Case Name:

Wawanesa Mutual Insurance Co. v. Axa Insurance (Canada)

Between
The Wawanesa Mutual Insurance Company,
Plaintiff (Appellant), and
Axa Insurance (Canada), Respondent (Respondent)

[2012] O.J. No. 4196

2012 ONCA 592

Docket: C54858

Ontario Court of Appeal
Toronto, Ontario

K.M. Weiler, R.A. Blair and P.S. Rouleau JJ.A.

Heard: May 17, 2012.
Judgment: September 11, 2012.

(98 paras.)

*Insurance law -- Automobile insurance -- Accident benefits -- Medical expenses -- Medical examinations -- Compulsory government schemes -- Recovery by insurer -- Appeal by Wawanesa from dismissal of appeal from arbitrator's decision, which denied its claim for indemnity from **Axa** for insurer-generated medical assessments of **Wawanesa** insureds, dismissed -- **Axa** conceded that its insured was liable for accidents involving **Wawanesa** insureds -- Wawanesa paid statutory benefits to its insureds, but was denied indemnification of costs of assessments -- Such costs were not subject to indemnification -- Law had not changed, despite fact that assessments were now mandatory -- Assessments were responsibility of first party insurer -- Regulatory scheme encouraged insurers to share costs of assessments to properly pay claims and control losses.*

Appeal by Wawanesa from the dismissal of its appeal from an arbitrator's decision in a dispute with **Axa** over indemnification. **Wawanesa** insured the drivers injured in two accidents involving an **Axa**-insured driver of a heavy commercial truck. **Wawanesa** was responsible to pay statutory benefits to its insured drivers. Axa conceded its insured was 100 per cent at fault in both accidents. It agreed that the loss transfer provisions of the Insurance Act applied, which obliged **Axa** to indemnify **Wawanesa** for the statutory benefits paid to its insureds. Wawanesa claimed this indemnification extended to the cost of insurer-generated medical assessments. Axa refused to indemnify these

costs because they were not incurred in relation to a benefit paid to the insureds. The dispute proceeded to private arbitration. The arbitrator considered herself bound to a prior court decision and ordered that Wawanesa was not entitled to recover the cost of insurer-generated medical assessments. She therefore rejected what she considered a compelling argument by Wawanesa that such costs were recoverable because they were mandatory. Wawanesa, as first party insurer, was required to pay statutory benefits within a limited time or request a medical examination of the insured, making assessments a part of the comprehensive scheme of benefit entitlement. Wawanesa's appeal to the Superior Court was dismissed after the judge concluded that there was no real change in the nature and scope of the new insurer examinations such that the prior case law cited by the arbitrator no longer applied.

HELD: Appeal dismissed. The proper interpretation of the current regulatory regime did not provide for first party insurers in Wawanesa's position to recover the costs of insurer-generated medical assessments from second party insurers. The history of the regulatory amendments indicated the parties were to work together on loss control measures, but it was ultimately the responsibility of the first party insurer to ensure benefits were paid promptly and correctly. Minor changes to the Statutory Accident Benefits Schedule over the years since the case upon which the arbitrator relied was decided did not trump the Insurance Act, which had not changed. Regardless of whether or not assessments were mandatory prior to 2006, they were as a rule carried out by first party insurers to provide a basis to terminate or deny benefits without risking a finding of bad faith. The arbitrator's interpretation of s. 275(1) of the Insurance Act encouraged agreements between insurers respecting the cost of insurer-generated medical assessments. This would provide the benefit of properly-assessed and promptly-paid claims to insureds as well as insurers, in accord with the purpose of the legislation.

Statutes, Regulations and Rules Cited:

Arbitration Act, 1991, S.O. 1991, c. 17

Indian Act, R.S.C. 1970, c. I-6, s. 87

Insurance Act, R.S.O. 1990, c. I.8, s. 268, s. 275(1), s. 275(2), s. 275(3), s. 275(4)

Statutory Accident Benefits Schedule -- Accidents After December 31, 1993 and Before November 1, 1996, O Reg. 776/93, s. 57, s. 57(1)

Statutory Accident Benefits Schedule -- Accidents Before January 1, 1994, R.R.O. 1990, Reg. 672

Statutory Accident Benefits Schedule -- Accidents on or After November 1, 1996, O. Reg. 403/96, s. 42

Statutory Accident Benefits Schedule -- Effective September 1, 2010, O. Reg. 34/10

Appeal From:

On appeal from the judgment of Justice Susan E. Greer of the Superior Court of Justice, dated July 7, 2011, with reasons reported at (2011) 107 O.R. (3d) 395.

Counsel:

Kevin D.H. Mitchell and John Bradbury, for the appellant.

Linda Matthews and Laura Hodgins, for the respondent.

The following judgment was delivered by K.M. Weiler J.A. and P.S. Rouleau J.A. Separate dissenting reasons were delivered by R.A. Blair J.A.

K.M. WEILER J.A.:--

INTRODUCTION

1 The issue in this case is whether the expense of insurer generated medical assessments conducted to assess a claimant's entitlement to benefits under the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996,* O. Reg. 403/96 (the "1996 *SABS*"), is recoverable under s. 275(1) of the *Insurance Act,* R.S.O. 1990, c. I.8, as payments "in relation to such benefits paid". For the reasons that follow, I hold that insurer generated medical expenses are not subject to indemnification under s. 275(1) of the *Insurance Act* and I would dismiss the appeal.

2 Section 275(1) of the *Insurance Act* provides that:

> The insurer responsible under subsection 268(2) for the payment of statutory accident benefits to such classes of persons as may be named in the regulations is entitled, subject to such terms, conditions, provisions, exclusions and limits as may be prescribed, to indemnification *in relation to such benefits paid by it* from the insurers of such class or classes of automobiles as may be named in the regulations involved in the incident from which responsibility to pay the statutory accident benefits arose. [Emphasis added].

Thus, the insurer responsible for the payment of statutory accident benefits ("Statutory Benefits") is entitled to indemnification "in relation to such benefits paid by it" from the insurers of certain classes of automobiles, including heavy commercial trucks.

3 The indemnification in s. 275(1) is commonly referred to as the "loss transfer provision" because it creates a mechanism to transfer the first party insurer's loss (arising from the payment of Statutory Benefits) to the second party insurer. Indemnity is paid according to the respective degree of fault of each insurer's insured: s. 275(2). There is no indemnity for the first $2000 of Statutory Benefits paid: s. 275(3). Disputes between insurers are resolved through arbitration under the *Arbitration Act, 1991,* S.O. 1991, c. 17: s. 275(4).

