Talamantes v. Metro. Life Ins. Co.

United States Court of Appeals for the Fifth Circuit

June 29, 2021, Filed

No. 20-50953

Reporter
2021 U.S. App. LEXIS 19660 *; 3 F.4th 166 **

ENRIQUE TALAMANTES, Plaintiff-Appellant, versus METROPOLITAN LIFE INSURANCE COMPANY, Defendant-Appellee.

Prior History: [*1] Appeal from the United States District Court for the Western District of Texas. USDC No. 1:18-CV-904.

Talamantes v. Metro. Life Ins. Co., 2020 U.S. Dist. LEXIS 218466 (W.D. Tex., Oct. 27, 2020)

Core Terms

benefits, disability, coverage, Temporary, policies, district court, insured, waiting period, provide coverage, provisions, summary judgment, parties, merits

Case Summary

Overview
HOLDINGS: [1]-District court erred in dismissing plaintiff's ERISA case based on its conclusion that the defendant insurer did not provide coverage due to the coverage being provided by another policy because a reading of the two policies at issue resulted in a conclusion that coverage was not available under the first policy and therefore coverage was afforded to plaintiff insured under defendant's policy; [2]-The provision in defendant's policy that specifically afforded coverage when an employee was actively at work during the transition period fit the facts here perfectly and provided coverage to plaintiff. The plain language of the policies made it clear that plaintiff's benefits coverage for his alleged longterm disability shifted from the original insurer to defendant.

Outcome
Judgment reversed and cause remanded.

LexisNexis® Headnotes

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

Civil Procedure > Judgments > Summary Judgment > Entitlement as Matter of Law

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Legal Entitlement

Civil Procedure > Appeals > Standards of Review > De Novo Review

HN1

ERISA cases are governed by standard summary judgment rules. Therefore, a district court's grant of summary judgment is reviewed de novo. Summary judgment is appropriate when there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.

Civil Procedure > ... > Federal & State Interrelationships > Federal Common Law > Applicability

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > Construction Against Insurers

Pensions & Benefits Law > ERISA > Civil Litigation > Federal Common Law

Pensions & Benefits Law > ERISA > Civil Litigation > Reasonable Expectations

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Ordinary & Usual Meanings

HN2

Interpretations of policy provisions in ERISA-regulated plans are governed by federal common law. When construing ERISA plan provisions, courts are to give the language of an insurance contract its ordinary and generally accepted meaning if such a meaning exists. Only if the plan terms remain ambiguous after applying ordinary principles of contract interpretation is a coaurt compelled to apply the rule of contra proferentum and construe the terms strictly in favor of the insured.

Counsel: For Enrique Talamantes, Plaintiff - Appellant: Lonnie Roach, Bemis, Roach & Reed, Austin, TX.

For Metropolitan Life Insurance Company, Linda Gail Moore, Esq., Estes Thorne & Carr, P.L.L.C., Dallas, TX.

Judges: Before DAVIS, DUNCAN, AND OLDHAM, Circuit Judges.

Opinion by: W. EUGENE DAVIS

Opinion

[167]** W. EUGENE DAVIS, *Circuit Judge*:

Plaintiff filed this ERISA suit to recover long-term disability benefits from MetLife, which denied coverage. The district court severed the coverage issue from the remaining issues in this case. The decision on coverage narrowed to whether Standard Insurance Co., the carrier for calendar year 2016, or MetLife, the carrier for 2017, provided coverage. The district court granted summary judgment in favor of MetLife and entered a final judgment dismissing the case. The court concluded that Standard, which had been previously dismissed, **[**168]** covered this claim. We disagree. Our reading of the Standard and MetLife policies leads us to conclude that Standard provided no coverage, and coverage was afforded to Plaintiff under MetLife's policy. We REVERSE and REMAND.

I. BACKGROUND

Plaintiff, Enrique Talamantes, **[*2]** was a Product Development Engineer for Becton, Dickinson and Company ("BD"). BD provided its employees with a group life and health plan ("the Plan") which is governed by ERISA. The Plan provides long-term disability ("LTD") coverage to BD's eligible employees, including Plaintiff. During the relevant time period, BD used two insurers, Standard Insurance Co. ("Standard") for the 2016 calendar year and MetLife Insurance Co. ("MetLife") for the 2017 calendar year, to fund LTD payments under the Plan.

