CITATION: Co-Operators Insurance Company v. Bennett, 2024 ONSC 467
DIVISIONAL COURT FILE NO.: Court File No.: DC-23-00000079
DATE: 20240207

ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Stewart, Nieckarz, and Leiper JJ.

BETWEEN:	
CO-OPERATORS GENERAL INSURANCE COMPANY Appellant	*Jamie Pollack, Amanda Lennox, and Emily Schatzker*, for the Appellant
– and –	
HELEN L. BENNETT & LICENCE APPEAL TRIBUNAL Respondents	*Lawson Hennick*, for the Respondent, Helen Bennett *Douglas Lee and Gün Köleoğlu*, for the Licence Appeal Tribunal
	HEARD at Toronto by videoconference: December 18, 2023

LEIPER J.

INTRODUCTION

[1] The Co-operators General Insurance Company appealed from a decision of the Licence Appeal Tribunal ("LAT") which determined that the respondent, Helen Bennett was eligible for funding for an attendant care benefit assessment.

[2] The issue on appeal is whether the LAT erred in law in its interpretation of the *Statutory Accident Benefits Schedule* -- Effective September 1, 2010, O. Reg. 34/10 (the "SABS").

[3] The parties agree that the standard of review to this Court is available only for an error in law and is one of correctness: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at para. 37.

[4] I find that there was no error in law by the LAT, confirm its interpretation of the *SABS,* and dismiss the appeal. These are the reasons for this finding.

BACKGROUND

[5] Helen Bennett, the respondent, was involved in a motor vehicle accident on December 5, 2018.

[6] Ontario's Motor Vehicle Legislation is governed by the *Insurance Act*, R.S.O. 1990, c. I.8. Section 268(1) of the *Insurance Act* deems that every motor vehicle insurance liability policy provides for the statutory benefits provided in the *SABS.*

[7] The LAT is a specialized tribunal with exclusive jurisdiction to resolve disputes "in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled": *Insurance Act*, R.S.O. 1990, c. I.8, s. 280(3).

[8] Section 268.3 of the *Insurance Act* empowers the superintendent to issue guidelines on the interpretation and operation of the *SABS.*

[9] One such guideline issued by the superintendent is the Minor Injury Guideline (the "MIG"). The objectives of the MIG are to speed access to rehabilitation, improve utilization of healthcare resources, provide certainty around cost and payment for insurers, and be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the *SABS*. The MIG sets out the goods and services that will be paid for by the insurer without approval if provided to an insured person who has sustained a minor injury.

[10] In this case, the appellant determined that Ms. Bennett's injuries were minor. However, it removed her from the minor injury treatment regime provided for by the MIG because of compelling evidence that she had a documented pre-existing medical condition that would prevent her from achieving maximal recovery if she was subject to the limits on goods and services authorized by the MIG.

The Statutory Framework

[11] "Minor injury" and the "MIG" are defined terms in the *SABS*:

> "minor injury" means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury;
>
> "Minor Injury Guideline" means a guideline,

> (a) that is issued by the Chief Executive Officer under subsection 268.3 (1.1) of the Act and published in The Ontario Gazette, and
>
> (b) that establishes a treatment framework in respect of one or more minor injuries;

[12] Section 18(1) of the *SABS* under the *Insurance Act* limits recovery for accident victims who suffer minor injuries benefits to a cap of $3,500 as follows:

> **Monetary limits re medical and rehabilitation benefits**
>
> **18.** (1) The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500 plus the amount of any applicable harmonized sales tax payable under Part IX of the *Excise Tax Act (Canada)* for accidents that occur on or after June 3, 2019 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 18 (1); O. Reg. 123/19, s. 2 (1).

[13] An injured person like the respondent may be excluded from this limit or to the limits on good and services that are authorized under the MIG, by way of s. 18(2) of the *SABS* which reads:

> (2) Despite subsection (1), the limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the limit or is limited to the goods and services authorized under the Minor Injury Guideline. O. Reg. 34/10, s. 18 (2); O. Reg. 347/13, s. 1; O. Reg. 123/19, s. 2 (2).

[14] In the case of more serious injuries, higher caps apply. These are set out in s. 18(3). The caps also apply to medical, rehabilitation and "where applicable" to attendant care benefits, (including assessments) by virtue of s. 18(5) of the *SABS.*

[15] Section 38(3) of the *SABS*, which the LAT cited in its finding that the respondent was eligible for an attendant care assessment benefit, sets out a scheme for attendant care benefits and assessments for those benefits. By virtue of s. 38(3)(i)(B), assessment plan benefits are available to insured persons with "predominantly minor injuries" but who do not come within the MIG due to their pre-existing injuries. The provision reads as follows:

Claims for medical and rehabilitation benefits and for approval of assessments, etc.

