No. 14-15420

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

VANDANA UPADHYAY,
Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE COMPANY, A CONNECTICUT CORPORATION, IN ITS CAPACITIES AS A FIDUCIARY AND AN ADMINISTRATOR OF THE SYMMETRICOM, INC. LONG TERM DISABILITY BENEFITS PLAN, AN ERISA-REGULATED EMPLOYEE WELFARE BENEFIT PLAN,
Defendants-Appellees.

On Appeal from the United States District Court
For the Northern District of California
Case No. 3:13-cv-01368-SI

BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS IN SUPPORT OF PLAINTIFF-APPELLANT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, *Amicus Curiae*, United Policyholders, states that it is a non-profit 501(c)(3) consumer organization, that it does not have a parent corporation, and that no publicly-traded corporation owns 10% or more of the stock of United Policyholders.

Dated: August 22, 2014

By: s/Michelle L. Roberts
Michelle L. Roberts
Attorney of Record for *Amicus Curiae*
United Policyholders

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I. STATEMENT OF INTEREST OF THE *AMICUS CURIAE*

This brief is filed pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure. All parties have consented to its filing. United Policyholders ("UP") submits this amicus curiae brief in support of Plaintiff-Appellant Vandana Upadhyay and asks this Court to grant Upadhyay's request to reverse the District Court's grant of summary judgment in favor of Aetna on its defense that plaintiff's action is contractually barred by the limitations provision in the Symmetricom, Inc. Long Term Disability Benefits Plan.

UP is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP monitors the implementation and application of laws and rules under the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*., and helps consumers resolve concerns and disputes related to those laws and rules. Given that a substantial portion of in-force LTC insurance products are subject to ERISA, UP has a corresponding interest in this case.

UP's work is divided into three program areas: *Roadmap to Recovery* (claim assistance), *Roadmap to Preparedness* (promoting insurance/financial literacy) and *Advocacy and Action* (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations,

foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

Advancing the interests of policyholders through participation as *amicus curiae* in insurance-related cases throughout the country is an important part of UP's work. UP's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth*, 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.*, 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including *TRB Investments, Inc. v. Fireman's Fund Ins. Co.,* 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as *amicus curiae* include: *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013); *US Airways v. McCutchen*, 133 S. Ct. 1537 (2013); *Hardt v. Reliance Standard Life Insurance Co.*, 130 S. Ct. 2149 (2010); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004); and *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). UP also was granted leave to file an *amicus* brief in *Skinner v. Northrop Grumman Retirement Plan B*, No. 10-55161 (Doc. 53) (9th Cir. 2012).

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

II. STATEMENT OF *AMICUS CURIAE*

Pursuant to Rule 29(c)(5) of the Federal Rules of Appellate Procedure, the undersigned counsel hereby certifies that no party's counsel authored the brief in whole or in part; no party nor a party's counsel contributed money that was intended to fund preparing or submitting the brief; and no person — other than the *Amicus Curiae*, its members, or its counsel — contributed money that was intended to fund preparing or submitting the brief.

III. SUMMARY OF ARGUMENT

In this case, the District Court held that Upadhyay's ERISA action was untimely under the provisions of the Symmetricom, Inc. Long Term Disability Plan ("the Plan") because the contractual deadline for filing suit ended on July 1, 2010, even though Upadhyay had a right to file her claim for benefits after that time and did so on December 15, 2010. *Upadhyay v. Aetna Life Ins. Co.*, No. C13-1368 SI, 2014 WL 186709, at *5-6 (N.D. Cal. Jan. 16, 2014); 1ER 11-20. In construing the relevant Plan provision, the District Court did not apply superseding state insurance law that supplants the Plan's strict deadline for filing claims and which enabled Upadhyay to file her claim at any time up to 90 days following the

time she is no longer disabled and eligible for benefits (or, if not reasonably possible, up to one-year-and-90-days). Cal. Ins. Code § 10350.7. Upadhyay's claim could not be barred for untimeliness based on a controlling statute contrary to the Plan's term.

