21-1830

IN THE

United States Court of Appeals

FOR THE SECOND CIRCUIT

ANDREW NITKEWICZ, as Trustee of THE JOAN C. LUPE FAMILY TRUST on behalf of himself and all others similarly situated,

Plaintiff-Appellant,

—against—

LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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INTRODUCTION

New York requires life insurers to refund "any premium actually paid for any period beyond the end of the policy month in which" the death occurred. N.Y. Ins. Law § 3203(a)(2) (the "Statute"). Since Plaintiff timely paid his policy's annual "planned premium" of $53,877.72 on May 7, 2018, and the insured died on October 6, 2018—less than one year later—Lincoln must issue a premium refund. JA8, Compl. ¶ 4.

The principal argument in Lincoln's Response Brief ("RB") is that an annual planned premium payment cannot, as a matter of law, be "actually paid for any period" because a "Planned Premium is not the amount needed to continue the policy." RB 22. But the words "amount needed to continue the policy" are not in the Statute; "for any period" is. The Policy says that the policyholder "intend[s]" to pay the "Annual" Planned Premium exactly once per year for the life of the contract. JA64; JA75. If someone agrees that she intends to make a specific payment amount once per year for the life of a contract, and she makes that exact payment amount once per year, it surely follows that each annual payment amount was made "for" the following year, until the next payment becomes due. That is all the Statute requires.

Reversal is also warranted even under the district court's (and Lincoln's) erroneous interpretation of the Statute. Because of the Coverage Protection

Guarantee Rider ("CPGR"), Plaintiff's May 2018 premium payment did, as a factual matter, extend and *guarantee* coverage for a year. Lincoln does not dispute this key fact, nor could it. And reversal would be warranted even without the CPGR because discovery would be required to determine whether the $53,877.72 premium payment was sufficient to provide coverage for any period beyond the month of the insured's death.

In short, Lincoln attempts to eat its cake and have it too. The Policy expressly calls the $53,877.72 Plaintiff paid every year an "annual" "premium," yet Lincoln now says it's not really annual nor a premium. Similarly, Lincoln says that only the monthly cost of insurance charges pay for insurance and stop the Policy from being cancelled, yet the CPGR expressly says the opposite: that once paid (as here), the annual planned premium stops cancellation. And Lincoln finally asserts that the fifteen percent load charge imposed on the yearly annual premium apparently pays for nothing, even though the Policy says it pays for expenses, the CPGR rider, and the "cost of insurance."

Another New York insurance company (Athene Life), faced with materially the same situation, issued such a refund for another universal life policy insuring the same insured. JA9, Compl. ¶ 7. Lincoln's unique refusal to issue a refund is a breach of contract. Reversal is warranted.

ARGUMENT

I. Lincoln's Interpretation of the Statute and Policy is Incorrect

a. Lincoln's Monthly Deduction Focus Is Wrong and Not a Defense to the Statute's Premium Refund Requirement

Lincoln argues that universal life premium payments cannot be refundable because "the monthly deductions" alone "actually pay for the insurance." *See, e.g.*, RB at 2. But reliance on this monthly deduction versus premium distinction contradicts the plain language of the Statute and the Policy, the fundamentals of how life insurance works, and even if it were correct, it would not support dismissal.

First, Lincoln's argument relies on inserting words into the Statute that are not there. There is no way to conclude that timely annual premium payments, when "actually paid" once each year as the Policy envisions, are not payments paid "for any period," without first reading into the Statute a "guaranteed coverage" or "needed to continue" requirement. Lincoln acknowledges that the Statute lacks any such requirement, and even disclaims trying to insert one. *See* RB at 25 ("Nitkewicz argues that the District Court created a requirement that the period of coverage for purposes of Section 3203(a)(2) must . . . 'guarantee' coverage. The Court did no such thing."). But Lincoln cannot support its position without reading in such a guaranteed coverage requirement. *See, e.g.*, RB at 22 (arguing that

Plaintiff's premium payment is not a payment "for" a year (nor "for any period") because the "Planned Premium is not the amount needed to continue the policy").

In concluding otherwise, the district court (and now Lincoln) inappropriately "brushed aside" the Legislature's decision against limiting the Statute to premium payments that guarantee coverage. *Gibbons v. Bristol-Myers Squibb Co.*, 919 F.3d 699, 705-06 (2d Cir. 2019). The court instead replaced the Legislature's chosen wording "with others of [its] own." *Murphy v. Smith*, 138 S. Ct. 784, 788 (2018). The Court cannot read the phrase "guarantee coverage"—or any equivalent, like "needed to continue"—into the Statute without violating "a fundamental principle of statutory interpretation that 'absent provision[s] cannot be supplied by the courts.'" *United States v. Dawkins*, 999 F.3d 767, 782 n.18 (2d Cir. 2021) (citation omitted).

