



ONTARIO REGULATION 34/10

made under the

INSURANCE ACT

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STATUTORY ACCIDENT BENEFITS SCHEDULE — EFFECTIVE SEPTEMBER 1, 2010

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**PART I
GENERAL**

Citation

1. This Regulation may be cited as the *Statutory Accident Benefits Schedule — Effective September 1, 2010*.

Application and transition rules

2. (1) Except as otherwise provided in section 68, the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents occurring on or after September 1, 2010.

(2) Subsections 25 (1), (3), (4) and (5), Parts VIII and IX, other than subsections 50 (2) to (5), and Parts X, XI and XII apply with such modifications as are necessary in respect of benefits provided under the Old Regulation with respect to accidents that occurred on or after November 1, 1996 and before September 1, 2010 and, for that purpose, the following rules apply:

1. References in paragraph 2 of subsection 25 (1), subsections 38 (1), (5), (7), (9), (10), (11), (12) and (14), sections 40 and 41 and subsection 44 (3) to the Minor Injury Guideline shall be read as references to the *Pre-approved Framework Guideline* referred to in the Old Regulation that would apply.
2. An amount that would, but for subsection 3 (1.3) of the Old Regulation, be paid under the Old Regulation after August 31, 2010 shall be paid under this Regulation in the amount determined,
 - i. under the Old Regulation, other than under section 24 of that Regulation, or
 - ii. under subsections 25 (1), (3), (4) and (5).
3. An amount described in paragraph 2 that is paid under this Regulation shall not include any amount previously paid under the Old Regulation.

(3) The benefits set out in this Regulation shall be provided in respect of accidents that occur in Canada or the United States of America, or on a vessel plying between ports of Canada or the United States of America.

(4) Benefits payable under this Regulation in respect of an insured person shall be paid by the insurer that is liable to pay under subsection 268 (2) of the Act.

(5) Subject to Part VII, the insurer shall pay the benefits under this Regulation despite section 225, subsection 233 (1), section 240 and subsection 265 (3) of the Act.

Definitions and interpretation

3. (1) In this Regulation,

“accident” means an incident in which the use or operation of an automobile directly causes an impairment or directly causes damage to any prescription eyewear, denture, hearing aid, prosthesis or other medical or dental device;

“authorized transportation expense” means, in respect of an insured person, expenses related to transportation,

- (a) that are authorized by, and calculated by applying the rates set out in, the Transportation Expense Guidelines published in *The Ontario Gazette* by the Financial Services Commission of Ontario, as they may be amended from time to time, and
- (b) that, unless the insured person sustained a catastrophic impairment as a result of the accident, relate to transportation expenses incurred only after the first 50 kilometres of a trip;

“business day” means a day that is not,

- (a) Saturday, or
- (b) a holiday within the meaning of section 88 of the *Legislation Act, 2006*, other than Easter Monday and Remembrance Day;

“chiropractor” means a person authorized by law to practise chiropractic;

“dentist” means a person authorized by law to practise dentistry;

“disability certificate” means, in respect of a person, a certificate from a health practitioner of the person’s choice that states the cause and nature of the person’s impairment and contains an estimate of the duration of the disability in respect of which the person is making or has made an application for a benefit described in this Regulation;

“Guideline” means,

- (a) a guideline, including the Minor Injury Guideline, issued by the Superintendent under subsection 268.3 (1) of the Act and published in *The Ontario Gazette*,
- (b) a guideline that is included in the professional fee guidelines or the *Optional Indexation Benefit Guidelines*, as published in *The Ontario Gazette* by the Financial Services Commission of Ontario, or
- (c) a guideline published in *The Ontario Gazette* that is an amended version of a guideline referred to in clause (a) or (b);

“health practitioner” means, in respect of a particular impairment,

- (a) a physician,
- (b) a chiropractor, if the impairment is one that a chiropractor is authorized by law to treat,
- (c) a dentist, if the impairment is one that a dentist is authorized by law to treat,
- (d) an occupational therapist, if the impairment is one that an occupational therapist is authorized by law to treat,
- (e) an optometrist, if the impairment is one that an optometrist is authorized by law to treat,
- (f) a psychologist, if the impairment is one that a psychologist is authorized by law to treat,