Moreover, even absent California insurance law extending the deadline to submit proof of loss, the District Court's application of the contractual limitations provision undermines and runs afoul of California's notice-prejudice rule and it should be held invalid on that basis. Because Defendants neither alleged nor demonstrated any prejudice in receiving notice of Upadhyay's disability claim beyond the Plan's stated deadline for proof of loss, Upadhyay's lawsuit was timely. Additionally, the Plan's contractual limitations provision, without consideration of California law, significantly hampers ERISA's civil enforcement scheme because courts of law will not entertain lawsuits for benefits until a plan participant has fully exhausted administrative remedies, a detailed process that can take up to and beyond 16 months.

Lastly, Aetna not only invited Upadhyay to file a civil action beyond the time that it now asserts had already passed, but it failed to inform her of the Plan's contractual limitations provision in the claim denial letter, which violates ERISA. As such, the contractual limitations period cannot be enforced to bar Upadhyay's

lawsuit. Her suit is timely under the applicable statute of limitations. *See Upadhyay*, 2014 WL 186709, at *5; 1ER18.

United Policyholders respectfully requests that the Court 1) find that the California Insurance Code supplants the Plan's deadline for filing claims, thereby extending the date on which accrual of the contractual limitation period begins; 2) find that California's notice-prejudice rule requires extending a Plan's proof of loss deadline to the date when a claimant submits a claim that does not prejudice an insurer; and 3) find that the Plan's contractual limitations provision cannot be enforced against Upadhyay because it did not inform her of the Plan's provision in the letter denying her appeal in violation of ERISA.

IV. ARGUMENT

A. The California Insurance Code Is a "Controlling Statute" Which Prevents Aetna's Contractual Limitations Provision from Taking Effect.

As a general rule, a court must give effect to an ERISA plan's limitations provision unless it determines either that the period is unreasonably short, or that a "controlling statute" prevents the limitations provision from taking effect. *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 612, 187 L. Ed. 2d 529 (2013). The California Insurance Code ("the Code") requires disability insurance policies, like the one in the present case, to incorporate various provisions and language prescribed by the Code. Cal. Ins. Code § 10350. An

insurer may substitute one or more corresponding provisions provided they are not less favorable in any respect to the insured. *Id*. Where a provision in a policy conflicts with any provision of the Code, the rights, duties, and obligations of the insurer and insured are governed by the Code rather than the policy. Cal. Ins. Code § 10390.

Here, the Plan provides: "No legal action can be brought to recover any benefit after 3 years from the deadline for filing claims" which is "90 days after the end of the elimination period" or "the first 90 days of a period of disability." *Upadhyay*, 2014 WL 186709, at *5; 1ER19. In other words, the Plan provides a claim deadline that is 90 days following the date of disability. However, the Plan's deadline is in conflict with the Code, which provides:

> Proofs of Loss: **Written proof of loss must be furnished to the insurer** at its said office **in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable** and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Cal. Ins. Code § 10350.7 (emphasis added). To illustrate with an example, say that a claimant is disabled from January 1, 2014 to December 31, 2014 and is entitled to continuing monthly disability payments after a 90-day elimination period. The

Plan requires that the claimant submit her claim by April 1, 2014; however, the Code permits the claimant to submit her proof of claim at any time up to March 31, 2015 under ordinary circumstances. The Plan requires that the claimant file suit by April 1, 2017; however supplanting the Plan's deadline with the Code deadline, a claimant has until March 31, 2018 to file suit. Because the Plan's provision is "less favorable" than the Code, it must be substituted with the Code's deadline to submit a claim.

The District Court in this case was required by California statutory law to substitute the Plan's strict 90-day deadline with the Code's more generous claim filing deadline. For the duration of Upadhyay's disability and 90 days thereafter, Upadhyay was free to submit her initial proof of claim. Since she had been continuously disabled as of the date she submitted her claim (2ER247, *et seq*.), it was timely. Defendant takes the position that Upadhyay had to have filed a lawsuit before she even knew that Aetna would deny her claim. Such a conclusion cannot be reconciled with California law or ERISA's claim and appeals process.

