Proskauer

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Editor's Overview

As Amy Covert and Aaron Feuer discuss below, the U.S. Supreme Court granted certiorari in *Heimeshoff v. Hartford Life & Accident Insurance Co*. where it is expected to rule next term on whether plan sponsors may dictate in the plan document when claims for benefits accrue. The decision may have significant implications for defending benefit claims based on a statute of limitations defense depending on the scope of the Court's ruling. Next, Eugene Holmes discusses various benefit issues in Puerto Rico. In particular, he focuses on the impact of the Affordable Care Act, ERISA and the PBGC.

As always, be sure to review the Rulings, Filings, and Settlement of Interest where we discuss domestic partner health benefits, PCORI fees under the Affordable Care Act, and health care reimbursement claims.

The Supreme Court to Opine On the Use of Contractual Limitation Periods in ERISA Plans*

By Amy Covert and Aaron Feuer

Last year, we reported on how the federal discovery rule – pursuant to which claims for benefits do not accrue until the participant could reasonably have discovered the claim – can require plans to defend the merits of dated claims.[1] In that article, we noted that efforts to protect plans had taken the form of contractual provisions that not only narrow the limitations period, but also prescribe when the claim accrues for statute of limitations purposes. We noted then that although most circuit courts had enforced such contractual provisions, some had not, and we had hoped that the courts that have declined to enforce contractual accrual provisions would soon "see the light" and reverse course. Now, with the Supreme Court's granting of *certiorari* in *Heimeshoff v. Hartford Life & Accident Insurance Co.*,[2] it is likely that that the high court will provide guidance and uniformity on this issue.

ERISA's Rules on Statutes of Limitations and Contractual Limitations Periods

ERISA does not contain a statute of limitations period for suits challenging the denial of benefits by a plan administrator. Rather, courts borrow the limitations period from the most analogous state statute. Although state law determines the relevant statute of limitations period for benefit claims, federal common law determines when a claim for relief accrues. Courts utilize the federal "discovery rule" to determine the accrual date for an ERISA benefits claim. The rule generally provides that a statute of limitations begins to run when a plaintiff discovers or should have discovered the injury that forms the basis for the claim. In the ERISA context, the discovery rule has evolved to the so-called "clear repudiation rule," pursuant to which a benefit claim will accrue when a fiduciary repudiates a claim for benefits and that repudiation is clear and made known to the beneficiary. Some courts applying this standard have concluded that the limitations period runs from when the participant was on reasonable notice of the claim.[3] Regardless, a formal denial of the claim is not required.

The fact that courts borrow from state law to determine the limitations period does not prevent parties from contracting for a shorter limitations period. Federal courts have generally enforced contractual limitation periods for benefit claims as long as they are made known to participants and beneficiaries and are not "manifestly unreasonable." The courts are less consistent in enforcing contractual accrual provisions.

The Supreme Court recently granted *certiorari* in *Heimeshoff* to resolve the circuit split on the question of "[w]hen should a statue of limitations accrue for judicial review of an ERISA disability adverse benefit determination?"

Heimeshoff v. Hartford **– The District Court Ruling**

Julie Heimeshoff had been a Wal-Mart employee for nearly twenty years. In 2005, she filed a claim for long term disability benefits as a result of various ailments caused by fibromyalgia. Wal-Mart's disability plan was administered by Hartford Life & Accident Insurance Co. Hartford denied Heimeshoff's claim in December 2005, finding that she had failed to provide satisfactory proof of her disability. After an appeal, Hartford issued its "last and final denial letter" on November 25, 2007.[4]

On November 18, 2010, Heimeshoff filed suit against Hartford and Wal-Mart, challenging the denial of her benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"). Hartford moved to dismiss the lawsuit arguing that Heimeshoff's claim was barred by the plan's limitation period, which required that legal actions be brought within three years from the time that proof of loss was due under the plan.