On November 9, 2016, Plaintiff became disabled due to trigeminal neuralgia[1] and underwent microvascular decompression surgery. In light of this disability, Plaintiff was approved for and paid short-term disability ("STD") benefits for 34 days under the Plan from November 18, 2016 through December 22, 2016. The Plan's STD benefits were paid by BD and administered by Sedgwick Claims Management Services ("Sedgwick") and did not involve Standard or MetLife. On December 23, 2016, Plaintiff returned to full-time active work. Standard's policy terminated on December 31, 2016, and MetLife's policy became effective on January 1, 2017. On January 12, 2017, Plaintiff stopped working and again became **[*3]** disabled because of a relapse in his trigeminal neuralgia symptoms.

After a minor dispute over reinstating the STD benefits, Sedgwick approved Plaintiff for the maximum amount of STD benefits (146 days) from January 12, 2017 through June 7, 2017. When added to the 34 days of STD benefits paid earlier, these benefits were paid by BD for a total of 180 days. After the STD benefits were exhausted, Sedgwick forwarded Plaintiff's claim for LTD benefits to Standard, the LTD benefits insurer for 2016—the year Plaintiff's disability began. Without addressing the merits

[1] Trigeminal neuralgia is a disease that affects trigeminal nerves in the face causing chronic pain.

of Plaintiff's disability, Standard denied Plaintiff's LTD claim on the basis that it was not covered under its policy.

Following denial, Plaintiff made a LTD benefits claim against MetLife in June 2018. MetLife was the LTD benefits insurer for calendar year 2017—the year Plaintiff's disability relapsed. After receiving no response, Plaintiff filed the instant lawsuit against the Plan, Standard, and MetLife on October 22, 2018, alleging that Plaintiff was entitled to recover LTD benefits under the civil enforcement provisions of ERISA.

On May 30, 2019, Plaintiff settled with Standard resulting in its dismissal. After resolving **[*4]** discovery issues related to the settlement, Plaintiff, MetLife, and the Plan stipulated to the dismissal of the Plan leaving Plaintiff and MetLife the only parties in this suit. Plaintiff and MetLife then jointly moved to bifurcate the trial on the issue of coverage and the merits of Plaintiff's disability claim under the policy. The district court granted the motion, and Plaintiff and MetLife jointly submitted a stipulation of the material facts relevant to the coverage issue. The parties filed cross motions for summary judgment asking the district court to decide whether MetLife **[**169]** provided coverage to Plaintiff under the terms of the policy.

The district court granted summary judgment in favor of MetLife concluding that "a harmonious reading of Standard's and MetLife's insurance policies shows that MetLife owes no payable benefits to Plaintiff." Plaintiff timely appealed.

II. DISCUSSION

HN1[2] Therefore, a district court's grant of summary judgment is reviewed de novo.[3] Summary judgment is appropriate when "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of **[*5]** law."[4]

HN2[] Interpretations of policy provisions in ERISA-regulated plans are governed by federal common law.[5] "When construing ERISA plan provisions, courts are to give the language of an insurance contract its ordinary and generally accepted meaning if such a meaning exists."[6] "Only if the plan terms remain ambiguous after applying ordinary principles of contract interpretation are we compelled to apply the rule of *contra proferentum* and construe the terms strictly in favor of the insured."[7]

B. Coverage Under the Policies

MetLife contends it does not cover Plaintiff's claim because the Standard policy provides the necessary coverage. The MetLife policy excludes payment of benefits if the claim is covered by another policy.[8] Both policies cover Plaintiff under the general coverage provisions of the respective policies. Standard's policy states in its insuring clause, "If you become Disabled while insured under the Group Policy, we will pay LTD Benefits according to the terms of the Group Policy after we receive Proof of Loss." MetLife's policy describes when its insurance takes effect and provides coverage when an employee was covered under a prior plan: "If You are Actively at Work **[*6]** on the day before the Replacement Date, You will become insured for Disability Income Insurance under this certificate on the Replacement Date." The Replacement Date is January 1, 2017, and it is undisputed that Plaintiff was "Actively at Work" the day before the new policy attached. The parties agree that MetLife will not provide coverage for benefits due if coverage is provided by Standard's policy.

