in accordance with Section 405 of ERISA.

(h) Any determination by the Administrator, or any authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

8.2. Examination of records. The Administrator will make available to each Participant such of its records as pertain to the Participant for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

8.3. Reliance on tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Administrator.

8.4. Named fiduciary. The Administrator will be a "named fiduciary" for purposes of section 402(a)(1) of ERISA with authority to control and manage the operation and administration of the Plan, and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

8.5. Claims and review procedures. The Administrator will establish claims and review procedures under section 503 of ERISA.

8.6. Indemnification of Administrator. The University agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator or acting for the Administrator in connection with the Plan, including any Employee or former Employee who formerly served or acted in such a capacity, against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the University occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

8.7. HIPAA and protected health information. The Plan and the Administrator shall fully comply with 45 C. F. R, Part 164, Security and Privacy, including but not limited to § 164.504(f) (the "Regulation") in all respects as of the date the Regulation requires such compliance by the Plan.

(a) Notwithstanding anything in the Plan to the contrary, any disclosure of protected health information (PHI), as defined in the Regulation, shall be limited to such disclosure as permitted by the Regulation.

(b) The Plan may disclose summary health information, as defined in the Regulation, to the University as sponsor of the Plan if the University requests summary health information for the purpose of (A) obtaining premium bids from health plans for providing health insurance coverage under the Plan or (B) modifying, amending or terminating the Plan.

(c) To the extent permitted by the Regulation, the University may use PHI for the administration of the Plan in accordance with the provisions of the Plan, such Plan

administration to include all activities reasonably related to Plan design, funding, enrollment, claims payment or denial (including any appeals of denied claims), employee communications, compliance with applicable law, other matters pertaining to the Plan in the ordinary course of business and resolution of any disputes relating to the Plan.

(d) The Plan will disclose PHI to the University only upon receipt of a certification by the University that the Plan documents have been amended as reflected in this Section 8.7 and the University agrees to:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the University with respect to such PHI;

(3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University;

(4) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(5) Make available PHI in accordance with Regulation §164.524;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Regulation §164.526;

(7) Make available the information required to provide an accounting of disclosures in accordance with Regulation §164.528;

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation;

(9) If feasible, return or destroy all PHI received from the Plan that the University still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure that adequate separation exists between the Plan and the University as set forth below.

(11) The following employees or classes of employees or other persons under the control of the University will be given access to the PHI to be disclosed:

(A) Employees working in the University Benefits Department, or any other department involved in administration of the Plan.

(B) Any Employee who has had Plan administration duties and responsibilities delegated to the Employee by the Administrator.

(C) Any auditors, attorney or actuary, physician, vocational expert, or any other person or entity appointed to provide professional or administrative services to the Plan or to the University in connection with the Plan.

(12) The access to and use by the Employees and other persons described above shall be restricted to the Plan administration functions that the University performs for the Plan.

(13) Any issues of noncompliance by the employees and other persons described above shall be dealt with promptly by the University's Assistant Vice President, Health Plans or any other duly authorized officer taking immediate steps to (i) investigate the alleged noncompliance, (ii) if noncompliance has occurred, correct the noncompliance in accordance with applicable law, (iii) initiate appropriate disciplinary actions against the individuals responsible for the noncompliance, and (iv) institute procedures to ensure that such noncompliance does not recur.

(14) The Plan may disclose PHI to the University to carry out Plan administrative functions that the University performs only consistent with the Regulation.

(15) A health insurance issuer or HMO with respect to the Plan shall not disclose PHI to the University except as permitted by the Regulation.

(16) The Plan shall not disclose and may not permit a health insurance issuer or HMO to disclose PHI to the University as otherwise permitted by the Regulation unless a statement required by Regulation §164.520(b)(1)(iii)(C) is included in the appropriate notice, and shall not disclose PHI to the University for the purpose of employment-related actions or decision or in connection with any other benefit or employee benefit plan of the University.