The United States District Court for the District of Connecticut agreed with Hartford, concluding that Hartford's policy "unambiguously" provided that no legal action could be brought more than "3 years after the time written proof of loss is required to be furnished according to the terms of the policy." Proof of loss must be submitted "within 90 days after the start of the period for which The Hartford owes payment."[5] The court concluded that these provisions were unambiguous. Because Heimeshoff's proof of loss was due no later than September 30, 2007 and she had not filed suit until November 18, 2010, the court dismissed her claim as time-barred.[6]

The Second Circuit Affirms

Heimeshoff appealed the District Court's dismissal of her claim, arguing that the limitations period should not have begun to run until after her administrative claim was denied. The Court of Appeals rejected her challenge, relying on Second Circuit precedent that in turn relied on decisions of the Sixth, Seventh, Eighth and Tenth Circuits, holding that ERISA allows a limitations period to being running before the right to bring a judicial claim accrues, unless the application of the shortened limitations period would be unreasonable in the particular case.[7] Accordingly, it held that the district court properly dismissed Heimeshoff's claim as untimely as she had filed her lawsuit several months after the plan's three year period had expired.

The Supreme Court Will Consider Whether A Contractual Limitations Period Is Enforceable

In April, the Supreme Court granted Heimeshoff's petition for *certiorari*. The high court agreed to address the question of when a statute of limitations should accrue for judicial review of an ERISA disability plan's adverse benefits determination.

According to Heimeshoff, many ERISA plans require claimants to exhaust administrative remedies before filing suit, while "the limitations period begins running and wastes away while the claimant is going through the administrative review process." Heimeshoff contends that this "contradicts ERISA's well-established requirement that the beneficiary exhaust her administrative remedies before filing suit." In her petition, Heimeshoff argues that the circuits "conflict" over the accrual time for ERISA statutes of limitation, with the Fourth and Ninth circuits prohibiting limitations periods that begin running before a legal claim has accrued and the Second, Fifth, Sixth, Seventh, Eighth, and Tenth circuits upholding such limitations periods.

In its brief in opposition to Supreme Court review, Hartford argues that Heimeshoff mischaracterizes "the nature and degree of conflict among the circuits" on the issue of contractual limitations periods. According to Hartford, she misstates the position of the Ninth Circuit, and it is only the Fourth Circuit that has taken a position contrary to the majority of the circuits, which have upheld the enforceability of a contractual limitations period similar to the one in Hartford's policy unless its application would be unreasonable in a particular case.

The Circuit Split

Although the degree of the split is disputed, everyone agrees that the Fourth Circuit has clearly refused to enforce accrual provisions derived from an ERISA plan's contractual limitations language that begin running before a claimant can file suit in court. In *White v. Sun Life Assurance Co. of Canada*,[8] the Fourth Circuit considered facts almost identical to those in *Heimeshoff*, but it specifically refused to enforce a contractual accrual date that began upon the date proof of loss was required to be furnished. Recognizing that such provisions allow the limitations period to run before a claimant can file a judicial challenge (*i.e.*, before an administrative claim is exhausted), the court opined that such accrual provisions create "incentives to delay [that] would undermine internal appeals processes as mechanisms for full and fair review and undermine the civil right of action as a complement to internal review."[9] The Fourth Circuit refused to adopt a case-by-case, fact-intensive assessment of the reasonableness of the accrual provision.

Proskauer's Perspective

As we have previously reported, the reasoning of the Second, Sixth, Seventh, and Eighth Circuits is more consistent with the enforcement of the contractual provisions of ERISA plans. If the high court's contract-based analysis in *McCutchen*[10] is indicative, then we would expect the Court to base its decision on the ERISA principle that written terms of a plan should be enforced as written, upholding the Second Circuit's decision.

A ruling in Hartford's favor could have broad implications and could conceivably lead to the application of the accrual rules in other contexts that could serve to more substantially reduce stale claims by participants. For example, a pension plan could include provisions requiring that a challenge to benefit calculations must be filed within a reasonable period after a participant receives an annual statement of their accrued benefit, or when the participant terminates employment, rather than at the point of retirement, when relevant information may no longer be readily accessible.

Whichever way it rules, the Supreme Court's decision on this issue should provide uniformity with respect to plan rules on the accrual of benefit claims and should simplify the calculation of deadlines to file a suit for benefits under ERISA.

Benefit Issues in Puerto Rico: Impact of the ACA, ERISA and the PBGC*

This article highlights some recent developments that employers with Puerto Rico employee benefits arrangements should consider concerning compliance with U.S. federal laws on health care reform and the Patient Protection and Affordable Care Act ("ACA"), fiduciary duties under the Employee Retirement Income Security Act of 1974 ("ERISA"), and Pension Benefit Guaranty Corporation ("PBGC") coverage issues. A failure to comply with applicable U.S. federal laws in Puerto Rico may result in costly litigation and civil penalties as well as criminal penalties.