The Opening Brief's analogy of paying for yearly ballet tickets, where a small additional payment or refund may be required if something unexpected happens, illustrates the difference between a payment "for any period" and payment "for any period of guaranteed coverage". Op. Br. at 8. Lincoln offers no response to this anology. Similarly, Lincoln offers no response to the dictionary definition of "for," which is used to indicate the "object, aim, or purpose of an action." Opening Br. at 8. Here, the Policy explicitly says that the "intent" of the

policyholder is to make the Annual Premium Payment once per year,[1] JA75, which is just another way of saying that the "object, aim, or purpose" is that each annual premium payment be the one and only premium payment for that year. That is plainly a payment "for" a "period" (here, a year) under the plain terms of the Statute.

Second, Lincoln's position that universal life premiums can never pay for a period of coverage contradicts the immediately preceding statutory paragraph. NY Ins. L. § 3203(a)(1) (requiring that when there are insufficient funds to cover charges for "one month" in a universal life policy, "in which the amount and frequency of premiums may vary," the insured must be given 61 days "to pay **sufficient premium to keep the policy in force for three months**.").[2] This provsion recognizes that a universal life premium can pay for coverage for "for *three months*", even where the charges are deducted for "one month." And if a universal life premium can pay for coverage for three months, it can also be paid for six months, or nine months, or a year. That simple fact undermines Lincoln's repeated argument that only monthly deductions, not UL premiums, can pay for a period of coverage. Similarly, the Policy's reinstatement provision requires the

[1] JA75 ("The Planned Premium is the amount of premium You intend to pay. The Premium Frequency is how often You intend to pay the Planned Premium.").

[2] Unless otherwise noted, all emphases are added.

policyholder to "pay an amount . . . that is sufficient to keep this policy in force for at least (2) months," JA76, which cannot be reconciled with Lincoln's view that coverage, as a matter of law, is necessarily and always extended only one month at a time via monthly deductions.

Third, Lincoln contends that only monthly deductions meet the statutory test of something that is "actually paid" for "any period." RB at 11. But that ignores the statutory structure, text, and the Policy. The refund provision in the Statute focuses on what the policyowner *pays* – the "premium" – not on what charges the insurer subsequently *deducts* from those premiums. "Premiums" and "deductions" are two different concepts that are distinguished within the same statute. *See* N.Y. Ins. L. § 3203(a)(16) (requiring the insurer to disclose that changes in "the amount of cost of insurance or other expense **charges deducted** under the policy . . . may require more **premium** to be paid."). Premiums are the only thing "actually paid" to keep the policy in force, and are the source of funds from which cost of insurance and other charges are deducted. Against that background, the Statute requires a refund of the "premium" from which those charges are deducted, not a refund of the deduction itself. And that makes sense: the insurer can only "refund" to the policyholder something the policyholder paid; and the policyholder pays the "premium."

Nor does it make any difference that Lincoln processes the deductions once per month. If someone actually pays their mortgage once per year into an account controlled by the mortgagee, each annual mortgage payment is still actually paid "for" a year period, even if the bank only deducts 1/12 of that amount monthly. Similarly, if someone pays for a year's worth of natural gas for their home, that payment is still for a year's worth of coverage, even if the year's payment covers the costs of 12 monthly deliveries. The situation here is no different. What matters under the Statute is the period of time the payment is "for," not how often charges are deducted from that payment.

In support of its contention that the "Policy is clear that coverage is purchased monthly, not annually," RB at 27, Lincoln cites three provisions from the Policy—none of which bear the weight Lincoln places on them. *See* JA62 ("We apply a charge to each premium You pay, and then add the balance to the Policy Value. We deduct the cost of providing the coverage (the cost of insurance) plus the cost of any additional benefits and/or riders and administrative charges from this value each month as a 'monthly deduction.'"); JA75 ("The Premium Frequency is how often You intend to pay the Planned Premium."); *id.* ("Payment of a Planned Premium may not prevent this policy from terminating.").

The first provision explicitly says that *premiums* fund the policy, from which the charges are deducted, and the Policy explains that *premiums* can keep the

Policy in force – *i.e.*, provide coverage – when they are (as here) high enough to cover the charges. *See* JA62 ("The Policy Value is a key component of Your policy. It's where Your premiums go and where We assess Our charges for providing coverage."). The second provision also supports Plaintiff: a reasonable insured would interpret that sentence to mean she could choose to pay for coverage on a yearly or some other basis (*e.g.*, six months with "semi-annual" premiums). JA10, JA100. And the third sentence is irrelevant because the Statute is not limited to premium payments that guarantee coverage.