4 As of March 1, 2006, when an insured person submits an application for any benefit to its insurer, the insurer is required to pay the benefit in full within a matter of days, or, under s. 42 of the 1996 *SABS,* have the insured assessed by "persons chosen by the insurer who are members of a health profession or are social workers or who have expertise in vocational rehabilitation". For ease of reference, I refer to these s. 42 examinations as insurer generated medical assessments.

5 Before I provide an overview of the facts leading to the appeal in this case and the decisions of Arbitrator Samworth and Greer J. of the Superior Court, it is necessary to provide some background on s. 275(1) of the *Insurance Act* and its relationship to insurer generated medical assessments.

BACKGROUND: Section 275(1) of the *Insurance Act*

(1) Part of Ontario's no-fault auto-insurance scheme

6 Section 275(1) of the *Insurance Act* came into existence in June, 1990 when the first threshold no-fault auto-insurance scheme was introduced in Ontario under the *Ontario Motorist Protection Plan* (OMPP). The *Statutory Accident Benefits Schedule*, a series of regulations and schedules under the *Insurance Act*, governs the provision of first party benefits to people injured as a result of the use or operation of a motor vehicle.[1],

7 As stated by this Court in *Meyer v. Bright* (1993), 15 O.R. (3d) 129, at para. 6, the amendments to the *Insurance Act* were enacted for the purpose of:

> ... significantly limiting the right of the victim of a motor vehicle accident to maintain a tort action against the tortfeasor. The scheme of compensation provides for an exchange of rights wherein *the accident victim loses the right to sue unless coming within the statutory exemptions, but receives more generous first party benefits, regardless of fault, from his or her own insurer.* The legislation appears designed to control the cost of automobile insurance premiums to the consumer by eliminating some tort claims. At the same time, *the legislation provides for enhanced benefits for income loss and medical and rehabilitation expenses to be paid to the accident victim regardless of fault*. [Emphasis added].

8 The *Meyer* court also expressed the opinion, at para. 9, that the legislation was essentially remedial. In the words of Jennings J. in *Guardian Insurance Company v. Jevco Insurance Company*, unreported decision, November 20, 2000, at p. 2, "this is remedial legislation, designed to get needed funds to an insured expeditiously and with a minimum of fuss".

9 From the insurers' perspective, the legislative changes to the *Insurance Act* meant that the costs of claims would largely be determined by the injuries to their own insured rather than being limited to their insured's degree of negligence. As a result, an insurer that predominantly provides insurance to, say, motorcyclists, faced greatly increased costs because their insured are highly vulnerable to suffering injuries. By contrast, the costs of an insurer that primarily insures heavy commercial trucks decreased because their insured are relatively less likely to suffer injury. See: *State Farm Automobile Insurance Company v. Markel Insurance Company of Canada*, unreported arbitration decision of Arbitrator Samis, February 4, 2011; Bulletin No. A-11/94, Property & Casualty - Auto, Loss Transfer: standardized forms and procedures, Ontario Insurance Commission, D. Blair Tully, Commissioner, June 6, 1994, at p. 2 (the "1994 Bulletin").

(2) The 1992 and 1994 Interpretation Bulletins

10 The former Ontario Insurance Commission (now the Financial Services Commission of Ontario), issued two interpretation bulletins after the loss transfer provision in s. 275(1) was first introduced in 1990. The first bulletin, issued July 7, 1992, states that "[t]he purpose of loss transfer is to balance the costs of no-fault benefits between different classes of vehicles": Bulletin No. A-9/92, Property & Casualty - Auto, Loss Transfer, Ontario Insurance Commission, Donald C. Scott, Commissioner, July 7, 1992, at p. 1 (the "1992 Bulletin").

11 Using a question and answer format, the 1992 Bulletin described the way that loss transfer should operate. One of the questions was: "Does the second-party insurer reimburse the first-party insurer for loss adjustment expenses and other claims-related expenses incurred by the first-party insurer?" The answer was: "No. Reimbursement is only made for the *actual benefit paid*." [Emphasis added].

12 The 1994 Bulletin was released following amendments to the SABS provision in s. 268 of the *Insurance Act*. The 1994 Bulletin introduced a "Notice of Loss Transfer" form and a "Request for Indemnification" form. It also used a question and answer format to describe how the indemnification process was supposed to work. The 1994 Bulletin contains the following question and answer, at p. 4:

> Which statutory accident benefits may be the subject of a loss transfer indemnification request?
>
> First party insurers are entitled to be reimbursed for all accident benefit payments made under the *Statutory Accident Benefits Schedule*, subject to the $2000 deductible discussed below. Now that the new *Schedule* is in effect, loss transfer is now available for the following kinds of benefits:
>
> * the cost of any assessment conducted under the *Schedule*;
> * the cost of services provided by a case manager related to the coordination of medical, rehabilitation and attendant care services; and
> * all expenses covered by the *Schedule*

13 The new Schedule referred to in the 1994 Bulletin was the *Statutory Accident Benefits Schedule - Accidents After December 31, 1993 and Before November 1, 1996*, O. Reg. 776/93. It first introduced s. 57(1) which reads as follows:

> The insurer shall pay for all reasonable expenses incurred by or on behalf of an insured person in obtaining and attending an examination or assessment for the purpose of this Regulation or in obtaining a certificate or report for the purpose of this Regulation, including,
>
> (a) fees charged by a person who conducts an examination or assessment or provides a certificate or report; and
> (b) transportation expenses incurred in attending an examination, including transportation expenses for an aide or attendant.

(3) Interpretation of s. 275(1) by Arbitrator Ayers and Mandel J. in *Jevco*

14 The change between the 1992 and 1994 Bulletins led to the issue of loss transfer in relation to insurer generated medical assessments being raised in *Jevco Insurance Company v. Prudential Insurance Compa* ny, unreported arbitration decision of Arbitrator Ayers, Q.C., January 23, 1995, aff'd (1995), 22 O.R. (3d) 779 (Ont. Gen. Div.), by Mandel J.

