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Office of Regulations and Interpretations
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Re: Claims Procedure Regulations for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Assistant Secretary Borzi:

I write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I am interested in the content of these regulations because I am an attorney whose practice is focused on the representation of claimants in ERISA-governed disability benefit disputes. I am well poised to comment because I have focused my practice for over twenty-five years on the representation of individuals who have been denied employer provided health, life, and disability benefits.

My firm of fourteen attorneys represents hundreds of individuals a year whose benefits have been improperly denied. Over the course of my career, I have personally represented or supervised the representation of over 2,500 claimants. In the vast majority of the initial meetings with clients, I am asked, "how can they deny my claim?" or "why would they deny my claim?" In every instance, the answer is the same, "because they can." I have explained to an untold number of clients that it is always in the interest of the profit motivated insurers or self-funded plans to deny all possible claims. This response may seem very cynical, and it doesn't ignore the fact that Billions of Dollars of claims are paid without dispute. However, if insurers and for profit claims administrators are going to seek the benefits of being "claim fiduciaries," they should be eager to ensure that every claimant receives a "full and fair review." Unfortunately, that will not be the case. The entities responsible for administering ERISA disability claims will contest any alteration of the regulations which might dilute their ability to deny claims on technical grounds.

Rather than provide a detailed legal analysis of the proposed regulations[1], I would like to take the opportunity to speak on behalf of my clients, past, present and future. For obvious reasons, my legal knowledge will be part of my comments, but I would like to focus on the expectations of my clients as to what would constitute an unrestricted full & fair review.

In *Pilot Life v. Dedeaux*, the Supreme Court, in its "*infinite wisdom*," determined that state laws providing protection to insurance consumers were pre-empted by the remedial scheme provided by the ERISA

[1] I wholeheartedly join in the detailed analysis drafted by some of my colleagues, which I attach hereto as part of my submission.

Statute. That ruling gave the insurance industry license to run rampant over the rights of ERISA governed claimants, without the fear of having to either compensate claimants for extra-contractual damages, or have the threat looming over their actions of a punitive damage award for truly outrageous conduct.

However, the ERISA remedial scheme as enacted by Congress, did provide some limited protections for claimants. It promised the right to a "federal action" in the event of an allegedly wrongfully denied claim. Lawyer and layperson alike know what constitutes a "federal action." It means a trial with a jury of ones' peers, witnesses to testify on the claimants' behalf, the opportunity to testify on ones' OWN behalf, so the trier of facts could judge the credibility of the claimant and his physicians, and also question the rationale for the denial of the claim by the profit motivated insurer. A federal action provides the Plaintiff the right of discovery to ascertain how the insurer made the decision to deny the claim.

Again, in a civil federal action, unlike a criminal action where the burden of proof to convict is beyond a reasonable doubt, in an ERISA action, the claimant obviously need only prove his or her case by a preponderance of the evidence. ***Oh wait***, preponderance of the evidence is only the fallback provision! After the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989),*the concept that a claimant would prevail if their evidence outweighed the evidence put forth by the insurer, went totally by the wayside. In *Firestone*, the Supreme Court provided a detailed roadmap for insurers and other plan administrators to afford themselves a method of assuring themselves victory in all "federal actions" that didn't involve the most outrageous of denials. All the insurers or claims administrators needed to do to achieve the right to guarantee victory in almost all cases was to bestow upon themselves "discretion" to interpret plan language or determine eligibility for benefits. Under the arbitrary and capricious standard of review which accompanied the self-grant of discretion, insurers didn't have to establish their claim denials were correct, but rather not totally unreasonable.[2]

Not surprisingly, after the decision in *Firestone*, the ERISA litigation landscape underwent wholesale change. The first thing that happened was that every disability carrier and claims administrator inserted discretionary language in their insurance policies and/or the "plans" the administrators drafted on behalf of employers. Did employers really make a decision to vest discretion with insurance carriers? Of course not. 1) they had no idea the language was in the policies they were purchasing; 2) they were not given the option of purchasing policies which did not contain discretionary language; and 3) many disability carriers refused to even sell policies unless they contained discretionary language.[3] Discretion is plans and insurance policies underwriting plans are included by those who benefit monetarily via their inclusion.

In 2016, over 25 years after the issuance of the decision in *Firestone*, state legislators, urged by consumers, are seeking to ban discretionary clauses in group disability policies utilizing the ERISA savings

[2] Some Courts held that for an insurer to prevail under this standard, they need only have something more than a scintilla of evidence supporting their decision. Full and fair review INDEED!

[3] To suggest that profit motivated disability carriers didn't understand the benefit to them of the protections afforded by ERISA, one need merely review the memo prepared by a senior claims officer at UNUM. (See attached as Exhibit 1). In fact, UNUM took such advantage of ERISA that the New York Attorney General, along with the Insurance Commissioners of all 50 States took action to require UNUM to offer to reopen over 200,000 denied disability claims. ("UNUM Regulatory Settlement Agreement.)

clause. Of course, the insurance industry is battling at every turn to maintain the right to include these one-sided provisions in their policies. When they fail, and the states ban the clauses, the insurance industry refuses to concede their validity, fighting their applicability in the courts.[4] Of course, even if the states manage to ban discretionary clauses within insured plans, they are powerless to regulate self-funded plans, which in turn assert that they allow "unbiased" third party administrators to make claim determinations, so not conflict exists. When a plan such as AT&T or Verizon pays $25,000,000 – $50,000,000 a year to a TPA, even the mere suggestion that the TPA has no interest in pleasing the Plan Sponsor by keeping claim payments as low as possible is just plain ludicrous.

The foregoing are just some of the ways in which the ERISA statute, enacted to provide claimants with necessary protections, has been reconfigured to provide the insurance industry with both a sword and shield to use against claimants.

Even the prior claims regulations enacted by the Department of Labor to afford protections to claimants have been converted by the Courts to instead provide protections to employers and insurance companies.

The ERISA statute contains no requirement that the claimant, having received an adverse benefit decision, take any steps prior to initiating litigation. Given that the denial of disability income benefits often means the ability to pay rent or procure basic necessities such as groceries, the ability to obtain a speedy resolution in court is essential for claimants. As the Department is well aware, the pre-2002 claims regulations required claims administrators to afford claimants the ability to seek reconsideration of an adverse benefit decision. This claim regulation, as enacted, appeared to be a voluntary right which could only benefit a claimant, by assuring that the claimant had the opportunity to correct any factual errors or supplement evidentiary support for his disability. However, the Federal Court's, again in their "*infinite wisdom*," likened the right to a request for reconsideration of an adverse benefit decision to an "administrative review" and mandated that absent incontrovertible evidence of futility, that the claimant "exhaust their so called administrative remedies" prior to initiating litigation. Originally given a mere 60 days to complete their mandated appeal[5], claimants who did not timely submit their appeal found that their failure did not merely deprive them of their right to appeal, but COMPLETELY FORECLOSED THEIR ACCESS TO A FEDERAL ACTION. A regulation enacted to provide a benefit to claimants was instead used by the insurance industry to avoid judicial oversight of their actions. Again, so much for the concept that insurance companies or TPA's acting as claims administrators can be unbiased fiduciaries seeking to provide a full and fair review.

Current evidence that providing a full and fair review is not something plan sponsors or administrators seek to achieve is evidenced by the sequence of events in the case of *Legras v. Aetna Life & Federal Express Corporation Long Term Disability Plan*, 786 F.3d 1233, (9th Cir. 2015). In *Legras*, the claimant's LTD claim was denied. The date he received notification of the denial of his claim was not contested. However, the 180th day following his notification was on a Saturday. The attorney who had been retained to appeal the denial

[4] For example, see *Fontaine v. MetLife*, 800 F.3d 883 (7th Cir. 2015); *Gonda v. The Permanente Medical Group, Inc.* 10 F.Supp.3d 1091, (N.Dist. Cal. 2014); *Cerone v. Reliance Standard Life Ins. Co., 9 F.Supp.3d 1145 (S. Dist. Cal. 2014)*

[5] Subsequently changed to 180 days in the 2002 amended regulations.

believed that because the 180th day fell on a Saturday, that he could timely submit the appeal if he did so on the Monday following the 180th day.

Acting on behalf of Fed-X, not only did Aetna refuse to consider the appeal, but when litigation ensued, it asked the Court to dismiss the litigation on the ground that the claimant had not timely exhausted his "administrative remedies," and therefore was deprived of his right to have his case decided by the court on the merits. The 90+ year old District Court Judge, Manuel Real, who is reversed by the 9th Circuit more often than any other District Judge within the Circuit, granted the motion.

My firm was asked to appeal the dismissal to the 9th Circuit. In a published decision, the 9th Circuit determined that in compliance with the intent and purpose of ERISA, the appeal would be considered timely, and ordered the matter was remanded to Aetna for a merits determination.

However, a clear ruling by the 9th Circuit to give the claimant the right to a full and fair review did not satisfy Aetna and/or Federal Express. Inexplicably, Defendants have filed a petition for certiorari with the U.S. Supreme Court.[6] Rather than acknowledge the incontrovertible, that a two day difference in receiving the appeal would have no impact on its ability to reconsider the denial, defendants are taking all possible steps to prevent Mr. Legras from having his claim considered by the Court on its merits. Once again, this is a perfect example of a claims administrator attempting to take what was once a voluntary procedure intended to benefit the claimant, into a shield preventing the claimant from having his claim considered on its merits. Full and fair review indeed?

The fact that the Department is in the process of enacting new claim handling regulations is sufficient evidence that it is cognizant of the failure of insurers to accept their responsibilities as claim fiduciaries. However, while the proposed regulations are clearly a step in the right direction, there are areas which need to be addressed to assure that claimants receive the full and fair review to which they are entitled. In short, enhanced claim regulations are the only viable method of ensuring that the courts and the insurers are mindful of the fact that the "E" in ERISA stands for "Employee," and not Employer or Insurer.

The following are the author's suggestions on strengthening the amended regulations in order to provide claimants with consistent full and fair reviews:

STATUTE OF LIMITATIONS ISSUES

The DOL has invited comment in the statute of limitations issues that have developed since the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid*. Ins Co., 134 U.S. 604 (2013). The decision has created more ambiguity than existed prior to the issuance of the decision. It is unclear when the statute begins to run, and when the statute is tolled. In addition, it created the inherently inequitable possibility that a statute of limitation might run before the claimant has completed the exhaustion requirements, thus barring litigation forever.

[6] See attached Exhibit 2.

In addition, many plans have "contractual limitations provisions" which provide for statutes of limitation as short as 60 days. In my own practice, I have had clients seek representation for the first time AFTER their contractual time to bring suit has already run.

These inequitable situations can be rectified by the inclusion in the amended regulations providing:

Contractual Limitations may not be any shorter than the comparable breach of contract action under the State Law in which the action is brought;

Contractual or Statutory Limitations are tolled from the date of an adverse benefit decision, until the date the claims administrator has advised the claimant in writing that their pre-litigation remedies are exhausted, and that they are able to bring suit under ERISA Section 502(a);

When a claims administrator advises a claimant of their right to bring suit, they must provide the exact date that the statute of limitation will run.

DISCRETION BESTOWED UPON A FINANCIALLY CONFLICTED CLAIMS ADMINISTRATOR

The concept that a claimant has a right to a federal action, but the District Court will give deference to an entity that has a financial interest in denying claims has never been justifiable, and will never be justifiable. Discretion may not be inappropriate if vested upon a TRULY independent unbiased entity, but as long as the entity is a profit motivated entity, discretion is inequitable is cannot exist alongside the concept of a full and fair review.

The fix for this problem could not be simpler:

Discretion to interpret plan terms or determine eligibility for benefits may not be bestowed upon an entity that exists to generate income for its owners.