Fourth, equally meritless is Lincoln's argument that universal life premiums are categorically nonrefundable because "in a universal life policy (as is the case here), premiums are never 'due.'" RB at 38. The Policy states otherwise; it refers to the "PREMIUM DUE DATE." JA64. Finally, that universal life insurance may "provide[] flexibility" to policyholders by allowing them to elect *not* to make a Planned Premium, RB at 28, does not change the fact that an owner who *does* timely pay each annual Planned Premium payment, once per year, would reasonably understand each annual payment to be "for" the following year, particularly when, as here, the payment was in fact designed to *guarantee* yearly coverage. *See infra* subsection II.

b. Lincoln's Interpretation of "Actually Paid" Is Meritless

Lincoln argues that Plaintiff's premium was not "actually paid" for any period because coverage is only "actually paid" for when each monthly charge is deducted. RB at 17. But that misconstrues the Statute and defies common sense. The term "actually paid" means what it says: a premium is "actually paid" when there is a payment that is actually made, as opposed to a premium that was due, but not paid (an unpaid premium). *See* § 3203(a)(2) (distinguishing an "unpaid premium" from a premium "actually paid"); *see also https://www.merriam-webster.com/dictionary/actually* (Definition of Actually: in act or in fact). The Statute refers to a 3-month grace period payment that is due, but not paid, as an "unpaid premium." Here, the Annual Planned Premium was actually paid – a check was actually written and cashed – so that part of the Statute is satisfied.

Lincoln argues the term "actually" "distinguishes the actual transfer of funds in exchange for insurance coverage" from "statements of intent that, once acted upon, increase the Policy Account value." RB at 17-18. That convoluted definition finds no textual support in any dictionary or otherwise. And it makes no sense: Plaintiff's annual $53,877.72 premium payment to Lincoln was not a "statement of intent." Plaintiff wrote that check, and Lincoln cashed it. And Lincoln cites no policy provision to support its suggestion that this Court must conclude as a matter of law that this money was merely "held in consideration of the non-insurance

component of the Policy." RB at 18. Nor could Lincoln. As explained in the Opening Brief: "The policyholder paid an annual $53,877.72 annual premium, the vast majority of which was added to the cash value of the Policy, and then that cash value was reduced every month to cover the monthly charges." Opening Br. at 22.

Lincoln also fails to meaningfully address Plaintiff's argument that the term "actually paid" undermines the district court's interpretation of "for any period." Opening Br. at 18-19. By concluding that only monthly deductions can be paid for a period, the district court read "actually paid" right out of the Statute. Unlike monthly deductions, which are automatically taken from the Policy's account value, premiums can be due but not "actually paid" by the policyholder. The district court thus "adopt[ed] a statutory interpretation that would render ['actually paid'] superfluous"—contrary to well-settled law. *United States v. Kozeny*, 541 F.3d 166, 168 (2d Cir. 2008).

c. There is No Universal Life Exemption in the Statute

The district court's ruling effectively creates a judicially-crafted improper statutory exemption that the Legislature did not make: exempting flexible premium universal life policies. *See* Opening Br. at 19-20. Because Lincoln cannot deny this practical effect of the court's ruling, Lincoln embraces it.

Lincoln argues that "[n]o inference can be drawn from the lack of an explicit exemption" in the Statute. RB at 45. But that argument turns a basic canon of statutory interpretation on its head. The "express mention of one thing excludes all others." *Georges v. United Nations*, 834 F.3d 88, 93 (2d Cir. 2016). Accordingly, the Statute's "express mention" of two exemptions "implies" there are no others. *Id.*; *see also United States v. Merz*, 653 F. App'x 72, 75-76 (2d Cir. 2016) (summary order) ("[The statute] names no fewer than 26 instruments that qualify as securities. Noticeably absent from this list, however, is a withdrawal slip. . . . Accordingly, we assume that Congress intended to exclude it."). The Statute's refund requirement applies to "[a]ll life insurance policies" except "single premium or paid-up policies." N.Y. Ins. L. § 3203(a)(2). And the immediately preceding paragraph in the Statute refers to flexible premium policies, *i.e.*, "policies in which the amount and frequency of premiums may vary." *Id.* § 3203(a)(1). But these universal life policies are not exempted in the next paragraph.

Lincoln tries to bolster its universal life exemption request because "versions" of the Statute were enacted "decades before modern universal life insurance was created." RB at 44. But the Statute explicitly refers to universal life policies, and says "all" policies are covered (except those specifically excluded), and "all" means all, including policies created thereafter. Lincoln's argument also

overlooks that the Statute has been frequently amended, and that the paragraph immediately above the refund provision explicitly refers to universal life contracts, *i.e.*, "policies in which the amount and frequency of premiums may vary." If the Statue meant to exempt universal life policies from the refund provision, the Legislature knew how to do so, but did not.[3] Lincoln's cases about the need to construe statutes as a whole also cut in Plaintiff's favor. The Legislature's decision to treat flexible-premium policies differently for other rules within the same Statute undercuts Lincoln's argument that the Legislature exempted universal life policies *sub silentio* from the Statute.