B. California's Notice-Prejudice Rule Works in Conjunction with ERISA's Civil Enforcement Scheme to Protect the Internal Claims Process.

ERISA's internal claims procedure for disability benefit claims is often a time-consuming process, necessitated by numerous factors governing the assessment of disability and the good-faith exchange of information between

participants and plan administrators. The time periods in ERISA's implementing regulations provide flexible deadlines, such that the internal claim and appeal process, which claimants must exhaust before they can file a lawsuit, may not be completed within a set period of time and can vary widely on a case-by-case basis. California's notice-prejudice rule – under which an insurer cannot avoid liability based on untimely proof of claim, unless the insurer shows it was prejudiced by the delay – requires that an insurer accept a late claim in most circumstances and engage in the appeals process. *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 364, 119 S. Ct. 1380, 1384, 143 L. Ed. 2d 462 (1999).

Even though the District Court did not find that Defendants were prejudiced by Upadhyay filing her claim less than four years following the date of her disability, it found that Defendants did not have to show prejudice to prevail on a limitations defense challenging the timeliness of an ERISA action. *Upadhyay*, 2014 WL 186709, at *6; 1ER20. Defendants do not have to show prejudice to prevail on a limitations defense, but where notice-prejudice governs the claim filing deadline and an insurer cannot show prejudice in accepting the claim, enforcing the Plan's limitations provision completely eviscerates California's notice-prejudice rule. It does so by causing, in many circumstances, a claimant's deadline for filing suit to run before she has had the opportunity to exhaust administrative remedies or providing a limitations period that is "unreasonably

short." *See Heimeshoff*, 134 S. Ct. at 610. Parties may not contract around the notice-prejudice requirement. *Ward*, 526 U.S. at 376. Yet, enforcing a Plan's contractual limitations period against a claimant whose claim the insurer had to accept under the Code effectively denies the participant access to ERISA's civil enforcement scheme. This is in direct contradiction to one of ERISA's stated goals because it in effect requires the claimant to file a protective lawsuit before there is a final claim denial. As such it is adverse to the interests of our overburdened judiciary and the universal goal of efficient dispute resolution. A decision which affirms the District Court's decision will cause these two unwanted effects. To understand how and why the notice-prejudice rule is rendered nugatory by application of the Plan's limitations provision, it is important to take note of the intricacies of the ERISA claim and appeals process.

1. The Internal Claims Procedure for Disability Claims.

ERISA sets forth basic procedural safeguards that govern the administration of employee welfare benefit plans. 29 U.S.C. § 1133. Every employee benefit plan must: (1) provide adequate notice in writing to any participant whose claim for benefits 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 for a full and fair review by the appropriate named fiduciary of the decision

denying the claim. *Id*. With respect to the administration of disability claims, ERISA's implementing regulations provide certain minimum requirements for a participant's initial claim for benefits and for an appeal of an adverse determination. *See* 29 C.F.R. § 2560.503-1, *et seq*.

The regulations require that a plan render a decision on a benefit claim within a reasonable period of time, but not later than 45 days after the plan receives the claim. 29 C.F.R. § 2560.503-1(f)(3). However, the plan may extend the period to make a decision for up to 30 days if the administrator determines that, due to matters beyond the plan's control, a decision cannot be rendered within that extension period. *Id*. The plan may take two 30-day extensions following the initial 45-day deadline, provided that it issues a notice which explains the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. *Id*. The participant then has *at least* 45 days within which to provide the specified information. *Id*. The deadlines by when a plan administrator must render a determination are tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. 29 C.F.R. § 2560.503-1(f)(4). The deadlines provided by the regulations are not absolute, in certain situations providing only a floor on the time that a claimant must provide certain information. As such, a

plan's initial determination on a claim may occur as quickly as 45 days following a plan's receipt of the claim or many months later.