15 Jevco took the position that the words "in relation to" in s. 275(1) are broad enough to include insurer generated medical assessments. If the legislature intended to restrict indemnification to the *actual benefits paid* to or on behalf of the insured, it would have used the word "for" instead

of the phrase "in relation to". Jevco argued that an earlier arbitration decision (which relied heavily on the 1992 Bulletin in holding that s. 275(1) was not intended to include insurer generated medical assessments) ought to be revisited in light of the 1994 Bulletin.

16 Jevco argued that the new Schedule referred to in the 1994 Bulletin did not alter the basic no-fault benefits to which insureds were entitled under the predecessor legislation. Rather, the Ontario Insurance Commission simply changed its position with respect to whether the costs of first-party insurer generated medical assessments were recoverable from the second party insurer.

17 On the other hand, Prudential argued that the 1994 Bulletin only dealt with assessments conducted at Designated Assessment Centres (DACs) which were to be set up around the province. These were the assessments referred to in s. 57 of the "new Schedule". Unlike insurer generated medical assessments, DAC assessments were intended to be totally independent and for the benefit of the insured.

18 Arbitrator Ayers agreed with Prudential's position. He concluded, at p. 8, that:

> Unlike section 64(5)(a) [now s. 42 of the 1996 *SABS*] of the Schedule which contemplates an examination of the insured by a health practitioner of the insurer's choice, the [DAC] assessments contemplated by the Act are to be totally independent of both the insurer and the insured and, presumably, of benefit to both.

19 The arbitrator held that the insurer generated assessments that Jevco was seeking reimbursement for were part of the insurer's loss control efforts and "usually of little or no benefit to the insured." Accordingly, he dismissed Jevco's claim for indemnification.

20 On appeal, Mandel J. upheld the arbitrator's decision and dismissed Jevco's claim. Mandel J. observed that the insurer generated assessment is one in which the insured does not have a say. While insurers are to adopt a co-operative role in the medical treatment of their insured, such examinations are part of loss control efforts as opposed to benefits administration. Such loss control efforts were never intended by the legislature to be indemnified and transferred to the automobile insurer. These costs were not directed to the payment of no-fault benefits, but to limiting them.

21 Mandel J. acknowledged that the words "in relation to" in s. 275(1) may be very wide in scope. However, the apparent purpose of the provision was not to indemnify an insurer in the position of Jevco for insurer generated medical assessments. On *Jevco's* interpretation, an insurer would be entitled to the costs directly connected to the payment of Statutory Benefits, including overhead. Mandel J. determined that there was no connection between administration costs incurred for the purpose of limiting Statutory Benefits and the costs of Statutory Benefits paid.

22 Finally, Mandel J. also considered s. 275(3) of the *Insurance Act*. That section provides that there is to be no indemnification for the first $2,000 of no-fault benefits paid. He held that it would be absurd if Jevco paid out $1,000 in no-fault benefits and could not recover these costs but *could* claim indemnification for the entire cost of medical assessments. If the legislature had intended insurer generated medical assessment costs to be indemnified under s. 275(1) then the wording of s. 275(3) would so indicate. Mandel J.'s decision was not appealed.

(4) Indemnification of insurer generated medical assessments since *Jevco*

23 Following Mandel J.'s decision in *Jevco*, it appears that no court decisions have dealt with the issue of whether indemnification can be claimed for insurer generated medical assessments until

now. However, Between November 1, 1996 and March 1, 2006, the question of whether the first party insurer could claim indemnification for the expense of a medical assessment at a DAC was raised in several arbitrations with decisions going both ways. For example, *Liberty Mutual Insurance Company v. Zurich Insurance Company*, unreported arbitration award of Arbitrator Guy Jones, August 23, 2005 held that, unlike insurer generated medical assessments, medical assessments at a DAC were not purely loss control measures and were recoverable; on the other hand, *State Farm Mutual Automobile Insurance Company v. Ing Insurance Company*, unreported arbitration decision of Arbitrator Brown, February 16, 2005, held that DAC medical assessments came within the ratio of *Jevco* and were not recoverable.

24 The 1996 *SABS* retained the DAC features until a series of amendments that came into force on March 1, 2006. Following those amendments, DACs were abolished. Now when an insured submits an application for a benefit, the insurer is required, pursuant to s. 42 of the 1996 *SABS*, to either pay the benefit in full within a matter of days, or notify the insured person that the insurer requires the insured to be examined.

25 Having set out the history of s. 275(1) of the *Insurance Act* and its relationship to insurer generated medical assessments, I turn to the facts of this case.

OVERVIEW

(1) Facts

26 In this case the appellant, **Wawanesa** Mutual Insurance Company (**Wawanesa)**, and the respondent, **Axa** Insurance Company (Canada) (**Axa)**, are both automobile insurers. In two separate motor vehicle accidents, one occurring on October 6, 2005, and one occurring on August 21, 2006, a **Wawanesa** insured driver of a car was injured by an **Axa** insured driver of a heavy commercial truck. **Wawanesa** was responsible for paying Statutory Benefits to its insured drivers pursuant to the 1996 *SABS*.

27 Axa conceded that its insured was 100 per cent at fault in both accidents and agreed that the loss transfer provisions of the *Insurance Act* applied. Thus, **Axa** was required to indemnify **Wawanesa** for the Statutory Benefits it paid to its insured drivers. The issue that is the subject of this appeal concerns Wawanesa's claim for indemnification in relation to the cost of insurer generated medical assessments. Axa refused to indemnify these costs on the basis that they were not "in relation to a benefit" paid to the insured. Pursuant to s. 275(4) of the *Insurance Act*, the dispute proceeded to private arbitration.

(2) Arbitrator Samworth's Award

28 After reviewing the 1996 *SABS* in light of the 2006 amendments, Arbitrator Samworth summarized Wawanesa's argument that insurer generated medical assessments were no longer part of "expenses relating to loss control". Wawanesa took the position that, as a result of the 2006 amendments to the 1996 *SABS*, insurer generated medical assessments were now mandatory because the first party insurer was required to pay Statutory Benefits within a limited time or request a medical examination of the insured. Thus, the assessments are now part of a comprehensive scheme dealing with benefit entitlement. They became a different class of expense when the DAC assessment process was abolished and should be recoverable under s. 275(1) of the *Insurance Act*.