ENSURING THE CLAIMANT HAS THE OPPORTUNITY TO RESPOND TO ALL EVIDENCE CONSIDERED BY THE CLAIMS ADMINISTRATOR

Under the current claims regulations, and mixed court rulings, the claims administrator can introduce newly obtained evidence and rely upon such evidence in the final appeal denial. Given the right to a full and fair review, it is inherently inequitable to deny the claimant to have the ability to comment on all relevant evidence. Again, the fix for this problem could not be simpler:

The claimant shall have the right to respond to or rebut any evidence introduced by the claims administrator during the pre-litigation review procedures. If the claimant is denied such a right, and litigation ensues, the claimant shall have the right to augment the claim record during litigation.

INTRODUCTION OF SSDI FINDINGS SUBSEQUENT TO THE CLOSE OF THE CLAIM RECORD, BUT PRIOR TO TRIAL

In almost twenty-five years of practice, I have never seen a group LTD policy or plan which did not offset SSDI benefits received by the claimant. Given the consistent dollar for dollar offset taken by the insurer or plan, if a claim is being paid, the insurer or plan has every incentive to insure the claimant is receiving SSDI benefits. The plans mandate the claimant apply for the benefits, and will take an assumed offset if the claimant doesn't apply.

As such, the decision of the SSA, as an independent unbiased governmental body, should be relevant to a District Court's decision as to the claimant's eligibility to receive LTD benefits. While the insurer/administrator will argue the standards are different, in reality the SSA has a much much higher standard for awarding benefits. **If the plan provides for an offset for SSDI, the District Court should be required to consider the findings of the SSA, notwithstanding the decision having been entered after the close of the claim record.**

UTILIZATION OF UNQUALIFIED OR BIASED EXPERTS TO DENY A CLAIM

As a practitioner who sees innumerable claim files, I have occasion to see reports generated on behalf of insurers on a very frequent basis by the same physician records reviewers. In my experience, these reviewers are often retired, and receive if not all, a significant majority of their income from providing reviews to insurance companies. They are aware if they support a claimant, they will be taken off the list of approved reviewers.

I also often see reports either generated by physicians who are not qualified to offer opinions on the condition at issue, or who have taken positions that the condition disabling the insured is NEVER DISABLING.

For example, I have often seen insurers retain a pediatric neurologist to opine on whether an adult is disabled by multiple sclerosis. As childhood multiple sclerosis is unknown, a pediatric neurologist will likely not have treated an individual with multiple sclerosis since residency. Such a peer reviewer will clearly not be qualified to deal with the complicated and intricate nature of a multiple sclerosis diagnosis, and the wide variety of symptoms which might disable an individual.

Lyme disease and Fibromyalgia are, from the perspective of insurers/administrators, suspect conditions. To avoid paying claims based on these conditions, insurers will often retain "experts" who have decided before looking at a single medical record that the disease in question is NEVER disabling.

In order to rectify these problems, if an insurer/administrator relies upon a physician peer reviewer to deny a claim, the claim record must contain compelling evidence that the reviewer has no financial bias to render a finding of no disability, and that the reviewer is unbiased regarding the condition, and has the requisite qualifications and in fact treats individuals with the requisite condition.

PROHIBITION ON INSURERS/PLANS PLACING IMPEDIMENTS ON CLAIMANTS HAVING THEIR APPEALS SUBMITTED BY REPRESENTATIVES

The current regulations permit adverse claims decisions to be appealed by the claimant, or their authorized representatives. In my experience, numerous carriers insist that the claimant fill out a specific form generated by the carrier in order for their appeal to be submitted by a designated representative. In the interim, prior to receiving their designated form, insurers will sometimes communicate directly with the claimant, and attempt to dissuade them from retaining counsel to assist them with their appeal. To prevent this from occurring in the future, the regulations should provide:

> **A letter by an attorney licensed to practice in their own state shall be sufficient to constitute authorization to represent a claimant during the appeal of an adverse benefit decision. Once such letter is received, the insurer/administrator shall discontinue any direct communication with the claimant, but shall communicate only with counsel.**

PRODUCTION OF CLAIMS GUIDELINES DURING THE APPEAL PROCESS

Pursuant to the current regulations, insurers/administrators are required to maintain claims handling guidelines, and to produce upon request copies of all guidelines used in the administration of the subject claim. However, in my vast experience, insurers/administrators responding to request for such claims guidelines, typically take the position that the guidelines were not specifically utilized in the handling of the subject claim. In essence, if the claims handler was aware of a guideline, but didn't specifically review it in making an adverse claims decision, the guideline is not produced. Again, this issue can be fixed via a simple regulation alteration providing:

> **In the event a request is made for all relevant claims guidelines, the insurer/administrator shall produce all guidelines which were used, or which WERE AVAILABLE FOR USE DURING THE CONSIDERATION OF THE SUBJECT CLAIM. In addition, any claims guidelines used for the administration of ERISA LTD claims are not subject to production under any type of confidentiality or protective order.**

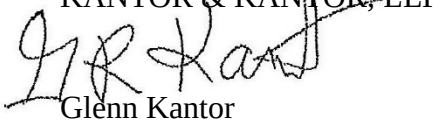
EFFECTIVE DATE OF PROPOSED REGULATIONS

When the 2002 amended claims regulations were promulgated, insurers, and courts, took the position that if a claim had been initiated prior to the effective date of the new regulations, the insurer/administrator was not bound to comply with the amended regulations. This led to both confusion, and the inequity of a claimant who had been receiving benefits for a number of years having fewer protections than claimants with recent claims. Again, this problem is simply rectified.

> **Upon becoming effective, the 2016 amended regulations should be deemed by the terms of the regulations to be applicable to any claim not finalized, including the finalization of any pre-litigation exhaustion requirements.**

Thank you for your consideration of the foregoing. While I understand that the Department has asked for written comments, I would suggest that bringing together counsel experienced in the area, along with industry representatives to discuss a cost benefit analysis of the amended regulations, would benefit all involved parties.

Very truly yours,
KANTOR & KANTOR, LLP



Glenn Kantor

Enclosures

No. _____

In the Supreme Court of the United States

AETNA LIFE INSURANCE COMPANY and
FEDERAL EXPRESS CORPORATION
LONG TERM DISABILITY PLAN,
Petitioners,

v.

ANDRE LEGRAS,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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EXHIBIT B

QUESTION PRESENTED

Whether a court may create federal common law to rewrite contractual language in an ERISA plan, where the plan's language complies with ERISA and its implementing regulations?

PARTIES TO THE PROCEEDING

Pursuant to Rule 14.1(b), the following list identifies all of the parties appearing here and before the United States Court of Appeals for the Ninth Circuit.

The Petitioners here and appellees below are Aetna Life Insurance Company and the Federal Express Corporation Long Term Disability Plan.

The Respondent here and appellant below is Andre LeGras.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6, Petitioners state as follows:

The parent company and sole shareholder of Petitioner Aetna Life Insurance Company is Aetna, Inc., a publicly-held corporation.

Petitioner Federal Express Corporation Long-Term Disability Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001, *et seq*. The Plan Administrator for the Federal Express Corporation Long-Term Disability Plan is Federal Express Corporation. The parent company of Federal Express Corporation is FedEx Corporation, a publicly-held corporation.

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RULES

Aetna Life Insurance Company and the Federal Express Corporation Long Term Disability Plan respectfully petition the Court for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the court of appeals is reported at 786 F.3d 1233. The district court's opinion is not published, but available at 2012 U.S. Dist. LEXIS 116827.

JURISDICTION

The court of appeals issued its opinion and judgment on May 28, 2015. 786 F.3d 1233. The court of appeals denied Petitioners' petition for rehearing on July 7, 2015. App. 31-32.

The court has jurisdiction to issue a writ of *certiorari* in this case under 28 U.S.C. § 1254(1) and Rule 13.3.

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1104(a)(1) Fiduciary duties [ERISA § 404(a)(1)]:

> **(a) Prudent man standard of care:**
>
> (1) Subject to sections 403(c) and (d), 4042, and 4044 [29 U.S.C. §§ 1103(c), (d), 1342, 1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –
>
> (A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV….

29 U.S.C. § 1133 Claims procedure [ERISA § 503]:

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied,

setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1135 Regulations [ERISA § 505]:

Subject to title III and section 109 [29 U.S.C. § 1029], the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this title. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records (subject to section 504(a) and (b) [29 U.S.C. § 1134(a) and (b)]).

29 C.F.R. § 2560.503-1 Claims procedure

(a) Scope and purpose. In accordance with the authority sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. § 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described

in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notifications of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section.

…

(h) Appeal of adverse employment determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

…

> (3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures –
>
> > (i) Provide claimants at least 180 days following receipt of an adverse benefit determination within which to appeal the determination;
> >
> > …
>
> (4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

STATEMENT OF THE CASE

I. ERISA

Congress enacted ERISA to provide a uniform regulatory regime over employee benefit plans. *See* 29 U.S.C. § 1001(b). One of the principle goals of ERISA is to enable employers "to establish a uniform administrative scheme, which provides a set of

standard procedures to guide processing of claims and disbursement of benefits." Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987). ERISA was intended to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990). "Otherwise the inefficiencies created could work to the detriment of plan beneficiaries." Id.

ERISA requires that all employee benefit plans be "established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1). Benefit plans set forth their terms in written plan documents, which constitute "contracts." CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1879, 179 L. Ed. 2d 843 (2011). ERISA's principal function is to "protect contractually defined benefits," Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148, 150 S. Ct. 3085, 87 L. Ed. 2d 9 (1985), and its statutory scheme "is built around reliance on the face of written plan documents." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83, 115 S. Ct. 1223, 131 L. Ed. 2d 94 (1995).

Once an employee benefits plan is established, the administrator's duty is to see that the plan is maintained pursuant to the documents and instruments insofar as they comply with ERISA. *See* Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 612, 187 L. Ed. 2d 529 (2013); 29 U.S.C. § 1104(a)(1)(D). "ERISA's focus [is] on what a plan

provides." U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537, 1548, 185 L. Ed. 2d 654 (2013).

Under ERISA, "[a] civil action may be brought…by a participant…to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). The statute does not state whether exhaustion of administrative remedies is a precondition of filing that action. *See* id. However, because ERISA directs employee benefit plans to provide adequate written notice of the reasons for denials of claims by plan participants and to create procedures for the review of such denials of claims, federal courts have interpreted ERISA as requiring exhaustion of administrative remedies as a prerequisite to bring suit under the statute. *See* Vaught v. Scottsdale Health Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008); Metropolitan Life Ins. Co. v. Price, 501 F.3d 271, 279 (3d Cir. 2007); Powell v. AT&T Communications, Inc., 938 F.2d 823, 826 (7th Cir. 1991). "[A]s a matter of sound policy," federal courts require a claimant to first avail himself of a plan's internal review procedures before bringing suit in federal court. Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980).

The United States Department of Labor enacted regulations applicable to benefit claims made under ERISA plans after January 1, 2002, which include deadlines requiring plan administrators to conclude appeals in a timely manner. The regulations require a plan administrator to decide an initial claim within 45 days of receipt, with two 30-day extensions allowed. *See* 29 C.F.R. § 2560.503-1(f)(3). If the claim is denied,

the claimant has 180 days from receipt of the denial to appeal. *See* id. § 2560.503-1(h)(3)(i).

II. Factual Background

Respondent Andre LeGras is a former employee of Federal Express Corporation ("FedEx") and a participant in the Petitioner Federal Express Corporation Long Term Disability Plan ("the Plan"). App. 27. LeGras was injured, and he became eligible for long-term disability benefits for an Occupational Disability, as defined by the Plan. Id. He received benefits for an Occupational Disability under the Plan for 24 months. Id. There is no dispute that LeGras received all of the Occupational Disability benefits to which he was entitled under the Plan.

