

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN JOSE DIVISION

SUMAN DHAMIJA, ) Case No.: 5:13-CV-02541-LHK  
)  
Plaintiff, ) ORDER REMANDING CASE AND  
v. ) DENYING DEFENDANTS' MOTION TO  
LIBERTY LIFE ASSURANCE COMPANY OF ) DISMISS  
BOSTON, BBVA COMPASS BANCSHARES, )  
INC., LONG-TERM DISABILITY PLAN, and )  
DOES 1 through 10, )  
Defendants. )

Plaintiff Suman Dhamija (“Dhamija”) brings this action against Defendants Liberty Life Assurance Company of Boston and BBVA Compass Bancshares, Inc., Long-Term Disability Plan under 29 U.S.C. § 1132(a)(1)(B) of the Employment Retirement Income Security Act of 1974 (“ERISA”), alleging violations of the terms of her long-term disability plan. (“Compl.”) ECF No. 1 at 4.

Before the Court is Defendants' Motion to Dismiss for Failure to Exhaust Administrative Remedies. ("Mot.") ECF No. 6. Dhamija opposes the Motion, ("Opp'n") ECF No. 18, and Defendants replied, ("Reply") ECF No. 20. Pursuant to Civil Local Rule 7-1(b), the Court finds this matter appropriate for resolution without oral argument and hereby VACATES the October 17,

1 2013 Hearing and Case Management Conference. For the reasons stated herein, the Court DENIES  
2 Defendants' Motion to Dismiss and REMANDS for further administrative review.

3 **I. BACKGROUND<sup>1</sup>**

4 Dhamija worked for BBVA starting in April 2008. Compl. ¶ 7. BBVA provided long-term  
5 disability insurance to Dhamija. *Id.* ¶ 6. Liberty Life Assurance Company ("Liberty Life") is the  
6 claims administrator for the BBVA Compass Bancshares, Inc. Long-Term Disability Plan ("LTD  
7 Plan"). ("Wharton Decl.") ECF No. 7 ¶ 5. BBVA is the plan administrator, but the insurance policy  
8 that insures the LTD Plan "vests discretionary authority in Liberty Life." *Id.* ¶ 6. Thus, Liberty Life  
9 has the "ultimate discretion and authority to determine all questions of eligibility for payments  
10 under the Plan, to determine the amount and manner of payment of benefits under the Plan, and to  
11 construe and interpret the terms of [the] Policy." *Id.* Liberty Life is also "the sole source of  
12 payment of benefits under the Plan." *Id.*

13 Dhamija allegedly became disabled on or around July 8, 2011, and thereafter submitted a  
14 claim to Liberty Life for long-term disability benefits. Compl. ¶¶ 7, 9. Liberty Life granted long-  
15 term disability benefits to Dhamija for eight months until Liberty Life denied Dhamija's claim for  
16 disability benefits on August 28, 2012. *Id.* ¶ 9.

17 On the same day Liberty Life denied Dhamija's claim for benefits, Liberty Life sent  
18 Dhamija a letter explaining Liberty Life's decision to deny benefits. ("August 28 Letter") McGee  
19 Decl. Ex. B, ECF No. 8-1. The August 28 Letter informed Dhamija that she had a right to appeal  
20 the denial and explained the procedure for filing an appeal. *Id.* The Letter requested that any appeal

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21 <sup>1</sup> The Ninth Circuit treats a motion to dismiss an ERISA denial-of-benefits claim for failure to  
22 exhaust administrative remedies as an unenumerated motion to dismiss. *See Bilyeu v. Morgan*  
23 *Stanley Long Term Disability Plan*, 683 F.3d 1083, 1088 (9th Cir. 2012). In addressing such a  
24 motion, the Court may rely on evidence extrinsic to the pleadings and may resolve disputed issues  
25 of fact. *Id.*; *see also Payne v. Peninsula Sch. Dist.*, 653 F.3d 863, 881 (9th Cir. 2011) (en banc)  
("In entertaining an unenumerated motion to dismiss, the court may look beyond the pleadings  
and decide disputed issues of fact.") (internal quotation marks omitted). The Court will therefore  
consider the exhibits accompanying the parties' briefs in deciding this Motion.

1 of the denial be accompanied by medical and other information that supported the claim and stated  
2 that any appeal must “state the reasons why you feel your claim should not have been denied.” *Id.*

3 In addition to sending the August 28 Letter, Liberty Life claims to have left Dhamija a  
4 voicemail on August 28, 2012, informing Dhamija that her benefits claim had been denied.  
5 (“Eubanks Decl.”) ECF No. 10 ¶ 6. Liberty Life also claims to have phoned Dhamija on August  
6 29, 2012, to inform her for a second time that her claim had been denied and that she could appeal  
7 the decision. *Id.* ¶ 7; *see also* (“Dhamija Decl.”) ECF No. 18-2 ¶ 2.