Health Care Reform

Parts of health care reform apply in Puerto Rico because the ACA amends the Public Health Service Act ("PHSA") and the Social Security Act ("SSA"), both of which apply in Puerto Rico. The ACA's applicable requirements become effective over time and certain requirements do not apply to "grandfathered" plans. Some of the new requirements that are already in effect are that employers must ensure their health insurance plans:

- ???do not set lifetime dollar limits on the value of essential health benefits;

- ???do not set annual limits on the dollar value of essential health benefits below a minimum threshold;
- ???do not exclude individuals under the age of nineteen for pre-existing conditions;
- ???offer preventive care without any cost to insured individuals;
- ???cover dependent children until the age of twenty-six;
- ???provide an effective appeals process for insured individuals to challenge adverse benefit determinations;
- ???only retroactively rescind coverage in limited circumstances;
- ???provide annual quality of care reports; and
- ???provide uniform summaries of benefits and coverage.

In 2014, additional requirements will become effective and will be applicable in Puerto Rico. Among them are prohibitions of exclusions for pre-existing conditions and annual limits on the dollar value of essential health benefits. In addition, employers must limit their new hire waiting period for insurance coverage to ninety days.

The most controversial parts of the ACA do not apply in Puerto Rico. These are the so-called "pay-or-play" employer mandate and individual minimum essential coverage mandate. The employer mandate requires employers to pay certain penalties and/or fees based on the level of health benefits that the employer provides to its employees. The individual mandate requires most individuals to pay certain penalties if they do not secure minimum essential health coverage for themselves and their dependents. The ACA treats all bona fide residents of the U.S. territories as having minimum essential health insurance coverage. Therefore, individuals are exempt from the mandate.

The two mandates are implemented through the U.S. Internal Revenue Code ("USIRC"). While the majority of U.S. federal laws apply in Puerto Rico, one notable exception is the USIRC, which generally treats Puerto Rico as a foreign country. Residents of Puerto Rico and their employers are instead subject to the Puerto Rico Internal Revenue Code ("PRIRC"). Although the Puerto Rico Internal Revenue Code ("PRIRC") is similar to the USIRC, it does not directly mirror the USIRC. Therefore the employer mandate is also inapplicable in Puerto Rico. In addition, premium tax credits are also currently unavailable in Puerto Rico. Employers should remain aware, however, that Puerto Rico could amend the PRIRC to adopt the mandates.

Another key component of ACA is the establishment of health insurance marketplaces. While they will become available in the Unites States on October 1, 2013, it is unclear whether Puerto Rico will establish a marketplace. If Puerto Rico does establish a marketplace, it will receive a funding allocation for premium assistance and cost-sharing assistance to residents who use the marketplace.

Fiduciary Considerations

ERISA demands that fiduciaries discharge their duties solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan. In addition, fiduciaries are required to discharge their duties relative to the plan with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of a similar enterprise.

ERISA's fiduciary standards are particularly important because ERISA preempts all laws in Puerto Rico that directly or indirectly relate to an employee benefit plan, including defined benefit plans, defined contributions plans, and welfare plans offered by an employer or union. In other words, an ERISA fiduciary must comply with ERISA's fiduciary standards, regardless of any laws in Puerto Rico that might provide different standards. Recently, in *Puerto Rico Telephone Co. v. Sistema de Retiro de los Empleados del Gobierno y la Judicatura* (D.P.R., Case No. 09-1085, 2013 U.S. LEXIS 56796), the U.S. District Court for the District of Puerto Rico applied ERISA's preemption provision to a Puerto Rico statute that required the transfer of certain assets to a governmental plan and specificallynoted that ERISA preempts any Puerto Rican law that refers to an employee benefit plan or is connected with an employee benefit plan.

In order to meet the ERISA fiduciary standards, it is incumbent upon a fiduciary to take courses of action that are reasonable when making decisions that further the purposes of the plan. This means that a fiduciary must adhere to procedural prudence standards when making decisions impacting the plan (e.g., establishing comprehensive protocols for selecting and monitoring investment options or hiring experts where needed), just as a prudent person would. To be clear, there is no requirement that the prudent process deployed by the fiduciary render the "most favorable" result in all instances. In fact, courts have generally been reluctant to find a fiduciary liable for breaches where a prudence process was followed, but participants and beneficiaries were nevertheless adversely impacted.