29 Arbitrator Samworth found Wawanesa's argument compelling and consistent with the 1994 Bulletin. However, she held that she was bound by the decision of Mandel J. in *Jevco* and ordered that Wawanesa was not entitled to recover the cost of insurer generated medical assessments despite the legislative changes to the 1996 *SABS* that took effect on March 1, 2006. She concluded that, "absent a concurrent change to Section 275 of the *Insurance Act*, which did not occur, I do not see any way around Justice Mandel's decision and I feel I remain bound by it." Thus, whether the costs of insurer generated medical assessments were mandatory or optional, they were not subject to indemnification.

(3) The decision of Justice Greer

30 Wawanesa appealed from Arbitrator Samworth's decision to Greer J. of the Superior Court of Justice. Wawanesa sought a declaration that insurer generated medical assessment expenses were recoverable under s. 275(1) as a result of the 2006 amendments to the 1996 *SABS*.

31 Justice Greer held that the issue before her was a question of law, and the standard of review was correctness. After summarizing Arbitrator Samworth's award and the positions of the parties, she dismissed the appeal. She held, at para. 23:

> I see no real change in the nature and scope of the new insurer examinations. Some change of wording in the Schedule is not, in my view, sufficient to make the substantial change in how the Act and *Schedules* and Bulletins are to be interpreted. *Jevco*, *supra*, is still good law and will remain so until the legislation is changed.

ANALYSIS

Standard of Review

32 The only issue before the court is the proper interpretation of s. 275(1) of the *Insurance Act*. In particular: whether the cost of insurer generated medical assessments are recoverable as payments made "in relation to" Statutory Benefits paid to an insured. As Greer J. observed, this issue raises a question of law and the standard of review is correctness. See *Dunsmuir v. New Brunswick*, 2008 SCC 9, [2008] 1 S.C.R. 190, at para. 50. Thus, this court must undertake its own analysis to determine whether the words "in relation to such benefits paid by it" in s. 275(1) of the *Insurance Act* provide for first party insurers to be indemnified for insurer generated medical assessments. I set out the proper approach to this analysis below.

The Purposive Approach to Statutory Interpretation

33 The Supreme Court of Canada has consistently endorsed Elmer Driedger's purposive approach to statutory interpretation: see *Bell ExpressVu Limited Partnership v. Rex*, 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 26; *Canada 3000 Inc. Re; Inter-Canadian (1991) Inc. (Trustee of)*, 2006 S.C.C. 24, [2006] 1 S.C.R. 865, at para. 36. As Driedger explains, at p. 87 of his *Construction of Statutes*, 2d ed., (Toronto: Butterworths,1983):

> [T]he words of an Act are to read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

34 The purposive approach to statutory interpretation requires the court to take the following three steps: (1) it must examine the words of the provision in their ordinary and grammatical sense; (2) it must consider the entire context that the provision is located within (*Bell Expressview*, at para. 27); and (3) it must consider whether the proposed interpretation produces a just and reasonable result (*Bapoo v. Co-operators General Insurance Co.*, (1997) 36 O.R. (3d) 616 (C.A.), at para. 8).

35 The factors comprising the "entire context" include the history of the provision at issue, its place in the overall scheme of the Act, the object of the Act itself, and the legislature's intent in enacting the Act as a whole and the particular provision at issue: Pierre-Andre Cote, *The Interpretation of Legislation in Canada*, 3d. ed., (Scarborough: Thomson Canada Limited, 2000) at p. 387. A just and reasonable result promotes applications of the Act that advance its purpose and avoids applications that are foolish and pointless (Ruth Sullivan, *On the Construction of Statutes*, 5th ed., (Canada: LexisNexis, 2008), at p. 299).

36 I turn now to the application of the purposive approach to determine the proper interpretation of s. 275(1) of the *Insurance Act*.

(1) The ordinary and grammatical meaning of the words

37 For ease of reference s. 275(1) is again reproduced below:

> The insurer responsible under subsection 268(2) for the payment of statutory accident benefits to such classes of persons as may be named in the regulations is entitled, subject to such terms, conditions, provisions, exclusions and limits as may be prescribed, to indemnification in relation to such benefits paid by it from the insurers of such class or classes of automobiles as may be named in the regulations involved in the incident from which the responsibility to pay the statutory accident benefits arose.

38 As I have explained, s. 275(1) entitles the insurer responsible for the payment of SABS "to indemnification in relation to such benefits paid by it" from the insurers of certain classes of automobiles whose insured are responsible for the accident.

39 Here, Wawanesa, the insurer responsible for the payment of SABS, argues that s. 275(1) cannot be limited to the payment of Statutory Benefits alone. If this was what the legislature intended, it could simply have said that the first party insurer is entitled to indemnification "of" such benefits paid. Instead the legislature used the phrase "in relation to" such benefits paid.

40 I agree that the phrase "in relation to" would be superfluous if it only encompassed indemnification for the actual Statutory Benefits paid. For that reason, Axa does not dispute that the amount the insured pays for a medical assessment in support of his or her claim to establish entitlement to Statutory Benefits is, by virtue of s. 57 of O. Reg. 776/93, "in relation to such benefits paid". In addition, the transportation expenses paid by the insured to attend a s. 57 assessment, including transportation expenses for an attendant to go with the claimant, are "in relation to" Statutory Benefits and subject to indemnification.

41 Wawanesa relies on *Nowegijick v. R.*, [1983] 1 S.C.R. 29, at p. 39, in support of its argument that the words "in relation to" are words of "the widest possible scope". Thus, insurer generated medical assessments ought to be in the same position as medical assessments in support of an insureds' claim to establish entitlement to Statutory Benefits under s. 57.

42 I have difficulty with this argument for two reasons: (1) *Nowegijick* involved the interpretation of a statutory income tax provision respecting the Crown and Aboriginal people. That context is unique and no meaningful analogy can be drawn to the context that s. 275(1) of the *Insurance Act* is situated within; (2) the phrase "in relation to" conveys a connection between two related subjects. In my view, Statutory Benefits paid to an insured, and the cost of an insurer generated medical assessment, are not connected in the manner the appellant suggests. I explain each of these concerns in turn.

43 In *Nowegijick*, Dickson J. (as he then was) interpreted the phrase "in respect of such property" as it was used in s. 87 of the *Indian Act*, R.S.C. 1970, c. I-6. Dickson J. rejected the interpretation provided in a Revenue Canada Bulletin and held that the wages of an Indian, earned off the reserve, were personal property and exempt from income tax. In so holding, he explained, at p. 36, that:

> [T]reaties and statutes relating to Indians should be liberally construed and doubtful expressions resolved in favour of the Indians. If the statute contains language which can reasonably be construed to confer tax exemption that construction, in my view, is to be favoured over a more technical construction which might be available to deny exemption.

