IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

DUSTY BAUER AND ALLAN AGABABA,	§	
Plaintiffs,	§	
v.	§	**No. 1:20-CV-00112-LY**
	§	
NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA AND AIG CLAIMS, INC.,	§	
Defendants.	§	

REPORT AND RECOMMENDATION
OF THE UNITED STATES MAGISTRATE JUDGE

TO THE HONORABLE LEE YEAKEL
UNITED STATES DISTRICT JUDGE:

Before the court are Plaintiffs' Motion for Judgment on the Administrative Record (Dkt. #12) and Defendants' Motion for Summary Judgment (Dkt. #14).[1] After reviewing the entire case file, relevant case law, and determining a hearing is not necessary, the undersigned issues the following Report and Recommendation to the District Court.

I. BACKGROUND

Before the court is a dispute governed by the Employee Retirement Income Security Act of 1974 ("ERISA") concerning accidental death benefits allegedly owed upon the death of Shelly Bernstein ("Decedent"). *See* Dkt. #1. Continental Airlines, Inc. ("Continental") sponsored The United Airlines Consolidated Welfare Benefit Plan (the "Plan"), which included a Personal

[1] These motions were referred by United States District Judge Lee Yeakel to the undersigned pursuant to 28 U.S.C. § 636(b), Rule 72 of the Federal Rules of Civil Procedure, and Rule 1(d) of Appendix C of the Local Rules of the United States District Court for the Western District of Texas.

Accident Insurance Program.[2] AR 2146-82.[3] The Plan, an ERISA-regulated employee welfare benefit plan, was funded by group policies issued by National Union Fire Insurance Company of Pittsburgh, PA ("NUFIC"). Specifically, NUFIC issued two Group Accidental Death Insurance Policies to United: Policies BSC 9137941 and PAI 9137944 (the "Policies"). AR 2048-2049 (Policy BSC 9137941); AR 2080-2144 (Policy PAI 9137944). The Policies covered, among others, Continental employees. Flight attendants received $14,000 in basic accidental death and dismemberment ("AD&D") benefits under Policy BSC 9137941, and Decedent elected $500,000 in supplemental benefits under Policy PAI 9137944. *Id.*

In addition to detailing the limited conditions under which NUFIC would pay accidental death benefits, the Policies provided various contractual limitation periods. AR 2054-2056; AR 2086-2088. Some of these limitation periods are as follows:

> **Notice of Claim**. Written notice of claim must be given to the Company within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at Chartis Claims Department, P.O. Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify the Insured Person, is deemed notice to the Company. . . .
>
> **Proof of Loss**. Written proof of loss must be furnished to the Company within 365 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. . . .
>
> **Legal Actions**. No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may

[2] Continental merged with United Airlines ("United") at an unspecified date, at which time the name Continental ceased to be used. Dkt. #14 at 7. Accordingly, the terms United and Continental are synonymous for the purposes of this dispute.

[3] The Administrative Record, cited as AR __, is found at Dkt. #11.

> be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Id.

Decedent began working for Continental (now United) as a Guam based flight attendant in 2006. Altogether, Decedent elected $514,000 in death benefits per the two Policies. She designated her two children – Plaintiffs Dusty Bauer and Allan Agababa – as co-primary beneficiaries. On August 13, 2013, Decedent was found deceased in her apartment. AR 29, 371. Her death was identified as a "homicide" and Allan Agababa was arrested and tried twice for her Aggravated Murder. AR 29. Both trials ended in mistrial and all charges were dismissed against him without prejudice on October 25, 2017. AR 1296-98.