38. (3) A treatment and assessment plan must,

(a) be signed by the insured person unless the insurer waives that requirement;

(b) be completed and signed by a regulated health professional; and

(c) include a statement by a health practitioner approving the treatment and assessment plan and stating that he or she is of the opinion that the goods, services, assessments and examinations described in the treatment and assessment plan and their proposed costs are reasonable and necessary for the insured person's treatment or rehabilitation and,

(i) stating, if the treatment and assessment plan is in respect of an accident that occurred on or after September 1, 2010,

(A) that the insured person's impairment is not predominantly a minor injury,
or

(B) that the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by the health practitioner, the insured person does not come within the Minor Injury Guideline because the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the limit or is limited to the goods and services authorized under the Minor Injury Guideline, or

(ii) stating, if the treatment and assessment plan is in respect of an accident that occurred before September 1, 2010, that the expenses contemplated by the treatment and assessment plan are reasonable and necessary for the insured person's treatment or rehabilitation. O. Reg. 34/10, s. 38 (3); O. Reg. 347/13, s. 4; O. Reg. 251/15, s. 13 (3); O. Reg. 123/19, s. 7.

(Emphasis added)

[16] Before the LAT, and on appeal, the appellant submits that the respondent was not entitled to benefits for an attendant care assessment because although she was removed from the MIG due to her pre-existing condition, she nevertheless only suffered minor injuries in her accident. As counsel put it, "either you have a minor injury, or you do not." The appellant argues that the

respondent was excluded from any attendant care assessment on a plain reading of ss. 14.2 and 25(2) of the *SABS*, and the MIG is irrelevant to the determination of the question.

[17] Section 14.2 reads:

> **Insurer liable to pay benefits**
>
> **14.** Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:
>
> 1. Medical and rehabilitation benefits under sections 15 to 17.
> 2. If the impairment is not a minor injury, attendant care benefits under section 19.
> O. Reg. 34/10, s. 14. (Emphasis added)

[18] Section 25(2) limits the entitlement found in s. 25(1) to in-home attendant care assessments in the following terms:

> **Cost of examinations**
>
> **25.** (1) The insurer shall pay the following expenses incurred by or on behalf of an insured person:
>
> 1. Reasonable fees charged for preparing a disability certificate if required under section 21, 36 or 37, including any assessment or examination necessary for that purpose.
>
> 2. Fees charged in accordance with the Minor Injury Guideline by a person authorized by the Guideline for preparing a treatment confirmation form and for conducting an assessment or examination and preparing a report as authorized by the Guideline.
>
> 3. Reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan under section 38, including any assessment or examination necessary for that purpose, if any one or more of the goods, services, assessments or examinations described in the treatment and assessment plan have been:
>
> i. approved by the insurer,
> ii. deemed by this Regulation to be payable by the insurer, or
> iii. determined to be payable by the insurer on the resolution of a dispute described in subsection 280 (1) of the Act.
>
> 4. Reasonable fees charged by an occupational therapist or a registered nurse for preparing an assessment of attendant care needs under section 42, including any

> assessment or examination necessary for that purpose.
>
> 5. Reasonable fees charged for preparing an application under section 45 for a determination of whether the insured person has sustained a catastrophic impairment, including any assessment or examination necessary for that purpose. O. Reg. 34/10, s. 25 (1); O. Reg. 44/16, s. 2.
>
> (2) Despite subsection (1), an insurer is not required to pay for an assessment or examination conducted in the insured person's home unless the insured person has sustained an impairment that is not a minor injury. O. Reg. 34/10, s. 25 (2). (Emphasis added)

[19] The appellant submits that because s. 25(2) does not refer to the MIG limits, but only to whether the person has "sustained an impairment that is not a minor injury", that this is a stand-alone constraint that prevents the respondent from being eligible for funding for an in-home assessment. The appellant submits that the phrase, an "impairment that is not a minor injury" is not the same as circumstances in which a person is subject to the MIG constraints. It argues that the LAT erred in law and conflated "minor injury" with the MIG. This is the same argument that was made before the LAT. I turn next to the LAT's decision and reasons on this point.

The LAT Decision

[20] In rejecting the appellant's submission, the LAT found that once a claimant is removed from the MIG, the claimant is no longer subject to the limits under the MIG for minor injury claimants, and the test for services becomes what is "reasonable and necessary" under s. 14(2). The LAT concluded that the insurer cannot "split the determination" and continue to categorize the injuries as "minor" once an injured person has been removed from the MIG.