For example, if a participant files a disability claim on January 1, the first 45-day deadline for the plan administrator to render a decision falls on February 15. The plan administrator may determine on February 10 that it requires additional information to make a decision, notifies the claimant of such, and extends the time to render a decision by the first 30-day permissible extension. The claimant must be given *at least* 45 days, to provide the plan with the requested information before it may deny the claim. Assuming that the claimant furnishes the requested information on day 45, or March 27, the plan now has until April 26 to render a determination.

However, the plan may determine on April 25 that it again requires additional information to make a decision and notifies the claimant of the information that she must submit. The claimant must be given *at least* 45 days, or until June 9, to provide the requested information. The claimant may need additional time beyond 45 days and any plan administrator, engaging in good faith, would grant any reasonable request for an extension. Assuming that the claimant seeks and obtains an extension for a total of 60 days to furnish the requested information, or June 24, the second 30-day extension for the plan to render a decision falls on July 24. The plan issues a written denial on that date.

The regulations require that a plan give a claimant *at least* 180 days following notification of an adverse benefit determination within which to appeal such determination. 29 C.F.R. § 2560.503-1(h)(3)(i) and (h)(4). Upon the plan's receipt of the claimant's appeal, it has 45 days to render a determination. *Id*. at (i)(1)(i); (i)(3). However, if special circumstances prevent a plan from making a determination within 45 days, it may take an additional 45 days if it notifies the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. *Id*. at (i)(1)(ii); (i)(3). If a plan extends the period of time within which it has to make a benefit determination on review due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. *Id*. at (i)(4).

Continuing with the above example, the claimant's appeal is due *at least* 180 days following receipt of the claim denial letter. If the claimant received the denial letter on July 24, her appeal is due by January 20, more than one year after submission of the claimant's initial benefit application. The claimant may require additional time beyond 180 days to submit an appeal and nothing in the regulations

requires that a claimant must submit an administrative appeal within 180 days – it is a *minimum* period of time. Indeed, a plan engaging in good faith in the review process will grant a claimant any reasonable request for an extension of time. The claimant may have a medical test scheduled 60 days after the deadline which would aid the administrator in making a decision. The claimant may require an additional 60 days following the test for follow up diagnostic testing and to gather medical records. For purposes of this example, the claimant required an additional 120 days to submit all of the necessary information with her appeal, or until May 20. The plan's first 45-day deadline begins to run at that time. However, the plan determines on day 40, or June 29, that there is still more information it needs to render a decision. It sends written notice to the claimant informing her of its need for additional information. The regulations permit tolling of the period for making a benefit determination on review until the claimant responds to the request for additional information.

If the claimant responds to the request for information within 45 days, or by August 13, the plan may take the remainder of the first 45-day period (five days in this example since the tolling period started at day 40), plus an additional 45 days, making a final determination not due until October 2. In this example, with only relatively modest extensions of time all permitted by the regulations, an adverse claim and appeal decision took approximately 21 months from the submission of

the original application for benefits.[1] The date of the final written denial, provided that it was issued by the statutory deadline, is the absolute earliest date that the claimant may be found to have exhausted administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing suit under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

However, the pre-litigation administration of the claim may take even longer than that: plans are permitted to require participants to exhaust not just one, but two levels of internal appeals, before they can file suit. *See* 29 C.F.R. § 2560.503-1(i)(3)(i); *see also Bernikow v. Xerox Corp. Long-Term Disability Income Plan*, 517 F. Supp. 2d 646, 653 (W.D.N.Y. 2007) (dismissing the plaintiff's Complaint with prejudice where the plaintiff did not exhaust the plan's second level of administrative appeal). A mandatory second level of appeal could easily extend the claim and appeal process by an additional year for a total of nearly three years to exhaust administrative remedies.