44 The Supreme Court of Canada has underscored the importance of the *sui generis* fiduciary obligation owed by the federal Crown to First Nations with respect to dealings involving First Nations' lands and property: *Wewaykum Indian Band v. Canada*, 2002 SCC 79, [2002] 4 S.C.R. 245, at paras. 72 to 85. The presumption that ambiguities in statutes relating to Indians should be resolved in favour of Indians arises as a function of that unique relationship.

45 **Wawanesa** and **Axa** are not in a fiduciary relationship towards one another. They may owe each other a duty of good faith, but that does not create a presumption in favour of the insurer responsible for the payment of SABS. Rather, any dispute respecting indemnification and loss transfer is to be resolved by private arbitration before a neutral third party. The insurance context is distinct from the Aboriginal context and the broad construction of the words "in respect of" in *Nowegijick* cannot necessarily be imputed to the words "in relation to" at issue in this case.

46 My second concern relates to the "connection" between SABS paid and insurer generated medical assessments. After setting out the unique context in which s. 87 of the *Indian Act* is interpreted, Dickson J. held, at p. 39 that:

> The words "in respect of" are, in my opinion, words of the widest possible scope. They import such meanings as "in relation to", "with reference to" or "in connection with". The phrase "in respect of" is probably the widest of any expression *intended to convey some connection between two related subject matters*. [Emphasis added].

47 Dickson J.'s reasoning indicates that, like the words "in respect of", the words "in relation to" are intended to convey some connection between two related subject matters. In this case that connection must be between the Statutory Benefits paid and the cost of the insurer generated medical assessment. Wawanesa argues that these two subjects are connected because an insurer generated medical assessment is used to determine if Statutory Benefits are paid to an insured. I do not think the analysis can stop there.

48 In this case the "connection" only exists if Statutory Benefits are actually paid. If Wawanesa denies Statutory Benefits to its insured as a result of an insurer generated medical assessment, it cannot seek indemnification from Axa for the cost of the assessment. This is true even though **Wawanesa** may have saved **Axa** a great deal of money. The legislature could not have intended that if the insurer generated medical assessment saves all of the Statutory Benefits from being paid unnecessarily, there is no indemnification for the cost of the assessment, *but* if the insurer generated medical assessment only saves some Statutory Benefits from being paid unnecessarily, there is full indemnification for the cost of the assessment. The supposed "connection" leads to an anomalous result.

49 Furthermore, the "connection" should be between insurer generated medical assessments and the Statutory Benefits paid by the first party insurer to the named classes of persons, *its insured*. The cost of an insurer generated medical assessment is not paid to the insured. Rather, it is paid to the doctor who conducted the examination on behalf of the first party insurer. Again, I find that the "connection" analogy does not fit with the plain wording of s. 275(1).

50 In conclusion, I agree that the ordinary meaning of the words "in relation to" in s. 275(1) encompasses more than the Statutory Benefits paid by an insurer to its insured. However, I am not satisfied that those words are necessarily broad enough in scope to include insurer generated medical assessments. Before I reach a final conclusion on this point I must consider the entire context in which the words of s. 275(1) are situated.

(2) Consideration of the entire context

51 I set out much of the relevant context to be considered in the discussion of the background of s. 275(1) at the outset of my reasons. However, some further discussion is necessary.

The 1992 and 1994 Interpretation Bulletins

52 In this case the entire context includes the *Insurance Act* as well as the subordinate regulations and schedules. The purpose of s. 275(1) is an integral part of that context. Thus, regard must be had to the 1992 and 1994 Bulletins which were issued by the body responsible for administering the *Insurance Act* and its regulations, and for advising the Minister of Finance. The Supreme Court of Canada took an analogous approach to resolving doubt about the meaning of a tax provision in *Placer Dome Canada Ltd. v. Ontario (Minister of Finance)*, 2006 S.C.C. 20., [2006] 1 S.C.R. 715, Lebel J. (writing on behalf of the court) observed, at para. 10, that "the administrative practice and interpretation adopted by the Minister, while not determinative, are important factors to be weighed".

53 Wawanesa submits that the proposed interpretation of s. 275(1) is supported by the 1994 Bulletin. That Bulletin was intended to provide insurers with a clear understanding of how loss transfer works. It stated, at p. 4, that "loss transfer is now available for [...] the cost of any assessment conducted under the *Schedule*".

54 I am not persuaded by this aspect of Wawanesa's argument for three reasons. Firstly, there are two bulletins that must be considered. The 1992 Bulletin states that the second-party insurer does not reimburse the first-party insurer for loss adjustment expenses and other claims-related expenses incurred by the first-party insurer. Reimbursement is only made for the actual benefits paid. If there was a shift in the Insurance Commissioner's interpretation of s. 275(1) between 1992 and 1994, it may be reflective of ambiguity in the statute itself and, as held in *Placer Dome*, at para 40,

"cannot be relied upon as an interpretive tool except to support the view that the statutory definition falls short of being clear, precise and unambiguous."

55 Unlike *Placer Dome*, this is not a situation where the Commissioner decided that its interpretation in 1992 was incorrect. Nor did it result in a change in administrative practice between insurers. Despite the 1994 Bulletin, the cost of insurer generated medical assessments has not been subject to indemnification when Statutory Benefits are paid, nor has it been subject to any court challenge since *Jevco*, until now.

56 Secondly, closer examination of the wording of the 1994 Bulletin does not lead to the construction Wawanesa wishes to place on it. There is an old saying that "he who pays the piper calls the tune." On Wawanesa's interpretation of s. 275(1), that means the second party insurer who indemnifies the first party insurer ought to be able to request an insurer generated medical assessment for the purpose of determining whether an insured is entitled to continue receiving Statutory Benefits. However, the 1994 Bulletin does not contemplate this scenario.

57 The 1994 Bulletin provides that the second party insurer should be entitled to receive: (1) a summary of Statutory Benefits paid in respect of a request for indemnification; and (2) basic information about the condition of the person receiving accident benefits. It was not anticipated that the second party insurer would be entitled to receive "detailed medical and other personal information about the insured person".