Lincoln also advances a purported policy argument for why the Statute should not apply to flexible premium universal life policies. According to Lincoln, "universal life policies are not the same as term life policies" because "universal policies include features and benefits that term policies do not," RB at 38, and it therefore "makes sense" to create a universal life statutory exemption, *id.* at 45. "But it is not our place to limit language enacted by Congress in order to pursue the policy goals posited by the defendants." *Dawkins*, 999 F.3d at 782. Here, the Legislature could have (but chose not to) treat flexible-premium policies

[3] *Arbegast v. Board of Education of South New Berlin Central School*, 65 N.Y.2d 161 (1985) is inapposite because the court interpreted an undefined statutory term by reference to case law, *id.* at 169, which is not the approach that Lincoln (nor the district court) takes.

differently for purposes of the Statute's refund requirement. By contrast, the Legislature took the opposite approach in the Statute's immediately preceding subsection. *See* N.Y. Ins. L. § 3203(a)(1). Lincoln Life repeatedly cites *Gaidon v. Guardian Life Insurance Co. of America*, 94 N.Y.2d 330 (1999), to suggest that universal life policies are "more complex" relative to term policies because the former offer more "features." RB at 2, 16-17, 38. But *Gaidon* did not even address a breach of contract claim, much less decide whether an insurance statute might apply differently to one policy over another.

Lincoln's policy arguments are also misguided. Lincoln does not (and could not on a motion to dismiss) provide specific information about any "features and benefits," much less explain how the Plaintiff received enough "features and benefits" to justify Lincoln retaining over $25,000 of premiums paid for the period after the insured's death. Nor could Lincoln. Plaintiff received, at most, a $125 discount on monthly cost-of-insurance charges, and for just five months. *See* JA288 at n.5. Plaintiff also forfeited any interest accrued. And the only other "feature" that Lincoln identifies is that universal life insurers have a smaller "amount at risk" relative to term life, but this "feature" cuts in favor of applying the refund requirement (to the extent policy arguments like this are even considered). RB at 39. If less is at risk for the insurer, then the insured is getting even less for her money.

In any event, Lincoln's policy arguments cannot create a statutory exemption where none exists. "Interpretation begins with the text of the statute. If the text is unambiguous, [the court's] task is at an end unless the text produces a manifestly absurd result, an exceptionally rare occurrence." *In re Dubroff*, 119 F.3d 75, 76 (2d Cir. 1997). It was not "manifestly absurd" for the Legislature to prohibit insurers from retaining premiums paid for a period after the insured died.

II. In the Alternative, Reversal Is Warranted Because of the CPGR and Disputed Fact Questions.

Even under the Lincoln's interpretation of the Statute, the district court erred by granting the motion to dismiss. Plaintiff's purchase of the CPGR transformed his annual planned premium payment into one that did, in fact, *guarantee* coverage for a year. To the extent the Policy alone does not make this clear (it does, *see* JA87), Plaintiff should have been granted leave to amend the Complaint to elaborate additional facts.

Lincoln does not dispute that, because of the CPGR, payment of the annual premium in 2018 guaranteed coverage for the following year. And under any interpretation of the Statute, the payment of such a premium is one that must be refunded. Lincoln even concedes that such a refund would be owed under a term policy because "in a term policy, the premium is due on a specific date and its payment extends coverage for a length of time identified in the contract." RB at 38. The very same is true for Plaintiff's premium payment under the CPGR: it is

due on each policy anniversary, and once paid, it extends coverage for a full year, until the next Planned Premium Payment is due and paid.

The district court focused on its finding that "payment of the Planned Premium may not prevent th[e] Policy from terminating," JA335, Op. at 11, but that abstract point overlooks the fact that Plaintiff's payment of *this* annual premium indisputably *did* prevent the Policy from terminating, pursuant to the CPGR. Reversal is therefore warranted even under the district court's (erroneous) standard for whether something is actually paid "for any period."

Lincoln's primary response is that the CPGR "does not actually pay for any period of coverage" because it does not "supply funds for any monthly deduction." RB at 46-47. But the Policy says that the CPGR "can ensure that Your ***coverage will continue*** even if the Cash Surrender Values are insufficient to cover the monthly deductions." JA87. The Policy therefore guarantees coverage for a year after each Planned Premium is timely paid, independent of whether there are funds to cover monthly deductions.

Backed into a corner, Lincoln's last retort is: "Let us be clear: The monthly deduction pays for the CPGR. JA87." Response Br. at 47. But the cited page – JA87 – says that "planned **premium** payments" can "satisfy" the CPGR. *Id.* In no sense do monthly deductions alone "pay for the CPGR."