MetLife argues that two general provisions in Standard's policy continue to provide coverage for Plaintiff. The first is the insuring clause discussed previously. The second is the general rule for coverage after Standard's policy ends or is changed:

> During each period of continuous Disability, we will

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[2] *Green v. Life Ins. Co. of N. Am., 754 F.3d 324, 329 (5th Cir. 2014)*.

[3] *Id.*

[4] *Id.* (quoting *Fed. R. Civ. P. 56(a)*).

[5] *Id. at 331*.

[6] *Id.* (quoting *Provident Life & Accident Ins. Co. v. Sharpless, 364 F.3d 634, 641 (5th Cir. 2004)*).

[7] *Id.* (quoting *Wegner v. Standard Ins. Co., 129 F.3d 814, 818 (5th Cir. 1997)*).

[8] "Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable."

> pay LTD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. **[**170]** Your right to receive LTD Benefits will not be affected by . . .

Termination of the Group Policy after you become Disabled. Fortunately, the policies have more specific provisions that apply to the situation in this case—a transition from one policy to another during a period of temporary recovery.

Plaintiff relies on a specific provision in Standard's policy that excludes coverage when an **[*7]** employee experiences a temporary recovery. That specific provision describing the rules for a "Temporary Recovery" acknowledges:

> You may temporarily recover from your Disability and then become Disabled again from the same cause or causes without having to serve a new Benefit Waiting Period.[9] Temporary Recovery means you cease to be Disabled for no longer than the applicable Allowable Period.

It is undisputed that Plaintiff met the conditions described above to be temporarily recovered. The Standard policy next details the effects of a Temporary Recovery. Herein lies the exclusion:

> B. Effect of Temporary Recovery
> If your Temporary Recovery does not exceed the Allowable Periods [90 days], the following will apply.
> 1. The Predisability Earnings used to determine your LTD Benefit will not change.
> 2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.
> 3. No LTD Benefits will be payable for the period of Temporary Recovery.
>
> ***4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured during your period of Temporary Recovery [*8]*** .
>
> 5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.[10]

We agree with Plaintiff that paragraph four in Standard's policy under the "Effect of Temporary Recovery" clause primes the general insuring clauses relied on by MetLife and excludes coverage for LTD benefits under the precise circumstances of this case. Because Plaintiff became insured under MetLife's policy during his temporary recovery, the above exclusion in Standard's policy applies, and MetLife provides LTD benefits coverage. MetLife's provision specifically affording coverage when an employee is actively at work during the transition period fits the facts here perfectly and provides coverage to Plaintiff.

MetLife makes much of the fact that paragraph four says, "after benefits become *payable"* and argues that this is not the same as being merely eligible for coverage under a new policy.[11] This argument, however, overlooks the fact that whether the benefits are payable is dependent on the merits of Plaintiff's disability claim. To accept MetLife's argument that benefits were not payable under its policy would leave the claimant in the dark about whether **[*9]** he had coverage until he litigated his disability claim. The parties agreed to **[**171]** bifurcate the coverage and merits issues, and on remand, MetLife is free to litigate the disability issue and any other contested issues other than coverage.

Finally, MetLife's argument that Plaintiff's relapse in disability makes the disability "continuous" and triggers paragraph five of Standard's policy, captioned "Effect of Temporary Recovery," is similarly unavailing. Paragraph five contains an important qualifier: "***Except as stated above***, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability."[12] In other words, when there is a temporary recovery and allowable relapse, Standard considers no interruption (thus continuous disability) ***except*** when, under paragraph four, the employee becomes insured and benefits become payable under a new policy that affords coverage during the temporary recovery.

C. The Waiting Period

Both policies provide for a waiting period during which an employee must be disabled before LTD benefits are triggered. The Standard policy required Plaintiff to be disabled for 180 days before becoming eligible for LTD

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[9] A Benefit Waiting Period is "the period you must be continuously Disabled before LTD Benefits become payable." This period is defined as "Through the end date of any Employer-sponsored short term disability benefits or salary continuation program, or 180 days, if longer." During the Benefit Waiting Period, Standard does not pay LTD benefits.