On May 29, 2018 – close to five years after Decedent's death – Plaintiffs through counsel submitted a claim for accidental death benefits per the Policies. AR 29. On May 30, 2018, NUFIC, through its claim administrator AIG, acknowledged receipt of the claim and informed Plaintiffs that it appeared based on the information received from United that Decedent had "no coverage on the date of loss" because her "coverage ended June 30, 2013 as she was on a Leave of Absence with no pay prior to her death." AR 16. That said, NUFIC requested additional information from United regarding Decedent's leave of absence. AR 57-58, 250-57. Upon receiving such information from United, NUFIC informed Plaintiffs on July 25, 2018 that the information received further supported that Decedent's last day of work was June 26, 2013, and that she called in sick on June 27, 2013 to July 2013. AR 111-12. This information strengthened NUFIC's position that Decedent's coverage "ended June 30, 2013 [because] she was on a Leave of Absence with no pay prior to her death and no longer had benefits." *Id.* NUFIC requested that Plaintiffs provide any information they had in support of Decedent's eligibility. *Id.*

In response, Plaintiffs alleged that Decedent "returned to work in July, 2013, which is why she was eligible for benefits again." AR 144. Moreover, Plaintiffs provided a transcript from Allan Agababa's criminal trial, "in which United's Health and Benefits Administrator, Norma Yoshida, testified under oath that [Decedent] was covered for $500,000 in personal accident insurance at the time of her death." *Id.*

On April 2, 2019, NUFIC informed Plaintiffs that it had completed review of the underlying claims for accidental death benefits and "concluded that no benefits are payable." AR 1576. NUFIC found that Decedent "was on an unpaid leave of absence on the date of her death, and that the type of leave she was on did not allow her coverage to continue." AR 1578. Additionally, NUFIC determined that Decedent "was not receiving disability income from United on 8/13/2013" and, thus, the underlying Waiver of Premium benefit rider was not triggered. AR 1577-78.[4] Regarding the testimony of Norma Yoshida, NUFIC determined her statements were "inaccurate based on the information United provided . . . after [Plaintiffs] reported the loss." AR 1578. Accordingly, NUFIC "determined [it] must decline payment of these claims as [Decedent] was not eligible for coverage on the date of loss, and was not covered under these policies on the date of loss as premium was not paid for the date of loss." *Id.*

On August 13, 2019, Plaintiffs appealed the foregoing decision. AR 1729-31. After conducting its appellate review, NUFIC again determined that benefits are not payable under the Policies on November 11, 2019. AR 804-11. Consequently, Plaintiffs filed the above-styled suit on January 31, 2020, seeking the court's reviewal of NUFIC's denial of benefits under ERISA.

Now before the court are the parties' respective motions for summary judgment. *See* Dkt. #12, #14. All responsive briefings have been timely filed by the parties. *See* Dkt. #19, #21, #22,

[4] Plaintiffs contend that if the Waiver of Premium benefit rider was triggered, benefits would be owed under the circumstances of this case. *See* Dkt. #12.

#23. Because the two referred motions address the same arguments and repeatedly reference each other, the court will address these motions simultaneously. *Compare* Dkt. #12, *with* Dkt. #14.

Plaintiffs argue NUFIC's decision should be reversed or remanded because (1) NUFIC's decision was not based "on actual personnel records such as payroll or flight records"; (2) the decision directly conflicts with Norma Yoshida's sworn testimony and her belief that Decedent was covered under the Policies; and (3) it ignores evidence that Decedent was approved for disability payments and, thus, the Waiver of Premium benefit rider was triggered. Dkt. #12. Defendants disputes these contentions and argue that judgment should be granted in their favor because (1) the abuse of discretion standard should apply; (2) NUFIC properly interpreted the Plan and the Policies; (3) NUFIC had a reasonable basis for its decision; and (4) NUFIC's decision was supported by the record and should be affirmed even under a *de novo* review. *See* Dkt. #14. Additionally, Defendants posit that AIG is not a properly part in this suit, and Plaintiffs' claims are barred by the Policies' limitations provision. *Id.*

II. STANDARD OF REVIEW

ERISA permits a plan beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); *Faciane v. Sun Life Assurance Co. of Canada*, 931 F.3d 412, 417 (5th Cir. 2019). "Standard summary judgment rules control in ERISA cases." *Ramirez v. United of Omaha Life Ins. Co.*, 872 F.3d 721, 725 (5th Cir. 2017) (quotation omitted).