Even without the CPGR, reversal is required because the district court's coverage standard raises a disputed fact question. The Statue itself recognizes that a universal life "premium" payment can be "sufficient" to "keep the policy in force for 3 months." N.Y. Ins. L. § 3203(a)(1). That statutory framework presupposes that there is a way to calculate the amount of premium "sufficient" to provide coverage "for three months," even though charges are assessed for "one month." This framework likewise presupposes there is a way to calculate the amount of premium "sufficient" to provide coverage for 6 months, or 9 months, or a year. Even without the CPGR, Plaintiff's premium payment guaranteed coverage for some amount of time. Whether the Annual Planned Premium was *in fact* sufficient to keep the Policy in force for a year is a *fact* question that cannot be resolved against Plaintiff on the pleadings, particularly when the Complaint more than plausibly alleges that Plaintiff's $53,877.72 premium payment was sufficient to extend his coverage for a full year, and did so for every year before 2018. JA11, Compl. ¶ 18.

III. Lincoln's *Contra Proferentem* and Statutory Construction Arguments Are a Strawman and Incorrect

A reasonable insured would understand the Policy's specified "ANNUAL" "premium" to be paid for an "annual" period. *See* Opening Br. at 13-16.

Lincoln sidesteps this argument by mischaracterizing it. Plaintiff is not asking the Court to adopt a canon of construction that automatically construes the

Statute in favor of the owner. The quesiton is whether, *under the terms of the Policy*, it is reasonable to conclude that the payment of the Planned Annual premium is a payment "for any period," *e.g.*, a year. Accordingly, as Plaintiff argued, the *Policy*'s "annual" premium provision (not the Statute) should be interpreted consistent with an ordinary person's understanding, and subject to *contra proferentem* principles. Opening Br. at 14-16.

Plaintiff's argument is well-supported by blackletter law. "When interpreting terms in insurance policies, [courts] are to construe the language at issue as would the ordinary [person] on the street or ordinary person when he [or she] purchases and pays for insurance." *First Invs. Corp. v. Liberty Mut. Ins. Co.*, 152 F.3d 162, 167 (2d Cir. 1998). Relatedly, "if the language of the policy is doubtful or uncertain in its meaning, any ambiguity must be resolved in favor of the insured and against the insurer." *Westview Assocs. v. Guar. Nat'l Ins. Co.*, 95 N.Y.2d 334, 340 (N.Y. 2000). Lincoln mentions none of these cases.[4]

[4] Even the cases that Lincoln cites acknowledge that "provisions of an insurance policy drafted by the insurer are generally construed against the insurer if ambiguous." *State Farm Mut. Auto. Ins. Co. v. Fitzgerald*, 25 N.Y.3d 799, 804 (2015); *see also U.S. Fire Ins. Co. v. Gen. Reinsurance Corp.*, 949 F.2d 569, 573 (2d Cir. 1991) (explaining that "an ambiguous policy [should] be construed against the insurer," but declining to apply that rule to a dispute between two insurers).

Lincoln also argues that the Statute should be "construed in the narrowest sense that its words and underlying purposes permit" because the Statute (supposedly) abrogated a common law New York rule about premium refunds. RB at 16. Lincoln did not make this argument below, and the district court did not cite it. It is incorrect. Lincoln's claim about the alleged common law in New York is based on two cases that have nothing to do with life insurance, and that came *decades after* the Statute was first enacted in 1923. They do not and cannot stand for the proposition that there is a New York presumption against refunding unearned *life insurance premiums*, because those decisions (which, again, had nothing to do with life insurance) were issued long after New York passed a statute mandating the return of unearned life insurance premiums.

The case Lincoln cites—*Oden v. Chemung County Industrial Development Agency*, 87 N.Y.2d 81, 85 (1995)—supports Plaintiff in another way. "[A]part from the express statutory reservations, there are to be no limitations on the types of economic losses or the types of collateral benefits that the offset is intended to reach." *Id.* at 88. Here, apart from the two express policy-type exemptions, there can be no others. And Lincoln's other case, *Fleetwood Acres v. Federal Housing Administration*, 171 F.2d 440, 442 (2d Cir. 1948), is inapposite. The *Fleetwood* court rejected the plaintiff's argument that he had a contractual agreement with the

insurer to return any unearned premium. By contrast, the refund requirement in this case is required by Statute.

IV. Lincoln's Appellate Arguments Not Relied Upon By The District Court Are Meritless

Unable to defend the district court's erroneous analysis, Lincoln raises alternative arguments. First, Lincoln points to the New York Department of Financial Services' ("NYDFS") Product Outlines. RB at 19-20. Second, Lincoln argues that Plaintiff puts too much weight on the word "premium." RB at 18. These arguments are meritless.