(17) To the extent the Plan (including but not limited to this Section 8.7) fails to comply with the Regulation, the Plan shall be deemed to be automatically amended to so comply and the Plan shall in any event be administered in accordance with any and all such deemed automatic amendments.

(e) The Plan will disclose electronic PHI, as defined in 45 C.F.R. §160.103, to the University only upon receipt of a certification by the University that the Plan documents have been amended to include this Section 8.7(e) and the University agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan as required by the Regulation.

(2) Ensure that any agents, including subcontractors, to whom it provides electronic PHI received from, or created or received by the Plan, agree to implement reasonable and appropriate safeguards to protect the Plan's electronic PHI.

(3) Report to the Plan any security incidents of which it becomes aware. For this purpose a security incident shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and such other incidents as shall be identified in the Regulation from time to time.

(4) Ensure that adequate separation between the Plan and the University required in 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

ARTICLE 9

AMENDMENT AND TERMINATION OF PLAN

9.1. Amendment and termination of Plan. The power to amend the Plan, in whole or in part, shall be vested in the University, which shall have the sole discretion to make all amendments to the Plan or any of its provisions. Such amendment shall be effected by a written instrument signed by an officer of the University, or his or her authorized delegate, and delivered to the Administrator. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by the University or any other Participating Employer.

9.2. Termination of Plan. The University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time, without liability, by a written instrument signed by an officer of the University, or his or her authorized delegate, and delivered to the Administrator. Upon termination or discontinuance of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made only in accordance with Article 7.

ARTICLE 10

MISCELLANEOUS

10.1. Information to be furnished. Benefit Eligible Employees shall provide the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.2. Limitation of rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or any Participating Employer except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.3. Employment not guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Participating Employers.

10.4. Benefits solely from general assets. Except as may otherwise be required by law, the benefits provided hereunder will be paid solely from the general assets of the Participating Employers. Nothing herein will be construed to require any Participating Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of any Participating Employer from which any payment under the Plan may be made.

10.5. Nonassignability of rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.6. Reclassification of Employment Status. Notwithstanding anything herein to the contrary, an individual who is not characterized or treated by a Participating Employer as a common-law employee shall not be eligible to participate in the Plan. However, in the event that such an individual is reclassified or deemed to be reclassified as a common-law employee of a Participating Employer, the individual shall be eligible to participate in the Plan as of the actual date of such reclassification (to the extent such individual otherwise qualifies as a Benefit Eligible Employee hereunder and the requirements of Article 3 are satisfied). If the effective date of any such reclassification is prior to the actual date of such reclassification, in no event shall the reclassified individual be eligible to participate in the Plan retroactively to the effective date of such reclassification.

10.7. No guarantee of tax consequences. Neither the Administrator nor the Participating Employers make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify his or her Participating Employer if the Participant has reason to believe that any such payment is not so excludable.

10.8. Indemnification of Participating Employers by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Qualifying Health Care Expenses, such Participant shall indemnify and reimburse his or her Participating

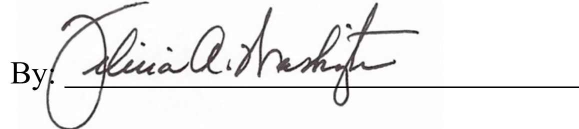
Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.9. Actions on behalf of Participating Employers. The University shall act for and on behalf of all Participating Employers in all matters pertaining to the Plan, and every act done by, agreement made with, or notice given to the University shall be binding on all such Participating Employers.

10.10. Governing law. To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan will be construed, administered and enforced according to the laws of the State of California.

IN WITNESS WHEREOF, the University has caused this Plan to be executed in its name and on its behalf by an officer or a duly authorized delegate effective January 1, 2023.

University of Southern California



By: ________________________________

Its: Senior Vice President, Human Resources______

Date: _05/26/23____________________

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<u>Appendix A</u>

Participating Affiliates

None