Summary judgment is appropriate under Rule 56 of the Federal Rules of Civil Procedure only "if the movant shows there is no genuine dispute as to any material fact and that the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a). A dispute is genuine only if the

evidence is such that a reasonable jury could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254 (1986).

The party moving for summary judgment bears the initial burden of "informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrates the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The burden then shifts to the nonmoving party to establish the existence of a genuine issue for trial. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 585–87 (1986); *Wise v. E.I. Dupont de Nemours & Co.*, 58 F.3d 193, 195 (5th Cir. 1995). The parties may satisfy their respective burdens by tendering depositions, affidavits, and other competent evidence. *Estate of Smith v. United States*, 391 F.3d 621, 625 (5th Cir. 2004).

The court will view the summary judgment evidence in the light most favorable to the non-movant. *Griffin v. United Parcel Serv., Inc.*, 661 F.3d 216, 221 (5th Cir. 2011). The non-movant must respond to the motion by setting forth particular facts indicating that there is a genuine issue for trial. *Miss. River Basin Alliance v. Westphal*, 230 F.3d 170, 174 (5th Cir. 2000). "After the non-movant has been given the opportunity to raise a genuine factual issue, if no reasonable juror could find for the non-movant, summary judgment will be granted." *Id.*

III. ANALYSIS

Despite the variety of arguments made by the parties, the undersigned concludes this matter begins and ends with the Policies' contractual limitations provision. The Policies state that no legal action "may be brought after the expiration of three years after the time written proof of loss is required to be furnished." Dkt. #14 at 23; AR 2056, 2088. Claiming Plaintiffs failed to commence their legal action within this requisite time frame, Defendants argue the underlying contractual limitations period lapsed and, consequently, Plaintiffs' suit is barred. *Id.* at 23-24. In response,

Defendants' posit only that this argument "is a new justification for denial of the claim that was not articulated to Plaintiffs in advance of this litigation, and is therefore improper because the denial letter did not contest the timeliness of Plaintiffs' claims." Dkt. #21 at 9-10. Supporting this contention, Plaintiffs cite Fifth Circuit precedent for the proposition that "[a]llowing plan administrators to offer new justifications for a denial after the claims process had ended would undermine the claims system that Congress envisioned when it drafted ERISA's administrative review provisions." *See George v. Reliance Standard Life Ins. Co.*, 776 F.3d 349, 353 (5th Cir. 2015). In short, Plaintiffs argue their claims are not barred despite the underlying contractual limitations provision because Defendants did not articulate its reliance on the three-year limitations provision "in a written denial letter prior to exhaustion of the administrative review process." Dkt. #21 at 10.

ERISA does not provide a statute of limitations for suits to recover benefits. *Faciane*, 931 F.3d at 417 (citing *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 105 (2013)). The limitations period for analogous claims under state law may fill the gap. *See, e.g., Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 230 (5th Cir. 1997); *Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992). Alternatively, the parties may fill the gap by agreement: "Absent a controlling statute to the contrary, a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable." *Heimeshoff*, 571 U.S. at 105-06; *Faciane*, 931 F.3d at 417.

This principal was most clearly defined in *Heimeshoff*, where the Supreme Court stated that parties may provide limitation periods by contract, and that parties may select the date on which the contractual time limit begins to run. *Heimeshoff*, 571 U.S. at 106. This rule dates to the Supreme Court's opinion in *Order of United Commercial Travelers of America v. Wolfe*, 331 U.S.

586 (1947). There, the Court held that "in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period." *Wolfe*, 331 U.S. at 608.

In *Heimeshoff*, the Supreme Court further articulated that contractual time limits on lawsuits are "especially appropriate when enforcing an ERISA plan." *Heimeshoff*, 571 U.S. at 108. This is because

> "[e]mployers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) . . . Th[e] focus on the written terms of the plan is the linchpin of "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

Id. at 108. Consequently, the court "must give effect to the Plan's limitations provision" unless the court determines "either that the period is unreasonably short, or that a 'controlling statute' prevents the limitations provision from taking effect." *Id* at 109.