The district court denied Lincoln's request for judicial notice of the Product Outlines as moot and did not rely on them. JA343, Op. at 19. The Outlines fall outside the four corners of the Complaint, raised disputed fact questions about industry custom and practice, and cannot be considered on a motion to dismiss. The Outlines are also inapposite under their own terms. Their "sole purpose" is to provide "general guidance to insurers," not to help courts interpret statutes. JA303.

Lincoln argued below that the Product Outlines can be noticed as "legislative facts" for "how the materials use or analyze concepts." JA 114-15. But Lincoln did not (and does not) cite any cases that take judicial notice of a document that purportedly interprets a statute. Rather, Lincoln cited cases taking judicial notice of documents relevant to *factual* questions.

For example, Lincoln relied on (and again cites) *Apotex Inc. v. Acorda Therapeutics, Inc.*, RB at 20 n.3, where this Court took judicial notice of an FDA guidance document for the purpose of "undercut[ting]" the "inference that a citizen petition is an anticompetitive weapon if it attacks a rival drug application and is denied the same day that the application is approved." 823 F.3d 51, 55-56, 59-60 (2d Cir. 2016). This Court did not characterize the document as a "legislative fact" and instead took judicial notice of the document under Federal Rule of Evidence 201. *Id.* *Apotex* is therefore irrelevant under Lincoln's own standard, which is predicated on the notion that "Rule 201 does not apply to legislative facts." JA114.

Kurcsics v. Merchants Mutual Ins. Co., 49 N.Y.2d 451, 458 (1980) had nothing to do with "judicial notice"—words that appear nowhere in the opinion. *Kurcsics* instead considered an agency regulation, which is nothing like an informal "guidance" document; even then, the court disregarded the regulation as contrary to the statute's plain meaning. *Id.* at 459. The better comparison is *Casey v. Odwalla, Inc.*, 338 F. Supp. 3d 284, 294 (S.D.N.Y. 2018), in which the court refused to take judicial notice on a motion to dismiss of an FDA letter that defendant submitted to argue that its products' labels did not violate the law. The *Casey* court reasoned that the document was not judicially noticeable because

"Plaintiffs dispute the assertions contained in the FDA Letter." *Id.* The same outcome is warranted here.

Even were this Court to consider the Product Outlines, they do not support dismissal. The Outlines say that if the insured dies "during a period for which the amount needed to continue the policy has been applied," then the insurer must refund "such amount applied for any period beyond the policy month in which the death occurred." JA132. The Outlines do not say what it means for the insured in a universal life policy to die "during a period for which the amount needed to continue the policy has been applied," but in context of the prior section about grace periods, it plainly refers to someone dying while the premiums have been paid – *i.e.*, outside a grace period. The Outlines also do not define the term "applied," nor address the key question whether a planned premium, which is made for the following year, is "applied for" an annual period. If it is, then the Outlines support Plaintiff.

In any event, Lincoln's interpretation is plainly wrong. Under Lincoln's interpretation, there will *never* be for universal life policies an "amount applied for any period beyond the policy month in which the death occurred," rendering the Outlines meaningless. And even under Lincoln's interpretation, the balance of the planned premium must be refunded because it guarantees coverage for the following year due to the CPGR.

Alternatively, at least as interpreted by Lincoln, the Outlines contradict the plain language of the Statute and should therefore be disregarded. "[N]o deference is due to [any] agency interpretations at odds with the plain language of the statute itself." *Leonard F. v. Israel Disc. Bank of New York*, 199 F.3d 99, 106 (2d Cir. 1999). Here, under Lincoln's interpretation, the Outlines interpret the statute to call for a return of the *monthly deduction*, but the Statue calls for a refund of the *premiums* paid by the policyholder. Further, under Lincoln's interpretation, the Outlines insert a guaranteed coverage requirement that the Statute lacks.

Lincoln's attempt to square the Outlines with the Policy's reinstatement and grace period provisions undermines Lincoln's argument that only monthly deductions pay for insurance. Following termination, for reinstatement, the Policy requires a policyholder to "pay an amount . . . that is sufficient to keep this policy in force for at least (2) months," JA76, which cannot be reconciled with Lincoln's view that coverage is extended only *one* month at a time via the monthly deductions. If an insured passes away two weeks after "pay[ing] an amount that is sufficient to keep this policy in force for at least (2) months," then there would be "premium actually paid for [a] period beyond the end of the policy month in which such death occurred." N.Y. Ins. Law § 3203(a)(2).

As for the word "premium" in the Statute, Lincoln suggests that Plaintiff puts "all the statute's weight on the word 'premium.'" RB at 18. But this

argument is a red herring, particularly because the district court *agreed* with Plaintiff that his premium "was a 'premium'" under the Statute, and Lincoln does not challenge this conclusion. *See* JA333, Op. at 9; RB 15 n.2. Lincoln's cases are also inapposite; they concerned disagreements over whether contracts required alternative dispute resolution procedures. RB at 18.