Fiduciaries must maintain comprehensive contemporaneous records of actions taken to establish prudence and if the fiduciary does not have sufficient understanding of an area, he or she is responsible for researching the area and taking such other actions necessary to gain the proper knowledge and understanding of the issue.

In addition to adhering to the ERISA fiduciary standards described above, fiduciaries must ensure that arrangements with their service providers are "reasonable" and that only "reasonable" compensation is paid for services rendered in accordance with ERISA section 408(b)(2). In order to effectively discharge this duty, fiduciaries must obtain information from service providers that would enable them to make informed decisions about the scope of services, the costs of such services, the capabilities of the service provider and identifying any potential conflicts of interest. In this regard, the final regulations issued under ERISA section 408(b)(2) require service providers to disclose all compensation they receives under an arrangement.

Defined Benefit Plans

Another important development that employers and fiduciaries should be aware of is that the PBGC recently withdrew two older opinion letters (Opinion Letters 77-172 and 85-19), which addressed whether territorial defined benefit plans are covered by Title IV of ERISA. This withdrawal may be an indication that further PBGC guidance for Puerto Rico based defined benefit plans is forthcoming. The status of PBGC coverage for Puerto Rico defined benefit plans is one that has been the subject of review and analysis by the PBGC for quite some time.

The Opinion Letters reflected the PBGC's long standing position that a Puerto Rico based plan could be subject to Title IV of ERISA even if the plan had not made an affirmative election to be formally treated as a qualified plan under the Internal Revenue Code. It is difficult to draw any definite conclusions from the PBGC's decision to withdraw the Opinion Letters, but it appears that the PBGC may now consider the affirmative election to be a prerequisite before a Puerto Rico based plan is subject to Title IV of ERISA.

Proskauer's Perspective

While much attention has been given to the impact of the mandatory provisions involving health care reform in the U.S. mainland, employers with Puerto Rico health and welfare plans also must ensure compliance with the applicable ACA requirements. In addition, employers should be aware that Puerto Rico could amend the PRIRC to adopt a provision similar to or the same as the USIRC provisions of health care reform, which means further analysis of benefit plans to ensure compliance.

In addition, employers should keep in mind that the ERISA fiduciary standards apply equally to Puerto Rico based plans. Thus, fiduciaries for Puerto Rico based plans must be mindful that ERISA demands that they discharge their duties for the exclusive benefits of plan participants and beneficiaries and that they act with the care, skill and prudence of a prudent person. In this regard, fiduciaries must maintain good contemporaneous records of actions taken to establish prudence and diligently monitor service provider compliance and closely evaluate the disclosures in accordance the final regulations under ERISA 408(b)(2) to ensure that only reasonable compensation is paid to service providers.

Lastly, employers and fiduciaries for Puerto Rico based plans should diligently monitor the developments related to the PBGC's recent decision to withdraw the Opinion Letters since plans not covered by Title IV of ERISA are not subject to PBGC premiums, liabilities under ERISA section 4062(e), or the PBGC reporting requirements.

Rulings, Filings, and Settlements of Interest

DOMA Held Unconstitutional

By Roberta Chevlowe

The Defense of Marriage Act, which defines "marriage" and "spouse" as excluding same-sex partners, was struck down by the U.S. Supreme Court today in a 5-4 decision on equal protection grounds. Stay tuned for information about our upcoming Webinar regarding the impact of the Court's decision on employer-provided benefits. We will also post a link to our Client Alert in the coming days.

Health Benefits Provided to Same-Sex Spouses

By Thelma Ofori and Roberta Chevlowe

As we await the decision of the U.S. Supreme Court in *U.S. v. Windsor*, which may come as early as this week, many employers are considering the potential impact that the decision may have on the health benefits that they provide to their employees, regardless of whether they currently offer health benefits to their employees' same-sex spouses.

If the Court determines that the federal Defense of Marriage Act ("DOMA") is unconstitutional, the definition of "marriage" and "spouse" for purposes of federal law will no longer exclude same-sex spouses. Such a ruling would appear, on the one hand, to ease some of the burdens associated with administering health pans, and, on the other hand, add to the administrative burdens.