- (g) a physiotherapist, if the impairment is one that a physiotherapist is authorized by law to treat,
- (h) a registered nurse with an extended certificate of registration, if the impairment is one that the nurse is authorized by law to treat, or
- (i) a speech-language pathologist, if the impairment is one that a speech-language pathologist is authorized by law to treat;

“impairment” means a loss or abnormality of a psychological, physiological or anatomical structure or function;

“insured automobile” means, in respect of a particular motor vehicle liability policy, an automobile covered by the policy;

“insured person” means, in respect of a particular motor vehicle liability policy,

- (a) the named insured, any person specified in the policy as a driver of the insured automobile and, if the named insured is an individual, the spouse of the named insured and a dependant of the named insured or of his or her spouse,
 - (i) if the named insured, specified driver, spouse or dependant is involved in an accident in or outside Ontario that involves the insured automobile or another automobile, or
 - (ii) if the named insured, specified driver, spouse or dependant is not involved in an accident but suffers psychological or mental injury as a result of an accident in or outside Ontario that results in a physical injury to his or her spouse, child, grandchild, parent, grandparent, brother, sister, dependant or spouse’s dependant,
- (b) a person who is involved in an accident involving the insured automobile, if the accident occurs in Ontario, or
- (c) a person who is an occupant of the insured automobile and who is a resident of Ontario or was a resident of Ontario at any time during the 60 days before the accident, if the accident occurs outside Ontario;

“minor injury” means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae;

“Minor Injury Guideline” means a guideline,

- (a) that is issued by the Superintendent 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;

“neuropsychologist” means a psychologist authorized by law to practise neuropsychology;

“occupational therapist” means a person authorized by law to practise occupational therapy;

“Old Regulation” means Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or After November 1, 1996), made under the Act;

“person in need of care” means, in respect of an insured person, another person who is under 16 years of age or who requires care because of physical or mental incapacity;

“personal and vocational characteristics” include,

- (a) employment history,
- (b) education and training,
- (c) vocational aptitudes,
- (d) vocational skills,
- (e) physical abilities,
- (f) cognitive abilities, and
- (g) language abilities;

“physician” means a person authorized by law to practise medicine;

“physiotherapist” means a person authorized by law to practice physiotherapy;

“private corporation” means a corporation whose shares are not publicly traded and that is not controlled by one or more corporations whose shares are publicly traded;

“psychologist” means a person authorized by law to practise psychology;

“registered nurse with an extended certificate of registration” means a person authorized by law to practise nursing who holds an extended certificate of registration under the *Nursing Act, 1991*;

“regulated health profession” means a profession governed by a College as defined in the *Regulated Health Professions Act, 1991* or the Ontario College of Social Workers and Social Service Workers under the *Social Work and Social Service Work Act, 1998*;

“regulated health professional” means a member of a regulated health profession;

“self-employed person” means a person who,

- (a) engages in a trade, occupation, profession or other type of business as a sole proprietor or as a partner, other than a limited partner, of a partnership, or
- (b) is a controlling mind of a business carried on through one or more private corporations some or all of whose shares are owned by the person;

“self-employment” means a trade, occupation, profession or other type of business the essential tasks of which are carried on by a self-employed person;

“spouse” has the same meaning as in Part VI of the Act;

“sprain” means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear;

“strain” means an injury to one or more muscles, including a partial but not a complete tear;

“subluxation” means a partial but not a complete dislocation of a joint;

“whiplash associated disorder” means a whiplash injury that,

- (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
- (b) does not exhibit a fracture in or dislocation of the spine;

“whiplash injury” means an injury that occurs to a person’s neck following a sudden acceleration-deceleration force.

- (2) For the purposes of this Regulation, a catastrophic impairment caused by an accident is,
- (a) paraplegia or quadriplegia;
 - (b) the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg;
 - (c) the total loss of vision in both eyes;
 - (d) subject to subsection (4), brain impairment that results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, *Lancet* i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
 - (e) subject to subsections (4), (5) and (6), an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
 - (f) subject to subsections (4), (5) and (6), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

(3) Subsection (4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (2) (d), (e) or (f) can be applied by reason of the age of the insured person.

(4) For the purposes of clauses (2) (d), (e) and (f), an impairment sustained in an accident by an insured person described in subsection (3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (2) (d), (e) or (f), after taking into consideration the developmental implications of the impairment.