V. The District Court Erred In Concluding that the 15% Load Charge Applied to the Annual Premium Somehow Does Not Pay for Insurance

The district court also independently erred by disregarding the 15% load charge (here, $8,081.66) that Lincoln imposes on all premium payments. Opening Br. at 28-30. The Policy expressly states that this load charge is "applied to **cover the company's cost of insurance and** other expenses." JA62. The district court effectively substituted the Policy's use of "and" with "or."

Lincoln does not deny that this load charge covers the company's cost of insurance. So Lincoln tries to divert attention away from this point by criticizing Plaintiff for "denigrat[ing]" the load charge." RB at 50. Plaintiff does no such thing. Plaintiff simply requests a refund of that portion of the load charge paid for the period beyond the policy month of the insured's death, as required by the Statute.

Lincoln next argues that the load charge does not "relate to any specific period [of coverage]." RB at 49. But surely the $8,081.66 charge taken from Plaintiff's annual premiums paid for *something*. And since the only thing that

Plaintiff ever received for this annual 15% payment following the insured's death was the insurance, it is plausible that this charge paid for . . . that insurance. At a minimum, discovery is necessary to determine which period the charge covered. The unexplained but supposedly "complicated tax consequences" that Lincoln references (RB at 50) do not suggest otherwise and cannot be proven on the pleadings alone. In the case that Lincoln cites, the court disregarded as "irrelevant" any tax consequences of the plaintiff's interpretation. *Buck v. Am. Gen. Life Ins. Co.*, 2018 WL 5669173, at *1 (D.N.J. Oct. 31, 2018).

Finally, Lincoln does not respond to Plaintiff's argument that premium payments were revenue to Lincoln and therefore paid for insurance. *See* Opening Br. at 27-28 (explaining that Lincoln admits to using premium payments to offset the death benefits paid to policyholders). This too raises a disputed issue of fact.

VI. Lincoln's Defense of the District Court's Parade of Horribles Is Misguided and Does Not Support Dismissal

While the district court claimed to identify "myriad issues" that would result from accepting Plaintiff's arguments, the court mentioned just two examples. The Opening Brief put those concerns to rest. Opening Br. at 30-34. Lincoln's attempt to revive them falls flat.

First, the district court wondered how to account for "an unplanned deposit into the Policy Account" (which is not alleged in this case). JA337, Op. at 13. Lincoln similarly suggests "there is no non-arbitrary way to assign any particular

or identifiable portion of a Planned Premium to any period of coverage." RB at 22. But the Opening Brief provided the easily determinable answer. Opening Br. at 31-32. For example, payment of half of the annual premium is payment for half a year.

Instead of responding to Plaintiff's argument, Lincoln asks different but just as answerable questions, such as how to deal with any accrued interest and how to account for money in the Policy Account prior to the annual premium payment. RB at 22. The answer is, again, simple: Lincoln gets to (and already does) keep any accrued interest and any cash in the Policy Account on top of the premium payment. Plaintiff merely seeks a prorated refund of the premium paid for the period beyond the end of the policy month after the insured's death.

Even if these strings of creative hypotheticals were not easily answerable (nor, at worst, properly the subject of discovery), their mere existence does not warrant dismissal. Addressing other potential facts that may or may not arise can be left for another day. *See, e.g., Ratha v. Phatthana Seafood Co., Ltd.*, 2022 WL 571015 (9th Cir. Feb. 25, 2022) ("These are perplexing questions. Their difficultly admonishes us to observe the wise limitations on our function and to confine ourselves to deciding only what is necessary to the disposition of the immediate case." (quoting *Whitehouse v. Ill. Cent. R.R. Co.*, 349 U.S. 366, 372–73 (1955)). Lincoln's own case explains that "[t]he fact . . . that terms of a policy of insurance

may be construed as ambiguous where applied to one set of facts does not make them ambiguous as to other facts which come directly within the purview of such terms." *Morgan Stanley Grp. Inc. v. New England Ins. Co.*, 225 F.3d 270, 276 (2d Cir. 2000) (citation omitted).

Second, the district court worried that crediting Plaintiff's interpretation of the refund requirement would "seemingly" allow insurance companies, under the Statute's grace period refund provision, to deduct an unpaid planned premium from policy proceeds. JA338, Op. at 14. But that misconstrues the statute. Section 3203(a)(1) sets forth a formula for the premium due in a universal life policy once the policy enters grace – a premium sufficient to "keep the policy in force for three months." Section 3203(a)(2), in turn, says that if someone dies during the grace period, the carrier can deduct the "portion" of the applicable "**unpaid** premium." Put together, the "unpaid premium" plainly refers to any "unpaid" grace premium due, not to unpaid planned premiums. For example, if the grace premium owed is $10,000 (which, by statute, is the premium sufficient to pay for 3 months of coverage), and the grace premium is not paid and the insured dies after 2 months, then the insurer would be permitted to deduct $6,666 from the death benefit payment (assuming the policy allows that), which is equal to the "unpaid" portion of the grace period. That fact does not somehow create a parade of horribles that the district court manufactured. This also confirms that the universal life *premiums*

owed to get a policy out of grace pays for 3 months of coverage, which Lincoln and the District Court says is impossible.