58 Further, the 1994 Bulletin makes it clear that the second party insurer is not entitled to "dispute the accident benefits payments made by the first party insurer to its insured". Rather, the second party insurer can only dispute the reasonableness of a payment and its obligation to reimburse the first party insurer for that payment. Most significantly, the 1994 Bulletin contemplates first and second party insurers taking a co-operative approach to determining when an insurer generated medical assessment is necessary. It states:

> A second party insurer may be more willing to pay requests for indemnification if it is certain that the first party insurer is employing loss control measures. *Second party insurers are not prohibited from reaching agreements with first party insurers on loss control measures and reimbursement for the cost of employing these measures.* However, it is the responsibility of the first party insurer to ensure that benefits are paid correctly and promptly. The second party insurer should not be in a position to dictate claims handling decisions in respect of a claim where loss transfer applies. [Emphasis added.]

59 If the 1994 Bulletin contemplated that insurer generated medical expenses would automatically be subject to indemnity, there would be no need to say that first party insurers and second party insurers are permitted to enter into agreements for the cost of "loss control measures".

60 The third reason that I reject Wawanesa's argument respecting the 1994 Bulletin is that I understand the 1994 Bulletin to relate indemnification for the cost of "any assessment" to the "new Schedule now in effect". The 1994 Bulletin prefaced the statement that the cost of any assessment is subject to indemnification by saying "[n]ow that the *new* Schedule is in effect, loss transfer is now available for the following kinds of benefits". Insurer generated medical assessments existed prior to the new Schedule. However, the new Schedule introduced s. 57 of O. Reg. 776/93 for the first time. As I have explained, that provision requires the insurer to pay for expenses incurred by the

insured in attending a medical assessment to determine his or her entitlement to Statutory Benefits, as well as transportation expenses incurred in attending the assessment.

61 For these reasons, I am satisfied that the existing interpretation of the regulatory regime, which disallows indemnification for insurer generated medical assessments, is in accordance with the directions of the insurance industry's regulator as contained in the 1992 and 1994 Bulletins.

The 2006 amendments to the 1996 SABS

62 Wawanesa submits that each time the loss transfer regulatory scheme is changed the interpretation of s. 275(1) of the *Insurance Act* ought to be re-examined. Prior to 2006, insurer generated medical assessments were considered a loss control mechanism. Wawanesa asserts that with the abolition of DACs in 2006 and other changes to the 1996 *SABS*, insurer generated medical assessments "became a mandatory component of benefit administration rather than an optional loss control mechanism". This constitutes a substantial change.

63 I would dismiss this submission because it is inconsistent with two principles of statutory interpretation. First, regulations and schedules are subordinate to the statute. If there is any conflict between them, the statute prevails: *Belanger v. The King* (1916), 54 S.C.R. 265. Thus, a change to the *SABS* regulatory scheme set up under the *Insurance Act* does not necessarily require a re-interpretation of the loss transfer provisions in the Act.

64 Second, where two reasonable interpretations of a statute are available and one of these would result in a substantial change to the law, the court will prefer the interpretation that does not alter the law: *Dreidger*, at p. 143 . I am not satisfied that the 2006 amendments to the 1996 *SABS* constituted a substantial change to the law, thus the existing interpretation of s. 275(1) should not change. I would adopt Axa's argument that insurer generated examinations may not have been explicitly mandatory prior to the 2006 amendments. However, in practice, a first party insurer could not terminate or deny Statutory Benefits without a medical opinion suggesting that the insured was no longer entitled to such benefits. Despite the absence of mandatory language in the regulations and schedules prior to 2006, insurers who terminated benefits without a medical assessment faced the risk of being held to have acted in bad faith.

65 For these reasons, I am not satisfied that the interpretation of s. 275(1) with respect to first party insurer generated medical examinations ought to change as a result of the 2006 amendments to the 1996 *SABS*.

(3) The existing interpretation of s. 275(1) leads to a just and reasonable result

66 Wawanesa argues that the object of s. 275(1) is to shift the cost of paying benefits from the first party insurer to the second party insurer. Thus, an interpretation that allows the cost of insurer generated medical assessments to be indemnified furthers the object of the statute and produces a just and reasonable result. In addition, the only parties directly affected by such an interpretation are the insurers.

67 I disagree. Wawanesa's argument ignores the remedial aspect of the legislation mentioned earlier at para 8, namely to put Statutory Benefits into the hands of an insured person as soon as possible. For this reason the legislation allows the cost of an insured's medical assessment to be indemnified pursuant to s. 57 of O. Reg. 776/93.

68 Contrary to the remedial aspect of the no-fault legislative scheme, the payment of Statutory Benefits is likely to be delayed if first party insurers are automatically indemnified for the cost of

insurer generated medical assessments. In these circumstances, first party insurers would be more likely to seek a medical assessment of the insured, even in situations where it would not currently be considered necessary. With the abolition of DACs in 2006, a tool that was used to achieve a more co-operative approach to the management of the care of an insured was removed from the no-fault auto-insurance scheme. It would not be just or reasonable to interpret s. 275(1) in a manner that further diminishes the likelihood of an expeditious payment of Statutory Benefits to an injured insured.

69 By contrast, the current interpretation of s. 275(1) encourages agreements between first and second party insurers respecting the cost of insurer generated medical assessments. **Wawanesa** could face a challenge from **Axa** if it did not act reasonably and simply paid Statutory Benefits without exercising its right to an insurer generated medical assessment in appropriate cases. Wawanesa incurs the risk that it will not be indemnified for Statutory Benefits at all if it does not require an insurer generated medical assessment where appropriate. Thus, there is an incentive for **Wawanesa** to enter co-operative agreements with **Axa** to share the cost of insurer generated medical assessments and ensure that Satutory Benefits are paid appropriately. This accords with the text of the 1994 Bulletin and results in a real benefit to both insurers. I am satisfied that this result is both just and reasonable.

CONCLUSION

70 For the reasons I have given I would dismiss the appeal. Section 275(1) of the *Insurance Act* does not entitle first party insurers to indemnification for the cost of insurer generated medical assessments. The interpretation urged by Wawanesa does not accord with the ordinary wording of the provision, its history and context, or the rules of statutory interpretation. When the purpose of the *Insurance Act* as a whole is considered, the current interpretation of s. 275(1) produces a result that is both just and reasonable. I agree with Greer J. that an amendment to s. 275(1) of the *Insurance Act* is necessary if the cost of insurer generated medical assessments is to be indemnified by a second party insurer.

