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In the
United States Court of Appeals
For the Second Circuit

AUGUST TERM 2021

ARGUED: MAY 5, 2022

DECIDED: JUNE 7, 2022

No. 21-1514

JOHN MCQUILLIN,
Plaintiff-Appellant,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,
Defendant-Appellee,

Appeal from the United States District Court
for the Eastern District of New York.

Before: WALKER, CALABRESI, and CABRANES, *Circuit Judges.*

John McQuillin appeals from the dismissal in the Eastern District of New York (Joanna Seybert, *J.*) of his lawsuit seeking long-term disability benefits under the Employee Retirement Income Security Act of 1974 from Hartford Life and Accident Insurance Company. The suit was dismissed because the district court concluded that McQuillin had failed to exhaust his disability plan's

1 administrative remedies. McQuillin asserts that his administrative
2 remedies should have been deemed exhausted because Hartford, in
3 violation of the applicable ERISA regulation, failed to provide a final
4 decision on his benefits within 45 days of his administrative appeal.
5 For the reasons that follow, we agree with McQuillin, **REVERSE** the
6 district court, and **REMAND** for further proceedings.

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JOHN M. WALKER, JR., *Circuit Judge*:

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John McQuillin appeals from the dismissal in the Eastern
District of New York (Joanna Seybert, *J.*) of his lawsuit seeking long-
term disability benefits under the Employee Retirement Income

1 Security Act of 1974 (ERISA) from Hartford Life and Accident
2 Insurance Company (Hartford). The suit was dismissed because the
3 district court concluded that McQuillin had failed to exhaust his
4 disability plan’s administrative remedies. McQuillin asserts that his
5 administrative remedies should have been deemed exhausted
6 because Hartford, in violation of the applicable ERISA regulation,
7 failed to provide a final decision on his benefits within 45 days of his
8 administrative appeal. For the reasons that follow, we agree with
9 McQuillin, **REVERSE** the district court, and **REMAND** for further
10 proceedings.

11 **BACKGROUND**

12 **I. The Initial Denial**

13 In September 2019, Appellant McQuillin, suffering side effects
14 from prostate cancer treatment, applied for long-term disability
15 benefits. McQuillin’s claim was reviewed by Appellee Hartford,
16 which administered the disability plan for his prior employer, Wright
17 Medical Technology.

18 Hartford denied McQuillin’s claim in a letter dated October 25,
19 2019, “based on the fact that [Hartford] didn’t have enough proof of
20 loss to evaluate [his] disability” and that it was missing certain
21 medical records “necessary to make a decision on [McQuillin’s]
22 claim.”¹ The letter stated that McQuillin could appeal the decision
23 and correctly informed him that ERISA required Hartford to provide
24 a “final decision” within 45 days of the appeal, a period that Hartford
25 could extend with prior written notice.² The letter also informed him
26 that if he disagreed with the decision on administrative appeal, he

¹ App. 209.

² *Id.* at 210.

1 could file a lawsuit. In response, McQuillin filed the administrative
2 appeal with additional evidence on April 11, 2020.

3 II. The Appeal

4 The administrative appeal was governed by 29 C.F.R.
5 § 2560.503-1, which was promulgated by the Department of Labor
6 pursuant to ERISA, and which “sets forth minimum requirements”
7 for the review of disability claims.³ Among other things, disability
8 plans must give claimants “a reasonable opportunity to appeal an
9 adverse benefit determination.”⁴ The review must take “into account
10 all . . . information submitted by the claimant . . ., without regard to
11 whether such information was . . . considered in the initial benefit
12 determination.”⁵ The administrator must also provide the claimant
13 with “any new . . . evidence” or “rationale” it is considering as the
14 basis for denying benefits.⁶ The plan administrator must inform the
15 claimant of its “benefit determination on review” within 45 days,
16 unless “special circumstances” require a 45-day extension.⁷ If an
17 extension is needed because the claimant has not provided necessary
18 information, then the period for making the benefit determination
19 will be tolled until the claimant does so.⁸

20 On April 23, 2020, twelve days after McQuillin filed his appeal,
21 Hartford responded with a letter saying that it had “completed [its]

³ 29 C.F.R. § 2560.503-1(a).

⁴ *Id.* § 2560.503-1(h)(1). An “adverse benefit determination” is defined as “[a] denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit.” *Id.* § 2560.503-1 (m)(4).

⁵ *Id.* § 2560.503-1(h)(2)(iv).

⁶ *Id.* § 2560.503-1(h)(4)(i)-(ii).

⁷ *Id.* § 2560.503-1(i)(1)(i), (3)(i).

⁸ *See id.* § 2560.503-1(i)(4).