[10] Emphasis to policy language added.

[11] Emphasis added.

[12] Emphasis added.

benefits. In the event **[*10]** that MetLife provides a replacement policy, MetLife agrees to adopt the previous policy's waiting period and waive its own waiting period so long as five conditions are met.[13]

Plaintiff was paid STD benefits for 180 days. It is unclear to us what, if any, issue is presented as to whether Plaintiff met the waiting period under MetLife's waiting period waiver clause. Because this is a merits issue, we leave this determination to the district court to reconsider on remand.

III. CONCLUSION

The Standard and MetLife policies outline how to transition coverage between old and new policies, as well as provide special rules for employees who temporarily recover during a transition. The plain language of the policies make it clear that Plaintiff's benefits coverage for his alleged longterm disability shifted from Standard to MetLife. Based on the foregoing we REVERSE and REMAND for further proceedings not inconsistent with this opinion.

June 29, 2021

MEMORANDUM TO COUNSEL OR PARTIES LISTED BELOW

Regarding: Fifth Circuit Statement on Petitions for Rehearing or Rehearing En Banc

No. 20-50953 Talamantes v. Metro Life Ins USDC No. 1:18-CV-904

Enclosed is a copy of the court's decision. The court has entered **[*11]** judgment under ***FED. R. APP. P.*** *36*. (However, the opinion may yet contain typographical or printing errors which are subject to correction.)

FED. R. APP. P. *39* through *41*, and ***5TH CIR. R.*** *35*, *39*, and *41* govern costs, rehearings, and mandates. ***5TH CIR. R. 35*** **and** ***40*** **require you to attach to your petition for panel rehearing or rehearing en banc an unmarked copy of the court's opinion or order**. Please read carefully the Internal Operating Procedures (IOP's) following ***FED. R. APP. P.*** *40* and ***5TH CIR. R.*** *35* for a discussion of when a rehearing may be appropriate, the legal standards applied and sanctions which may be imposed if you make a nonmeritorious petition for rehearing en banc.

Direct Criminal Appeals. ***5TH CIR. R.*** *41* provides that a motion for a stay of mandate under ***FED. R. APP. P.*** *41* will not be granted simply upon request. The petition must set forth good cause for a stay or clearly demonstrate that a substantial question will be presented to the Supreme Court. Otherwise, this court may deny the motion and issue the mandate immediately.

Pro Se Cases. If you were unsuccessful in the district court and/or on appeal, and are considering filing a petition for certiorari in the United States Supreme Court, you do not need to file **[*12]** a motion for stay of mandate under ***FED. R. APP. P.*** *41*. The issuance of the mandate does not affect the time, or your right, to file with the Supreme Court.

Court Appointed Counsel. Court appointed counsel is responsible for filing petition(s) for rehearing(s) (panel and/or en banc) and writ(s) of certiorari to the U.S. Supreme Court, unless relieved of your obligation by court order. If it is your intention to file a motion to withdraw as counsel, you should notify your client promptly, **and advise them of the time limits for filing for rehearing and certiorari**. Additionally, you MUST confirm that this information was given to your client, within the body of your motion to withdraw as counsel.

The judgment entered provides that Appellant pay to Appellee the costs on appeal. A bill of cost form is available on the court's website www.ca5.uscourts.gov.

JUDGMENT

This cause was considered on the record on appeal and was argued by counsel.

IT IS ORDERED and ADJUDGED that the judgment of the District Court is REVERSED, and the cause is REMANDED to the District Court for further proceedings

[13] "Special Rules for Groups Previously Insured Under a Plan of Disability Income Insurance." "Rules for Temporary Recovery from a Disability under the Prior Plan." "We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You: 1. received benefits for a disability that began under the Prior Plan; 2. returned to work as an active Full-Time employee prior to the Replacement Date; 3. become Disabled, as defined in this certificate after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability; 4. are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and 5. would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

in accordance with the opinion of this Court.

IT IS FURTHER ORDERED that Appellant pay to Appellee the costs **[*13]** on appeal to be taxed by the Clerk of this Court.

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