In November 2010, Respondent Aetna Life Insurance Company ("Aetna"), the third-party claims paying administrator for the Plan, notified LeGras that he must establish that he suffered a qualifying Total Disability, as defined by the Plan, in order to continue receiving benefits beyond May 24, 2011. App. 4, 27. On April 15, 2011, Aetna sent LeGras a letter stating that he did not meet the definition of Total Disability under the Plan, and thus would not receive disability benefits beyond May 24, 2011. Id. Aetna's letter to LeGras stated: "If you disagree with the above determination, in whole or in part, you may file a request to appeal this decision within 180 days of receipt of this notice." Id.

On April 18, 2011, LeGras received the letter, notifying him of both Aetna's benefits decision and the deadline for submitting an appeal. App. 4, 27. The 180th day from that date was Saturday, October 15,

2011. App. 4, 27-28. LeGras, however, did not send a request to appeal Aetna's benefits decision within the 180-day period after he received this notice, but waited until Monday, October 17, 2011 to submit his appeal. App. 4, 28. LeGras has never explained why he failed to submit his appeal within the 180 calendar-day period after he received notice of the denial of his claim. App. 16.

Aetna denied LeGras's request for an appeal as untimely because he failed to send it on or before October 15, 2011 – 180 days after his receipt of the denial letter. App. 4, 28. In rejecting LeGras's appeal, Aetna referred to specific language in the Plan requiring that a written appeal "be sent to the Administrator within 180 days of the…date the claimant receives the written denial of such claim." App. 27.

III. Proceedings in the District Court

On July 31, 2012, the United States District Court entered an order granting the Motion for Judgment on the Pleadings filed by Defendants Aetna Life Insurance Company and Federal Express Corporation Long Term Disability Plan. App. 25-30. The District Court held that Plaintiff LeGras failed to timely exhaust his internal administrative remedies under the Plan by not submitting an internal appeal within the time frame set forth in the Plan. App. 29-30. LeGras filed his Notice of Appeal to the United States Court of Appeal for the Ninth Circuit on August 21, 2012.

IV. Proceedings in the Court of Appeals

After the parties filed their respective briefs, oral argument was held on March 7, 2014 before a three-

judge panel of the Court of Appeals. On May 28, 2015, the United States Court of Appeals for the Ninth Circuit reversed the decision of the District Court in a published opinion. LeGras v. Aetna Life Ins. Co., et al., 786 F.3d 1233 (9th Cir. 2015).

The panel majority of the Ninth Circuit held that it was error for Aetna and the district court to conclude that LeGras's administrative appeal was untimely. It concluded that, although the 180-day appeal period specified in Aetna's denial letter ended on Saturday, October 15, 2011, "ERISA federal common law required that Aetna accept LeGras' appeal as timely as he mailed it on the first weekday following the weekend." App. 14.

Although it recognized that the Plan complied with ERISA's implementing regulations requiring that it give claimants like LeGras 180 days to file an administrative appeal, the panel majority of the Ninth Circuit found the deadline ambiguous because ERISA and its implementing regulations did not specify a method of computing the deadline. App. 6. As the panel majority saw it, it needed to "protect the interest of [plan] participants" like LeGras, who "face[d] the possibility of losing long-term disability benefits because of a two-day difference..." App. 6, 8.

To excuse LeGras' untimely request for appeal, the panel majority adopted the federal courts' method for calculating court filing deadlines that is found in Rule 6(a) of the Federal Rules of Civil Procedure. App. 8-10. In so doing, the panel majority created a new federal common law: "[W]here the deadline for an internal administrative appeal under an ERISA-governed insurance contract falls on a Saturday, Sunday, or legal

holiday, the period continues to run until the next day that is not a Saturday, Sunday, or legal holiday." App. 10.

One of the panel judges dissented from this decision, stating: "To excuse LeGras's untimeliness, the majority turns a simple case of contract interpretation into an opportunity to (without precedent) expand federal common law surrounding [ERISA] to rewrite private contracts." App. 14. According to the dissent, the majority panel of the Ninth Circuit should have followed other federal circuit courts who had decided they were bound to apply clear and unambiguous terms in a private ERISA contract. App. 22. Because the 180-day deadline in the Plan complied with ERISA regulations, the dissenting judge believed it was unnecessary and inappropriate for the majority to use federal common law to intrude upon the ability of parties to enforce the terms of their private contract. App. 17, 22-23.

REASONS FOR GRANTING THE PETITION

This case meets every criterion for *certiorari* review. The Ninth Circuit's decision conflicts with other circuits, and its approach conflicts with this Court's decisions. The subject matter is of significant importance to millions of ERISA plans, plan administrators, and plan participants across the nation. Just as important, the Ninth Circuit's approach renders it impossible for plan participants and administrators to rely on the provisions and deadlines in their benefit plans. After all, any given judge could choose to rewrite them or erase them from the contract. That is precisely the opposite of what Congress wanted when it enacted a statute designed to

facilitate uniform and efficient administration of employee benefit plans. The petition should be granted.

I. The Court should grant review to resolve an exceptionally important question of ERISA plan interpretation.

This case warrants review because it involves an important federal question and the Ninth Circuit's resolution of that question conflicts with relevant decisions of this Court.

A. Courts must enforce the terms of an ERISA plan.

This is a claim for "benefits due…under the terms of the plan." *See* 29 U.S.C. § 1132(a)(1)(B). Under ERISA, any question of entitlement of benefits begins with the plan. ERISA's entire scheme is built on "reliance on the face of written plan documents." U.S. Airways, Inc. v. McCutchen, 133 S. Ct. at 1548 (2013)(citation and internal quotation marks omitted). Plan administrators must act in accordance with those "governing" instruments. *See* 29 U.S.C. § 1104(a)(1)(D). It is those documents, not the statute itself, that primarily regulate how a plan participant may qualify for benefits.

In fact, ERISA "contains almost no federal regulation of terms of benefit plans." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985). Instead, Congress drew ERISA's provisions so as to preserve, not rescind, employers' freedom to define what benefits they will provide and on what terms. *See* McCutchen, 133 S. Ct. at 1548 ("The plan, in short, is the center of ERISA.");

CIGNA Corp. v. Amara, 131 S. Ct. at 1876-77 (Section 502(a)(1)(B) [29 U.S.C. § 1132(a)(1)(B)] "speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them.")(emphasis in original); Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003)("Employers have large leeway to design [ERISA] disability and other welfare plans as they see fit."); Lockheed Corp. v. Spink, 517 U.S. 882, 887, 116 S. Ct. 1783, 135 L. Ed. 2d 153 (1996)("Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kinds of benefits employers must provide if they choose to have such a plan.") Employers thus have a wide range of options and may decide whether to offer particular types of benefits (e.g. disability insurance, life insurance, or vision coverage) depending on the needs of their employees. That flexibility reflects a conscious decision on Congress's part. It encourages employers to make the voluntary decision to establish a benefit plan subject to ERISA. *See* Cronkright v. Frommert, 559 U.S. 506, 130 S. Ct. 1640, 1648-49, 176 L. Ed. 2d 469 (2010)("Enforcement represents a careful encouragement of the creation of such plans.")(citations and internal quotation marks omitted). Flexibility in plan design extends not only to what benefits are due, but also to how the plan will administer those benefits.

In enacting ERISA, Congress chose to regulate employee benefit plans, but at the same time it sought to avoid discouraging employers from offering benefits in the first place. Congress thus set out in ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, 122 S. Ct. 2151, 153

L. Ed. 2d 375 (2002). To accomplish that goal, ERISA relies on a "straightforward rule" of "hewing to" the contractual "plan documents" in which plans set forth their terms. Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300, 129 S. Ct. 865, 172 L. Ed. 2d 662 (2009).

This Court has repeatedly recognized the particular importance of enforcing plan terms as written in Section 502(a)(1)(b) claims, like LeGras's claim here. *See* Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 612 (2013); Amara, 131 S. Ct. at 1877; Cronkright, 130 S. Ct. at 1660-61; Kennedy, 555 U.S. at 300. "ERISA § 502(a)(1)(b) authorizes a plan participant to bring suit "to recover benefits due to him *under the terms of the plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan.*" Heimeshoff, 134 S. Ct. at 612 (quoting 29 U.S.C. § 1132(a)(1)(B)) (emphasis in the original). "A claim therefore stands or falls by the terms of the plan." Kennedy, 555 U.S. at 300 (internal quotations omitted).

Nevertheless, the court below rejected that fundamental principle when it nullified the Plan provision requiring participants to submit a request to appeal an adverse benefit decision within 180 days of their receipt of the notice of the decision, then replaced it with what the Court believed was a more equitable provision. App. 6-10. The effect of the Ninth Circuit's decision is to impose a new term or condition on all ERISA plans by reading an implicit limitation on the plan's rights: A plan will only be enforced when, in the court's view, the plan terms are fair and not just compliant with ERISA. But, ERISA plans are

voluntary, so encouraging an employer to voluntarily provide benefits requires both predictable regulation and reliable construction of the plan. This is precisely why the approach taken by the Ninth Circuit in this case is so harmful. Every person's notion of equity is uncertain and variable. Although perhaps momentarily gratifying to the sensibilities of a judge, imposing an involuntary and unpredictable obligation on an ERISA plan endangers the statutory ERISA scheme.

B. Courts must defer to an administrator's lawful and reasonable interpretation of an ERISA plan term.

Neither LeGras nor the courts below dispute that the Plan's 180-day deadline for internal appeals complied with the Department of Labor's regulations implementing ERISA. These regulations require that ERISA-governed disability plans "[p]rovide claimants *at least 180 days* following receipt of a notification of an adverse benefit determination within which to appeal the determination." 29 C.F.R. § 2560.503-1(b)(1), (h)(3)(i), (h)(4). That is exactly what the Plan here provided. It required that a written appeal "be sent to the Administrator within 180 days of the…date the claimant receives the written denial of such claim." App. 28. Aetna interpreted the "180 days" in its Plan to mean that plan participants like LeGras had 180 *calendar* days in which to submit requests for an appeal. App. 15, 27.

Aetna's interpretation of "180 days" in the plan provision was not unlawful because it does not conflict with the substantive or procedural provision of ERISA. The Plan vests Aetna, as the claims-processing

administrator, with discretion to interpret the provisions of the Plan and to make eligibility determinations for benefits. Therefore, the Ninth Circuit was required to sustain Aetna's interpretation of "180 days."

Analogizing from trust law, in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), the Supreme Court concluded that if an ERISA plan charges an administrator to exercise discretion in interpreting the plan's provision, the federal courts must not disturb the administrator's interpretation "if reasonable." Firestone Tire, 489 U.S. at 111. According to the Court, this conclusion inescapably followed because "ERISA abounds with the language and terminology of trust law." Id. at 110. If, as here, a fiduciary or administrator is "in existence, and capable of acting, a court of equity will not interfere to control [it] in the exercise of discretion vested in [it] by the instrument under which [it] act[s]." Id. at 111 (quoting Nichols v. Eaton, 91 U.S. 716, 724-25, 23 L. Ed. 2d 254 (1875)). Based on these principles of trust law, the Court concluded that in reviewing the actions of an administrator who has been granted discretion to interpret the terms of an ERISA plan, the federal courts must defer to the fiduciary's interpretation provided it is not an abuse of discretion. *See* id. at 115. Therefore, the court reviews the administrator's interpretation for an abuse of discretion, and is precluded from disturbing that interpretation if it is reasonable, even if the court comes to a different conclusion independently. *See* id.

Aetna's interpretation of "180 days" is reasonable. It is not contrary to the clear language of the Plan or

the ERISA regulation, nor does it render the Plan language meaningless or inconsistent. As discussed, the plan-documents rule that has been established by ERISA and this Court requires that this language be enforced as written. ERISA requires Aetna, as an administrator, to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of ERISA." 29 U.S.C. § 1104(a)(1)(D). Aetna did this by acting in accordance with the plain meaning of the "180 days" that was expressed in the Plan. By declining to enforce this Plan term as written, the Ninth Circuit violated the clear language of the Plan and failed to give Aetna's reasonable interpretation the deference it was due.