8 Dhamija does not recall the exact date she received the August 28 Letter, but alleges that  
9 she could not have received it earlier than September 4, 2012. Dhamija Decl. ¶ 3. Following receipt  
10 of the August 28 Letter, Dhamija faxed Liberty Life a request for all documents that Liberty Life  
11 used in support of its adverse benefits determination. McGee Decl. ¶ 10. Liberty Life promptly  
12 complied. *Id.* ¶ 11.

13 No further communication occurred between the parties until February 27, 2013 when  
14 Dhamija’s representative, Selene Wilkes of the DL Law Group, faxed a letter to Liberty Life “to  
15 confirm Ms. Dhamija’s appeal to Liberty Life . . . of [Liberty Life’s] denial of [Dhamija’s] . . .  
16 claim,” and asking Liberty Life to “not begin the review of [Dhamija’s] appeal until the appeal  
17 documents are complete.” (“February 27 Letter”) ECF No. 18-3 Ex. 1. Wilkes also left Liberty Life  
18 a voicemail to notify Liberty Life of Dhamija’s appeal. (“Wilkes Decl.”) ECF No. 18-3 ¶ 3. The  
19 next day Rhonda Eubanks of Liberty Life acknowledged receipt of the February 27 Letter in a  
20 phone conversation with Wilkes. *Id.* ¶ 5; Eubanks Decl. ¶ 10. Eubanks informed Wilkes that  
21 Dhamija’s appeal was time-barred and that the February 27 Letter would be forwarded to the  
22 “Appeals Review Unit.” Wilkes Decl. ¶ 5; Eubanks Decl. ¶ 10. Two days later, on March 1, 2013,  
23 Eubanks called Wilkes to confirm that Dhamija’s appeal was time-barred and that the February 27  
24 Letter would be forwarded to the Appeals Review Unit. Wilkes Decl. ¶ 6. Wilkes responded that  
25 same day by faxing another letter to Liberty Life disputing Liberty Life’s time-bar determination.  
26 (“March 1 Letter”) Wilkes Decl. Ex. 2.

1           On March 8, 2013, Liberty Life’s appeals review consultant, Kimberly Murray (“Murray”),  
2 sent a letter to Wilkes stating that Dhamija’s claim was time-barred and that “Liberty’s final  
3 determination was rendered on August 28, 2012[;] therefore no additional information will be  
4 considered.” (“March 8 Letter”) ECF No. 8-1 Ex. J. The March 8 Letter did not state that Liberty  
5 Life conducted a review of Dhamija’s claim independent of Liberty Life’s initial decision to deny  
6 benefits. *Id.* On March 25, 2013, Wilkes sent a letter with medical records to be reviewed by  
7 Liberty Life “in reconsideration of . . . Dhamija’s claim for benefits.” (“March 25 Letter”) McGee  
8 Decl. Ex. K. After receiving this new medical evidence, Liberty Life again decided not to conduct  
9 an administrative review of its August 28, 2012 adverse benefit determination. McGee Decl. ¶ 20.  
10 Dhamija subsequently filed this action on June 5, 2013. ECF No. 1.

11           **II.     LEGAL STANDARDS**

12           **A.     Notification of Adverse Benefit Decision Requirements Under ERISA**

13           “ERISA seeks to safeguard the well-being and security of working men and women and to  
14 apprise them of their rights and obligations under any employee benefit plan.” *Peralta v. Hispanic*  
15 *Bus., Inc.*, 419 F.3d 1064, 1070 (9th Cir. 2005) (internal quotation marks omitted). ERISA fulfills  
16 this purpose, in part, by requiring that “every employee benefit plan . . . provide adequate notice *in*  
17 *writing* to any participant or beneficiary whose claim for benefits under the plan has been denied.”  
18 29 U.S.C. § 1133(1) (emphasis added). The Department of Labor (“DOL”) has issued regulations  
19 interpreting Section 1133, which require that plan administrators “provide a claimant with *written*  
20 or electronic notification of any adverse benefit determination.”<sup>2</sup> 29 C.F.R. § 2560.503-1(g)(1)  
21 (emphasis added). The administrator must also “[p]rovide claimants at least 180 days following  
22 receipt of a notification of an adverse benefit determination within which to appeal the  
23 determination.” 29 C.F.R. § 2560.503-1(h)(3)(i); *see also id.* § 2560.503-1(h)(4).

24           **B.     Administrative Exhaustion**

25           <sup>2</sup> “[E]lectronic notification” is not at issue here. All communications between Dhamija and Liberty  
26 Life took place either in writing or over the telephone.