From the perspective of easing administrative burdens, such a ruling would allow employers to simplify some of their administrative procedures, because some existing processes otherwise applicable to opposite-sex spouses will now apply in the same way to same-sex spouses. For example, if the federal law definition of "spouse" could include same-sex spouses, an employer will no longer need to require that employees pay for this coverage on an *after-tax* basis because employees would be allowed to pay for the coverage with *pre-tax* dollars through a cafeteria plan. In addition, an employer will no longer be required to compute and impute for federal income tax purposes the value of same-sex spousal coverage provided by the employer.

However, DOMA's repeal (should it happen) likely would also add to employers' administrative burdens. For example, employers may be required to allow employees to make immediate changes to their health coverage elections depending on the terms of the plan, particularly when employees may have declined spousal coverage in light of the federal tax consequences. There will also be new COBRA and HIPAA obligations with respect to same-sex spouses.

Even employers that do not currently extend health benefits to employees' same-sex spouses will have issues to consider if DOMA is repealed. Depending on the terms of the employer's health plan and the impact of the Court's decision on applicable state law, employers may be required to offer this coverage. It also may cause employers to reconsider whether to provide domestic partner health benefits to *unmarried* couples.

We expect that the *Windsor*decision will create many questions (some without definite answers) for employers with regard to health coverage provided to same-sex spouses and partners, and it will be important for employers to review the issues carefully with their advisors.

The Future of Domestic Partner Health Benefits

By Gabrielle Blum and Roberta Chevlowe

If the U.S. Supreme Court rules that the federal Defense of Marriage Act ("DOMA") is unconstitutional in *Windsor v. U.S.*, which is expected to be decided this month, will employers that offer health benefits to employees' same-sex domestic partners cease offering "domestic partner" benefits separately from benefits for employees and their spouses? Currently, one rationale for offering same-sex domestic partner health coverage is based on an equitable argument that, because an employee's same-sex domestic partner typically cannot be treated as a spouse or dependent for federal tax purposes, a special coverage category is warranted. At the same time, this special status results in an economic hardship in that the employee must pay income tax on the value of coverage provided to the domestic partner. A repeal of DOMA would enable same-sex couples to avoid this economic hardship (at least with regard to federal income taxes). In other words, if DOMA is repealed, the definition of "spouse" for purposes of federal laws will no longer be limited to an opposite-sex spouse. Consequently, same-sex couples will have the opportunity to avoid federal taxation of their benefits by marrying. That could lead employers to conclude that the special category of domestic partner coverage is no longer needed.

On the other hand, employers also need to consider the impact of state law. If the Supreme Court strikes DOMA, that does not mean that state laws necessarily would change (it will depend on the rationale of the Court's decision). So if a state law prohibiting same-sex marriage stands, an employer that otherwise provided domestic partner coverage may keep that category of coverage in place in order to handle the case of employees living in states where only opposite-sex marriage is legal. Admittedly, if DOMA is repealed, it is likely that such a state would have to recognize an out-of-state same-sex marriage, nevertheless, there could be a number of other employees who may only have coverage for same-sex partners through domestic partner coverage.

Separately, there are employers who offer health benefits to *opposite-sex* domestic partners (in addition to coverage for same-sex domestic partners). The rationale for providing coverage to opposite-sex domestic partners (presumably providing coverage opportunities for the widest possible constituencies) does not necessarily change if DOMA is repealed.

Some additional considerations for employers in making design decisions in this area include:

- ??What does applicable state law (perhaps a "mini-DOMA" law) say about same-sex partners and their status for state tax purposes?

- ??What does state insurance law say about selling insurance that allows for same-sex partner coverage?

- ??How will the IRS and courts interpret general plan eligibility provisions in light of a decision by the Supreme Court to repeal DOMA? That is, suppose a plan precludes same-sex partners from being treated as spouses under the plan, but DOMA is repealed. Does that repeal effectively override the plan design decision since the couple involved would now include a recognized spouse for federal law purposes?

Employers operating in multiple states, including some where same-sex marriage is permitted and some where it isn't, will need to consider a variety of additional issues, including whether it makes sense to adopt a "one-size-fits-all" policy across all states with regard to domestic partner health benefits. It may make better sense to have different policies depending on the status of the law in the state in which the employee works or lives, but in either case the employer should be sure to consider the employee relations issues that may be implicated by its decisions.

A repeal of DOMA, should it occur, is not going to mean plan design decisions will necessarily be easy.