The Court in *Heimeshoff* analyzed the reasonableness factor under the confines of a limitation period prohibiting legal action "3 years after the time written proof of loss is required to be furnished according to the terms of the policy." *Id*. at 103. The Supreme Court characterized the three-year period as a "common contractual limitations provision." *Id*. at 104. Finding the three-year period reasonable even though the administrative review process in *Heimeshoff* consumed nearly two years and left the plan participant with only one year in which to file suit, the Court reasoned: "Heimeshoff does not dispute that a hypothetical 1–year limitations period commencing at the conclusion of internal review would be reasonable. We cannot fault a limitations provision that would leave the same amount of time in a case with an unusually long internal review process while providing for a significantly longer period in most cases." *Id*. at 109.

Accordingly, because the three-year limitations period did not give the plaintiffs "little chance" to timely file their lawsuit within the statute of limitations, the Court "conclude[d] that the Plan's [three-year] limitations provision [was] reasonable." *Id.* at 110. The Court added:

> Heimeshoff, drawing on a study by the American Council of Life Insurers of recent § 502(a)(1)(B) cases where timeliness was at issue, states that exhaustion can take 15 to 16 months in a typical case. Reply Brief 17–18, n. 3 (citing Brief for American Council of Life Insurers et al. as Amici Curiae 29). In our view, that still leaves ample time for filing suit.

Id. at 109 n.4.

Problematically for Plaintiffs, the limitation provision in this case is the same as the one in *Heimeshoff*: three years from the time required to submit proof of claim. Plaintiffs do not dispute that this time period has lapsed. Written proof of Plaintiffs' claim under the Plan was due by August 13, 2014 – 365 days after the date of loss on August 13, 2013. *See* AR 2054-2056. Accordingly, Plaintiffs should have commenced this legal action by August 13, 2017, three years from the time required to submit written proof. Instead of meeting this deadline, Plaintiffs waited until May 29, 2018 to file their claim for benefits and did not file their lawsuit until January 31, 2020. Accordingly, Plaintiffs missed their contractual limitation period for filing the above-styled lawsuit by well over two years.

As noted above, Plaintiffs' sole contention against the enforcement of this limitations provision is based on the fact that NUFIC did not include this argument in its denial letter. Dkt. #21 at 9 (citing 29 U.S.C. § 1133(1)). However, Defendants' contractual limitations argument relates to when Plaintiffs had to file the above-styled lawsuit, not missed deadlines that could permit the denial of Plaintiffs' claim. In other words, the relied upon contractual limitation does not serve as a basis for denying the underlying benefits claim, instead, it bars the filing of a lawsuit. This is highlighted by the fact that NUFIC could not have used the three-year contractual

limitations provision as a basis for denying Plaintiffs' claim, and thus could not have relied on the three-year limitation in its denial latter, because it bars only the untimely filing of lawsuits predicated on the administrator's denial. Accordingly, Plaintiffs' sole argument against the enforcement of the contractual limitation puts the cart before the horse and fails.

Plaintiffs do not challenge the presence of the limitation provision's reasonableness.[5] Nonetheless, in an abundance of caution, the court notes that the limitation period is reasonable. While the limitation period had expired by the time that Plaintiffs' administrative review was exhausted, this was only because Plaintiffs did not file their initial claim until nearly five years *after* the date of loss. AR 34. Had Plaintiffs filed their benefits claim within the time frame prescribed by the Policies – by August 13, 2014 – the three-year limitation period for filing suit would have provided adequate time for Plaintiffs to timely file the above-styled lawsuit.[6] Plaintiffs offer no excuses for the five-year delay preceding the filing of their initial claim. Nor do Plaintiffs attempt to argue the three-year limitation period on its face is unreasonable. Thus, it is apparent from the record that while the limitation period had lapsed before Plaintiffs had exhausted their administrative remedies, this lapse was entirely of Plaintiffs' own making.