“[T]he general rule governing ERISA claims [is] that a claimant must avail himself or herself of a plan’s own internal review procedures before bringing suit in federal court.” *Diaz v. United Agr. Emp. Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir.1980)). The administrative exhaustion requirement, while not explicitly in the text of the statute, is “consistent with ERISA’s background, structure and legislative history and serves several important policy considerations, including the reduction of 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.” *Id.*

### C. Standard of Review When Reviewing a Denial of Benefits Under ERISA

Under *Abatie v. Alta Health & Life Ins. Co.*, there are two standards of review that may apply to the review of an administrator’s adverse benefits determination. 458 F.3d 955, 962-63 (9th Cir. 2006) (en banc). In particular, if the plan does not “confer discretion on the administrator ‘to determine eligibility for benefits or to construe the terms of the plan,’ a court must review the denial of benefits *de novo*.” *Id.* at 963 (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). However, if the plan “*does* confer discretionary authority as a matter of contractual agreement, then the standard of review shifts to abuse of discretion.” *Id.* The plan must unambiguously provide discretion to the administrator to alter the standard of review from the default *de novo* review to the more lenient abuse of discretion standard. *Id.*

A plan administrator’s “technical violations of ERISA’s requirements” usually do not alter the standard of review unless the benefit administrator’s violations are “wholesale and flagrant,” *Gatti v. Reliance Standard Life Ins. Co.*, 415 F.3d 978, 985 (9th Cir. 2005); however, such technical violations are a factor to consider in determining whether a plan administrator abused its discretion in denying benefits, *see Abatie*, 458 F.3d at 972. Similarly, if “a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest,” that too

1 must be “weighed as a factor in determining whether there is an abuse of discretion.” *Id.* at 965  
2 (internal quotation marks omitted).

3 **III. ANALYSIS**

4 The central issue that this Court must resolve is whether Dhamija exhausted her  
5 administrative remedies prior to filing suit under ERISA. To demonstrate that Dhamija exhausted  
6 her administrative remedies, Dhamija must show that she filed a timely appeal after Liberty Life’s  
7 adverse benefit determination.

8 The LTD Plan gives Liberty Life the discretionary authority to interpret the terms of the  
9 LTD Plan and determine benefit eligibility, and thus the Court reviews Liberty Life’s conclusion  
10 that Dhamija’s appeal was time-barred for abuse of discretion. *See* Wharton Decl. Ex. A at 41  
11 (“Section 7 - General Provisions” provides that “Liberty shall possess the authority, in its sole  
12 discretion, to construe the terms of this policy and to determine benefit eligibility hereunder”).  
13 While the Court ultimately finds that Liberty Life committed a technical violation of ERISA, *see*  
14 *infra* Part III.A, the Court finds that the violation was not sufficiently “wholesale and flagrant” to  
15 alter the standard of review from abuse of discretion to de novo review. *Gatti*, 415 F.3d at 985  
16 (“[P]rocedural violations of ERISA do not alter the standard of review unless those violations are  
17 so flagrant as to alter the substantive relationship between the employer and employee, thereby  
18 causing the beneficiary substantive harm.”); *see also Abatie*, 458 F.3d at 971 (examples of  
19 “wholesale and flagrant” violations include an administrator failing to disclose policy details to  
20 employees, not offering employees a claims procedure, and failing to provide employees relevant  
21 plan information in writing). Rather, the Court weighs the “procedural irregularity” in this case as a  
22 factor “in deciding whether [Liberty Life’s] decision was an abuse of discretion.” *Abatie*, 458 F.3d  
23 at 972.

24 In addition, the Court recognizes that Liberty Life has a “structural” conflict of interest  
25 because Liberty Life both “has the ultimate discretion and authority to determine all questions of  
26 eligibility for payments under the Plan” and also “is the sole source of payment of benefits under

1 the Plan.” Wharton Decl. ¶ 6; *see Moody v. Liberty Life Assurance Co. of Boston*, 595 F. Supp. 2d  
2 1090, 1097 (N.D. Cal. 2009) (“A conflict of interest can exist for ERISA purposes when a  
3 professional insurance company both evaluates claims as the plan administrator and pays benefits  
4 under the plan.” (citing *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 114 (2008)); *see also Abatie*,  
5 458 F.3d at 965. Thus, the Court “weigh[s]” the existence of a structural conflict of interest “as a  
6 factor in determining whether the plan administrator has abused its discretion in denying benefits.”  
7 *Metro. Life Ins.*, 554 U.S. at 115 (internal quotation marks omitted).

8 Finally, the Court notes that Ninth Circuit decisions reviewing denial of benefits claims  
9 evidence a certain degree of “solicitude” for ERISA claimants. *See Eppler v. Hartford Life &*  
10 *Accident Ins. Co.*, No. 07-4696, 2008 WL 361137, at \*11 (N.D. Cal. Feb. 11, 2008). For instance,  
11 the Ninth Circuit has noted the need to “construe ambiguities in an ERISA plan against the drafter  
12 and in favor of the insured.” *Barnes v. Indep. Auto. Dealers Ass’n of Cal. Health & Welfare Benefit*  
13 *Plan*, 64 F.3d 1389, 1393 (9th Cir. 1995); *see also Bergt v. Ret. Plan for Pilots Employed by*  
14 *MarkAir, Inc.*, 293 F.3d 1139, 1145 (9th Cir. 2002); *Goldinger v. Datex-Ohmeda Cash Balance*  
15 *Plan*, 701 F. Supp. 2d 1205, 1210 (W.D. Wash. 2010). Moreover, when multiple documents in an  
16 ERISA plan conflict, the Ninth Circuit applies the plan document most favorable to the employee.  
17 *See Banuelos v. Constr. Laborers’ Trust Funds for S. Cal.*, 382 F.3d 897, 904 (9th Cir. 2004)  
18 (“Courts will generally bind ERISA defendants to the more employee-favorable of two conflicting  
19 documents . . . .”). This general policy of solicitude for ERISA claimants informs the Court’s  
20 analysis in this case.

