# Voluntary Short-Term Disability Insurance

*Employee Benefit Booklet*

*Administered By:*


**MEDICAL LIFE INSURANCE COMPANY**
Cleveland, Ohio

**SAU #80**

**Group Number: SA03985**

**CLASS I**

**MEDICAL LIFE INSURANCE COMPANY**
(herein called We, Us, Our)
20445 Emerald Parkway, Suite 400 • Cleveland, Ohio
1-800-692-1400

# CERTIFICATE

We agree to pay benefits subject to the provisions, definitions, limitations and conditions of the group Master Policy (herein called the Policy). The Policy, Group Policy Series T0003, is a contract issued by Medical Life Insurance Company to the Financial Services Trust (herein called the Trust).

This is your certificate of coverage. It is not valid unless accompanied by a copy of your signed Enrollment Form. This certificate replaces any group certificate previously issued under the Policy. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

## PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to Us. We will assist you in any way we can to help you understand your benefits.

President

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# Schedule of Benefits

**Amendment Effective Date: 07/01/2005**

**Class I** All eligible employees

**Voluntary Short Term Disability Weekly Benefit**

Your short-term disability weekly benefit shall be the amount you selected when you enrolled. The dollar amount of your weekly benefit, which may not exceed 70% of your Basic Weekly Income, is set forth on the copy of your signed enrollment form which accompanies this certificate.

Benefits begin on –

| | |
|---|---|
| 1st day of hospital: | No |
| Day of accident: | 1st |
| Day of sickness or pregnancy: | 8th |
| Maximum number of weeks payable: | 26 |

## ADDENDUM

Under the Benefit Provisions, the Reduction of Benefits shall be deleted in its entirety and replaced with the following:

Reduction of Benefits

The Voluntary Short Term Disability benefit and any combination of salary continuation or sick leave paid by the employer cannot combine for more than 100% of your pre-disability earnings.

# Definitions

**Accident** means an event that is sudden, unexpected and unintended and over which you have no control.

**Actively at Work** or **Active Work** means that an Employee is:

1. performing the normal duties of his occupation; and
2. working the minimum number of hours per week required by his employer.

An Employee will be considered Actively at Work if he was actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled workdays);
2. a holiday (except when such holiday is a scheduled workday);
3. a paid vacation; or
4. any non-scheduled workday.

**Application/Change Form** means a Policyholder's written Application for Group Voluntary Benefits as first submitted or later amended. This form sets forth coverage(s), eligible classes, Waiting Periods, benefit amounts and other information relevant to the Policyholder's Voluntary Benefit program.

**Basic Weekly Income** means the weekly compensation you earn from your normal occupation. It does not include earnings from overtime, bonuses, or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Income will include the weekly average paid in commissions during the preceding 12-month period.

**Contributory** means you pay all or a portion of the premium for your insurance coverage.

**Employee** means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's

normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

**Injury** means bodily injury resulting directly from an Accident and independently of all other causes. The injury must occur and disability must begin while you are covered under the Policy.

**Male Pronoun** whenever used includes the female.

**Non-contributory** means the Policyholder pays all of the premium for this insurance coverage.

**Physician** means your attending physician other than your spouse, parent, child, brother or sister.

**Plan** means the Voluntary STD Plan selected by the Policyholder.

**Policyholder** means the person, firm, or institution to whom the Policy is issued.

**Regularly Treated by a Physician** means you are attended by a Physician with medical training and clinical experience suitable to treat your disabling condition, and whose treatment is:

1. consistent with the diagnosis of the disabling condition; and
2. according to guidelines established by medical, research, and/or rehabilitative organizations; and
3. administered as often as needed to achieve the maximum medical improvement.

**Pregnancy** includes childbirth, miscarriage and complications of pregnancy.

**Sickness** means illness, disease or pregnancy. Disability must begin while you are covered under the Policy.

**Total Disability** or **Totally Disabled** means that you, as a result of Injury or Sickness are unable to perform the material and substantial duties of any occupation for which you are or become qualified by means of education, training or experience; and you

are not engaged in any employment or occupation for wage or profit.

