

BEFORE THE FACT

Most group disability policies include a provision that excludes coverage for illness or physical conditions that existed before the policy took effect. These pre-existing condition exclusions typically preclude coverage for disabilities that begin within 12 months of the coverage effective date if the disability is "caused by, contributed to by, or resulted from" a "pre-existing condition." Pre-existing condition is generally defined as a condition or any symptoms of such a condition for which the insured received medical treatment, consultation, care or services in the three months just prior to the effective date of coverage (the "look-back" period). However, exactly what constitutes a pre-existing condition can be difficult to define.

Not surprisingly, insurers argue that the pre-existing condition exclusion does not require that the condition be accurately diagnosed before the effective date of coverage. Rather, it is enough that an insured receives medical treatment for the symptoms of a condition not yet diagnosed that later proves to be disabling. The courts do not agree.

In *McLeod v. Hartford Life and Accident Ins. Company*, the Third Circuit addressed this issue and ruled that an insurer may not deny coverage under a pre-existing condition exclusion when treatment was for symptoms of an undiagnosed condition that no one even suspected was connected with the later-diagnosed disabling condition. After all, a doctor cannot provide treatment "for" a condition that he does not even know exists.

In *McLeod*, the insured had been receiving medical care for various ailments prior to the effective date of coverage, including a consultation with her physician for arm numbness on February 22, 1999, a date that fell within the look back period. *McLeod* became insured under the LTD policy on April 1, 1999 and it was not until August 1999 that she was diagnosed with multiple sclerosis (MS). *McLeod* continued working until January 2000, when she applied for disability benefits.

The insurer denied *McLeod's* application for LTD benefits on the ground that her disabling condition was a pre-existing condition for which benefits were not payable. Although the diagnosis of MS was not made until August 1999 – more than four months after her effective date of coverage – the insurer concluded that *McLeod* had "received medical care for manifestations, symptoms, findings or aggravations relating to or resulting from Multiple Sclerosis during the 90 day period prior to her insured effective date of April 1, 1999." *McLeod* sued the insurer, claiming that she had not received treatment for MS during the look-back period because the MS had not yet been diagnosed. The district court agreed with the insurer and *McLeod* appealed.

The Third Circuit reversed, holding that "despite language in the benefit plan aimed to cast a broad net as to what constitutes receiving medical care for a 'pre-existing condition,' *McLeod* did not receive treatment 'for' such a pre-existing condition prior to her effective date of coverage because neither she nor her physicians either knew or suspected that the symptoms she was experiencing were in any way connected with MS."

The court reasoned that the insurer could not "read back" a pre-existing condition for purposes of excluding coverage when the condition itself was not diagnosed in the look-back period, especially in a situation where other diagnoses were made as to the very symptoms that were now being attributed to the alleged

preexisting condition. Under the insurer's interpretation of the plan, "any symptom experienced before the excludable condition is diagnosed could serve as the basis for an exclusion so long as the symptom was later deemed consistent with that condition." If allowed, the pre-existing condition exclusion would become meaningless, as almost any medical treatment obtained during the look-back period might be tied to the subsequent diagnosis, regardless of whether there was a connection at the time of treatment.

As the court explained, it is hard to see how a doctor can provide treatment "for" a condition without knowing what that condition is or that it even exists. Moreover, the phrase "symptoms for which you received Medical Care" connotes an intent to treat or uncover the particular ailment that causes that symptom – even absent a timely diagnosis – rather than some nebulous or unspecified medical problem.

This decision is significant for insureds who may have been treated for a symptom of a chronic disease but had not yet been diagnosed with the disease at the time of treatment. Individuals with HIV/AIDS, diabetes and other conditions are among those who can cite this decision if denied disability benefits based on past treatment for a "symptom" of the disease before receiving a specific diagnosis.

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