1 review of the appeal” and the additional evidence, that it had
2 “overturned the original decision to deny [the claim],” and that it had
3 “forwarded [the claim] to the claim department . . . to determine if
4 [d]isability is supported.”⁹ The letter cautioned, however, that
5 payment was not guaranteed. The claims department would review
6 the information, determine if McQuillin was disabled, and render a
7 new decision.

8 III. The Lawsuit

9 On May 27, 2020, 46 days after filing his appeal, McQuillin sued
10 Hartford in the Eastern District of New York. In July, with the federal
11 litigation underway, Hartford again denied McQuillin’s benefits
12 claim, this time finding that he did not qualify as disabled. This denial
13 letter contained essentially the same appeal information as the initial
14 denial letter.

15 In May 2021, the district court accepted a magistrate judge’s
16 recommendation to dismiss McQuillin’s suit on the basis that he had
17 failed to exhaust his plan remedies because his claim was still under
18 review by Hartford when he filed suit. McQuillin timely appealed,
19 and the Secretary of Labor and the American Council of Life Insurers
20 filed opposing *amicus* briefs in support of McQuillin and Hartford,
21 respectively.

22 DISCUSSION

23 On appeal, McQuillin argues that the district court improperly
24 dismissed his complaint. We review a district court’s dismissal of
25 ERISA claims for failure to exhaust plan remedies *de novo*.¹⁰

⁹ App. 214.

¹⁰ *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 219 (2d Cir. 2006).

1 Under ERISA, a claimant may sue in federal court for benefits
2 due to him under his disability plan.¹¹ But first a claimant must
3 exhaust his plan's internal remedies.¹² A plan's remedies are deemed
4 exhausted if the plan administrator does not "strictly adhere" to
5 § 503-1's requirements.¹³ McQuillin asserts that, because Hartford
6 did not provide a "benefit determination on review" within the 45-
7 day window required by § 503-1(i)(3)(i), his administrative remedies
8 should be deemed exhausted. Although Hartford's April 23 letter
9 "overturned" the original decision and "forwarded" his claim to the
10 claims department for further consideration,¹⁴ McQuillin maintains
11 that the letter failed to render a "benefit determination." Thus,
12 because Hartford did not strictly adhere to the rule's requirements,
13 McQuillin's remedies were deemed exhausted such that he was free
14 to bring suit in district court. Hartford responds that its April letter
15 was a timely benefit determination on review because such a
16 determination need only resolve the issue appealed, not the entire
17 benefits claim.

18 The dispositive question in this appeal is whether a valid
19 benefit determination on review must determine whether a claimant

¹¹ See 29 U.S.C. § 1132.

¹² See *Halo v. Yale Health Plan*, 819 F.3d 42, 55 (2d Cir. 2016).

¹³ 29 C.F.R. § 2560.503-1(l)(2)(i) ("In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.").

¹⁴ App. 214.

1 is entitled to benefits.¹⁵ Based on the regulation’s plain language,
2 structure, and purpose, we hold that it must.¹⁶ We further hold that,
3 because Hartford did not extend the benefit determination period,
4 McQuillin’s duty to exhaust had ceased by the 46th day, the day he
5 filed his federal case. Thus, the district court erred in dismissing
6 McQuillin’s suit.

7 Resolving the issue in dispute requires careful interpretation of
8 the regulation.¹⁷ In performing this analysis, we consider the “text,
9 structure, history, and purpose of [the] regulation.”¹⁸ We turn first to
10 the regulation’s text.

11 I. Section 503-1’s Text

12 The text plainly supports McQuillin’s reading of the regulation.
13 Section 503-1 states that “[t]he plan administrator shall provide a

¹⁵ McQuillin raises other arguments in his brief that we need not address.

¹⁶ Our interpretation of the regulation largely accords with that advanced by the Secretary of Labor’s *amicus* brief. See generally Sec’y Br. 14-28. Because the regulation is not ambiguous, however, we do not defer to the Secretary under *Auer v. Robbins*, 519 U.S. 452 (1997). See *Kisor v. Wilkie*, 139 S. Ct. 2400, 2414 (2019) (cautioning that courts should exercise *Auer* deference only when regulations are “genuinely ambiguous, even after a court has resorted to all the standard tools of interpretation”).

¹⁷ The parties have not cited any caselaw on point, and we have found none. Hartford cites a district court decision, which we affirmed, upholding a claim denial after an appeal was remanded to the defendant’s claim department. *Mayer v. Ringler Assocs. Inc. & Affiliates Long Term Disability Plan*, No. 18 CV 2789 (VB), 2020 WL 1467374 (S.D.N.Y. Mar. 26, 2020), *aff’d* 9 F.4th 78 (2d Cir. 2021). But, as Hartford concedes, the parties in that case did not dispute the validity of the remand, and the reviewing courts did not express a view on the issue.

