No. 15-439

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

RESPONDENT'S BRIEF IN OPPOSITION

GLENN R. KANTOR
Counsel of Record
PETER S. SESSIONS
KANTOR & KANTOR LLP
19839 Nordhoff Street
Northridge, CA 91324
(818) 886-2525
gkantor@kantorlaw.net

SHELBY LEIGHTON
SCOTT L. NELSON
PUBLIC CITIZEN
LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000

Counsel for Respondent

February 2016

QUESTION PRESENTED

Pursuant to section 1133(2) of the Employee Retirement Income Security Act of 1974 (ERISA), a Department of Labor regulation requires employee benefit plan administrators to include in every plan a provision that affords at least 180 days for a plan beneficiary to appeal from a denial of benefits. The question presented is:

Whether the court of appeals correctly interpreted that regulation to require ERISA plans to allow an appeal to be filed on the next business day following the 180th day when the 180th day falls on a weekend or holiday.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes

Regulations

Rules

Restatements

INTRODUCTION

Respondent Andre LeGras seriously injured his back while working for petitioner Federal Express Corporation (FedEx), rendering him unable to work. When petitioner Aetna Life Insurance Company (Aetna), as claims administrator, denied him disability benefits under FedEx's long-term disability plan, LeGras sought to appeal through Aetna's internal appeals procedure, which, as required by ERISA and its implementing regulations, gave him 180 days to appeal the denial of benefits. Because the last day of the appeal period fell on a Saturday, LeGras filed his appeal the following Monday. Aetna denied his claim as untimely. LeGras sued Aetna and the benefit plan to challenge the denial of benefits, and the district court held that his lawsuit was barred because his Monday filing was not timely, and thus he had not exhausted the remedies available to him under the plan as required to bring a claim for the denial of benefits under ERISA.

The court of appeals reversed, holding that LeGras's claim was not barred by the prudential exhaustion requirement. The court determined that the appeal period under the plan was governed by the ERISA regulation mandating that plans give beneficiaries 180 days to appeal. Because the regulation did not specify how the 180-day appeal period should be calculated, the court construed the regulation to incorporate the method of computing time provided in Federal Rule of Civil Procedure 6(a), which would allow LeGras to file his appeal on the Monday following the Saturday that was the 180th day. Absent any contrary language in the plan, the court construed the plan's 180-day period to comply with the regulation.

The court of appeals' determination that ERISA's implementing regulations require the plan to calculate time pursuant to the method used in most other federal statutes does not warrant this Court's review. No other court of appeals has addressed the calculation of time under the regulation at issue, and the cases cited by petitioners to allege a circuit split have nothing to do with that question. The Ninth Circuit's decision is consistent with this Court's precedent holding that courts must interpret ambiguous plan terms to comply with applicable law, and both this Court and courts of appeals have consistently applied the rule adopted here to calculate time under federal statutes. Rather than departing from decisions of this Court and courts of appeals, therefore, the Ninth Circuit's opinion applies established legal principles to construe an applicable regulation and reads the terms of the plan to be consistent with the regulation, as ERISA and the regulations require. The clear rule applied by the court of appeals promotes the interests of plan beneficiaries while imposing no burden on plan administrators.

STATEMENT

Statutory Background

Congress enacted ERISA in large part "to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). To that end, ERISA regulates the administration of benefit plans by mandating minimum requirements for the processing of claims for benefits. *See* 29 U.S.C. § 1133. In particular, every employee benefit plan is required, "in accordance

with regulations of the Secretary [of Labor]," to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied," *id.* § 1133(1), and "to 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.* § 1133(2).

The Secretary of Labor has promulgated a regulation implementing section 1133 that describes in detail the claims procedures that employee benefit plans must follow. *See* 29 C.F.R. § 2560.503-1. That regulation defines "a reasonable opportunity for a full and fair review" as "at least 180 days following receipt of a notification of an adverse benefit determination." *Id.* §§ 2560.503-1(h)(3), (h)(3)(i), (h)(4). To provide the reasonable opportunity for appeal mandated by ERISA, a benefit plan therefore may not provide for an appeal period shorter than the 180-day period specified by the regulation. *See id.* § 2560.503-1(h)(4) ("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 the regulation.).