C. Courts cannot use federal common law to rewrite ERISA plan terms.

Besides ignoring the ERISA regulations and the opinions of this Court and other circuits, the problem with the Ninth Circuit's decision is that it created federal common law to get around the plain and unambiguous terms of the Plan. In doing so, the Ninth Circuit ignored the limit on courts' power to craft federal common law to impose an equitable doctrine on ERISA-governed plans. The court below claimed that its creation of federal common law in this instance was necessary to effectuate ERISA's goals of "protecting the interest of [plan] participants" and to provide "adequate safeguards…[that are] desirable in the interests of employees." App. 6 (citing 29 U.S.C. § 1001). In other words, the Ninth Circuit used federal common law to rewrite a plan term to achieve a result it believed was fair to plan participants.

The Ninth Circuit ignored the plain meaning of the Plan's internal appeal deadline of "180 days" and rewrote it, under the guise of federal common law, to impose a new term or condition of the Plan that the court believed was more favorable to plan participants. That approach conflicts with this Court's ERISA precedent in two key ways:

First, courts may not, under any circumstance, create federal common law to change or modify plan terms that are regulated by, and compliant with, ERISA. While this Court has instructed the lower federal courts to develop federal common law under ERISA as a gap-filling measure, *see* Firestone Tire, 489 U.S. at 110, "the authority of courts to develop a 'federal common law' under ERISA…is not the authority to revise the text of the statute." Mertens v. Hewitt Assocs., 508 U.S. 248, 258, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993). The Ninth Circuit turned that principle on its head when in concluded that it could create federal common law to impose its chosen time-computation method on ERISA regulations and ERISA plans. App. 10. Congress empowered courts to enforce the written terms of ERISA plans, not terms chosen at random by a judge. Applying federal law as the Ninth Circuit did here contradicts ERISA's "repeatedly emphasized purpose…to protect contractually defined benefits." Russell, 473 U.S. at 148.

Second, the decision below is wholly inconsistent with this Court's instruction that courts may not create federal common law for the purpose of reaching an equitable result. In a rare occurrence, the Supreme Court recently issued a unanimous decision on whether courts can apply equitable doctrines to trump the plain

language of an ERISA-governed plan. *See* U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537, 185 L. Ed. 2d 654 (2013). The majority opinion, authored by Justice Kagan, demonstrates that precedential case law and the legislative history provides a strong rationale for its decision that equitable doctrines cannot override the plain language of an ERISA contract.

Like the Ninth Circuit did in the decision below, the Third Circuit Court of Appels in McCutchen noted that Congress's intention in creating ERISA was to give plan beneficiaries greater rights than the plan's fiduciaries when enforcing the terms of a benefit plan. *See* McCutchen, 663 F.3d 671, 674 (3d Cir. 2012). Under this rationale, the Third Circuit found that equitable doctrines may be applied under section 502(a)(3) of ERISA [29 U.S.C. § 1132(a)(3)]. *See* id. In reviewing this decision, all of the Supreme Court justices agreed that an ERISA plan's terms, not equitable principles, govern an administrator's actions. *See* McCutchen, 133 S. Ct. at 1548. It held that using equitable defenses to override the plain language of the ERISA plan would go directly against the statutory scheme employed by Congress when it enacted ERISA. *See* id.

The decision in McCutchen is in line with this Court's conservative interpretation of ERISA. In Mertens, for example, the Court recognized that ERISA is an extremely comprehensive and ridiculed statute, which was the product of over a decade of congressional study into the United States' private employee benefits system. Mertens, 508 U.S. at 251. Therefore, the Court was reluctant to tamper with the legislative

scheme of ERISA by allowing remedial actions that were not specifically mentioned in ERISA. In Cronkright, the Court held that an administrator's interpretation of language in an ERISA plan was deferential, reasoning that following the plan administrator's interpretation promotes ERISA's policy interests of efficiency, predictability, and uniformity. *See* Cronkright, 449 U.S. at 507.

On the basis of general equity authority under ERISA, the Ninth Circuit essentially ordered the Plan to change, as to LeGras, the deadlines and structures set by the Plan's procedures. LeGras never actually asserted – nor has any court found – that the Plan's procedures violate the governing statute and regulations that might preempt or trump the Plan's provisions. The Ninth Circuit's invocation of equity pushed too far into rewriting the Plan's terms. It invoked equity to address the situation because the Plan's procedures, including its deadlines, do not violate the governing statute or regulatory mandates in a manner that requires creation of federal common law. The ERISA regulations expressly addressed the Plan term at issue in this case. Because ERISA explicitly addresses the time limitation for appeals, courts may not apply federal common law to this dispute. Review by the Court is warranted because the Ninth Circuit overstepped its bounds by crafting federal common law to rewrite a plan provision that is regulated by ERISA.

II. The Ninth Circuit's creation of federal common law to modify an ERISA plan is inconsistent with the approach of every other circuit to address the issue.

The Ninth Circuit stands alone in using federal common law to apply an equitable doctrine to an unambiguous provision in an ERISA plan. Its application of the equitable "weekend/holiday rule" in this case conflicts with the decisions of other circuits to consider the issue of whether to apply an equitable principle to an ERISA plan. Until the decision below in this case, all of the circuit courts to have confronted the issue presented here have answered it in the negative. They held that the plain meaning of ERISA plan terms should be enforced as written and equitable doctrines should not be applied unless the term is ambiguous and the administrator's interpretation of it is unreasonable. Because the Ninth Circuit's judicial rewrite of an ERISA regulation and an unambiguous ERISA plan term contradicts the decisions of five other circuit courts of appeal, this Court should grant review to end the confusion about the proper application of federal common law.

A. The Eleventh Circuit

In Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 n. 3 (11th Cir. 2010), *cert. denied*, 131 S. Ct. 943 (2011), the plan participant argued, as LaGras did in this case, that the court should apply an equitable principle to override the plan's deadline. *See* O'Hara, 604 F.3d at 1237. The Eleventh Circuit rejected this argument and found that refusing to enforce the provisions as written would "frustrate, rather than effectuate, ERISA's 'repeatedly emphasized purpose to

protect contractually defined benefits.'" Id. (quoting Russell, 473 U.S. at 148). The court of appeals explained that enforcing plan provisions as written is critical to plan solvency and thus benefits all plan participants. *See* id. at 1238.

B. The Third Circuit

The Third Circuit held that parties cannot invoke the reasonable expectations doctrine to create an ambiguity where the language in the ERISA plan itself is unambiguous. *See* Early v. United States Life Ins. Co., 2007 U.S. App. LEXIS 6870, *7 (3d Cir., Mar. 22, 2007). It reasoned that "straightforward language in an ERISA plan document 'should be given its natural meaning.'" Id. 2007 U.S. App. LEXIS 6870 at *9 (quoting Bill Gray Enters., Inc. Employee Health & Welfare Plan v. Gourley, 248 F.3d 206, 220 n. 13 (3d Cir. 2001)). To apply the reasonable expectations doctrine under ERISA as a matter of federal common law, the ERISA contract must be ambiguous, as "general ERISA principles simply do not permit us to re-write the terms of the insurance contract." Id. (internal quotation marks and citation omitted).

C. The Fourth Circuit

In United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998), the Fourth Circuit refused to incorporate general common law principles of reimbursement and subrogation to override unambiguous language in an ERISA plan. It reasoned that

> In reviewing ERISA-related disputes, resort to federal common law generally is inappropriate when its application would conflict with the

> statutory provisions of ERISA, discourage employers from implementing plans governed by ERISA, or threaten to override the explicit terms of an established ERISA benefit plan. And, courts should remain circumspect to utilize federal common law to address issues that bear at most a tangential relationship to the purposes of ERISA.

Stinnett, 154 F.3d at 171-72. In reaching this decision, the Fourth Circuit followed its decision in Coleman v. Nationwide Life Ins. Co., 969 F.2d 54 (4th Cir. 1992), where it refused to use estoppel principles to modify a written employee benefit plan because "it would conflict with ERISA's emphatic preference for written agreements." Coleman, 969 F.2d at 58.

D. The Fifth Circuit

In Jones v. Georgia Pacific Corp., 90 F.3d 114 (5th Cir. 1996), the policy provided that, for 31 days following his 65th birthday, the plan participant had the right to purchase an individual life insurance policy. *See* Jones, 90 F.3d at 114. If he died during that period, he would receive death benefits as if he had bought the new policy. *See* id. The plan participant did not purchase the individual policy within the 31-day period and died on the 32nd day following his 65th birthday. *See* id.

The district court agreed with the family of the plan participant that, because the 31st and final day of the acquisition period was a Sunday, the period should be extended for one day. *See* Jones, 90 F.3d at 116. Just like the Ninth Circuit held in the instant case, the district court in Jones concluded that the provision in

the insurance policy was ambiguous because it did not state what would happen if the 31st day fell on a Sunday. Therefore, the court decided to apply the legal maxim *dies dominicus non est juridicus* ("Sunday is not a day in law") as federal common law to write into the ERISA-governed policy a provision that would extend the period for one day if the 31st day fell on a Sunday. *See* id.

The Fifth Circuit disagreed. It concluded that the Plan's failure to address what would happen if a deadline fell on Sunday did not make the deadlines in the Plans ambiguous because "what they do not say cannot render what they do say ambiguous." Jones, 90 F.3d at 116. Noting that the time-calculation method in Federal Rule of Civil Procedure did not apply to contracts, the Fifth Circuit found no rule under federal common law that provided an extra day when the last day of a deadline falls on Sunday. *See* id. at 117 (citing J. Aron & Co. v. S/S Olga Jacob, 527 F.2d 416, 417 (5th Cir. 1976). Therefore, the circuit court held that the express terms of the policy dictated that the option to extend benefits under the policy ended on Sunday. *See* id. at 117.

Ten years later, the Fifth Circuit again refused to apply an equitable rule to an ERISA contract. In High v. E-Systems, Inc., 459 F.3d 573 (5th Cir. 2006), it concluded that eligibility for benefits under an ERISA plan is first governed by the plain meaning of the contract. *See* High, 459 F.3d at 578-79. Therefore, only when the plan terms remain ambiguous after applying ordinary principles of contract interpretation may courts apply the rule of *contra preferentem* to construe terms in favor of the insured. *See* id. The Fifth Circuit

held that it could not apply this rule in High's case because, even though the language was ambiguous, the plan gave the administrator discretion to interpret the plan. *See* id. Therefore, the court was bound to accept the administrator's interpretation of the language as long as it was reasonable. *See* id.

E. The Seventh Circuit

In Edwards v. Briggs & Stratton Ret. Plan, 639 F.3d 355 (7th Cir. 2011), the Seventh Circuit addressed whether an ERISA plan should have excused the fact that the plan participant's administrative appeal from a denial of her claim for disability benefits was eleven days late. *See* Edwards, 639 F.3d at 358. Just like the Plan in this case, the plan in Edwards had fixed a 180-day deadline for filing administrative appeals. *See* id. at 362. The Seventh Circuit found that, because the plan's deadline was clear and consistent with the regulations governing ERISA claims, the administrator was required to implement and follow the plain language of the plan. Therefore, the appellate court refused to apply federal common law to excuse the plan participant's late appeal as "substantially compliant" with the plan deadline:

> [I]t seems consistent neither with the policies underlying the requirement of exhaustion of administrative remedies in ERISA cases nor with judicial economy to import into the exhaustion requirement the substantial compliance doctrine. To so hold would render it effectively impossible for plan administrators to fix and enforce administrative deadlines while involving courts incessantly in detailed, case-by-

> case determinations as to whether a given claimant's benefits should be excused or not.
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> ***
>
> In this case…the plan adopted a reasonable deadline for the filing of administrative appeals from denials of benefits, and it likewise was reasonable for the plan to enforce that deadline in Edwards' case, given that…Edwards has never offered any explanation for her delay in filing her appeal.