¹⁸ *Kisor*, 139 S. Ct. at 2415.

1 claimant with . . . notification of a plan’s benefit determination on
2 review” within 45 days.¹⁹ The regulation does not separately define
3 “benefit determination,” but its meaning is clear. A plan must
4 provide an appealing claimant not just with a “determination,” or an
5 “appeal determination,” but with a “*benefit* determination.”²⁰ It is the
6 claimant’s benefits that the administrator has 45 days to decide, not
7 only the appeal or some other aspect of the claim.

8 The use of the word “determination” further underscores that
9 the administrator must comprehensively resolve the claim. *Merriam-*
10 *Webster’s Collegiate Dictionary* first defines the word as “a judicial
11 decision settling and ending a controversy.”²¹ Similarly, *Black’s Law*
12 *Dictionary* first defines the word as “[t]he act of deciding something
13 officially; esp., a final decision by a court or administrative agency.”²²
14 Of course, these two definitions are not exhaustive. As Hartford
15 points out, the *Collegiate Dictionary’s* second entry is “the resolving of
16 a question by argument or reasoning.”²³ Still, “determination”
17 unmistakably suggests finality. The word choice thus reinforces the
18 regulation’s natural reading that the review must determine the
19 claimant’s benefits, finally resolving the claim.

20 Hartford’s own usage supports this reading. In its letters to
21 McQuillin describing the appeal process, Hartford stated that ERISA
22 required it “to make a *final decision* no more than 45 days after” receipt

¹⁹ 29 C.F.R. § 2560.503-1(i), (j).

²⁰ *Id.* § 2560.503-1(i)(1)(i) (emphasis added).

²¹ *Determination*, Merriam-Webster’s Collegiate Dictionary (11th ed. 2007).

²² *Determination*, Black’s Law Dictionary (11th ed. 2019).

²³ *Determination*, Merriam-Webster’s Collegiate Dictionary (11th ed. 2007).

1 of the appeal.²⁴ Thus, when addressing a lay plan participant,
2 Hartford substituted “benefit determination on review” with “final
3 decision,” implicitly acknowledging that the determination had to be
4 a final denial or grant of benefits.

5 Hartford argues that “determination” does not imply finality
6 because § 503-1 uses the phrase “adverse benefit determination” to
7 “refer to decisions that require further administrative review.”²⁵ But
8 while the regulation does refer to adverse determinations on both
9 initial and appellate review, the former do not “require”
10 administrative review if the claimant chooses not to appeal.

11 Hartford’s strongest textual argument is what the regulation
12 does not say. The regulation expressly defines an “adverse benefit
13 determination” and provides detailed instructions on the form and
14 content of the notice required for such an “adverse” decision, but the
15 regulation does not describe notice requirements for other, non-
16 adverse outcomes.²⁶ Given that the regulation “sets forth minimum
17 requirements,”²⁷ Hartford argues that it had the flexibility to issue a
18 benefit determination on review that did not determine whether
19 McQuillin was entitled to benefits but instead remanded the question
20 for further internal consideration. This argument, however, reads the
21 word “benefit” out of the phrase “benefit determination on review.”
22 An outcome that does not determine benefits cannot be a “benefit
23 determination.” The term is not ambiguous simply because the
24 regulation defines other terms in more detail.

²⁴ App. 102, 210 (emphasis added).

²⁵ Appellee Br. 31.

²⁶ See 29 C.F.R. § 2560.503-1(j), (m)(4).

²⁷ *Id.* § 2560.503-1(a).

1 Whatever Hartford’s April 23rd letter did, it plainly did not
2 “determine” McQuillin’s “benefits.” The letter itself made that clear,
3 warning McQuillin that “the decision to reverse the prior [decision]
4 due to proof of loss does not guarantee payment of benefits.”²⁸ The
5 text of the regulation thus supports McQuillin’s argument that he did
6 not receive a timely benefit determination on review.

7 **II. Section 503-1’s Structure**

8 Section 503-1’s structure supports its plain meaning. The
9 regulation’s appeal process is clearly intended to result in a final
10 determination of benefits. The administrator handling the appeal
11 must “take[] into account” any evidence “relating to the claim”
12 whether or not it “was submitted or considered in the initial benefit
13 determination.”²⁹ The administrator may rely on new evidence or
14 rationales to deny the claim so long as the claimant is given notice and
15 an opportunity to respond.³⁰ In evaluating the available evidence and
16 reasoning, the administrator cannot “afford deference” to the initial
17 claim decision.³¹ This scope and method of review is consistent with
18 an appeals process that determines benefits conclusively, not one that
19 narrowly corrects certain errors and then remands for further
20 consideration.