21 **A. Whether Dhamija’s February 27, 2013 Letter Constituted An Appeal**

22 Plaintiff argues that the February 27 Letter faxed to Liberty Life “to confirm Ms. Dhamija’s  
23 appeal to Liberty” was sufficient to start the appeals process, if only to initiate Dhamija’s  
24 statutorily guaranteed review of her adverse benefit determination by an appropriate fiduciary.  
25 Opp’n at 12. Defendants respond that the February 27 Letter did not constitute an appeal under the  
26 Plan because the Letter did not explain why Liberty should have granted Dhamija’s claim for  
27

1 benefits, as the August 28 Letter required. Mot. at 6; *see also* August 28 Letter (“The written  
2 request for review must . . . state the reasons why you feel your claim should not have been  
3 denied.”).

4 The Court has not found binding Ninth Circuit authority that clearly delineates when a  
5 communication by a claimant following the denial of a claim constitutes an appeal. However,  
6 Judge Alsup’s opinion in *Eppler v. Hartford Life & Accident Insurance Co.* is instructive. 2008  
7 WL 361137 at \*10-11. In *Eppler*, the claimant filed suit under ERISA for wrongful denial of his  
8 long-term disability benefits. *Id.* at \*1. At issue was whether the claimant’s letter constituted an  
9 appeal, and thus required review. *Id.* at \*5. The claimant’s letter stated: “Mr. Eppler wishes to  
10 appeal The Hartford’s decision. In order to permit him to do so, and to respond adequately to The  
11 Hartford’s decision, we respectfully request that you provide to us [documents and information  
12 regarding the claim].” *Id.* at \*10. The court held that although the claimant failed to submit any  
13 further documents within the time for filing an appeal, this letter created a “duty to make a second,  
14 independent review, even if it were based on the same record with no new submissions.” *Id.* The  
15 court reasoned that conducting a second, independent review was proper given “the solicitude  
16 under ERISA for claimants.” *Id.* at \*11; *cf. Barnes*, 64 F.3d at 1393 (“We must construe  
17 ambiguities in an ERISA plan against the drafter and in favor of the insured.”).

18 Judge Alsup’s reasoning is supported by DOL regulations interpreting ERISA. In  
19 particular, while 29 C.F.R. § 2560.503-1(h)(2)(ii) requires that every employee benefit plan  
20 “[p]rovide claimants the *opportunity* to submit written comments, documents, records, and other  
21 information relating to the claim for benefits” following an adverse benefit determination, *id.*  
22 (emphasis added), the regulation does not *require* claimants to submit such additional information  
23 as a prerequisite to receiving review of the decision.

24 Furthermore, although the August 28 Letter expressly stated that Dhamija was required to  
25 “state the reasons why [she felt her] claim should not have been denied” in order to appeal, and the  
26 August 28 Letter requested that any appeal include additional medical documentation, the text of  
27

1 the LTD Summary Plan Description (“SPD”) does not include these requirements for submitting an  
2 appeal. The SPD states merely that a claimant, or her authorized representative, “may appeal a  
3 denied claim within 180 days” after receiving a notice of denial. Wharton Decl. Ex. B (“What Do  
4 You Do To Appeal A Claim Denial?”). The SPD nowhere states that a claimant must make an  
5 argument or otherwise state her position in order to appeal, nor does it require a claimant to submit  
6 additional documents in order to trigger an appeal. *Id.* Indeed, the SPD states that “[a] final  
7 decision on the review will be made within . . . 45 days following receipt of the written request for  
8 review . . . . without regard to whether all the information necessary to make an appeal decision  
9 accompanies the filing,” which suggests that the Plan’s procedure is to conduct reviews even in the  
10 absence of additional documentation or argument provided by a claimant. *Id.* (emphasis added).