Factual Background

Respondent Andre LeGras was employed by petitioner FedEx for twenty-three years as a ramp transport driver. Pet. App. 3. In October 2008, LeGras was loading a FedEx truck when he fell between the loading dock and the back of the truck, causing serious injuries to his back, including a hernia and a herniated disk. *Id.* He underwent several surgeries to remedy

these injuries, but he continued to experience severe back pain that rendered him unable to work. *Id.*

As an employee, LeGras was a beneficiary of FedEx's long-term disability plan. *Id.* at 3-4. After his injury, he applied for disability benefits under the plan, and in May 2009, Aetna, the plan's claims administrator, determined that he was disabled and awarded him benefits. *Id.* at 4. In 2011, however, Aetna informed LeGras that he would not receive benefits after May 2011 unless he provided proof of "total disability" as defined by the plan. *Id.* at 4.

Although LeGras produced evidence that he was totally disabled, he received a letter from Aetna on April 18, 2011, notifying him of its determination that he had not succeeded in proving that he had a total disability because he had not shown that he was unable to perform sedentary work. *Id.* Pursuant to section 1133(2) of ERISA, the letter 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.*

One hundred and eighty days from April 18 was October 15, which was a Saturday. *Id.* LeGras mailed his appeal the following Monday. *Id.* Aetna then notified LeGras that his appeal had been denied because it was not mailed on or before October 15. *Id.*

Procedural Background

LeGras filed an action in district court against Aetna and the FedEx disability plan pursuant to 29 U.S.C. § 1132, ERISA's civil enforcement provision. Pet. App. 4. After answering the complaint, petitioners filed a motion for judgment on the pleadings, arguing that LeGras had failed to exhaust his administrative remedies because he

had not filed a timely appeal under the terms of the plan.[1] *Id.* The district court granted the motion. *Id.* at 30.

LeGras appealed, and the Ninth Circuit reversed. *Id.* at 3. The court emphasized that the 180-day appeal period provided for in the plan is mandated by ERISA and its implementing regulations. *Id.* at 6. Because the regulations do not specify a method of computing time, however, the court was faced with "a number of unresolved ambiguities" in interpreting the minimum appeal period that a plan must provide pursuant to ERISA. *Id.* To resolve the ambiguity in computing time under the regulation, the court turned to federal common law. *Id.* The court explained that it was doing so against a backdrop of courts long employing federal common law to interpret ERISA and of ERISA's declared policies of "protect[ing] the interest of [plan] participants" and providing "adequate safeguards . . . [that are] desirable in the interests of employees." *Id.* (quoting 29 U.S.C. § 1001).

The court then described how this Court's opinions since 1890 have recognized the principle, now codified in Federal Rule of Civil Procedure 6(a), "that when a deadline falls on a weekend, it extends to the following business day." *Id.* at 7. Discussing an extensive line of its cases that applied Rule 6 "when interpreting time periods in various statutory contexts," such as Title VII and section 1983, the court concluded that computing

---

[1] Although ERISA itself does not require beneficiaries to exhaust administrative remedies before bringing suit, *see* 29 U.S.C. § 1132, the Ninth Circuit and other courts of appeals have applied a prudential exhaustion requirement to ERISA claims. *See, e.g.*, *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008); *Bickley v. Caremark RX, Inc.*, 461 F.3d 1325, 1328 (11th Cir. 2006); *Galman v. Prudential Ins. Co. of Am.*, 254 F.3d 768, 770 (8th Cir. 2001).

time in the manner provided for in Rule 6 "is generally accepted and vital" and "protects the interests of insureds, thereby effectuating the goals of ERISA." *Id.* at 10. The court therefore held 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." *Id.*

The court addressed several of the defendants' arguments against such a reading of the regulation. First, it rejected their contention 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." *Id.* Although the appeals process is provided in the plan, the court reasoned, it "is part of ERISA's mandatory claims processing standards," and those standards provide that 180 days is "the minimum amount of time that must be afforded to a claimant to file an administrative appeal." *Id.* at 10-11. Thus, interpretation of the 180-day term in the plan is "ultimately governed by ERISA" and any ambiguity "should be resolved to further the purposes and goals of ERISA." *Id.* at 11.