This *reductio ad absurdum* fails for another reason: it is undisputed that the insured in this case did not die during the grace period. And even if she had, the Policy already addresses precisely what happens: "If the Insured dies within the grace period, the amount needed to continue this policy to the end of the policy month of death will be deducted from the amount otherwise payable." JA76.

Lincoln's extended discussion of *Terry v. UNUM Life Insurance Co. of America*, 394 F.3d 108, 110 (2d Cir. 2005) misses the point of Plaintiff's argument. RB at 30-33. Plaintiff did not cite *Terry* to argue that the Legislature can never pass a law that is favorable to insurers. Rather, Plaintiff cited *Terry* to establish a proposition of law that Lincoln does not challenge; namely, that this grace period provision in the Statute cannot make the policyholder worse off than what is provided for in the Policy.

Lincoln also mischaracterizes Plaintiff's allegation about how another insurance company, Athene Life, complied with the Statute. Lincoln would like this Court to believe that Athene's payment of the premium refund was a "settlement," which is both patently false and appears nowhere in the Complaint. There was no settlement (and none alleged); rather, upon request, Athene easily complied with the Statute. JA9 Compl. ¶ 7. Plaintiff highlighted these facts to

refute Lincoln's argument that Plaintiff's interpretation of the Statute is "unprecedented." RB at 13.

Plaintiff also explained below that Lincoln's arguments about the Policy provisions at best "raises ambiguity" about the import of the planned premium, and the Athene Life example is relevant to this analysis. JA284. After all, a contract can be ambiguous "when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Int'l Multifoods Corp. v. Com. Union Ins. Co.*, 309 F.3d 76, 83 (2d Cir. 2002). And Plaintiff brought the Athene Life example to the district court's attention at every stage of the motion to dismiss (pre-motion letter, opposition brief, and hearing). JA25, JA287, JA364. There is no waiver.[5]

Finally, Lincoln agrees with Plaintiff that the district court was wrong to suggest that applying the Statute here would "invalidate Plaintiff's election" of the

[5] While beside the point, the "waiver" case that Lincoln cites is not even a waiver case. Response Br. at 51. *Singleton v. Wulff*, 428 U.S. 106, 108 (1976) concerned appellate jurisdiction, which is not disputed here. Lincoln's other cases are no better. *See L. Debenture Tr. Co. of New York v. Maverick Tube Corp.*, 595 F.3d 458, 466 (2d Cir. 2010) (rejecting party's attempt to substantiate its interpretation of the agreement by reference to "sentence fragments" quoted from another entity's SEC filings); *Greenfield v. Philles Recs., Inc.*, 98 N.Y.2d 562, 570 (2002) (applying "long-settled common-law contract rules [that] govern the interpretation of agreements between artists and their record producers").

Option 1 death benefit. RB at 43. That's because the prorated return of one premium payment is less than the Option II benefit (the specified benefit plus the entire Policy Account value). *See* JA77. Lincoln therefore makes a new argument—that providing the refund would "undermine the contractual election." RB at 43. This new argument overlooks the fact that the refund requirement is implied as a matter of law into every insurance contract by statute. Lincoln cannot escape requirements imposed by New York law because it claims to have ignored those statutory requirements in the first instance when developing the policies.

Plaintiff does not seek a windfall. Upon the insured's death, Lincoln was permitted to keep the entire cash value of the Policy; Plaintiff merely seeks a refund for the *pro rata* portion of the amount paid for the period beyond the policy month after the insured's death. The Statute, which applies to "all" insurance policies absent two exceptions inapplicable here, compels such an equitable and reasonable result.

CONCLUSION

This Court should reverse the district court's July 2, 2021 judgment dismissing the Complaint. Alternatively, this Court should vacate the judgment so that Plaintiff may be granted leave to file a first amended complaint.

Dated: March 2, 2022

/s/ Seth Ard

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CERTIFICATE OF COMPLIANCE

1. This brief complies with Local Rule 32.1(a)(4), including because this brief contains 6,935 words, excluding the parts of the document exempted by Fed. R. App. 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the typestyle requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word in Times New Roman 14-point font.

/s/ Seth Ard
Seth Ard

CERTIFICATE OF SERVICE

I hereby certify that on March 2, 2022, I caused the foregoing Reply Brief for Plaintiff-Appellant to be filed with the Clerk using the appellate CM/ECF system. All counsel of record are registered CM/ECF users, and service will be accomplished by the CM/ECF system.

/s/ Seth Ard