11 The SPD is a formal LTD Plan document governed by the requirements of 29 U.S.C.  
12 § 1022. *See Bergt*, 293 F.3d at 1143 (“[T]he SPD is a plan document and should be considered  
13 when interpreting an ERISA plan. The ERISA statute requires the plan fiduciaries to act solely in  
14 accordance with the *documents and instruments* governing the plan . . . .”) (internal quotation  
15 marks omitted). By contrast, the August 28 Letter informing Dhamija of Liberty Life’s decision to  
16 deny benefits is not a plan document and thus cannot modify or override the terms of the SPD  
17 itself. *See Helfrich v. Carle Clinic Ass’n, P.C.*, 328 F.3d 915, 916-17 (7th Cir. 2003) (employer  
18 communications do not trump summary plan description and other plan documents); *Eppler*, 2008  
19 WL 361137, at \*11 (plan controls over more restrictive denial letter); *cf. Banuelos*, 382 F.3d at 904  
20 (“Courts will generally bind ERISA defendants to the more employee-favorable of two conflicting  
21 documents . . . .”). Accordingly, to the extent the August 28 Letter sought to impose additional  
22 requirements for a claimant’s submission of an appeal, the SPD, with its less restrictive  
23 requirements, controls. Because the SPD did not require Dhamija to include arguments or  
24 additional documentation with her appeal, the Court rejects Defendants’ contention that the  
25 February 27 Letter failed to constitute an appeal simply because it lacked argument and  
26 accompanying documentation.

1 To bolster their argument that the February 27 Letter was not an appeal, Defendants cite a  
2 number of non-binding cases. The Court finds that all of these are distinguishable from the present  
3 case.

4 Defendants rely most heavily on *Werner v. Liberty Life Assurance Co.*, an unpublished  
5 Ninth Circuit opinion, which affirmed a district court's finding that a claimant's letter providing  
6 "notice of the intent to appeal," does not constitute an appeal. 336 F. App'x. 676, 677-78 (9th Cir.  
7 2009) (unpublished).<sup>3</sup> In *Werner*, the claimant sent a letter to the plan administrator on May 9,  
8 2005, specifically asking that the plan administrator "not take any action to consider the appeal."  
9 *Id.* at 677. The plan administrator sent a letter two months later confirming that the May 9, 2005  
10 letter was "not an appeal." *Id.* at 678. Almost seven months passed from the date of the plan  
11 administrator's letter until the claimant filed her actual appeal. *Id.* The Ninth Circuit affirmed the  
12 lower court's ruling that the claimant failed to timely exhaust her administrative remedies. *Id.*

13 The present case is factually distinguishable from *Werner*. Importantly, Dhamija's February  
14 27 Letter provided more than mere "notice of the intent to appeal." Dhamija's February 27 Letter  
15 explicitly stated that the letter was being faxed "to confirm Ms. Dhamija's appeal . . . of [Liberty  
16 Life's] denial of [Dhamija's] long term disability claim."<sup>4</sup> Wilkes Decl. Ex. 1. In addition, while  
17 the plan administrator in *Werner* informed the claimant that her May 9, 2005 Letter did not  
18 constitute an appeal, and thus "both parties understood [the claimant's] May 9, 2005 letter was not  
19 an appeal," 336 F. App'x at 677, Liberty Life did not inform Dhamija that her February 27 Letter  
20 was insufficient to constitute an appeal. Rather, Liberty Life took the position that the February 27

21 <sup>3</sup> Pursuant to Circuit Rule 36-3, unpublished Ninth Circuit authority is not binding precedent on  
22 this Court.

23 <sup>4</sup> Dhamija's February 27 Letter requested that Liberty Life "not begin the review of Ms. Dhamija's  
24 appeal" until Dhamija submitted additional information. Wilkes Decl. Ex. 1. Defendants argue that  
25 Dhamija's request that Liberty Life not begin its review of her appeal until she submitted  
26 additional documents demonstrates that the February 27 Letter could not itself have constituted an  
27 appeal. Mot. at 14. The Court is unconvinced. The February 27 Letter does not expressly condition  
28 Dhamija's appeal on the submission of additional documentation; the Letter simply asks that  
Liberty Life wait to conduct its *review* of the appeal until this additional documentation has been  
provided, which the February 27 Letter promises to provide "within 21 days." Wilkes Decl. Ex. 1.

1 Letter was submitted outside the 180-day appeal window and thus was untimely, a position  
2 Dhamija immediately contested. *See* Eubanks Decl. Exs. E (record of February 28, 2013 telephone  
3 conversation between Wilkes and Eubanks); F (March 1, 2013 letter from Wilkes contesting  
4 Liberty Life's timeliness conclusion).

5 Finally, the claimant in *Werner* waited seven months after the plan administrator informed  
6 her that her May 9, 2005 letter did not constitute an appeal before taking any action to file an  
7 appeal or otherwise contest the plan administrator's determination. 336 F. App'x at 678. By  
8 contrast, Dhamija immediately contacted Liberty Life to dispute Liberty Life's characterization of  
9 Dhamija's appeal as "outside the 180 day timeline," McGee Decl. Exs. H (Eubanks' phone log  
10 with conversation notes), I (Wilkes' fax to Eubanks disputing timeliness of appeal), and Wilkes  
11 submitted additional documents to Liberty Life on Dhamija's behalf on March 25, *id.* Ex. K. Given  
12 the factual differences between *Werner* and the present case, the Court finds *Werner* unpersuasive.