Second, the court addressed the defendants' reliance on the Fifth Circuit's decision in *Jones v. Georgia Pacific Corp.*, 90 F.3d 114 (5th Cir. 1996). Pet. App. 11. That case involved the interpretation of a contractual provision giving an employee a certain amount of time to convert employer-sponsored insurance coverage to an individual policy following the employee's retirement. *Jones*, 90 F.3d at 115 & n.1. The plaintiffs argued that the time period should be calculated pursuant to Rule 6, but the court rejected that argument because the option to

convert was solely contractual and the terms of the contract were unambiguous. *Id.* at 116-17. The Ninth Circuit here distinguished *Jones* on the grounds that it "did not interpret a contractual provision that was required by ERISA." Pet. App. 12. It emphasized that the conversion provision in *Jones* was an option contract term created by the defendants, who had full control over the length of the option period that they offered and how to define that period; in contrast, Aetna here did not have full control over the appeal period, but was required to comply with the "statutory and regulatory mandate." *Id.* In addition, the court pointed out that the Fifth Circuit in *Jones* had relied upon language not present in the provision here to conclude that the language of the plan was unambiguous. *Id.*

Finally, the court was not persuaded by the argument that computing the appeal deadline as required by the court's construction of the regulation would lead to confusion and administrative burden because administrators would have to keep track of holidays in different states. The court emphasized that, pursuant to ERISA, "the plan administrator is responsible for identifying, and clarifying, applicable due dates," and that the small burden imposed by the statute is "counter-balanced with the clarity and consistency attained by applying the time-computation method" applied by the court. *Id.* at 13.

REASONS FOR DENYING THE WRIT

I. There is no circuit split.

No other court of appeals has interpreted the regulation at issue here, and therefore no court of appeals has reached a holding that conflicts with that of the court below. Petitioners seek to manufacture a circuit split by relying on cases where courts of appeals have

declined to apply equitable doctrines to override the express language of an employee benefit plan. Those cases are inapposite.

For example, petitioners contend that the Ninth Circuit's opinion conflicts with that of the Eleventh Circuit in *Zurich American Insurance Co. v. O'Hara*, 604 F.3d 1232 (11th Cir. 2010). Petitioners state that, in *O'Hara*, "the plan participant argued, as LeGras did in this case, that the court should apply an equitable principle to override the plan's deadline." Pet. 21. That statement misconstrues both the holding of that case and the argument made by LeGras here. The issue in *O'Hara* was whether the common-law "make-whole" doctrine should "override the Plan's controlling language," which required the beneficiary to reimburse the insurance company after receiving a settlement from a third party. *See O'Hara*, 604 F.3d at 1237. The beneficiary there unsuccessfully argued that the court should refuse to enforce the subrogation provision in the plan and instead should apply the make-whole doctrine "as a matter of equity." *Id.*[2]

The argument rejected in *O'Hara* is entirely different from the one made by respondent here and accepted by the court below: that the plan must be construed to comply with the requirements of applicable regulations as interpreted by the court. Unlike the appeal provision here, ERISA and its implementing regulations did not require the plan term at issue in *O'Hara* to be included in the plan at all, and the court was not tasked with interpreting statutory and regulatory requirements. Thus, the Eleventh Circuit's decision not to apply an equitable doctrine *instead of* the plain language of a plan

[2] This Court reached a similar result in *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013).

has little relevance to the Ninth Circuit's decision to read the plan's terms (in the absence of clear language to the contrary) to conform to the minimum appeal period required by law.

For the same reasons, the Fourth Circuit's decision in *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998), which also addressed whether the court should decline to enforce the plain language of a plan's subrogation provision as a matter of equity, is irrelevant here. Moreover, that court's opinion in *Coleman v. Nationwide Life Insurance Co.*, 969 F.2d 54 (4th Cir. 1992), is even further off the mark. There, the court rejected the plaintiff's equitable estoppel argument on the grounds that the statements at issue constituted "an outright modification, not an interpretation of the plan" and that it had previously recognized a rule that equitable estoppel could not be used to modify unambiguous plan terms. *See id.* at 59. Because the court here did not modify any terms of the plan, and instead merely construed the plan to comply with its interpretation of the applicable law, the decision below does not conflict with *Coleman*.