2. Why a Full and Fair Review May – and Sometimes Should – Extend the Internal Claims Procedure.

ERISA imposes "higher-than-marketplace quality" standards on plan administrators. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008). It underscores the particular importance of accurate claims processing by insisting

[1] In *Heimeshoff*, the Court recognized that exhaustion takes about 15 to 16 months in a typical case (134 S. Ct. at 616, n. 4), but the ERISA Regulations do not require that the exhaustion process be completed by any set deadline.

that administrators provide a "full and fair review" of claim denials. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113, (1989) (quoting § 1133(2)).

The internal claims procedure described above provides the flexibility necessary for participants and administrators to work together in resolving claims short of litigation. There are a number of reasons why an internal claims procedure may extend for significant periods of time while a plan administrator is deciding a claim or reviewing an appeal of a denied claim.

First, courts generally discourage attorneys from participating in the claims process. *See Rego v. Westvaco Corp.*, 319 F.3d 140 (4th Cir. 2003). The congressional purpose of ERISA, which emphasized promotion of "the soundness and stability of plans with respect to adequate funds to pay promised benefits," (29 U.S.C. § 1001(a)) encourages participants to resolve their claims on their own without legal counsel. This Court recognized this purpose of ERISA in declining to award attorneys' fees for work done during the claims and appeal process because "some claimants and some plans may use informal internal review procedures, accomplished by nonlawyers, perhaps union or other employee representatives and plan representatives; a nonliteral reading of the statute which exposed the loser to the prevailing party's attorneys' fees might undermine such a process." *Cann v. Carpenters' Pension Trust Fund for N. California*, 989 F.2d 313, 317 (9th Cir. 1993).

For lay persons, and those whose life has been transformed by disability, the intricacies of ERISA and the statutory, regulatory, and contractual requirements necessary to establish a disability claim are unknown and daunting. The regulations implementing ERISA's full and fair review process recognize the necessary back and forth exchange of information by permitting the tolling of deadlines to render a decision. "In simple English, what [the regulations call] for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).

Second, in the disability claims context, there is a countless number of scenarios that justify an extended internal claims procedure with sometimes indefinite periods of tolling. For example, a diligent administrator may be required to toll the period of time to make a benefit determination pending a response to multiple requests for medical records from a claimant's treating physician which is necessary to process the claim. *See Evans v. American Express Financial Corp. Long-Term Disability Plan*, No. 3:01-1501, 2003 WL 23126327 at *7-8 (M.D. Tenn. Nov. 5, 2003) (finding time limits for responding to claim were tolled pending the administrator's receipt of all medical information necessary to process plaintiff's claim where administrator made numerous requests to the plaintiff's treating physicians). As courts have recognized the relevance of a finding of

disability by the Social Security Administration ("SSA") (*see e.g. Glenn*, 554 U.S. at 106; *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 635 (9th Cir. 2009), claimants may seek to toll a decision on their disability claim pending an award of benefits by the SSA or an administrator may request a claimant's SSA file for consideration. A process which encourages the consideration of more information, rather than less, maintains the integrity of a benefit review procedure. Indeed, the U.S. Supreme Court has recognized that a benefit determination is considered to be a fiduciary act. *Glenn*, 554 U.S. at 111. Administrators should be encouraged to take the time they need to make benefits determinations in accordance with their fiduciary duties to act for the "exclusive purpose of . . . providing benefits to participants . . . [and] in accordance with the documents and instruments governing the plan. . ." ERISA § 404; 29 U.S.C. § 1104. Stifling the benefits determination process with a threat of the sunset of an accrual period will lead to unnecessary litigation on a subpar claims record.

Third, claimants intending to appeal a denied claim may seek an attorney for assistance and may need additional time beyond the 180-day minimum time period to appeal. Given the importance of the administrative record to a claimant's benefit claim[2], administrators should and typically do grant reasonable extensions

[2] Depending on the applicable judicial standard of review of a denied benefits claim under § 502(a)(1)(B), a reviewing court's inquiry is generally limited to the four corners of the claim record developed during the course of administrative

of time to appeal while a claimant is seeking representation. *See, e.g., Duncan v. Hartford Life and Acc. Ins. Co.*, No. 2:11-cv-01536-GEB-CKD, 2013 WL 506465 at *2 (E.D. Cal. Feb. 8, 2013) (granting plaintiff's request for a 90-day extension for her appeal to "obtain an attorney").