Edwards, 639 F.3d at 362-63, 365. In reaching this conclusion, the Fifth Circuit reasoned that "ERISA plans have an interest in 'finality of decisions' regarding claims for benefits that militates against reopening a plan's administrative claim process willy-nilly." Id. at 362.

Prior to the Ninth Circuit's decision below, every circuit to consider the question enforced unambiguous benefit-plan provisions, observing that ERISA's primary purpose was to "protect the integrity of [ERISA] plans and expectations of their participants and beneficiaries." O'Hara, 604 F.3d at 1237 n. 3. The Ninth Circuit has also departed from its sister circuits who recognize that federal common law may only be applied to ERISA claims when the statutory text offers no guidance. *See* Grabois v. Jones, 89 F.3d 97, 101 (2d Cir. 1996)("[I]f the question is one of federal law, it must be resolved either by the ERISA statute itself or, in the absence of a statutory provision, by federal common law."); Muse v. Int'l Bus. Machs. Corp., 103 F.3d 490, 495 (6th Cir. 1996)(stating "federal common law is developed under ERISA only in those instances

in which ERISA is silent or ambiguous"); Thomason v. Aetna Life Ins. Co., 9 F.3d 645, 647 (7th Cir. 1993)("Courts may develop…federal common law only where ERISA itself 'does not expressly address the issue before the court.'" (quoting Nachwalter v. Christie, 805 F.2d 956, 959 (11th Cir. 1986))).

Thus, after the Ninth Circuit's decision, the same case, with the same internal deadline in an ERISA plan, will come out differently in almost every other federal circuit than it would in the Ninth Circuit. This is a real and intolerable conflict on the same matter of law and fact. The decision of the Ninth Circuit threatens to ignore the text and guidance offered by ERISA and its implementing regulations. It also threatens to undermine the exhaustion requirement under ERISA, and the related principle of deference to plan administrators. Therefore, this Court should grant *certiorari* to resolve the disagreement between the circuits and to restore the proper, intended balance between federal courts and ERISA plan administrators.

III. The question presented is exceptionally important to plan sponsors, administrators, and participants across the nation.

The Court should grant review because the ERISA interpretation presented in this case creates intolerable regulatory uncertainty and the Ninth Circuit's common-law "weekend/holiday" rule is fundamentally at odds with ERISA's statutory objectives.

First, ERISA seeks to facilitate efficient administration of employee benefit plans. *See* Kennedy, 129 S. Ct. at 875-76. By focusing on benefit determinations solely on the plan documents, ERISA

promotes simplicity, ease of administration, and quick payment of claims. *See* id. Everyone benefits from this scheme – employees, employers, and plan administrators. *See* id. But the Ninth Circuit's decision undermines this goal by allowing parties to litigate over the meaning and calculation of plan deadlines that differ from state to state. Under the Ninth Circuit's rationale, plan administrators must keep track of the legal holidays in every federal and state jurisdiction where it has plan participants, thus making the administration of the plan more complex and expensive for plan sponsors and administrators. For example:

- Does the claimant live in a state that celebrates Patriots' Day, which may be celebrated on different days in different states (*Compare* 4 M.R.S. § 1051 (Maine statute designating the third Monday in April as Patriots' Day) *with* ALM GL ch. 6, § 12J (Massachusetts statute designating April 19th as Patriots' Day))?

- Does the deadline fall on Susan B. Anthony Day (which is celebrated in West Virginia on Election Day, but only in even-numbered years)(*See* WEST VA. CODE § 2-2-1(a)(14))?

- Does the deadline fall on Lincoln's Birthday, which is celebrated on different days in some states (*Compare, e.g.,* WEST VA. CODE § 2-2-1(a)(11) *with* BURNS IND. CODE ANN. § 1-1-9-1(a)), and not celebrated at all in others (i.e., Tennessee)?

These regulatory variations generate administrative inefficiencies that inevitably increase the cost of sponsoring and administering employee benefit plans.

Second, ERISA was designed to establish a uniform set of substantive and procedural standards governing employee benefit plans. *See* Rush, 536 U.S. at 379. That goal of procedural uniformity is incompatible with the Ninth Circuit's decision. The divergence between the Ninth Circuit and other federal circuit courts to consider the issue is directly at odds with ERISA's objective of "provid[ing] a uniform regulatory regime over employee benefit plans." Aetna Health, Inc. v. Davila, 542 U.S. 200, 208, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004). As long as that disagreement persists, a plan that has participants in the Ninth Circuit will be subject to different deadlines than a plan in any other circuit, and a plan with participants across the country will be subject to numerous different deadlines. Congress did not envision a system where employees in San Francisco and Phoenix have different ERISA rights and responsibilities from those in Boston, Chicago, and Dallas. As discussed, one of the principle goals of ERISA was to establish a uniform administrative scheme that provides a set of standards to guide the processing of claims and disbursement of benefits. *See* Fort Halifax, 482 U.S. at 9. "Uniformity is impossible, however, if plans are subject to different legal obligations in different states." Englehoff v. Englehoff, 532 U.S. 141, 121 S. Ct. 1322, 1328, 149 L. Ed. 2d 264 (2001). The Court should grant review to establish national uniformity on this critical issue of ERISA law.

Third, ERISA seeks to ensure that participants may "*on examining the plan documents*, determine exactly what [their] rights and obligations are under the plan." Schoonejongen, 514 U.S. at 83. Participants need an authoritative place to go to determine their benefits. But, if the master plan can be retroactively changed to rewrite its deadlines, as the Ninth Circuit did in this case, participants cannot rely on the deadlines in that document. Instead, they will be forced to ascertain which dates are considered "legal holidays" in their particular state before they can determine when they must submit claims and appeals for benefits. This is exactly the type of intolerable scenario that Congress wanted to avoid.

Finally, review is warranted because the Ninth Circuit's decision impedes government regulation of ERISA plans. Congress charged various government agencies with regulatory powers under ERISA, and that framework is built around the face of written plan documents. For example, the Department of Labor can impose civil penalties on plan fiduciaries who breach their duty, codified in 29 U.S.C. § 1104(a)(1)(D), to act "in accordance with the documents and instruments governing the plan," under 29 U.S.C. § 1132(1). The Department also promulgates and enforces related regulations, such as 29 C.F.R. § 2560.503-1(b), which requires employers to ensure that "benefit claims determinations are made in accordance with governing plan documents." Allowing courts to retroactively reform unambiguous plan documents could seriously undermine the Department of Labor's enforcement regime.

There can be no question that the question presented is sufficiently important to warrant review. ERISA governs the interactions between the majority of employees and their employers across the country – millions of people and thousands of plans. The need for review, and correction, is particularly urgent here because the Ninth Circuit's approach threatens the viability of ERISA plans that provide so many Americans with benefits.

CONCLUSION

This case presents precisely the sort of ERISA-distorting errors this Court has previously granted *certiorari* to correct. In Cronkright, for example, this Court overturned the lower court's decision to limit the deference owed an ERISA plan administrator, recognizing that the "uniformity problems that arise from creating *ad hoc* exceptions" affect the enforcement of ERISA plans. Cronkright, 130 S. Ct. at 1651. That perfectly describes the Ninth's Circuit's decision to interject an *ad hoc* exception to the enforcement of unambiguous plan terms.

This case is an excellent vehicle to resolve the question presented. The factual record is well-developed and undisputed in all relevant parts. With the decision below, the Ninth Circuit has irrevocably split with other circuit courts to have weighed in on the issue. For the reasons discussed, the Ninth Circuit's decision will begin to cause administrative complications and increase the costs and complexity of litigation – just what ERISA was designed to prevent. Given the circuit conflict and the importance of the issue presented, review is not just appropriate, it is essential.

The petition for writ of *certiorari* should be granted.

Respectfully submitted,

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APPENDIX

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 12-56541
D.C. No. 2:12-cv-02128-R-JCG

[Filed May 28, 2015]

ANDRE LEGRAS, *Plaintiff-Appellant*,	)
v.	)
AETNA LIFE INSURANCE COMPANY; FEDERAL EXPRESS CORPORATION LONG TERM DISABILITY PLAN, *Defendants-Appellees*.	)

OPINION

Appeal from the United States District Court
for the Central District of California
Manuel L. Real, District Judge, Presiding

Argued and Submitted
March 7, 2014—Pasadena, California

Filed May 28, 2015

Before: Harry Pregerson, Richard A. Paez,
and N. Randy Smith, Circuit Judges.

Opinion by Judge Paez;
Dissent by Judge N.R. Smith

SUMMARY*

ERISA

The panel reversed the district court's dismissal of an action challenging the denial of an application for continued long-term disability benefits under the Employee Retirement Income Security Act.

The panel held that the district court erred in dismissing the action for failure to exhaust administrative remedies. The plaintiff's internal appeal from the denial of his benefits application was denied as untimely under a 180-day appeal period. The panel held that the plaintiffs' notice of internal appeal was timely because it was filed on the Monday after the Saturday on which the 180-day period ended. The panel adopted this method of counting time as part of ERISA's federal common law.

Dissenting, Judge N.R. Smith wrote that as a matter of contract interpretation, the plaintiff's administrative appeal was untimely.

COUNSEL

Peter S. Sessions (argued) and Glenn R. Kantor, Kantor & Kantor LLP, Northridge, California, for Plaintiff-Appellant.

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* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

David P. Knox (argued), Federal Express Corporation, Memphis, Tennessee, for Defendants-Appellees.

OPINION

PAEZ, Circuit Judge:

Andre LeGras appeals the district court's judgment in favor of Defendants Federal Express Corporation Long Term Disability Plan and AETNA Life Insurance Company (collectively, "AETNA"). In a letter denying LeGras's application for continued long-term disability benefits, AETNA informed LeGras that he could file an internal appeal of the decision within 180 days. The 180-day period ended on a Saturday. Although LeGras mailed his appeal the following Monday, AETNA denied it as untimely. The district court dismissed LeGras's action for failure to exhaust administrative remedies. We reverse. We hold that because the last day of the appeal period fell on a Saturday, neither that day nor Sunday count in the computation of the 180 days. As LeGras mailed his notice of appeal on Monday, it was timely. This method of counting time is widely recognized and furthers the goals and purposes of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. We therefore adopt it as part of ERISA's federal common law.

I.

In October 2008, LeGras seriously injured himself while working as a ramp transport driver for Federal Express Corporation ("FedEx"), a job he had held for twenty-three years. LeGras suffered a serious back injury that caused severe and sustained pain. Subsequent surgeries did not correct the problem. As an employee of FedEx, LeGras was a participant and

beneficiary of FedEx's Long Term Disability Plan ("LTD Plan" or "Plan"). In May 2009, he began receiving disability benefits under the Plan. Subsequently, AETNA, the Plan's Claims Paying Administrator, informed LeGras that his benefits would terminate on May 24, 2011, unless he could establish that his disability qualified as a "total disability" under the LTD Plan.

After LeGras attempted to make the required showing, AETNA sent LeGras a letter explaining that the evidence he submitted did not establish that he suffered from a total disability. Of concern to AETNA was LeGras's alleged failure to prove that he could not "sit or use [his] upper extremities for sedentary work." LeGras received the letter at 1:23 p.m. on April 18, 2011. The letter stated, "[i]f you disagree with the above determination, in whole or in part, you may file a request to appeal this decision within 180 days of receipt of this notice."

The parties agree that the 180-day appeal period expired on October 15, 2011, a Saturday. LeGras mailed his appeal the following Monday. On January 17, 2012, AETNA denied LeGras's appeal as untimely. LeGras filed an action in the district court pursuant to 29 U.S.C. § 1132, the civil enforcement provision of ERISA. After answering the complaint, AETNA filed a motion for judgment on the pleadings under Federal Rule of Civil Procedure 12(c). AETNA argued that LeGras failed to exhaust his administrative remedies because he mailed his appeal after the 180-day period specified in the April 18, 2011 denial letter lapsed. The

district court granted the motion and entered judgment in favor of AETNA.[1]

LeGras timely appealed.[2]

II.

