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District Court Holds Breach of Contract Claims are Time-Barred

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The LHD/ERISA Advisor

Plaintiff Gene Myers ("Plaintiff"), a physician, made a claim for individual disability insurance (IDI) benefits under an individual disability policy arising from low back injury caused by wearing a heavy leaded gown worn during an interventional coronary procedure. As part of its investigation, Provident requested CPT codes to determine Plaintiff's occupation. Plaintiff did not provide the requested CPT codes and the claim was denied for failure to do so in 2010. In 2014, Plaintiff requested that the carrier re-analyze his claim, contending that relying solely on such information was improper. Provident again conducted an evaluation of the claim and ultimately determined in 2017 that Plaintiff was disabled effective 2005, but found that Plaintiff's disability was due to sickness, not illness. Accordingly, benefits were not payable for lifetime, but instead for a shorter period of time under the policy.

Plaintiff filed suit, challenging, inter alia, Provident's determination that his disability was due to sickness, not illness. The Plaintiff alleged that (1) a breach of contract occurred in 2017 when Provident paid past due benefits, but failed to timely pay interest and fees; and (2) a breach of contract occurred in 2017 when Provident first determined that Plaintiff's disability resulted from "sickness." Provident moved to dismiss those counts on the grounds that they were barred by the statute of limitations.

The Court agreed that those two claims were time barred. First, the Court held that submitting the same claim for re-analysis did not extend or otherwise alter the limitations period. As such, even though Provident did undertake a second review of the claim and ultimately paid benefits, the statute of limitations began to run from the original 2010 denial. Second, Plaintiff argued that a substantive decision must exist in order for the statute of limitations to run, rather than a denial for failure to provide documents. Borrowing from ERISA case law, Plaintiff argued that the original denial, on essentially administrative grounds, was not a clear and continuing repudiation. As such, the statute of limitations should run from Provident's 2017 determination. The Court declined to extend that principal, grounded in ERISA, to a non-ERISA matter. Thus, the court held that the original 2010 denial was the triggering event.

Plaintiff also filed counts for bad faith, RICO, and fraud which are still pending before the Court.

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Service Areas

Life, Health, Disability & ERISA Litigation