**Treatment** means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

**Waiting Period** means the number of days you must be Actively at Work before you are eligible to enroll in the Voluntary Benefit program. The Waiting Period is set forth in the Application/Change Form.

## Eligibility and Effective Date Provisions

### Eligibility

Active Employees are eligible to enroll for Voluntary Benefits if they:

1. work the minimum number of hours per week shown on the Policyholder's Application/Change Form; and
2. are in an eligible class as shown on the Application/Change Form; and
3. have completed the applicable Waiting Period.

### Annual Enrollment

A time period to be determined by the Policyholder will be designated as the Annual Enrollment period. Eligible Employees may enroll in the Plan, apply for additional coverage, or request changes to their current Voluntary Benefit program(s) only during the Annual Enrollment. Employees hired after the Annual Enrollment period may enroll within 31 days following their eligibility date; if a new Employee does not elect Voluntary

coverage within that time period, he must wait for the next Annual Enrollment to enroll.

## Enrollment and Effective Dates

Voluntary STD coverage is Contributory; to enroll for Voluntary STD or request changes in coverage, an eligible Employee must complete the Enrollment Form(s) and agree to pay the applicable premium. All effective dates are subject to:

1. the Deferred Effective Date provision; and
2. your payment of or written consent to pay the applicable premium.

Coverage will become effective for Employees who are eligible on the Plan Effective Date at 12:01 a.m. on the later of the Plan Effective Date, the Employee's eligibility date, or the date the Employee signs the form.

Coverage will become effective for Employees hired after the Plan Effective Date on the later of the following dates:

If the Enrollment Form is signed on or before the end of the Waiting Period, initial coverage will become effective on the day following completion of the Waiting Period.

If the Enrollment Form is signed after the end of the Waiting Period, but within 31 days after that day, initial coverage will become effective on the date the Employee signs the Enrollment Form.

If there is no Waiting Period, initial coverage will become effective on the date the Employee signs the forms, provided he enrolls within 31 days of his eligibility date.

All increases to Voluntary STD coverage elected during subsequent Annual Enrollment periods will become effective on the date agreed to by the Policyholder and Us.

### Deferred Effective Date

An Employee must be Actively at Work for his insurance coverage to become effective. If an Employee is not Actively at Work on the date his coverage would otherwise begin, the coverage will begin on the day he is again Actively at Work.

### Eligibility after Termination of Employment

If an Employee's coverage ends due to termination of employment and he is rehired at a later date, he must meet all the requirements of a new Employee.

## Premium Provisions

Premiums are payable in United States dollars on or before their due dates. Your Employer has agreed to deduct from your pay any premiums payable for your insurance. Your Employer agrees to remit such premiums for the entire time this Plan is in effect.

Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would have otherwise terminated.

# Termination Provisions

## Termination of Employee Coverage

Insurance coverage will end at 12:00 midnight on the earliest of: the date your eligibility ceases;

1. the date the Policy or Plan is canceled or amended so as to terminate coverage for the class to which you belong;
2. the premium due date if you stop making any required contribution toward payment of premiums; or (if earlier)
3. the date you cancel your Voluntary coverage(s); or
4. the date employment terminates. Cessation of Active Work will be deemed termination of employment, except if you are Totally Disabled and eligible for benefits under the Policy and premiums continue to be paid when due.

Termination of coverage due to (2) above will not prejudice any claim for a loss incurred prior to such termination.

# General Provisions

## Statements

In the absence of fraud, all statements made in any application shall be deemed representations and not warranties and no statement made by you in applying for insurance under the Policy will be used to reduce or deny a claim unless a signed copy of your Enrollment Form is or has been given to you.

## Incontestability

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. Except for fraud, we will not contest the validity of an Insured's insurance after his insurance has been in force for two (2) years during his lifetime.