13 Defendants also rely on *Edwards v. Briggs & Stratton Retirement Plan*, a Seventh Circuit  
14 case, which held that a claimant's untimely appeal cannot be remedied under the doctrine of  
15 "substantial compliance." 639 F.3d 355, 361-62 (7th Cir. 2011). In *Edwards*, the claimant sent a  
16 letter to her administrator stating that the claimant would "decide whether or not to appeal" after  
17 reviewing documents upon which the administrator based its adverse benefit determination. *Id.* at  
18 364 (internal quotation marks omitted). Three months later, the claimant sent a second letter  
19 notifying her plan administrator that she planned to file an administrative appeal "soon." *Id.*  
20 However, the claimant did not send any actual appeal until almost two weeks after the appeal  
21 deadline. *Id.* at 359. The court noted that it was "undisputed that [the claimant's] appeal from the  
22 Plan's original denial of benefits was untimely . . . [and that the claimant had] meaningful access to  
23 review procedures." *Id.* at 361. The claimant nevertheless argued that she "substantially complied"  
24 with the appeal procedure, and thus, that her appeal was timely. *Id.* at 361-62. Under these  
25 circumstances, the court declined to rely on the "substantial compliance" doctrine—which typically  
26 applies to excuse plan administrators that commit minor procedural violations from the more

1 onerous *de novo* review of benefits denials—to find the exhaustion requirement satisfied. *Id.* at  
2 361-63.

3 Here, Dhamija’s February 27 Letter explicitly stated that she wished to appeal Liberty  
4 Life’s denial of her claim. Moreover, Dhamija immediately disputed that her February 27 Letter  
5 was untimely in the March 1 Letter. Importantly, Dhamija does not raise the issue of “substantial  
6 compliance” as a mitigating factor. Thus, *Edwards* is inapposite to the present case.

7 In addition, Defendants analogize to *Swanson v. Hearst Corp. Long Term Disability Plan*, a  
8 Fifth Circuit case, which held that an initial letter stating an “intention to appeal” without  
9 supporting documents could not remedy an untimely appeal submitted more than three years after  
10 the initial notice letter. 586 F.3d 1016, 1017-19 (5th Cir. 2009) (per curiam). The claimant in  
11 *Swanson* sent a letter on August 25, 2003 stating an “intention to appeal” the administrator’s  
12 adverse benefits determination. *Id.* at 1017. The administrator informed the claimant’s counsel that  
13 the August 25, 2003 Letter did not constitute an appeal. *Id.* The claimant then waited more than  
14 three years to file an appeal on February 27, 2007. *Id.* The Fifth Circuit held that the August 25,  
15 2003 letter was not an actual appeal because it only evinced an “intention to appeal” and “included  
16 no factual or substantive arguments, and no evidence . . . [such that there was] nothing for [the  
17 administrator] to consider on appeal.” *Id.* at 1018-19 (internal quotation marks omitted).

18 The present case bears only a passing resemblance to *Swanson*. In addition to explicitly  
19 requesting an appeal in her February 27 Letter, Dhamija did not idle for more than three years  
20 before engaging in further discussions with Liberty Life about her appeal. To the contrary, Dhamija  
21 followed up with Liberty Life concerning her appeal immediately upon learning that Liberty Life  
22 considered the February 27 Letter untimely. *See* March 1 Letter. Moreover, it is unclear whether  
23 the plan in *Swanson* required claimants to submit supporting documents to appeal an adverse  
24 benefit determination, whereas in this case, the LTD Plan’s SPD imposes no such requirements on  
25 claimants who wish to appeal. To the extent that the Fifth Circuit interpreted ERISA as requiring  
26 claimants to submit supporting documents before their appeal may be heard, the Court disagrees

1 for the reasons stated above. The Court finds *Swanson* unpersuasive in the present context and  
2 declines to rely on it.<sup>5</sup>

3 Because the February 27 Letter fulfills the LTD Plan’s minimal requirements for filing an  
4 appeal, because Defendants cite neither binding nor persuasive authority to the contrary, and in  
5 light of the need to construe any ambiguities concerning the requirements for filing an appeal under  
6 the LTD Plan against Liberty Life, *see Barnes*, 64 F.3d at 1393, the Court finds that the February  
7 27 Letter constituted an appeal under the LTD Plan.

8 **B. Whether Dhamija’s Appeal Was Timely**

9 Dhamija contends that the receipt date of the written denial notice is the proper starting date  
10 for the 180-day appeals window to run, as stated in the August 28 Letter. Opp’n at 4; *see also*  
11 August 28 Letter (“The written request for review must be sent within 180 days of the *receipt* of  
12 this letter.”) (emphasis added). Dhamija argues that the start date for the 180-day window should  
13 be no earlier than September 4, 2012, because that is the earliest date that Dhamija could have  
14 received the letter. *Id.* at 9.