Disabled claimants may be overwhelmed by the volume of documentation that they must obtain and submit to prove their claims, and often must rely on their medical providers to respond to requests for information. Therefore, an administrator should not be incentivized to render a hasty determination on the merits of a claim before it has all of the necessary records. But allowing insurers to construct in litigation new arguments that a claimant had a reasonable amount of time post-exhaustion to file a lawsuit prior to the expiration of a statute of limitations period that began accruing well before the claim was even filed, does just that.

3. Defendants' Interpretation of the Plan's Limitations Provision Requires All Claims to Be Filed Within One Year, Completely Eviscerating the Notice-Prejudice Rule.

In this case, Defendants' interpretation of the Plan's limitations provision made it such that Upadhyay had to file suit before she even filed a claim for benefits that could be denied. Upadhyay's delay did not prejudice the insurer.

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exhaustion. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 969-70 (9th Cir. 2006) (collecting circuit cases limiting a district court to the administrative record on abuse of discretion review).

But, in order for a claimant to have at least six months post-exhaustion to file a lawsuit,[3] assuming a typical 16-month exhaustion process, she would have to file her claim no later than 14 months following the date of disability. And, that is only two months after most California claimants' short-term disability benefit payments end.[4]

[3] We do not suggest that six months is a reasonable amount of time to file a lawsuit. Indeed, it is difficult for participants to find an attorney knowledgeable about ERISA claims. The ERISA bar representing individuals is extremely small. For example, in 2010, there were 852 attorney members of the Employee Benefit Committee of the Section of Labor and Employment Law of the American Bar Association; of those, only 101 classified themselves as representing Employee-Plaintiffs, or approximately less than twelve percent (12%) of the total membership. Brief of AARP and National Employment Lawyers Association, as *Amici Curiae*, in Support of Petitioner, *Hardt v. Reliance Standard Life Ins. Co.*, 2010 WL 768489 (U.S.)(Appellate Brief). A participant who has just been denied income replacement benefits because she is not gainfully employable due to a medical condition is often in a multi-factor crisis situation. Instead of relying on benefits that she believed would protect her and her family against the hardship of disability, she is now in the midst of making alternative arrangements to fund basic life necessities and medical treatment. While battling a medical condition that has deprived her of the ability to care for herself, she now has to fight a denial of a benefit claim against a large company. It may take her several weeks, months, or years to get her life in order before having the wherewithal to seek out the small community of ERISA attorneys who may be willing to take her case. *See e.g.*, *Steffy v. Liberty Life Assur. Co. of Boston*, No. 09–538, 2009 WL 3255219 (W.D. Penn. Oct. 7, 2009) (due, in part, to cognitive difficulties stemming from dementia, participant missed deadline to file a claim).

[4] Most California residents who become unable to work as a result of disability qualify for California's State Disability Insurance ("SDI") benefit program. SDI provides income replacement for 52 weeks and starts after a 7-day waiting period. *See* Employment Development Department online at http://www.edd.ca.gov/Disability/FAQ_DI_Eligibility.htm (last accessed August 17, 2014).

By its terms, the Plan's provision impermissibly attenuates the period of time that a plan participant has to submit a claim because even though an insurer may still be required to accept a late claim, if it denies the claim the participant will not have meaningful access to the courts to enforce her rights because any lawsuit would be time-barred. "By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." *Ward*, 526 U.S. at 377. This Court has recognized the importance of the notice-prejudice rule above an insurer's hard deadline for submission of proof of claim,

> We are fully cognizant of the complications and extra burdens that the notice-prejudice rule imposes on insurers. UNUM forcefully brings these to our attention. In this limited respect, a plan's written terms are altered. Moreover, the notice-prejudice rule is more difficult to administer and provides less predictability than does the calendar. All of this, of course, may generate additional litigation. UNUM's concerns are real-but that does not alter the scope of the saving clause written into the law by Congress or the validity of the notice-prejudice rule adopted in California. Moreover, we presume that insurers structure their premiums and conduct their financial affairs around the principle that they may have to honor and pay for the coverage provided.