We review de novo an order granting a motion for judgment on the pleadings under Rule 12(c). *Fleming v. Pickard*, 581 F.3d 922, 925 (9th Cir. 2009). We accept the factual allegations in the complaint as true, and view them in a light most favorable to the plaintiff. *Hoeft v. Tucson Unified Sch. Dist.*, 967 F.2d 1298, 1301 & n.2 (9th Cir. 1992).

The federal statute governing claims procedures under ERISA requires that "in accordance with regulations of the Secretary [of Labor], every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). The regulation implementing 29 U.S.C. § 1133 states that a "reasonable opportunity for a full and fair review" is "at least 180 days following

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[1] ERISA itself does not require a participant or beneficiary to exhaust his administrative remedies before bringing an action under ERISA's civil enforcement provision. *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008). Nonetheless, we have imposed a prudential exhaustion requirement. *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980); *Vaught*, 546 F.3d at 626 n.2 (clarifying that the exhaustion requirement in cases under ERISA's civil enforcement provision are prudential, not jurisdictional).

[2] We have jurisdiction pursuant to 28 U.S.C. § 1291.

receipt of a notification of an adverse benefit determination within which to appeal . . . .” 29 C.F.R. § 2560.503-1(h)(3), (h)(3)(i), (h)(4). Neither the governing statute, nor the implementing regulation, “specify a method of computing time.”[3] *Cf.* Fed. R. Civ. P. 6(a). This leaves a number of unresolved ambiguities. For instance, did the 180 days begin on April 18, 2011, the day LeGras received the notice, or on the following day? Does the final day end at 1:23 p.m., 5:00 p.m., or midnight? And, as is relevant here, if the final day lands on a weekend or holiday, is the participant permitted to file his appeal on the next business day? The widespread understanding that a deadline falling on a Saturday, Sunday, or holiday extends to the next business day answers this question.

Congress, in enacting ERISA, has “empowered the courts to develop, in light of reason and experience, a body of federal common law governing employee benefit plans.” *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499. (9th Cir. 1984). This federal common law “supplement[s] the explicit provisions and general policies set out in ERISA . . . governed by the federal policies at issue.” *Id.* at 1500. One of ERISA’s declared policies is to “protect the interest of [plan] participants” and to provide “adequate safeguards . . . [that are] desirable in the interests of employees.” 29 U.S.C. § 1001. Indeed, we have repeatedly stated that ERISA is remedial legislation that should be construed liberally to “protect[] participants in employee benefits plans.” *McElwaine v. US West, Inc.*, 176 F.3d 1167,

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[3] Similarly, the parties do not suggest that the LTD Plan contains an explanation of how the appeal period is to be computed. We therefore assume that it does not contain such a provision.

1172 (9th Cir. 1999); *Batchelor v. Oak Hill Med. Grp.*, 870 F.2d 1446, 1449 (9th Cir. 1989); *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1984).

We have developed ERISA federal common law furthering these interests several times before. *See, e.g.*, *Security Life Ins. Co. of America v. Meyling*, 146 F.3d 1184, 1191 (9th Cir. 1998) (recognizing under ERISA federal common law that a recission remedy exists when an insured makes material false representations about his health); *Schikore v. BankAmerica Supplemental Ret. Plan*, 269 F.3d 956 (9th Cir. 2001) (invoking federal common law to incorporate the mailbox rule into ERISA). For example, we adopted the doctrine of reasonable expectations as a principle to apply when interpreting ERISA-governed insurance contracts. *Saltarelli v. Bob Baker Grp. Med. Trust*, 35 F.3d 382 (9th Cir. 1994). In so holding, we reasoned that "protecting the reasonable expectations of insureds appropriately serves the federal policies underlying ERISA." *Id.* at 386. Further, express incorporation of the principle elsewhere demonstrated "its widespread acceptance and vitality." *Id.* at 387.[4]

There is nothing novel about the principle we adopt here that when a deadline falls on a weekend, it extends to the following business day. The Supreme Court recognized this general understanding in 1890.

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[4] The dissent argues that we have extended the holding of *Saltarelli* to "read an insured's 'reasonable expectations' into any term of an ERISA plan without limits." Dissent at 19. Contrary to the dissent's argument, we do nothing more than cite *Saltarelli* as an example of incorporating a widely accepted principle—the reasonable expectations doctrine—as part of ERISA's federal common law.

Street v. United States, 133 U.S. 299, 306 (1890) (". . . a power that may be exercised up to and including a given day of the month may generally, when that day happens to be Sunday, be exercised on the succeeding day"). Further, the Fifth Circuit has stated that this "rubric has universal acceptance." *Armstrong v. Tisch*, 835 F.2d 1139, 1140 (5th Cir. 1988). LeGras faces the possibility of losing his long-term disability benefits because of a two-day difference in the computation of the time period to pursue an administrative appeal. Although the stricter time-computation method may be convenient for AETNA's purposes, it would be contrary to the purposes of ERISA to adopt a method that is decidedly protective of plan administrators, not plan participants.

Further, that a deadline extends to the next business day when it falls on a Saturday, Sunday, or holiday is widespread. For example, Federal Rule of Civil Procedure 6 ("Rule 6") states that this principle applies to "any local rule or court order, or in any statute that does not specify a method of computing time."[5] Fed. R. Civ. P. 6(a).[6] We have consistently

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[5] The relevant part of Rule 6(a)(1)(C) provides as follows:

> When the period is stated in days or a longer unit of time: . . . include the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.

[6] In addition to his federal common law argument, LeGras argued that Rule 6(a) should apply directly. However, because LeGras presented two alternative arguments that could warrant reversal, we need not address that argument. Further, even though LeGras

applied Rule 6 when interpreting time periods in various statutory contexts. *See, e.g.*, *Minasyan v. Mukasey*, 553 F.3d 1224, 1227–28 (9th Cir. 2009) (addressing the beginning of the one-year period of limitations for filing an asylum application); *Payan v. Aramark Mgmt. Servs. Ltd. P'ship*, 495 F.3d 1119, 1125–26 (9th Cir. 2007) (addressing the timeliness of a Title VII action after receipt of a right-to-sue letter from the Equal Employment Opportunity Commission); *Patterson v. Stewart*, 251 F.3d 1243, 1246 (9th Cir. 2001) (addressing the "appropriate ending" of the one-year grace period under the Anti-terrorism and Effective Death Penalty Act of 1996); *Cooper v. City of Ashland*, 871 F.2d 104, 105 (9th Cir. 1989) (per curiam) (holding that because the last day of Oregon's two-year statute of limitations in a personal injury suit under 42 U.S.C. § 1983 ended on the Saturday preceding Columbus Day, the plaintiff could file on the following Tuesday); *Hart v. United States*, 817 F.2d 78, 80 (9th Cir. 1987) (holding that where the last day of the six-month limitations period under the Federal Tort Claims Act ended on a Saturday, the plaintiff could file on the following Monday). Additionally, many

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did not make a federal common law argument in district court, he is permitted to make that argument on appeal because he properly preserved his claim. *See Lebron v. Nat'l R.R. Passenger Corp.*, 513 U.S. 374, 379 (1995) ("Our traditional rule is that once a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below.") (internal quotation marks and brackets omitted).

regulations explicitly incorporate this method for computing time.[7]

Incorporating this time-computation method into ERISA's federal common law protects the interests of insureds, thereby effectuating the policy goals of ERISA. Further, the concept is generally accepted and vital. *See Saltarelli*, 35 F.3d at 387. Therefore, we hold that, where the deadline for an internal administrative appeal under an ERISA-governed insurance contract falls on a Saturday, Sunday, or legal holiday, the period continues to run until the next day that is not a Saturday, Sunday, or legal holiday.

AETNA attempts to skirt the issue by minimizing the role that ERISA plays in our analysis of this case. It argues that LeGras's "appeal was pursuant to the . . . Plan—not ERISA or any ERISA regulation." In other words, AETNA contends that we should not apply the above time-computation method because the 180-day period for appeal is set by contract, rather than by statute or regulation. What AETNA overlooks is that the 180-day appeal period is part of ERISA's mandatory claims processing standards. As noted

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[7] *See, e.g.*, 15 C.F.R. §§ 280.206(e) (expressly computing time such that, if the last day is a Saturday, Sunday, or legal holiday, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday), 719.8(e) (same), 766.5(e) (same), 785.6(e) (same); 17 C.F.R. § 171.4(a) (same); 22 C.F.R. § 103.8(c) (same); 30 C.F.R. § 700.15(b) (same); 38 C.F.R. § 42.27(a) (same); 29 C.F.R. § 2200.2(b) (applying the Federal Rules of Civil Procedure, which includes Rule 6(a), where no specific provision exists); 40 C.F.R. § 304.12 (applying the time-computation manner as described in Rule 6(a)); 45 C.F.R. § 1630.13(a) (same); 49 C.F.R. § 240.7 (applying the time-computation provisions of Rule 6).

above, under ERISA's implementing regulations, the minimum amount of time that must be afforded to a claimant to file an administrative appeal is 180 days. 29 C.F.R. § 2560.503-1(h)(3), (h)(3)(i), (h)(4). Although the 180-day appeal period is imposed by the Plan, the Plan is ultimately governed by ERISA. Any ambiguity in calculating the 180 days should be resolved to further the purposes and goals of ERISA.

As support for its position that the LTD Plan is a private contractual arrangement and therefore should not be subject to the time-computation method we adopt, AETNA relies heavily upon a Fifth Circuit case, *Jones v. Georgia Pacific Corp.*, 90 F.3d 114 (5th Cir. 1996). In *Jones*, a decedent's heirs brought suit when the decedent's former employer and life insurance company refused to pay life insurance benefits. *Id.* at 115. The ERISA-covered group plan expired on the decedent's sixty-fifth birthday, *id.*, but included an option provision that allowed him to convert the employer-provided policy to a non-ERISA individual policy within "the thirty-one day period immediately following the date of [] cessation [of coverage]," *id.* n.1. If the employee died within thirty-one days, then he would be covered under the group policy as if he had purchased the new policy. *Id.* at 114. The decedent died on the thirty-second day after his sixty-fifth birthday without having applied for the individual life insurance policy. *Id.* at 115. When the insurance company declined to pay the death benefit, his heirs brought suit and argued that, because the thirty-first day was a Sunday, the option period should have continued to Monday, the next business day. *Id.* The district court applied Rule 6(a)'s next-business-day provision, and granted summary judgment to the heirs. *Id.* at 117.

Reversing, the Fifth Circuit held that the provision did not apply because the option to convert the group plan to an individual plan was a private contractual agreement. *Id.* at 117–18.

Jones is distinguishable and does not support AETNA's argument. First, unlike this case, *Jones* did not interpret a contractual provision that was required by ERISA. In fact, the court emphasized that defendants, as offerors of a private option contract, had "full control of . . . the length of time during which the power of acceptance shall last." *Id.* at 117. By contrast, AETNA set the appeal period at 180 days to achieve the minimum possible compliance with a statutory and regulatory mandate. In doing so, AETNA did not "full[y] control" the length of time by which an appeal could be filed. *See id.* Second, the *Jones* court's reasoning hinged on its determination that there was no ambiguity in the contractual provision. *Id.* at 116. In particular, the court explained that "[t]he qualifying phrase 'immediately following' can have no other meaning than the 31 days in their normal and natural sequence, without concern as to the days of the week . . . ."[8] *Id*. In contrast, AETNA's April 18, 2011 denial letter contains no such qualifying clause or explanation of how LeGras should calculate the 180-day appeal period.