## Misstatement of Age

If you misstated your age, your true age will be used to determine the termination date of coverage; and premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

## Conformity with State Law

If any part of the Policy does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

## Workers' Compensation

The Policy does not replace or change any requirements for coverage under any Workers' Compensation or similar law.

Notice of Claim - Claim Forms

If you incur a loss that may result in a claim for benefits under the Policy, written notice must be given to Us at Our home office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

When We receive written notice of a claim, we will send the claimant forms with which to file proof of loss. If these forms are

not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

Proof of Loss We must receive written proof of loss within 90 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof, and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 90 days will not invalidate or reduce any claim.

### Legal Action

No action at law or in equity may begin prior to 60 days after we receive valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

## Benefit Provisions

### Total Disability Benefit

We will pay benefits to you if you become Totally Disabled while insured under the Policy. The day benefits begin and the maximum period for which benefits are payable are shown in the Schedule of Benefits. The amount of the Short Term Disability benefit shall be based on your enrollment form.

Successive periods of Total Disability separated by your return to Active Work for at least 30 days will be considered a new period of disability for which the Schedule of Benefit supplies applies with regard to the day benefits begin and the maximum period for which benefits are payable.

## Partial Disability Benefit

We will pay a Partial Disability Benefit if we receive proof that you, while covered under the Policy, are Partially Disabled following a period of Total Disability which has continued for at least 30 days.

The amount of benefit, the day benefits begin, and the maximum benefit period are set forth in the Schedule of Benefits. Receipt of a Partial Disability Benefit will not extend the Maximum Benefit Period shown in the Schedule of Benefits.

Partial Disability or Partially Disabled means you are working, but as a result of the Injury or Sickness which caused Total Disability, you are:

1. able to perform one or more, but not all, of the material and substantial duties of your occupation on a full time or part time basis; or
2. able to perform all of the material and substantial duties of your occupation on a part time basis; and
3. are earning less than 80% of your Pre-disability Earnings at the time the Partial Disability employment begins.

You will no longer be considered Partially Disabled when you are able to increase your current earnings by increasing the number of hours you work or the number of duties you perform in your occupation but you do not do so.

Pre-Disability Earnings means your Basic Weekly Wage in effect immediately prior to the date Total Disability begins. The Partial Disability Benefit will be the lesser of:

1. the Maximum Weekly Benefit shown in the Schedule of Benefits; or
2. your Pre-disability Earnings minus your Partial Disability income.

## Payment of Benefits

We will make benefit payments at regular intervals at least as often as once every two weeks. If benefits are due for a period of less than one (1) week, payments will be made at a daily rate of 1/7th the weekly benefit.

Reduction of Benefits The combination of benefits payable under the Policy and Other Income Benefits set forth below may not exceed 70% of your Basic Weekly Income. We will reduce the amount of your Short Term Disability payment by the Other Income Benefits you receive or are eligible to receive, as follows:

1. disability income payments under any state compulsory disability benefit law; or
2. employer sponsored income replacement plan, including but not limited to any formal or informal sick leave or salary continuation program.

For the purpose of this provision, eligible to receive means that:

1. you could have received the Other Income Benefits if you had applied for such benefits or appealed any denial of such benefits; or
2. you could have used such sick leave or salary continuation during the receipt of benefits under the Policy.

The benefit payable will never be less than the minimum weekly benefit of $100.

## Pre-Existing Condition Exclusion

Benefit amounts selected at initial Enrollment, as well as increases selected during subsequent Annual Enrollment periods will be subject to the following Pre-existing Condition exclusion.

Pre-existing Condition means a Sickness or Injury for which you received treatment within 12 months prior to your effective date.

**Treatment** means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

The Policy will not cover any Total Disability:

1. which is contributed to, caused by, or results from a Pre-existing Condition; and
2. which begins in the first 12 months after your coverage effective date.