71 I would award the costs of the appeal to Axa and fix those costs at $10,000 on a partial indemnity basis inclusive of disbursements and all applicable taxes.

K.M. WEILER J.A.
P.S. ROULEAU J.A.:-- I agree.

R.A. BLAIR J.A. (dissenting):--

Overview

72 I have had the opportunity of reading the draft reasons of my colleague, Justice Weiler. Respectfully, I take a different view of the appeal.

73 My colleague has very carefully outlined the history and contours of Ontario's insurance scheme for the payment of statutory benefits to persons injured in automobile accidents, and for the sharing of the costs of those benefits as amongst insurers through what is called the "loss transfer provision" contained in s. 275(1) of the *Insurance Act*, R.S.O. 1990, c. I.8. I need not repaint that picture here.

74 For convenience, though, I set out the provisions of s. 275(1):

> The insurer responsible under subsection 268 (2) for the payment of statutory accident benefits to such classes of persons as may be named in the regulations is entitled, subject to such terms, conditions, provisions, exclusions and limits as may be prescribed, to *indemnification in relation to such benefits paid by it* from the insurers of such class or classes of automobiles as may be named in the regulations involved in the incident from which responsibility to pay the statutory accident benefits arose. [Emphasis added.]

75 The appeal raises one issue only: whether the disbursement incurred by a first insurer for a medical assessment conducted to gauge whether a claimant is entitled to benefits under the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996,* O. Reg. 403/96 (the "1996 *SABS*"), is a payment made by that insurer "in relation to" the benefits paid to the claimant, when those benefits are paid. If it is such a payment, the insurer is entitled to be indemnified for that payment under s. 275(1).

76 In my view it is. I would allow the appeal for the following brief reasons.

Analysis

77 I accept the purposive and contextual approach to statutory interpretation and the principles to be applied in conducting that exercise, as set out by my colleague. They are well-established by *Bell ExpressVu Limited Partnership v. Rex,* 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 26, and the related jurisprudence. In my view, however, the interpretation that I place on the words "in relation to" in this context is faithful to the modern approach.

78 The words "in relation to" (coupled with the words "in respect of") have been held by the Supreme Court of Canada to be "words of the widest possible scope ... *probably the widest of any expression* intended to convey some connection between two related subject matters" (emphasis added): *Nowegijick v. R.*, [1983] 1 S.C.R. 29, at p. 39, per Dickson J. Respectfully, I do not accept, as my colleague suggests, that Dickson J. meant to limit his words only to the context of an aboriginal dispute over the payment of income tax. There is nothing in the context of his discussion of the issues in *Nowegijick* to suggest that was his intention.

79 Nor do I accept that there is no connection between a disbursement that the first insurer must now incur before it can deny payment of statutory benefits where entitlement may be in doubt - and, therefore, if the assessment favours the claimant, before it can decide to pay - and the benefits ultimately paid. Clearly, there is. The benefits would not have been paid without the assessment and the assessment would not have been made had the first insurer not paid for it. To say that there is no connection between the expense of the assessment and the payment of the benefits based on the assessment is to take a very narrow view of the words "in relation to". It is simply not consistent with according them "the widest possible scope" of meaning as called for in *Nowegijick*.

80 My colleague's approach follows that of Mandel J. in *Jevco Insurance Company v. Prudential Insurance Company* (1995), 22 O.R. (3d) 779 (Ont. Gen. Div.). That decision was not appealed and appears to have governed the practice in the loss transfer payment area in the intervening years. In it, Justice Mandel held that the cost of insurer generated medical assessments was not a benefit under the SABS Schedule but, rather, was part of the first insurer's "loss control efforts" and administrative expenses and, therefore, not recoverable under s. 275(1). There has been some controversy in the arbitration community over this result, but in the end, arbitrators have concluded that they were bound by the decision in *Jevco*.

81 In this case, for example, as my colleague notes, Arbitrator Samworth found the appellant Wawanesa's argument that insurer generated medical assessments should be the subject of indemnification under s. 275(1) compelling. Wawanesa's contention was that such medical examinations are now in effect mandatory because, since the 2006 amendments to the 1996 SABS, the first insurer is required either to pay the statutory benefits within a limited period of time, or to request a medical examination of the insured to enable it to assess the claim. The payment for the assessment is therefore part of a comprehensive scheme dealing with benefit entitlements rather than part of the first insurer's loss control measures. Arbitrator Samworth concluded, however, that she was bound by the decision in *Jevco* and dismissed the appellant Axa's claim.

82 Respectfully, in my view, *Jevco* was wrongly decided.

83 Much of the analysis of Mandel J. in *Jevco* turned on his view that "[t]he apparent purpose of the legislation is the indemnification of *benefits actually paid* and not administration costs" (at p. 783) (emphasis added). The view that the legislation encompasses indemnification only for *benefits actually paid* is simply incorrect, based on the clear language of s. 275(1). Had the legislature intended the loss transfer provisions to embrace only benefits actually paid, the section would provide for "indemnification *for* such benefits" and not for indemnification "*in relation to*" such benefits paid. Indeed, my colleague accepts that the wording of s. 275(1) encompasses more than the actual statutory benefits paid. What is "more" is a function of the scope of the phrase "in relation to such benefits paid by it", and on this appeal concerns only whether it is wide enough to include the cost of insurer generated medical assessments. I am satisfied that it does.

84 Several concerns appear to underlie the view that s. 275(1) encompasses only indemnification for actual statutory benefits paid.

85 First is the opinion expressed by Mandel J. and by my colleague that the disbursement incurred for an insurer generated medical assessment is a component of that insurer's "administrative costs" and part of its "loss control efforts", and therefore not something that is related to the payment of no-fault statutory benefits. While I agree that the legislature did not intend that the first insurer be reimbursed for its general overhead and administrative costs, I do not think it follows that characterizing the cost of insurer generated medical assessments in this fashion necessarily leads to the conclusion that the disbursement is not made "in relation to [the statutory] benefits paid by it".

86 A thing or concept may stand "in relation to" more than one thing or concept. As a simple example, the spokes on a wheel are situated "in relation to" the hub of the wheel, but they are also situated "in relation to" the rim. Here, the issue is not whether the disbursement for the insurer generated assessment is a payment made "in relation to" the first insurer's loss control efforts, or even to its administrative costs in a broad sense. The issue is whether the payment is made "in relation to" the statutory benefits paid. One does not preclude the other, in my view.