Stay tuned…

IRS Says PCORI Fees Are Deductible

By Paul Hamburger and Emily Erstling

As employers plan for paying various health care reform fees, one question that arises is whether the fees owed are tax deductible. In particular, it has been unclear whether the fees paid pursuant the Affordable Care Act to fund the Patient-Centered Outcomes Research Institute ("PCORI") would be deductible business expenses under Section 162 of the Internal Revenue Code (the "Code"). On June 7, 2013, the Office of the Chief Counsel of the IRS released a memorandum concluding that, in general, the payment of the PCORI fee should be tax deductible as an ordinary business expense.

Health care reform established PCORI to study medical treatment practices and outcomes in the U.S. To help fund PCORI, health care reform adopted Code sections 4375-4377 which require issuers of specified health insurance policies and sponsors of certain self-insured health plans to pay an annual fee to help fund PCORI, beginning with plan or policy years ending after September 30, 2012. For plan and policy years ending after September 30, 2012, and before October 1, 2013, the applicable dollar amount is $1. For plan and policy years ending after September 30, 2013, and before October 1, 2014, the applicable dollar amount is $2. For plan and policy years beginning on or after October 1, 2014, and before October 1, 2019, the applicable dollar amount is further adjusted to reflect inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services. The applicable dollar amount is then multiplied by the average number of lives covered by the plan or policy to come up with the bottom line dollar amount owed. That amount is then reported on IRS Form 720 (which has been updated for this purpose).

The IRS Chief Counsel memorandum opining that these fees generally are deductible business expenses provides helpful additional guidance for employers as they calculate and determine their PCORI fee liability.

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Express Plan Terms Allow Self-Insured Plan to Recover Medical Benefits Paid to Employee Post-McCutchen

By Anthony Cacace

In *Quest Diagnostics v. Bomani, et al.*, 11-CV-00951 (D. Conn., June 19, 2013), the court granted Quest Diagnostic's ("Quest") motion for summary judgment, ruling that Quest, as the fiduciary to its self-insured medical plan, could recover medical benefits paid to its employee after the employee was injured in an accident and recovered a settlement from the responsible third-party. Citing the Supreme Court's recent ruling in *U.S. Airways, Inc. v. McCutchen*, the district court ruled that the plan had a right under ERISA Section 502(a)(3) to recover the medical benefits paid to the employee based on the reimbursement provision of the plan, which clearly stated that the employee was "responsible for reimbursing the plan for 100% of the amounts paid by the medical plan…regardless of whether [the employee] ha[s] been made whole." The court rejected the defendants' argument that the "make-whole doctrine," which would prevent the employee from paying monies from his personal injury recovery until he was "fully compensated for his injuries," limited the plan's right to recovery, reasoning that the explicit terms of the plan "unambiguously foreclose[d] the application of the make-whole doctrine." The court also ruled that Connecticut's anti-subrogation statue, which prohibits insurers from pursing recovery from third-party tort settlements, was preempted by ERISA and did not apply, because Quest's plan was self-insured.

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[1] Aaron A. Reuter, *Limiting ERISA's Limitations Period through the Use of Contractual Accrual Dates*, Bloomberg Law, http://about.bloomberglaw.com/practitioner-contributions/limiting-erisas-limitations-period/

[2]*Heimeshoff v. Hartford Life & Accident Insurance Co.*, 496 Fed. App'x 129 (2d Cir. 2012) *cert. granted* (U.S. Apr. 15, 2013) (No. 12-729).

[3] See, e.g., Novella v. Westchester County, 661 F.3d 128,147 (2d Cir. 2011); *Thompson v. Retirement Plan for Employees of S.C. Johnson & Son*, 651 F.3d 600 (7th Cir. 2011).

[4]*Heimeshoff v. Hartford Life & Accident Ins. Co.*, 3:10cv1813 (JBA), 2012 U.S. Dist. LEXIS 6882, at *2 (S.D.N.Y. Jan. 16, 2012).

[5]*Id.* at *12.

[6] The District Court also rejected Heimeshoff's argument that her claim was not time-barred because Hartford failed to include notice of the contractual limitations period in its denial letters. The Supreme Court did not grant *certiorari* on this issue.

[7] *Heimeshoff*, 496 Fed. App'x at 130.

[8] 488 F.3d 240 (4th Cir. 2007).

[9] *Id.* at 248 (internal quotations and citations omitted).

[10] *U.S. Airways v. McCutchen*, 569 U.S. __, 133 S. Ct. 1537 (2013).

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