21 This appellate review is bound by strict time limits. The
22 administrator must reach a determination within 45 days, or 90 days
23 following an extension for “special circumstances.”³² This latter limit,

²⁸ App. 214.

²⁹ 29 C.F.R. § 2560.503-1(h)(2)(iv).

³⁰ *Id.* § 2560.503-1(h)(4)(i)-(ii).

³¹ *Id.* § 2560.503-1(h)(3)(ii).

³² *Id.* § 2560.503-1(i)(1)(i), (3)(i).

1 meanwhile, can be tolled only if the claimant has not submitted the
2 “information necessary to decide [the] claim.”³³ Thus, § 503-1
3 protects the administrator from the claimant’s delays (provided the
4 administrator has already sought an extension) but otherwise firmly
5 limits the appeal’s duration, ensuring the timely resolution of claims.
6 If a remand qualified as a benefit determination on review, as
7 Hartford suggests, plans could render the 45-day limit meaningless.
8 Whenever pressed for time, or seeking to delay, administrators could
9 simply remand the case to their claims departments to consider or
10 reconsider evidence or issues. In theory, Hartford’s reading of the
11 regulation would allow for multiple remands, delaying resolution
12 indefinitely.³⁴

13 In response, Hartford emphasizes that the regulation requires
14 disability plans to “strictly adhere” to its provisions.³⁵ Strict
15 adherence, Hartford argues, implies explicit requirements.³⁶ Thus, it
16 cannot be expected to anticipate further unspecified requirements in
17 the regulation.

18 But, as we have discussed, § 503-1 explicitly required Hartford
19 to provide a *benefit* determination. And the text is reinforced by the
20 rule’s structure, which assumes a final decision on appeal. That
21 Hartford acted in a way not anticipated by the regulation does not

³³ *Id.* § 2560.503-1(i)(4).

³⁴ *Cf. Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 636 (10th Cir. 2003) (“It would be manifestly unfair to claimants if plan administrators could extend the process indefinitely by continually requesting additional information.”).

³⁵ 29 C.F.R. § 2560.503-1(l)(2)(i).

³⁶ *See Marino Indus. Corp. v. Chase Manhattan Bank, N.A.*, 686 F.2d 112, 115 (2d Cir. 1982) (“The corollary to the rule of strict compliance is that the requirements in letters of credit must be explicit.”).

1 excuse its failure to comply with the rule's requirements. As with the
2 text, the regulation's structure supports McQuillin's reading.

3 III. Section 503-1's History and Purpose

4 Finally, we briefly consider the regulation's history and
5 purpose. ERISA serves dual purposes: "ensuring fair and prompt
6 enforcement of rights under a plan and the encouragement and
7 creation of such plans."³⁷ The law represents "a careful balancing"
8 between these two interests.³⁸ In balancing them, the Department of
9 Labor has made clear that § 503-1 is intended to prevent plans from
10 "impos[ing] an unlimited number of levels of administrative appeals
11 of denied claims."³⁹ We therefore cannot adopt Hartford's
12 interpretation of the rule, which frustrates that purpose.

13 Hartford argues that its view is in keeping with the regulation's
14 purpose because it gives administrators flexibility in managing their
15 plans. The Department of Labor is cognizant that administrators need
16 flexibility in administering plans. The Department noted in an FAQ
17 that the regulation is "intended to preserve the greatest flexibility
18 possible for designing and operating claims processing systems
19 consistent with the prudent administration of a plan."⁴⁰ But this

³⁷ *Halo*, 819 F.3d at 55 (quoting *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 424 (2014)); see *id.* at 52 (noting that in regulatory interpretation, we consider both the regulation's purpose and that of the authorizing statute).

³⁸ *Id.* at 55 (quotation marks omitted).

³⁹ See Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70,246, 70,253 (Nov. 21, 2000) (preamble).

⁴⁰ Dep't of Labor, *Benefit Claims Procedure Regulation FAQs*, at B-4, <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation>.

1 general interpretive gloss does not outweigh the regulation's stated
2 purpose, reinforced by its text and structure, of limiting the number
3 of appeals a claimant must pursue.

4 Section 503-1's text, structure, history, and purpose are fully
5 consistent. A "benefit determination on review" must finally decide
6 the claimant's benefits within 45 days, assuming the absence of
7 special circumstances that require an extension. By the 46th day after
8 his appeal, Hartford had not determined McQuillin's benefits nor
9 extended its review time. So, McQuillin was deemed to have
10 exhausted his plan remedies and could bring suit in federal court.
11 Thus, the district court erred in dismissing his suit.

12 CONCLUSION

13 For the foregoing reasons, we **REVERSE** the judgment of the
14 district court and **REMAND** the case for proceedings consistent with
15 this opinion.