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[8] The operative text in *Jones* provided that "[t]he acquirement period is the thirty-one day period immediately following the date of such cessation," and that "[i]f a Participant . . . dies within the thirty-one day period immediately following the date he ceased to be a covered individual, the amount of insurance which he would have been entitled to . . . will be paid . . . ." *Jones*, 90 F.3d at 115 n.1.

Finally, AETNA warns that applying the time-computation method advocated by LeGras to the calculation of deadlines under ERISA's claims procedures would create confusion and great administrative burden. Specifically, AETNA contends that it would "put claims processors for ERISA-governed plans in the unenviable position of keeping up with all state holidays for all [fifty] states . . . ." AETNA's argument is unpersuasive. The plan administrator is responsible for identifying, and clarifying, applicable due dates in compliance with ERISA.[9] Although we recognize the burden placed on administrators to "keep[] up" with state holidays, this burden must be counter-balanced with the clarity and consistency attained by applying the time-computation method that we hold applies to calculating the 180-day period within which LeGras had to mail his notice of appeal.

III.

Although the 180-day appeal period specified in the April 18, 2011 denial letter ended on Saturday, October

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[9] ERISA's regulations require that plan administrators establish claims procedures that set forth the "applicable time limits" for challenging denied claims. 29 C.F.R. § 2520.102-3(s). The administrator must do so in a "sufficiently comprehensive" manner that is "calculated to be understood by the average plan participant." *Id.* § 2520.102-2(a). For instance, the regulations instruct administrators to use "clarifying examples and illustrations" where necessary. *Id.* Here, there is no indication that AETNA took any steps to clarify the time limit for appeal. Similarly, AETNA did not specify a date certain before which LeGras had to mail his request for appeal. Nor did it provide an illustration or example of how LeGras should calculate the 180-day period.

15, 2011, ERISA federal common law required that AETNA accept LeGras's appeal as timely as he mailed it on the first weekday following the weekend. It was error for AETNA and the district court to conclude that LeGras's administrative appeal was untimely. We reverse and remand to the district court with directions to remand to AETNA, the Plan's Claims Paying Administrator, for consideration of LeGras's appeal.

REVERSED AND REMANDED.

N.R. SMITH, Circuit Judge, dissenting:

Mr. LeGras had 180 days to appeal an adverse decision from AETNA Life Insurance Company ("AETNA"), denying him long-term disability benefits under a Long Term Disability Plan ("Plan") provided by his employer, Federal Express ("FedEx"). He lost his opportunity to appeal as a result of his own conduct; he sent his appeal to AETNA two days after the appeal period expired. Even LeGras agrees that he sent his appeal two days late. To excuse LeGras's untimeliness, the majority turns a simple case of contract interpretation into an opportunity to (without precedent) expand federal common law surrounding the Employee Retirement Income Security Act ("ERISA") to rewrite private contracts. I cannot go along with them in "bailing LeGras out."

"An ERISA plan is a contract that we interpret in an ordinary and popular sense as would a person of average intelligence and experience. We look first to the explicit language of the agreement to determine, if possible, the clear intent of the parties . . . ." *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 708 (9th Cir. 2012)

(internal quotation marks, citations, and alterations omitted). In general, "[c]ontract terms are to be given their ordinary meaning, and when the terms of a contract are clear, the intent of the parties must be ascertained from the contract itself." *Klamath Water Users Protective Ass'n v. Patterson*, 204 F.3d 1206, 1210 (9th Cir. 1999). "That the parties dispute a contract's meaning does not render the contract ambiguous; a contract is ambiguous if reasonable people could find its terms susceptible to more than one interpretation." *Doe 1 v. AOL LLC*, 552 F.3d 1077, 1081 (9th Cir. 2009) (internal quotation marks omitted).

The terms of this contract are not ambiguous. By the Plan's terms, LeGras had 180 days to file his appeal with AETNA by mail. All parties agree that LeGras received notice from AETNA that his long-term disability claim had been denied on April 18, 2011. It is also undisputed that October 15, 2011, is 180 days from the date of the notice. Where is the ambiguity? A person of average intelligence and experience would understand 180 days to mean precisely what LeGras understood it to mean here.[1] LeGras knew that the 180-day period ended on October 15, 2011; our only question: whether he should be allowed to extend that time by two days solely because the deadline for the 180-day appeal period happened to be on a Saturday.

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[1] The majority's attempt to distinguish *Jones v. Georgia Pacific Corp.*, 90 F.3d 114 (5th Cir. 1996), by holding that the terms of the plan at issue in *Jones* were not ambiguous, is not persuasive. Slip Op. at 11–12. In the only respect in which *Jones* is relevant to this case, this Plan is no more ambiguous than the plan in *Jones*; neither plan specifies what happens if the last day falls on a Saturday.

In other words, LeGras messed up; he failed to abide by his contract and now seeks an excuse to set aside his failure. LeGras has never offered any reason to explain why he failed to timely appeal. He could have mailed that appeal on any one of 180 days after April 18, 2011, including October 15, 2011. He offers no explanation why he did not. Post offices around the nation (even in Pocatello, Idaho) are open on Saturdays. LeGras offers no evidence to the contrary and no explanation why he did not send his appeal on that Saturday. All LeGras had to do (in order to preserve his rights) was mail the appeal within a six-month window. Instead, he flatly argues that he does not need to comply with his contract. Because the terms of the Plan are clear, the district court did not err when it dismissed LeGras's action with prejudice for failure to exhaust his administrative remedies. Our analysis should end here, with the contract.

To get around the plain terms of the contract, the majority is forced to create federal common law, in light of the ERISA regulations applicable to the Plan.[2] These regulations provide that an employee benefit plan "shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity

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[2] In doing so, the majority appears to go beyond the relief requested by LeGras. LeGras's briefing was focused on incorporating Fed. R. Civ. P. 6 into all time limits in insurance plans regulated by ERISA; LeGras would use the federal common law to accomplish that incorporation only if we determined Rule 6 did not directly apply, and then only to get him a couple of extra days to file. Although the basis for the majority's holding is not clear, it appears to have recognized that LeGras's Rule 6-based approach is not tenable and has instead opted to impose a rule of reasonableness on all terms in all ERISA insurance plans.

to appeal an adverse benefit determination." 29 C.F.R. § 2560.503-1(h)(1). In order to have a reasonable opportunity, an employee benefit plan must "[p]rovide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination." § 2560.503-1(h)(3)(i).

No one argues that the Plan did not comply with the ERISA regulations. Applying these regulations, the majority's logic "hits a dead end." The 180-day time limit in this case arises from the contract between LeGras, FedEx, and AETNA, and complies with the ERISA regulations. The Plan gave LeGras 180 days following receipt of the letter denying long term disability benefits to file his appeal, as the regulations outline. For that reason, LeGras never even asserted that the Plan, which incorporates the regulation's language, was in violation of ERISA or its implementing regulations. LeGras's only contentions in the district court and on appeal (prior to oral argument) were that Fed. R. Civ. P. 6 should be applied in some manner to the terms of the Plan and that AETNA breached the contract by denying his claim. In the absence of a claim that the Plan is non-conforming to the regulations, we do not have occasion to determine whether the 180-day time limit provided in the Plan and interpreted by AETNA is reasonable within the meaning of § 2560.503-1(h)(1). *See United States v. Pallares-Galan*, 359 F.3d 1088, 1094–95 (9th Cir. 2004) (noting that claims raised for the first time on appeal are deemed waived). Accordingly, the majority does not hold that the Plan violates ERISA; instead it undertakes to rewrite the terms of the contract.

The majority declines to accept LeGras's primary contention at oral argument and on appeal: that Rule 6 should be directly applied to compute the 180-day appeal period provided in the Plan. Instead, the majority suggests we must rewrite the unambiguous terms of the Plan, a private contract between the parties, in light of the federal common law and the purpose of ERISA.[3] I have no doubt that the majority is correct that we should construe ERISA liberally "in favor of protecting participants in employee benefit plans." *Batchelor v. Oak Hill Med. Grp.*, 870 F.2d 1446, 1449 (9th Cir. 1989). However, as already noted, we must begin with the contract. The terms of the contract are paramount, because "applying federal common law doctrines to alter ERISA plans is inappropriate where the terms of an ERISA plan are clear and unambiguous." *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 n.4 (11th Cir. 2010). The majority's holding ignores this limit on the reach of our power to craft federal common law for ERISA-regulated plans and drastically expands doctrines, meant to protect lay persons from deceptive plan drafting, to impose a "reasonableness" rule on every provision of an ERISA insurance plan. In doing so, the majority improperly conflates the requirement that an insured be given a reasonable opportunity to appeal an adverse decision with doctrines requiring an insurance contract to be interpreted in light of an insured's reasonable expectations.

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[3] Indeed, the majority's discussion of Rule 6, so central to LeGras's argument, is merely used to provide evidence that its preferred approach is "widespread" in other contexts. Slip Op. at 8–9.

Although the majority is correct that we have used the federal common law in cases interpreting ERISA plans, we have never used it in these circumstances. This is not a case, for example, where we are called upon to determine whether common law remedies are available regarding ERISA plans. *See Security Life Ins. Co. of Am. v. Meyling*, 146 F.3d 1184, 1191 (9th Cir. 1998). Further, in *Meyling*, we importantly noted that the plan terms limited whether the common law remedy was available in that particular case. *Id.* at 1192; *see Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992) ("Because the plan was unambiguous, the Greanys cannot avail themselves of the federal common law claim of equitable estoppel.").

The limiting power of unambiguous plan terms to the use of the federal common law also frames any discussion of the case that is the linchpin of the majority's holding: *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994). In that case, we endorsed the "reasonable expectations" doctrine for ERISA insurance plans, *id.* at 387, but we never suggested (as the majority now does) that the doctrine was available to revise unambiguous plan terms where those terms did not implicate questions of coverage. The majority interprets *Saltarelli* to mean that it can read an insured's "reasonable expectations" into any term of an ERISA plan without limits. However, the doctrine was never intended for this purpose. Instead, the "reasonable expectations" doctrine is meant to protect insureds "*regarding the coverage afforded by insurance carriers* even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer." *Id.* at 386 (internal quotation

marks omitted) (emphasis added). Therefore, in *Saltarelli*, we concluded that an exclusionary clause for preexisting conditions was unenforceable given that it was not plain and conspicuous. *Id.* at 386–87. We have never applied the "reasonable expectations" doctrine outside the context of determining the reach of insurance coverage. *See, e.g.*, *Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 n.1 (9th Cir. 1996) (declining to apply doctrine of reasonable expectations to plan administrator's discretion), *overruled on other grounds by Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999) (en banc).

The cases that the majority cites (to support its holding that an insured's reasonable expectation that the time period to mail an appeal would not end on a Saturday) are not persuasive. In *Street v. United States*, 133 U.S. 299 (1890), the Supreme Court held that an executive action taken one day outside of the Congressionally mandated time frame for the officer to act was legal in part because the last day was a Sunday. *Id.* at 305–06. Far from recognizing any "general understanding" regarding the performance of a legal act on a weekend, Slip Op. at 7–8, the Supreme Court grounded its holding in the purpose of the statute and the special nature of *Sunday* as a holiday or a *dies non*. *Id.* at 305–07. In *Armstrong v. Tisch*, the Fifth Circuit decided to incorporate Rule 6 into a regulation, because the deadline could fall on a date "on which the act cannot be legally done." 835 F.2d 1139, 1140 (5th Cir. 1988) (internal quotation marks omitted). The only act, that LeGras was legally required to do in order to preserve his appeal rights, was to mail a letter to AETNA. LeGras does not argue he could not legally mail a letter on a Saturday.

