MATRIX
ABSENCE MANAGEMENT
A MEMBER OF THE TOKIO MARINE GROUP

P.O. Box 13498
Philadelphia, PA. 19101
(800) 866-2301

February 18, 2022

Nikolay Yeghyan
12834 oxnard st apt 6
Los Angelas, CA 91606

Re: Claimant: Nikolay Yeghyan
Plan No: ASW 515780
Claim No: 2021-05-22-0052-ASW-01
Employer: Toshiba Global Commerce Solutions, Inc

Dear Nikolay Yeghyan:

Introduction

Matrix Absence Management, (Matrix) is the claims administrator for Toshiba Global Commerce Solutions, Inc. (the Plan). We completed our review of your claim for Short Term Disability benefits and determined that you are not entitled to an extension of disability benefits under the Plan as of July 15, 2021. Please allow us to offer an explanation as to how we arrived at that decision.

Claim History

Activity	Date
STD Claim Filed	**May 22, 2021**
Disability Start Date	**May 22, 2021**
Claimant's Position	**SVC Rep II**
STD claim Denial of Extension	**February 15, 2022**

Plan Provisions

The following sections of the Plan are applicable to this determination:

> *Objective Medical Evidence* "Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a

functional limitation. Objective Medical Evidence does not include Physician's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, nausea), age, transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community and the abnormality must support and correlate to the disability and not be merely an incidental finding.

Medical and File Information Reviewed

Document Date(s)	Document Type	Document Source
May 22, 2021	Intake	You filed your claim on line
May 22, 2021	HR Data Feed	Client
June 4, 2021	Authorization for Release of Information	Fax
June 4, 2021	Employee's Certification Regarding Fraud	Fax
June 23, 2021	Letter To Employee	USPS
July 20, 2021	Certification Of Health Care Provider	Fax
August 12, 2021	Medical Records	Fax
September 9, 2021	Medical Records	Fax
October 11, 2021	Letter To Employee	USPS
October 13, 2021	Medical Records	Fax
October 20, 2021	Off Work Note From Doctor	Fax
October 25, 2021	Medical records	Fax
November 23, 2021	Letter To Employee	USPS
January 3, 2022	Medical Records	Fax
January 27, 2022	Letter to Employee	USPS

Clinical Judgment or Rationale

Although the records show you had therapy sessions, the records that were received indicate you had generalized Anxiety Disorder and Major Depression Disorder symptoms and you exhibited depressed mood and flat, constricted, blunted affect. There is no escalation of treatment plan that has been noted other than continued therapy and extension of leave of absence. There is not sufficient evidence of any moderate to severe psychiatric symptoms that would preclude you from working in your own occupation as a SVC Rep II

Appeal Rights

First Level of Appeal: Any **Participant** or the representative of a **Participant** whose claim has been denied will have the right to request a review of the decision made on his or her claim. Such request must:

1. be in writing and submitted to the **Claims Administrator** at the following address:

   Matrix Absence Management Quality Assurance Review
   c/o RSLI
   PO Box 13498
   Philadelphia, PA 19101

2. be filed within one hundred eighty (180) days after receipt of the written decision;

3. set forth all of the grounds upon which the request for review is based and any facts in support thereof; and

4. set forth any issues or comments, which the **Participant** deems pertinent to his or her claim.

The **Participant** or his or her representative may review documents pertinent to his or her claim.

Upon receipt of the request for review of the decision, the **Claims Administrator** will consider the written request and provide the **Participant** with a written decision within forty-five (45) days after receipt of the request for review. This review:

1. shall give no weight to the initial adverse benefit determination;

2. will be rendered *de novo,* with a review of the entire file, including any new materials and arguments submitted since the initial adverse benefit determination;

3. will be rendered by an appropriately named individual who neither made the adverse benefit determination that is the subject of the appeal, nor is the subordinate of that individual;

4. will be rendered in consultation with a **Health Care Professional** who has appropriate training and expertise in the field of medicine involved in the medical judgment, if the initial adverse benefit determination was made in consultation with a **Health Care Professional** and if the adverse benefit determination is based in whole or in part on a medical judgment; and

5. will be rendered with the consultation of a **Health Care Professional** who was not the individual consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual, if the initial adverse benefit determination was made in consultation with a **Health Care Professional**.

Should additional time be required in which to review the **Participant's** request, the **Participant** will be notified on or before the date the forty-five (45) day

period expires. The extension notification sent to the **Participant** will indicate (i) the special circumstances requiring an extension, and (ii) the date and time by which the **Claims Administrator** expects to render a determination on review. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received unless specific circumstances warrant a tolling of the time limits and additional time for review and determination.