15 Defendants argue for several alternative start dates. Initially, Defendants propose the  
16 August 28 Letter mailing date as the start date for the 180-day appeal window, which would render  
17 the February 27 Letter untimely by three days. Mot. at 9. Next, Defendants suggest August 29,  
18 2012 as the proper start date since, Defendants assert, ERISA only requires “notification,” not  
19 written notification and Liberty gave Dhamija actual notice on August 29, 2012 over the phone. *Id.*  
20 at 10. An August 29 start date would put Dhamija’s February 27 Letter two days outside of the  
21 180-day appeal window. Finally, Defendants rely on the federal common law three-day mailbox  
22 rule to argue that August 31, 2012, three days after Liberty Life sent the August 28, 2012 Letter,  
23 should be the start date. *Id.* at 11. An August 31, 2012 start date would mean that Dhamija’s  
24 February 27 Letter, sent on the 180th day of her 180-day appeal window, was timely.

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<sup>5</sup> Defendants’ remaining cases are equally distinguishable for reasons similar to those discussed  
26 above.

1           Under ERISA, plan administrators must provide “written or electronic notification” of  
2 adverse benefit decisions. 29 C.F.R. § 2560.503-1(g)(1). Plan administrators must give claimants  
3 180 days from “receipt” of the written notice of adverse benefit decision to file their appeal. 29  
4 C.F.R. § 2560.503-1(h)(3)(i). Under federal common law, which governs in the ERISA context so  
5 long as it is not “inconsistent with ERISA’s objectives,” *Schikore v. BankAmerica Supplemental*  
6 *Ret. Plan*, 269 F.3d 956, 962 (9th Cir. 2001), if there is uncertainty about whether a party actually  
7 received a letter sent to them, then there is a rebuttable presumption that the letter was received in  
8 the “usual time,” *id.* at 961-62 (extending the mailbox presumption, that “the proper and timely  
9 mailing of a document raises a rebuttable presumption that the document has been received by the  
10 addressee in the usual time,” to the ERISA context).

11           Neither the voicemail left by Eubanks on August 28, 2012, nor the phone call made by  
12 Eubanks to Dhamija on August 29, 2012, meets the written notice requirements under ERISA or its  
13 regulations. *See* 29 U.S.C. § 1133(1) (“[E]very employee benefit plan shall . . . provide adequate  
14 notice in *writing* to any participant or beneficiary whose claim for benefits under the plan has been  
15 denied, setting forth the specific reasons for such denial, *written* in a manner calculated to be  
16 understood by the participant.”) (emphasis added); 29 C.F.R. § 2560.503-1(g)(1), (h)(3)(i). A  
17 phone call does not meet ERISA’s statutory and regulatory written notice requirements, regardless  
18 of any actual notice. *See, e.g., Rodolff v. Provident Life & Accident Ins. Co.*, 256 F. Supp. 2d 1137,  
19 1143 (S.D. Cal. 2003) (“[T]he regulations governing ERISA plans clearly state that the . . . clock  
20 for filing an appeal begins to run upon receipt of a *written* denial letter . . .”) (emphasis added);  
21 *Kansas v. Titus*, 452 F. Supp. 2d 1136, 1149 (D. Kan. 2006) (“[V]erbal notice fails to comply with  
22 the ERISA notification requirements . . .”). Requiring written (or electronic) notice of an adverse  
23 benefit determination is sound policy. ERISA mandates that a notification of an adverse benefits  
24 determination contain numerous pieces of information.<sup>6</sup> Some of this information, such as internal

25           <sup>6</sup> 29 C.F.R. § 2560.503-1(g) requires that any adverse benefit determination notice include:  
26           (i) The specific reason or reasons for the adverse determination;

1 plan rules and procedures or the “scientific or clinical judgment” supporting a decision, can be  
2 quite technical. ERISA also requires that such information be presented in “a manner calculated to  
3 be understood by the claimant.” 29 C.F.R. § 2560.503-1(g). Even if a plan’s representative verbally  
4 communicates all the required information to a claimant over the phone, the claimant is unlikely to  
5 understand and retain all the important information about the basis for the plan’s decision and the  
6 procedural safeguards in place to protect the claimant when the information is presented in this  
7 manner. The deficiencies in verbal notice, in addition to the plain language of the statutory and  
8 regulatory text, convince the Court that Liberty Life’s voicemail and phone call to Dhamija were  
9 not sufficient to begin Dhamija’s 180-day appeal window, and thus that the 180-day appeal  
10 window did not start on either August 28 or August 29, 2012.