Cisneros v. UNUM Life Ins. Co. of Am., 134 F.3d 939, 947 (9th Cir. 1998). The only way to preserve the notice-prejudice rule is to render nugatory any Plan term which serves to limit or restrict its application as Defendants' interpretation does in this case.

C. Aetna Cannot Enforce Its Contractual Limitations Period Against Upadhyay Because Aetna Violated ERISA's Notice Requirements.

ERISA's minimum regulations spell out the insurer's duty to inform beneficiaries about their right of judicial review, including time limits. The regulations requiring notice of the right to file an action were promulgated under Congress's mandate that ERISA employee benefit plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied," 29 U.S.C. § 1133(1), and "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review," *id.* § 1133(2). This clear and specific mandate was part of Congress's response to the "lack of employee information and adequate safeguards concerning" the operation of these plans, which threatened the "continued well-being and security of millions of employees and their dependents." *Id.* § 1001(a).

Through ERISA, Congress intended to "protect ... the interests of participants in employee benefit plans and their beneficiaries, by ... establishing standards of conduct, responsibility, and obligation for fiduciaries ... and by providing for appropriate remedies, sanctions, and **ready access to the Federal courts**." *Id*. §1001(b) (emphasis added).

It is undisputed that Aetna did not notify Upadhyay of the time limit for judicial review in any adverse determination letter. This is required by **29 C.F.R. § 2560.503-1(g)(1)(iv) and (j)(4)**:

> (**g) Manner and content of notification of benefit determination.** (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination.… **The notification shall set forth, in a manner calculated to be understood by the claimant** –
>
> …(iv) A description of the plan's **review procedures** and **the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action** under section 502(a) of the Act following an adverse benefit determination on review[.]
> * * *
> **(j) Manner and content of notification of benefit determination on review.** The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review.… In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –
> … (4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, **and a statement of the claimant's right to bring an action** under section 502(a) of the Act[.]

(Emphasis added.)

Although the U.S. Supreme Court has recognized the particular importance of enforcing plan terms as written (*Heimeshoff*, 134 S. Ct. at 612), it has also recognized that trust documents cannot excuse trustees from their duties under ERISA (*Fifth Third Bancorp. v. Dudenhoeffer*, 134 S. Ct. 2459, 2468-69 (2014)). Administrators must explicitly disclose contractual limitation periods in ERISA

plans in order for them to be enforceable. *Chappel v. Lab Corp. of Am.*, 232 F.3d 719 (9th Cir. 2000); *Novick v. MetLife*, 764 F. Supp. 2d 653, 659-64 (S.D.N.Y. 2011); *Moyer v. Metro. Life Ins. Co.*, --- F.3d. ---, No. 13-1396, 2014 WL 3866073 (6th Cir. Aug. 7, 2014). Because Aetna failed to do so, the Plan's contractual limitations provision cannot be enforced against Upadhyay.

V. CONCLUSION

For each of the foregoing reasons, United Policyholders, as *amicus curiae*, respectfully requests that this Court reverse the District Court's decision to grant of summary judgment in favor of Aetna on its defense that plaintiff's action is contractually barred by the limitations provision in the Symmetricom, Inc. Long Term Disability Benefits Plan.

DATED: August 22, 2014 Respectfully submitted,

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VI. CERTIFICATE OF COMPLIANCE

I certify that pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached brief is proportionately spaced, has a typeface of 14 points or more, and contains 5,650 words.

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9th Circuit Case Number(s) 14-15420

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