In *Heimeshoff*, the question was whether the limitation period was reasonable; whether it provided sufficient time in which the plaintiff could file her claim, the administrative review could be exhausted, and the plaintiff could subsequently file her lawsuit. Here, like in *Heimeshoff*, the Policies' three-year contractual limitation provided sufficient time for Plaintiffs to timely file their

[5] Plaintiffs also do not argue the limitation period should be equitably tolled. *See* Dkt. #21. The Supreme Court has noted, without deciding, that "[t]o the extent the participant [in an ERISA plan] has diligently pursued both internal review and judicial review but was prevented from filing suit by extraordinary circumstances, equitable tolling may apply" to ERISA claims. *Heimeshoff*, 571 U.S. at 114. Here, Plaintiffs have not any identifying extraordinary circumstances supporting equitable tolling. Thus, Plaintiffs' have not sufficiently argued that the contractual limitation period should be tolled.

[6] The administrator's review, including its appellate review, was concluded within a year and a half from the claim's filing. *See* AR 34, 804-811. Under this timeline, Plaintiffs themselves would have had at least a year to file this lawsuit within the limitation period had they not been dilatory in filing their claim for benefits.

claim, NUFIC to exhaust Plaintiffs' administrative remedies, and for Plaintiffs to subsequently file a timely lawsuit. The primary difference, however, is that Plaintiffs' unilateral conduct caused the limitation period to lapse prior to the exhaustion of their administrative remedies. Because this outcome was entirely due to Plaintiffs' conduct and in light of the foregoing, the underlying three-year limitation period was reasonable.

According to the terms of the Policies and the Plan that this dispute is predicated on, Plaintiffs should have filed their initial claim promptly, or at least not dilatorily, so they could then timely file this lawsuit if needed. Instead, Plaintiffs chose to sit on their hands and wait five years to instigate the underlying claim proceeding, causing the three-year limitation period to lapse and this lawsuit to be untimely filed. Accordingly, the undersigned recommends the District Court find Plaintiffs' ERISA action barred by the contractual limitations provision contained within the Policies. Because the undersigned reports that Plaintiffs did not file suit within the time allowed under the Policies' reasonable limitations period, it does not reach the various other arguments levied by the parties.

IV. RECOMMENDATIONS

Due to the fact that the contractual limitation period for legal action has run, the undersigned **RECOMMENDS** that Defendants National Union Fire Insurance Company of Pittsburgh, PA's and AIG Claims, Inc.'s Motion for Summary Judgment (Dkt. #14) be **GRANTED**. Additionally, the undersigned **RECOMMENDS** that Plaintiffs' Motion for Judgment on the Administrative Record (Dkt. #12) be **DENIED**.

Based on the foregoing, the undersigned **RECOMMENDS** that Plaintiffs' ERISA action be **DISMISSED WITH PREJUDICE**.

V. OBJECTIONS

The parties may file objections to this Report and Recommendation. A party filing objections must specifically identify those findings or recommendations to which objections are being made. The District Court need not consider frivolous, conclusive, or general objections. *See Battles v. United States Parole Comm'n*, 834 F.2d 419, 421 (5th Cir. 1987).

A party's failure to file written objections to the proposed findings and recommendations contained in this Report within fourteen (14) days after the party is served with a copy of the Report shall bar that party from de novo review by the District Court of the proposed findings and recommendations in the Report and, except upon grounds of plain error, shall bar the party from appellate review of unobjected-to proposed factual findings and legal conclusions accepted by the District Court. *See* 28 U.S.C. § 636(b)(1)(C); *Thomas v. Arn*, 474 U.S. 140, 150-53 (1985); *Douglass v. United Services Automobile Ass'n*, 79 F.3d 1415 (5th Cir. 1996) (*en banc*).

SIGNED February 10, 2021.

MARK LANE
UNITED STATES MAGISTRATE JUDGE