The Fifth Circuit's decision in *Jones*, 90 F.3d at 114, like the Fourth and Eleventh Circuit cases on which FedEx relies, involved the interpretation of a plan term that was not governed by ERISA or its implementing regulations. In that case, an employer-sponsored life insurance plan expired on each employee's sixty-fifth birthday, but included a provision allowing employees to convert the policy to a non-employer-provided individual policy within "the thirty-one day period immediately following the date" that the plan expired. *Id.* at 115 & n.1. The plan provided that, if the employee died within that thirty-one day period, he would still be covered as if

he had converted the policy. *Id.* The plaintiffs in *Jones* were heirs of an employee who died thirty-two days after his life insurance policy expired and who did not opt to convert the policy within that time. *Id.* They argued that, because the thirty-first day was a Sunday, the option period should have extended to the thirty-second day. *Id.* The court rejected that argument because the option was contractual and the terms of the contract, particularly the phrase "immediately following," were unambiguous. *Id.* at 116. Moreover, as the court pointed out, the Rule 6(a) principle, while applicable to legal deadlines established by statutes and rules, does not apply to deadlines that are set in purely private contracts. *Id.* at 117.

The court below correctly distinguished *Jones* on the grounds that the contractual provision at issue in that case was not required by a statutory or regulatory mandate and that it was not ambiguous. *See* Pet. App. 11. Moreover, unlike the statutorily-required appeal provision here, the plan provision in *Jones* was an option contract, and the defendants, as offerors of the contract, "had full control of its terms." *Jones*, 90 F.3d at 117. Here, by contrast, ERISA and its implementing regulation set minimum requirements for the terms of the plan, which thus necessarily governed the interpretation of the contract. Therefore, the court, not the administrator, had to determine how to calculate the minimum appeals period pursuant to the regulation.

Finally, the only case cited by petitioners that involves the 180-day appeal period requirement at issue in this case supports the holding below. In *Edwards v. Briggs & Stratton Retirement Plan*, 639 F.3d 355 (7th Cir. 2011), the plaintiff filed an appeal from the denial of benefits fifteen days after the 180-day deadline for filing

a notice of appeal. She argued that her late appeal should be excused because she was in "substantial compliance" with the appeal procedures. *See id.* at 361. Thus, like the Eleventh Circuit in *O'Hara* and unlike the Ninth Circuit below, the Seventh Circuit was faced with a beneficiary's request that it apply an equitable doctrine in place of the plain language of the plan. The court rejected that argument, stating that "the administrator must implement and follow the plain language of the plan, in so much as they are consistent with the statute. This includes *a deadline that is consistent with the regulations governing ERISA claims*." *Id.* at 362 (quoting *Wagner v. Allied Pilots Ass'n Disability Income Plan*, 383 Fed. Appx. 565, 569 (7th Cir. 2010)) (emphasis added). Although the court in *Edwards* was not required to construe the regulation—no party argued that the regulation could be read to require a fifteen-day extension—its statement supports the Ninth Circuit's conclusion that a plan's appeal provisions must be read to comply with ERISA regulations.

At best, therefore, the cases cited by petitioners stand for the proposition that courts will rarely apply an equitable doctrine to override the plain and unambiguous language of a plan, particularly if the language complies with ERISA. Here, however, the court was tasked with interpreting ambiguous, statutorily-required language. The court therefore first determined what the law required and then construed the provision to comply with the law. Rather than conflicting with the decisions of other courts of appeals, the Ninth Circuit's opinion is consistent with the recognition by the courts of appeals that plan terms must be construed to be consistent with ERISA, *see Call v. Ameritech Pension Plan*, 475 F.3d 816, 823 (7th Cir. 2007) (stating that "a plan must comply with the statute, of course"), and that, where ERISA's

requirements are not clear, federal common law "fills the gaps of ERISA to assist in the interpretation of ERISA plans," *Schikore v. BankAmerica Supplemental Retirement Plan*, 269 F.3d 956, 967 (9th Cir. 2001) (quoting *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997)); *see Stinnett*, 154 F.3d 168 (4th Cir. 1998) (recognizing that courts may apply federal common law "to effectuate the purposes of ERISA" when there are gaps in the statutory scheme); *Grabois v. Jones*, 89 F.3d 97, 101 (2d Cir. 1996) (stating that "if 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"). The adoption of this widely accepted approach does not warrant review.