[21] The LAT also found that s. 14(2) does not mention attendant care assessments, but merely excludes attendant care benefits for minor injuries such that, in any event, this subsection did not prevent the respondent from being eligible for an assessment.

[22] Finally, the LAT found that the use of the language in s. 25(2): "impairments that are not a minor injury" does not support a simultaneous finding that a person has sustained a minor injury while being placed beyond the treatment limits of the MIG.

[23] The LAT emphasized the treatment plan provisions in s. 38(3), extracted above:

> I find the wording of s. 38(3)(c)(1)B is clear. Where there is an initial determination by an insurer that an insured suffered predominantly minor injuries, but, as a result of pre-existing medical conditions, the person no longer remains in the MIG or under the funding limits of the MIG. Once the determination has been made that H.B. is removed from the MIG based on pre-existing conditions, there is no further MIG discussion regarding her injuries and impairments. She now has access to the

> next level tier of funding for medical and rehabilitation benefits and assessments that are reasonable and necessary. Further, her impairments are no longer considered predominantly minor.

[24] To summarize, the LAT's interpretation of the scheme is that a minor injury alone means the claimant is subject to the MIG, and the other constraints that flow from this categorization. However, once a claimant is put into the unusual category of having suffered a predominantly minor injury, alongside a documented pre-existing medical condition that will prevent maximal recovery, they are both not subject to the MIG, and cannot be said to have an impairment that is solely or considered "predominantly a minor injury." In other words, one must consider the entire description of their situation that includes a pre-existing medical condition and the expectation that the claimant is not expected to achieve maximal recovery if they are subject to the limits of the MIG.

[25] The appellant requested reconsideration on the basis the LAT had conflated the defined term "minor injury" with the MIG in interpreting the SABS as it applied to the respondent. The LAT rejected this submission and upheld the decision, finding that minor injuries are intertwined with the operation of the MIG framework. Once an insurer has removed a claimant from the MIG, whether it be because of "pre-existing injury, non-minor physical injuries or for psychological or chronic pain impairments (or any other such impairment not captured under the definition of a minor injury), there is no further reliance on any part of the MIG framework.

ANALYSIS

[26] I agree with the LAT's analysis because it accords with the principles of statutory interpretation by reading the words of the *SABS* in their ordinary and grammatical meaning, in harmony with the scheme and object of the *SABS*, and in accord with the intention of the legislature. The LAT rejected the respondent's piecemeal approach to interpretation, which would have separated minor injuries from the MIG constraints and applied this in a way to limit benefits payable to persons with a combination of pre-existing conditions, minor injuries from a motor vehicle accident and evidence that they could not achieve maximal recovery within the MIG constraints. This would lead to illogical results and treat those claimants as if they were still within the MIG, that is, as if they had "only" minor injuries. This illogical outcome is the result of focusing solely on the words in sections 14.2 and 25(2) of the *SABS* without regard to the other provisions dealing with the rehabilitation, treatment and assessment of persons found to have pre-existing conditions which would prevent maximal recovery by subjecting them to the MIG limits.

[27] The overall scheme of the *SABS* supports the LAT's finding that claimants with minor injuries and their placement within the framework for treatment of only minor injuries under the MIG are intertwined concepts. This interpretation is consistent with the objectives of the MIG and the scheme of this insurance legislation. Having minor injuries alone functions as a limit on those claimants, both by keeping them within the MIG and by limiting their entitlement to in-home assessments.

[28] The LAT's decision is consistent with its own jurisprudence, in which several claimants removed from the constraints of the MIG were found to be eligible for in-home assessments, because they were not merely suffering from a minor injury: See *17-006691 v. Unifund Assurance Company,* 2018 CanLII 112106 (ON LAT) at para. 53; *Polidori v. Motor Vehicle Accident Claims Fund* (MVACF), 2021 ONLAT 19009160/AABS at paras. 23-24; *17-002589 v. Wawanesa Mutual Insurance.,* 2018 CanLII 83505 (ON LAT) at paras. 31-36.

[29] Moreover, the LAT's interpretation is consistent with the consumer protection objective of insurance legislation: *Smith v. Co-operators General Insurance Co.* 2002 SCC 30 at para. 11.

Conclusion

[30] The appeal is dismissed. By agreement of the parties, no costs are ordered for or against the LAT, and the appellant will pay costs fixed in the amount of $1,000 all inclusive to the respondent.

Leiper J.

I agree

Stewart J.

I agree

Nieckarz J.

Date: February 7, 2024

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REASONS FOR DECISION

Leiper J.

Released: February 7, 2024