## Limitations

We will not pay benefits under the Policy for Disability:

1. due to Injury or Sickness arising out of or in the course of any employment for wage or profit; or
2. due to bodily Injury sustained as a result of your commission of or attempt to commit an assault or felony; or
3. for any period during which you are not being Regularly Treated by a Physician; or
4. due to any intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane, or the voluntary taking of any drugs unless taken as prescribed by a physician; or
5. for which you are eligible for benefits under any Workers' Compensation or similar law.

Denial of Workers' Compensation will not result in the payment of benefits under the Policy if the disability resulted from an occupational Sickness or Injury. Benefits are also not payable under the Policy if you are entitled to participate in Workers' Compensation and choose not to do so.

## Termination of Benefit Payments

Short Term Disability benefit payments will cease on the earliest of:

1. the date you are no longer Totally Disabled;
2. the end of the maximum benefit period;
3. the date your earnings exceed 80% of your Pre-disability Earnings; or
4. the date on which you begin to receive benefits under any retirement plan sponsored by the Policyholder. For the purpose of retirement benefits, begins to receive means the first day you are eligible to receive retirement benefits, regardless of the date retirement benefits are actually paid or actually begin; or
5. the date on which you begin to receive state unemployment compensation for your job with the Policyholder; or
6. the date you die.

Physical Examination We may examine you at our expense at any reasonable time upon receipt of a claim.

# *ERISA Information Statement

**Federal Law Requires We Include This Notice In Your Booklet**

The benefits described in Your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Medical Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the effective date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide You with a general understanding of Your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from this SPD.

## A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries.

**This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.**

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The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Medical Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company.

The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

## B. CLAIMS PROCEDURE

### * Disability Insurance Plans

### * (Applies to the Waiver of Premium based on disability in Life Certificates.)

When You or Your beneficiary are eligible to receive benefits, You or Your beneficiary, or Your authorized representative (collectively, "You") must notify the Plan Administrator by submitting the proper form.

You may do this by sending notice of Your claim to the Plan Administrator who has been appointed to assist Medical Life in

the claims processing for this Plan or by contacting Medical Life directly at:

Claims Department
Medical Life Insurance Company
20445 Emerald Parkway Suite 400
Cleveland, OH 44135
1-800-782-8533

Medical Life will give You a written response to Your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Medical Life notifies You in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If Your claim is extended due to Your failure to submit information necessary to decide Your claim, the time for decision shall be tolled from the date on which We send You notice of the extension until the date We receive Your response to Our request. This period will be no longer than 45 days after We have requested the information. At that time We will decide Your claim based on the information We have at the time.

If the claim is denied, in whole or in part, You will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that You have to follow to have the claim reviewed;
- a statement that You have the right to bring a civil action under section 502(a) of ERISA after You appeal Our decision and after You receive a written denial on appeal; and

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to You upon request; and
- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request.

If the claim has been denied, in whole or in part, You can appeal the denial to Us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a) request a review upon written application within 180 days of the claim denial;

b) request, free of charge, copies of all documents, records and other information relevant to Your claim; and

c) submit written comments, documents, records and other information relating to Your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Medical Life will make a decision no more than 45 days after We receive Your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Medical Life notifies You in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision.

If Your claim is extended due to Your failure to submit information necessary to decide Your claim on appeal, the time for Your decision shall be tolled from the date on which the notification of the extension is sent to You until the date We receive Your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

## Life Insurance Plans

A decision will be made by Medical Life no more than 90 days after receipt of due proof of Loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of Loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, You will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed; and
- the steps that You have to follow to have the claim reviewed.

Any denied claim may be appealed to Medical Life for a full and fair review. You may:

a) request a review upon written application within 60 days of receipt of claim denial;

b) review pertinent documents; and

c) submit issues and comments in writing.

A decision will be made by Medical Life no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

## C. ERISA NOTICE OF YOUR RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries.

No one, including Your Employers, Your union, or any other persons, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied in whole or in part You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim. Under ERISA, there are steps You can take to enforce Your rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $100 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in federal court. The court will decide who should pay costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

## D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or Employee. Nothing contained in this Plan shall be deemed to give any participant or Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or Employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.