Second Level of Appeal: Any **Participant** or the representative of a **Participant** whose appeal has been denied will have the right to request a review of the decision made on his or her claim. Such request must:

1. be in writing and submitted to the **Claims Administrator** at the following address:

   Matrix Absence Management Quality Assurance Review
   c/o RSLI
   PO Box 13498
   Philadelphia, PA 19101

2. be filed within one hundred eighty (180) days after receipt of the written decision;

3. set forth all of the grounds upon which the request for review is based and any facts in support thereof; and

4. set forth any issues or comments, which the **Participant** deems pertinent to his or her claim.

The **Participant** or his or her representative may review documents pertinent to his or her claim.

Upon receipt of the request for review of the decision, the **Claims Administrator** will consider the written request and provide the **Participant** with a written decision within forty-five (45) days after receipt of the request for review. This review:

1. shall give no weight to the initial adverse benefit determination;

2. will be rendered *de novo,* with a review of the entire file, including any new materials and arguments submitted since the initial adverse benefit determination;

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consultation with a Health Care Professional and if the adverse benefit determination is based in whole or in part on a medical judgment; and

5. will be rendered with the consultation of a Health Care Professional who was not the individual consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual, if the initial adverse benefit determination was made in consultation with a Health Care Professional.

Should additional time be required in which to review the **Participant's** request, the **Participant** will be notified on or before the date the forty-five (45) day period expires. The extension notification sent to the **Participant** will indicate (i) the special circumstances requiring an extension, and (ii) the date and time by which the **Claims Administrator** expects to render a determination on review. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received unless specific circumstances warrant a tolling of the time limits and additional time for review and determination. The decision of the Plan or **Claims Administrator** on any benefit claim will be final and conclusive upon all persons.

IMPORTANT NOTICE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, <u>we are asking that you NOT provide any genetic information</u> when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history; the results of an individual's or family member's genetic tests; the fact that an individual or an individual's family member sought or received genetic services; and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Your claim is subject to the Employee Retirement Income Security Act of 1974 ("the Act"). Pursuant to Section 518 of the Act, the 180 day period to appeal an adverse decision was temporarily suspended in response to the COVID-19 National Emergency. The temporary suspension will remain in effect for sixty days after the announced end of the National Emergency. Sixty days after the end of the National Emergency has been announced, the 180 day period for you to file for an appeal of your adverse decision will commence.

You have the right to bring a civil action under section 502(a) of the Act following an adverse benefits determination on review. However, your failure to request a review within the 180 day timeframe may constitute a failure to exhaust the administrative remedies available under the Act, and may affect your ability to bring a civil action under the Act. You may, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

What is needed to perfect your claim for benefits

Perfecting your claim means providing all the information and evidence necessary to establish your right to benefits under the Plan. In order to perfect this claim and to demonstrate that the requested disability benefits are payable, you must furnish us with information that has not already been submitted and may include the following:

- Medical records that show objective medical evidence precluding you from working after July 14, 2021.
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The foregoing suggestions are examples only, and are not suggestions or directions that you should obtain additional medical care or testing. Matrix does not direct care or provide medical advice. Rather, you should follow the advice of your health care provider(s).

The submission of additional information does not ensure that the denial will be overturned. All information will be considered and a decision made in accordance with the terms of the Plan.

Copies of Documents and Disability Claims and Appeals Handling Guidelines

You are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits.

A copy of the disability claims handling guidelines relied upon by Matrix in making this determination can be obtained at

https://matrixcos.com/-/media/images/brochureware/matrixcos/pdfs/disability-claims-and-appeals-decision-guidelines-2021.ashx

You may also obtain a printed copy of the guidelines upon request to your claims examiner.

Closing Paragraphs – Conclusion

In conclusion, based on our review of the Plan we did not receive objective medical evidence that would preclude you from working as a SVC Rep II beyond July 14, 2021. Your request for an extension of benefits after July 14, 2021, is denied.

Nothing in this letter should be construed as a waiver of any of Toshiba Global Commerce Solutions, Inc. rights and defenses under the Plan. All such rights and defenses are reserved to Toshiba Global Commerce Solutions, Inc. whether or not specifically mentioned in this letter.

If you have any questions, please contact us at 1-800-663-8044 X31350.

Sincerely,

Faith Forsythe

Faith Forsythe
STD Claims Department