II. The decision of the court of appeals is consistent with this Court's precedent.

A. This Court has consistently applied the rule adopted by the court of appeals when computing time pursuant to federal statutes.

As the court below explained, this Court's recognition of the rule that a period that ends on a weekend or holiday extends to the following Monday dates back to 1890. *See 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"). That approach was codified in Rule 6 of the Federal Rules of Civil Procedure, which applies to "computing any time period specified in these rules, in any local rule or court order, *or in any statute that does not specify a method of computing time*." Fed. R. Civ. P. 6(a) (emphasis added). Rule 6 provides that, when computing a period that is stated in days or a longer unit of time, one must "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." Fed. R. Civ. P. 6(a)(1)(C). By the plain terms of Rule 6, therefore, the rule adopted by the court of appeals below should apply to calculating time under ERISA.[3]

This Court has consistently used Rule 6 to calculate statutory time periods when a statute provides no method of calculation. For example, in *Union Nat'l Bank of Wichita v. Lamb*, 337 U.S. 38, 40-41 (1949), this Court interpreted the statute governing the time period within which an appeal could be taken to this Court from a state court of last resort. The Court held that, "since no contrary policy is expressed in the statute governing this review, we think that the considerations of liberality and leniency which find expression in Rule 6(a) are equally applicable" to the statute at issue. *Id.* at 41. This Court reached a similar conclusion in *Jones & Laughlin Steel Corp. v. Gridiron Steel Co.*, 382 U.S. 32, 32-33 (1965) (per curiam), regarding the time period for filing a notice of appeal in a court of appeals.

Particularly given ERISA's goal of "providing for appropriate remedies, sanctions, and ready access to the Federal courts," therefore, the choice of the Rule 6 method to interpret the 180-day regulation was consistent with this Court's precedent doing the same.

---

[3] The court below declined to decide the case on these grounds because it adopted the rule as a matter of federal common law. *See* Pet. App. 8.

B. The decision below is consistent with this Court's precedent regarding the interpretation of employee benefit plans under ERISA.

Petitioners argue that the decision below conflicts with decisions of this Court that have emphasized the significant latitude given to plan administrators to set the terms of employee benefit plans. *See, e.g.*, *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013); *Cigna Corp. v. Amara*, 563 U.S. 421, 436 (2011). These cases stand for the proposition that, absent a contrary mandate in the statute and its implementing regulations, courts must enforce—and cannot alter—the express terms of an ERISA plan. *See McCutchen*, 133 S. Ct. at 1548. Just as importantly, however, this Court clearly stated in those cases that plan terms must be consistent with the requirements of ERISA. *See McCutchen*, 133 S. Ct. at 1548 (citing 29 U.S.C. § 1104(a)(1)(D) for the proposition that "an administrator must act in accordance with the documents and instruments governing the plan *insofar as they accord with the statute*" (emphasis added) (internal quotation marks omitted)). The court here applied those precedents by interpreting the governing law and then applying it to the plan at issue.

Furthermore, contrary to petitioners' contention, this Court's holding in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), supports the decision below. In *Bruch* this Court held that a claim for the denial of benefits such as the one here "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115; *see also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002) (stating that this

Court held in *Bruch* "that a general or default rule of de novo review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion"). Petitioners have not asserted that the plan here gave Aetna discretion to interpret its procedural terms. But even if Aetna's interpretation were entitled to deferential review, nothing in *Bruch* permits a plan administrator to interpret plan language that is required by ERISA or its implementing regulations in such a way as to contradict those requirements.