Similarly, the majority's reliance on *Schikore v. BankAmerica Supplemental Retirement Plan*, 269 F.3d 956 (9th Cir. 2001), for the proposition that we must invoke the federal common law to rewrite the terms of the Plan, is misplaced. Slip Op. at 7. In *Schikore*, this court held that the mailbox rule applied to litigation involving an ERISA plan. *Id.* at 964–65. However, the question before the *Schikore* court was fundamentally different than the question before us now. That difference illuminates why deploying the federal common law is inappropriate in this case. The question in *Schikore* was "not the interpretation of a plan term . . . but, rather, whether an evidentiary rule of federal common law is applicable in the absence of a provision in a plan rejecting that rule." *Id.* at 962 n.3. The court in *Schikore* clearly stated that the mailbox rule "does not operate as a rule of construction." *Id.* at 961. The court was not tasked with construing the meaning of plan terms at all but with resolving "a critical evidentiary question: specifically, who bears the ultimate burden of establishing receipt when receipt is disputed and the evidence is inconclusive." *Id.* at 963. Our power to create federal common law with regard to ERISA plans was well suited to the task in *Schikore*. Faced with an evidentiary dispute, the court crafted a presumption to assist in the resolution of the case. However, our job in this case is decidedly different: we need only determine the meaning of 180 days within the context of the Plan. There is no dispute that LeGras failed to comply with this Plan provision.

Further, LeGras is distinguishable from the plaintiff in *Schikore*. We must determine, not whether LeGras complied, but whether we should come to his rescue after he unambiguously missed the 180-day

deadline. The Fifth Circuit has already answered this question in *Jones v. Georgia Pacific Corp.*, 90 F.3d 114 (5th Cir. 1996). There, the Fifth Circuit refused to apply Rule 6 to a private contract when the terms of that contract were unambiguous. *Jones*, 90 F.3d at 117. The majority's attempts, to distinguish the present case from *Jones*, compromise its own reasoning. The majority holds that *Jones* is not applicable because it "did not interpret a contractual provision that was required by ERISA . . . defendants, as offerors of a private option contract, had full control of the length of time during which the power of acceptance shall last." Slip Op. at 11 (internal quotation marks and alterations omitted). However, the *Jones* plan beneficiary lost his plan benefits, because he died one day outside of the time to make an election necessary to preserve his rights. *Jones*, 90 F.3d at 115. Therefore, the prudential considerations (the majority now asserts for LeGras) would be far more appropriate to trigger crafting federal common law for the beneficiary in *Jones*. He could not control the date of his death. On the contrary, LeGras had six months to mail a letter and failed to do so. The Fifth Circuit did not rescue Jones with federal common law; our case presents far less reason to rescue LeGras. The Plan is (similar to the contract in *Jones*) a private contract for which we are bound to apply its unambiguous terms. The Fifth Circuit got it right; it refused to, "in effect, write into the policy a provision that would extend the period . . . if [the deadline falls on a weekend]." *Id.* at 116.

We should do the same here. The Plan terms are clear and comply in every respect with ERISA regulations. LeGras had 180 days to notify AETNA that he wanted to appeal its decision. One can only

conclude that LeGras failed to abide by the clear and unambiguous terms of his contract. The analysis in this case should end there. But the majority (intent on "bailing LeGras out") unnecessarily intrudes upon the ability of the parties to enforce the terms of their negotiated private contract.

Therefore, I must respectfully dissent.

APPENDIX B

UNITED STATE DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV 12-02128 R (JCGx)

[Filed July 31, 2012]

ANDRE LEGRAS,	)
	)
Plaintiff,	)
	)
v.	)
	)
AETNA LIFE INSURANCE COMPANY; FEDERAL EXPRESS CORPORATION LONG TERM DISABILITY PLAN; AND DOES 1 THROUGH 10, INCLUSIVE,	)
	)
Defendants.	)

ORDER GRANTING DEFENDANTS AETNA LIFE INSURANCE COMPANY AND FEDERAL EXPRESS CORPORATION LONG TERM DISABILITY PLAN'S MOTION FOR JUDGMENT ON THE PLEADINGS

Date: July 16, 2012
Time: 10:00 a.m.

Before the Honorable Manuel L. Real
Courtroom No. 8

Complaint Filed: March 13, 2012
Trial Date: None Set

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FEDERAL EXPRESS CORPORATION
LONG TERM DISABILITY PLAN and
AETNA LIFE INSURANCE COMPANY

This matter came to be heard before the Honorable Manuel L. Real, United States District Judge in the Central District of California, on July 16, 2012. Counsel for all parties appeared and were heard. For the reasons set forth below, the Court grants Defendants' Motion for Judgment on the Pleadings and dismisses Plaintiff's Complaint with prejudice.

PROCEDURAL POSTURE

Plaintiff filed his Complaint against Defendants Aetna Life Insurance Company ("Aetna") and Federal Express Corporation Long Term Disability Plan ("LTD Plan") on March 13, 2012. Plaintiff claimed that Defendants wrongfully denied his appeal of a claim for long-term disability benefits under the LTD Plan. Plaintiff alleged the denial of his appeal violated § 1132(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq*., as amended. Defendant LTD Plan filed its Answer on April 11, 2012, and Defendant Aetna filed its Answer on April 13, 2012. On June 15, 2012, both Defendants filed the present Motion for Judgment on the Pleadings.

APPLICABLE STANDARD

"After the pleadings are closed—but early enough not to delay trial—a party may move for judgment on the pleadings." FED. R. CIV. P. 12(c). "[T]he same standard of review applicable to a Rule 12(b) motion applies to its Rule 12(c) analog," because the motions are "functionally identical." *Dworkin v. Hustler Magazine, Inc.*, 867 F.2d 1188, 1192 (9th Cir. 1989). A Rule 12(c) motion may thus be predicated on either: (1) the lack of a cognizable legal theory; or (2) insufficient facts to support a cognizable legal claim. *See Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1990). When considering a motion to dismiss under Rule 12(c), the court "must accept all factual allegations in the complaint as true and construe them in the light most favorable to the non-moving party." *Fleming v. Pickard*, 581 F.3d 922, 925 (9th Cir. 2009). "A judgment on the pleadings is proper if, taking all of

[plaintiff]'s allegations in its pleadings as true, [defendant] is entitled to judgment as a matter of law." *Compton Unified School Dist. v. Addison*, 598 F.3d 1181, 1185 (9th Cir. 2010).

FACTUAL ALLEGATIONS

The following allegations are taken from Plaintiff's Complaint, and are taken as true for purposes of Defendants' Motion. Plaintiff is a former employee of Federal Express Corporation and was a participant in the LTD Plan. Plaintiff suffered an injury on or about October 3, 2008. Plaintiff became eligible for long-term disability benefits under the LTD Plan on May 24, 2009, and he received long-term disability benefits for 24 months.

On November 24, 2010, Defendant Aetna informed Plaintiff that he must establish that he suffered a qualifying "Total Disability" in order for benefits to continue beyond May 24, 2011. On April 15, 2011, Aetna sent Plaintiff a letter stating it had reviewed his claim for continuing benefits and determined that no benefits were payable beyond May 24, 2011. Aetna's letter clearly stated "If you disagree with the above determination, in whole or in part, you may file a request to appeal this decision within 180 days of receipt of this notice." The LTD Plan also clearly states that a claimant must send the appeal to the LTD Plan administrator within 180 days.

Plaintiff received Aetna's letter, notifying him of the denial of his claim for continuing benefits and of the deadline for appealing the decision, on April 18, 2011. Therefore, the deadline for Plaintiff to submit his

appeal was Saturday, October 15, 2011.[1] Plaintiff did not send his appeal to Aetna until Monday, October 17, 2011. Plaintiff thus did not send his appeal letter until 182 days after he received his denial letter.

On January 17, 2012, Aetna sent Plaintiff another letter, stating that his claim was denied because he had not submitted his appeal within the 180 day time period required by the LTD Plan. Aetna referred to the LTD Plan language which requires that a written appeal be sent to the Administrator within 180 days of the date the claimant receives the written denial of such claim.

ANALYSIS

ERISA itself does not explicitly require a participant to exhaust all available internal remedies prior to bringing a federal lawsuit. *See* 29 U.S.C. § 1132. The Ninth Circuit, however, "long ago concluded that 'federal courts have authority to enforce the exhaustion requirement in suits under ERISA, and that as a matter of sound public policy they should usually do so.'" *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008) (quoting *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980)). The Ninth Circuit has explained:

> [T]he exhaustion doctrine is consistent with ERISA's background, structure and legislative history and serves several important policy considerations, including the reduction of

---

[1] At the hearing on Defendants' Motion, Plaintiff's counsel conceded that the deadline for submitting the appeal was October 15, 2011.

> frivolous litigation, the promotion of consistent treatment of claims, the provision of a nonadversarial method of claims settlement, the minimization of costs of claim settlement and a proper reliance on administrative expertise. [*Amato*, 618 F.2d] at 566-68. Consequently the federal courts have the authority to enforce the exhaustion requirement in suits under ERISA, and [] as a matter of sound policy they should usually do so." *Id*. at 568.

Diaz v. United Agric. Employee Welfare Benefit Plan & Trust, 50 F.3d 1478, 1483 (9th Cir. 1995). Failure to submit a required claim or internal appeal within the time frame set forth in an employee welfare benefit plan is one example of failing to exhaust administrative remedies. *See, e.g., Werner v. Liberty Life Assur. Co.*, 336 Fed. Appx. 676 (9th Cir. 2009) (affirming district court's dismissal of complaint for plaintiff's failure to timely exhaust internal administrative remedies).

In this matter, Plaintiff failed to timely exhaust his internal administrative remedies. The LTD Plan provides that any appeal must be sent to the Plan Administrator within 180 days of the receipt of the notice of denial. This time frame is reasonable. *See* 29 CFR § 2560.503-1(h). Plaintiff received written notice that his claim for benefits was denied on April 18, 2011. Accordingly, in order to be timely, his appeal had to be sent within 180 days of April 18, 2011 – or no later than October 15, 2011. Plaintiff did not send his appeal until October 17, 2011. He thus missed the deadline by two days. Consequently, he failed to properly exhaust his administrative remedies and his claim is barred.

When "the court determines that the allegation of other facts consistent with the challenged pleading could not possibly cure the deficiency," the court may dismiss a claim with prejudice. *Schreiber Distrib. Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1401 (9th Cir. 1986). In this matter, Plaintiff has clearly alleged the specific dates and times upon which he received his written notice of denial and upon which he sent his appeal. Plaintiff cannot allege any facts that will alter these dates without flatly contradicting what he has already alleged to be fact. Any attempt to amend the Complaint and state a viable claim would be futile. Dismissal with prejudice is therefore appropriate.

CONCLUSION

It is therefore ORDERED that Defendants' Motion for Judgment on the Pleadings is GRANTED and this matter is dismissed with prejudice. Judgment is entered in favor of Defendants.

DATED: July 31, 2012

/s/
HONORABLE MANUEL L. REAL
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 12-56541

D.C. No. 2:12-cv-02128-R-JCG
Central District of California,
Los Angeles

[Filed July 7, 2015]

ANDRE LEGRAS,	)
	)
Plaintiff - Appellant,	)
	)
v.	)
	)
AETNA LIFE INSURANCE COMPANY and FEDERAL EXPRESS CORPORATION LONG TERM DISABILITY PLAN,	)
	)
Defendants - Appellees.	)

ORDER

Before: PREGERSON, PAEZ, and N.R. SMITH, Circuit Judges.

A majority of the panel has voted to deny Appellees' Petition for Rehearing En Banc. Judge Smith voted to grant the petition.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc is DENIED.

PRIVILEGED

Jeff, looks good. See comment on last page. Ken D. 10/4/95

Provident Internal Memorandum

To: *IDC Management Group*
Glenn Felton

From: *Jeff McCall*

Date: *October 2, 1995*

Re: *ERISA*

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for all claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer pays the premium, the policy would usually, but not always, be considered to be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:ajr

Paul Douglas

EXHIBIT A