87 Second is the view that permitting the first insurer to be indemnified under s. 275(1) for the expense of an insurer generated medical assessment would contravene the purpose of the loss transfer provisions by shifting a broad range of "administrative costs" to the second insurer. To the extent that such a disbursement may form part of the first insurer's administrative costs, in a broad sense, it remains a discrete, specific expense related to the particular claim at issue and therefore falls within the parameters of the indemnification provided by s. 275(1), in my view. I do not think there is a bright line between "administrative costs" and "[statutory] benefits paid."

88 Third is the suggestion underlying the reasons in *Jevco* and those of my colleague that indemnification of the first insurer under s. 275(1) is limited to payments that are made by or on behalf of the insured and cannot encompass payments made by the first insurer, in effect on its own behalf, to satisfy itself that the benefits ought to be paid. If that view were correct, however, the legislature would have used the words "indemnification in relation to such statutory benefits paid *to or on behalf of the insured*." It did not.

89 In terms of a payment made "in relation to" a statutory benefit paid, I see no difference in principle between the cost of an *insurer* generated medical assessment, the cost of an *insured* generated medical assessment, and the cost of a mandatory DAC assessment under the former regime. It is accepted that the first insured is entitled to indemnification for the latter two. Yet all are equally obtained for the purpose of assessing whether the insured is, or is not, entitled to the statutory benefits claimed and the extent of those benefits.

90 There is no doubt that the no-fault regime enacted under the *Insurance Act* constitutes "remedial legislation, designed to get needed funds to an insured expeditiously and with a minimum of fuss", as Jennings J. so succinctly put it in *Guardian Insurance Company v. Jevco Insurance Company*, (20 November 2000), 00-CV-197938, at p.2. The issue raised on this appeal does not truly evoke the remedial nature of the legislation, however. It brings into play a contest between two insurers as to how the loss provisions are to be shared. The purpose of those provisions is simply to spread the cost of the payment of no-fault benefits between the insurers of different classes of vehicles in a more even-handed manner, and to do so in a way that does not interfere with the expeditious payment of statutory benefits to the injured insured. I am satisfied that indemnifying the first insurer for the cost of an insurer generated medical assessment is completely consistent with the purpose of the loss transfer scheme.

91 Much was made in argument over the differences between the 1992 and 1994 Interpretation Bulletins issued by the Ontario Insurance Commission regarding the loss transfer provision in s. 275(1). I do not think they are particularly helpful in deciding the correct interpretation of the words "in relation to" in that provision, however.

92 In the 1992 Bulletin, the Commission stated that reimbursement was to be made only "for the actual [statutory] benefits paid": Ontario Insurance Commission, *Property & Casualty - Auto, Loss Transfer*, Bulletin No. A-9/92 (6 July 1992) at p. 2 (Commissioner: Donald C. Scott). This interpretation is simply wrong for the reasons I have articulated. Whatever ambiguity there may be in the words "in relation to", it is perfectly clear that they do not confine the indemnification only to "the actual benefits paid." Otherwise the legislature would have used the word "for" rather than the phrase "in relation to." As noted above, my colleague recognizes this.

93 In the 1994 Bulletin - after certain amendments had been made to the SABS regime - the Commission stated that loss transfer was now available, amongst other things, for "the cost of *any* assessment conducted under the Schedule" (emphasis added), presumably including an insurer generated medical assessment: Ontario Insurance Commission, *Property & Casualty - Auto, Loss Transfer*, Bulletin No. A-11/94 (6 June 1994) at p. 4 (Commissioner: D. Blair Tully) (the "1994 Bulletin"). The wording of s. 275(1) had not changed, however.

94 While I agree that the administrative practice and interpretation adopted by a responsible agency may be factors for consideration in interpreting legislative provisions - see *Placer Dome Canada Ltd. v. Ontario (Minister of Finance)*, 2006 SCC 20, [2006] 1 S.C.R. 715, at para. 10 - I do

not see how they can be of much assistance when the agency has taken completely opposite interpretations of the same wording in the legislation on different occasions.

95 Finally, I do not think that the "new Schedule" referred to in the 1994 Bulletin is determinative of the issue here. In my opinion - while it may have reinforced the mistaken view that indemnification was intended only for payments made by or on behalf of the insured - the new Schedule has little bearing on whether the indemnification provision in s. 275(1) of the *Insurance Act* encompasses the payment of insurer generated medical assessments.

96 Section 57(1) of the new Schedule rearticulated the first insurer's obligation to reimburse its insured by providing that the insurer "pay all reasonable expenses *incurred by or on behalf of an insured person* in obtaining and attending an examination ... including, (a) fees charged by a person who conducts an examination or assessment or provides a certificate or report" (emphasis added). Section 57(1) provides for obligations as between the first insurer and its insured, however; it does not address whether a medical assessment generated by the first insurer, essentially on its own behalf, for the purpose of determining whether to pay the benefit in question is a payment made "in relation to" that benefit when paid. In that regard, I do not think that Greer J. erred in determining that the change in the new Schedule was not sufficient to drive a different interpretation respecting indemnification for the insurer generated medical assessment. Section 57(1) simply does not deal with that question.

Disposition

97 For all of the foregoing reasons, I would allow the appeal and vary the Order of Greer J. dated July 7, 2011, to grant the appeal from the arbitration award of Arbitrator Samworth. I would remit the matter to the Arbitrator to determine the quantum of the insurer generated medical assessments in question, with the direction that Wawanesa is entitled to be indemnified for the expenses of such medical assessments paid by it in relation to the statutory benefits that it has paid to its insured pursuant to s. 275(1) of the *Insurance Act*.

98 I would award the costs of the appeal to the appellant, fixed in the amount of $10,000, inclusive of disbursements and all applicable taxes.

R.A. BLAIR J.A.

cp/e/qljel/qlpmg

1 At present there are four different *Statutory Accident Benefits Schedules* in place governing different time periods: *Statutory Accident Benefits Schedule - Accidents After December 31, 1993 and Before November 1, 1996*, O. Reg. 776/93; *Statutory Accident Benefits Schedule - Accidents Before January 1, 1994*, R.R.O. 1990, Reg. 672; *Statutory Accident Benefits Schedule Accidents on or after November 1, 1996*, O. Reg. 403/96 (the "1996 *SABS*"); *Statutory Accident Benefits Schedule - Effective September 1, 2010*, O. Reg. 34/10.