11 Defendants argue in the alternative that the three-day mailbox rule should govern, and thus  
12 that the start date should be August 31, 2012. The Court need not determine whether the three-day  
13 mailbox rule applies here, because even assuming that it does, Dhamija’s claim is not time-barred.  
14 Counting from August 31, Dhamija faxed her February 27 Letter to Liberty Life on the 180th day

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15 (ii) Reference to the specific plan provisions on which the determination is based;  
16 (iii) A description of any additional material or information necessary for the claimant to  
17 perfect the claim and an explanation of why such material or information is necessary;  
18 (iv) A description of the plan’s review procedures and the time limits applicable to such  
19 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;  
20 (v) In the case of an adverse benefit determination by a group health plan or a plan  
21 providing disability benefits,

22 (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon  
23 in making the adverse determination, either the specific rule, guideline, protocol, or  
24 other similar criterion; or a statement that such a rule, guideline, protocol, or other  
25 similar criterion was relied upon in making the adverse determination and that a  
26 copy of such rule, guideline, protocol, or other criterion will be provided free of  
charge to the claimant upon request; or  
27 (B) If the adverse benefit determination is based on a medical necessity or  
28 experimental treatment or similar exclusion or limit, either an explanation of the  
scientific or clinical judgment for the determination, applying the terms of the plan  
to the claimant’s medical circumstances, or a statement that such explanation will be  
provided free of charge upon request.

1 of her 180-day appeal window. Accordingly, the Court finds that Dhamija’s February 27 Letter  
2 was timely, whether the period for appeal began to run on August 31 or several days thereafter.

3 **C. Whether Remand for Further Administrative Proceedings Is the Appropriate  
4 Remedy.**

5 “[R]emand for reevaluation of the merits of a claim is the correct course to follow when an  
6 ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a  
7 wrong standard to a benefits determination.” *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long*  
8 *Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996). However, “retroactive  
9 reinstatement of benefits is appropriate in ERISA cases where . . . but for [the insurer’s] arbitrary  
10 and capricious conduct, [the insured] would have continued to receive the benefits or where there  
11 [was] no evidence in the record to support a termination or denial of benefits.” *Grosz-Salomon v.*  
12 *Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th Cir. 2001) (alterations in original) (internal  
13 quotation marks omitted).

14 Here, Liberty Life misconstrued the LTD Plan and ERISA’s requirements, both by  
15 calculating the window for Dhamija’s appeal from the date Liberty Life *sent* its denial letter, as  
16 opposed to the date on which Dhamija *received* the denial letter, *see supra* Part III.B, and by  
17 imposing requirements for filing an appeal that do not appear in the SPD or any other Plan  
18 document, *see supra* Part III.A. These errors led Liberty Life to mistakenly conclude that  
19 Dhamija’s appeal was time-barred. However, these errors were not but-for causes of the decision to  
20 terminate Dhamija’s benefits. Liberty Life’s initial decision to deny benefits was based on a  
21 determination that Dhamija’s medical records did not support a finding that she was disabled. *See*  
22 August 28 Letter. This decision is independent from and predates any misapplication of the LTD  
23 Plan, and the Court cannot determine whether Liberty Life, had it considered the merits of  
24 Dhamija’s appeal, would have restored Dhamija’s disability benefits or not. Nor can the Court say  
25 that there is “no evidence in the record to support a termination or denial of benefits.” *Grosz-*  
26 *Salomon*, 237 F.3d at 1163. The August 28 Letter that denied Dhamija’s disability claim cites  
27

1 medical evidence that, if accurate, tends to show that Dhamija was not disabled. *See* August 28  
2 Letter (citing conversations between Liberty Life and Dhamija's treating physician, in which  
3 Dhamija's physician allegedly stated that "there are no abnormal physical findings beyond a few  
4 muscle tender points. . . . and no definitive diagnosis has been made.").

5 Because the Court cannot conclude either that "but for" Liberty Life's improper refusal to  
6 consider Dhamija's appeal, Dhamija "would have continued to receive the benefits," or that there is  
7 "no evidence in the record to support a termination or denial of benefits," *Grosz-Salomon*, 237 F.3d  
8 at 1163, the Court finds that the appropriate remedy is to remand this case for further  
9 administrative review. *See also Saffle*, 85 F.3d at 461; *accord Jones v. Metro. Life Ins. Co.*, 456 F.  
10 App'x 647, 649 (9th Cir. 2011); *Eppler*, 2008 WL 361137, at \*11. If, upon further administrative  
11 review, Liberty Life affirms its decision to deny Dhamija benefits, Dhamija may appeal to this  
12 Court at that time.

13 **IV. CONCLUSION**

14 Because Dhamija filed a timely appeal, the Court DENIES Defendants' Motion to Dismiss  
15 for Failure to Exhaust Administrative Remedies. The Court REMANDS the matter to Liberty Life  
16 to conduct a "full and fair review" of Dhamija's claim "that does not afford deference to the initial  
17 adverse benefit determination and that is conducted by an appropriate named fiduciary" as required  
18 by 29 C.F.R. § 2560.503-1(h).

19 **IT IS SO ORDERED.**

20  
21 Dated: October 16, 2013

  
22 LUCY H. KOH  
23 United States District Judge