Bruch's holding was based on principles of trust law, *see* 489 U.S. at 111, including the rule that "a deferential standard of review [is] appropriate when a trustee exercises discretionary powers." *Id.* It is well-established that the exercise of power by a trustee is *not* discretionary if "its exercise is required by the terms of the trust or by the *principles of law* applicable to the duties of trustees." Restatement (Second) of Trusts § 187, cmt. a (emphasis added). Thus, under *Bruch*'s reasoning, an ERISA administrator has no discretion to interpret the terms of a plan inconsistently with governing law. *See also Bruch*, 489 U.S. at 117 (stating that the "fundamental problem" with the court of appeals' interpretation of the plan is that "it strays far from the statutory language"). Rather than supporting deference to Aetna's interpretation of the plan in this case, therefore, this Court's decision in *Bruch* is fully consistent with the court of appeals' rejection of Aetna's denial of benefits.

III. This case does not present an important issue of federal law that warrants review by this Court.

That the decision below is the first appellate decision ever addressing whether the Rule 6 principle applies to

the regulation at issue is sufficient reason to conclude that the issue is not one of national importance meriting review by this Court. Even if there were some reason to think that the issue is one that might arise more frequently than this singular case might indicate, there would be no reason to conclude that the rule applied below will disrupt the functioning of ERISA so as to necessitate immediate intervention by this Court. To the contrary, application of the familiar and conventional rule for computing time embodied in Rule 6 will advance the goals of fairness, uniformity, and administrative efficiency embodied in ERISA.

As petitioners recognize, one of "the principal 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.'" *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)). The Ninth Circuit's decision does just that by setting forth a clear rule for the calculation of appeal periods in ERISA-governed plans that is consistent with the way time is calculated in myriad federal statutes and in all litigation in federal courts. *See* Fed. R. Civ. P. 6(a). The approach advocated by petitioners, on the other hand, would allow the method of calculating time to be determined by the plan administrator, causing inconsistency among plans rather than "a set of standard procedures." *Egelhoff*, 532 U.S. at 148. Moreover, rejecting the method of computing time used in Rule 6 would mean that the time periods for filing an appeal under the plan and for filing a complaint in federal court would be calculated differently, causing confusion for beneficiaries. *See supra* p. 13.

Petitioners contend that the rule applied by the court of appeals makes the administration of plans more complex because "plan administrators must keep track of legal holidays in every federal and state jurisdiction where it has plan participants." Pet. 28. The suggestion that the application of Rule 6 principles will cause administrative chaos would come as a great surprise to the thousands of judicial and agency administrators who regularly apply them to a host of deadlines established by statutes and rules. Moreover, plan administrators must keep track of legal holidays for a variety of reasons unrelated to the calculation of the appeal period, such as processing claims and paying employees. And this Court has held that much greater state-by-state differences in plan requirements do not impermissibly undermine the goals of ERISA. *See, e.g.*, *Moran*, 536 U.S. at 387; *Ward v. UNUM Life Ins. Co. of Am.*, 526 U.S. 358, 369 (1999).

In any event, this issue arises only in the situation where: (1) a plan provides that a claimant has the statutory minimum 180 days to appeal; (2) the 180th day happens to fall on a weekend or holiday; and (3) a plan beneficiary files an appeal from the denial of benefits on the next business day. Again, that no other court of appeals has addressed the issue suggests that disputes arising from these circumstances are rare. In the absence of another court of appeals decision reaching a conflicting result that would place plans in the position of calculating appeals periods differently in different states, there is no reason to think that the decision below will cause any disruption to ERISA plan administration. The impact of the rule adopted below on plan administrators is negligible, and it provides both beneficiaries and administrators with a clear rule regarding the calculation of the time in which appeals may be taken.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

GLENN R. KANTOR
Counsel of Record
PETER S. SESSIONS
KANTOR & KANTOR LLP
19839 Nordhoff Street
Northridge, CA 91324
(818) 886-2525
gkantor@kantorlaw.net

SHELBY LEIGHTON
SCOTT L. NELSON
PUBLIC CITIZEN
LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000

Counsel for Respondent

February 2016