(5) Clauses (2) (e) and (f) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,

- (a) in the case of an impairment that includes a brain impairment, a physician states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment;
- (b) in the case of an impairment that is only a brain impairment, a neuropsychologist states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
- (c) two years have elapsed since the accident.

(6) For the purpose of clauses (2) (e) and (f), an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 is deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

(7) For the purposes of this Regulation,

- (a) a person suffers a complete inability to carry on a normal life as a result of an accident if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident;
- (b) a person is a dependant of an individual if the person is principally dependent for financial support or care on the individual or the individual's spouse;
- (c) an aide or attendant for a person includes a family member or friend who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications;
- (d) payments for loss of income under an income continuation benefit plan are deemed to include,
 - (i) payments of disability pension benefits under the *Canada Pension Plan*,
 - (ii) periodic payments of insurance, irrespective of whether the contract for the insurance provides for a waiting period, deductible amount or similar limitation or restriction and irrespective of whether the contract is paid for in whole or in part by the employer, if the insurance is offered by the insurer,
 - (A) to persons who are employed while the contract for the insurance is in effect, and
 - (B) only on the basis that the maximum benefit payable is limited to an amount calculated with reference to the insured person's income from employment;
- (e) subject to subsection (8), an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,
 - (i) the insured person has received the goods or services to which the expense relates,
 - (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
 - (iii) the person who provided the goods or services,
 - (A) did so in the course of his or her regular occupation or profession, or
 - (B) sustained an economic loss as a result of providing the goods or services to the insured person;
- (f) an individual who is living and ordinarily present in Ontario is deemed to be the named insured under the policy insuring an automobile at the time of an accident if, at the time of the accident,
 - (i) the insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or

other entity, or

(ii) the insured automobile is being rented by the individual for a period of more than 30 days; and

(g) an individual who is not living and ordinarily present in Ontario is deemed to be the named insured under the policy insuring an automobile at the time of an accident if, at the time of the accident,

(i) the insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or other entity, and

(ii) the individual, his or her spouse or any dependant of the individual or spouse is an occupant of the insured automobile.

(8) If in a dispute to which sections 279 to 283 of the Act apply, a Court or arbitrator finds that an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit in respect of the expense, the Court or arbitrator may, for the purpose of determining an insured person's entitlement to the benefit, deem the expense to have been incurred.

PART II

INCOME REPLACEMENT, NON-EARNER AND CAREGIVER BENEFITS

INCOME REPLACEMENT BENEFITS

Interpretation

4. (1) In this Part,

“gross employment income” means salary, wages and other remuneration from employment, including fees and other remuneration for holding office, and any benefits received under the *Employment Insurance Act* (Canada), but excludes any retiring allowance within the meaning of the *Income Tax Act* (Canada) and severance pay that may be received;

“gross weekly employment income” means, in respect of an insured person, the amount of the person's gross annual employment income, as determined under subsection (2), divided by 52;

“other income replacement assistance” means, in respect of an insured person who sustains an impairment as a result of an accident,

(a) the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, other than,

(i) a benefit under the *Employment Insurance Act* (Canada),

(ii) a payment under a sick leave plan that is available to the person but is not being received, and

(iii) a payment under a workers' compensation law or plan that is not being received by the person because the person has elected under the workers' compensation law or plan to bring an action and is not entitled to the payment, and

(b) the amount of any gross weekly payment for loss of income, other than a benefit or payment described in subclauses (a) (i) to (iii) that may be available to the person as a

result of the accident under the laws of any jurisdiction or under any income continuation benefit plan but is not being received by the person and for which the person has not made an application.

- (2) The gross annual employment income of an insured person is determined as follows:
1. In the case of a person referred to in subparagraph 1 i of section 5 who was not a self-employed person at any time during the four weeks before the accident, the person's gross annual employment income is whichever of the following amounts the person designates:
 - i. The person's gross employment income for the four weeks before the accident, multiplied by 13.
 - ii. The person's gross employment income for the 52 weeks before the accident.
 2. Subject to paragraph 3, the person's gross annual employment income is his or her gross employment income for the 52 weeks before the accident if,
 - i. the person qualifies for a benefit under subparagraph 1 i of section 5 and was a self-employed person at any time during the four weeks before the accident, or
 - ii. the person qualifies for a benefit under subparagraph 1 ii of section 5.
 3. If the person described in subparagraph 2 i was self-employed for at least one year before the accident, the person may designate as his or her gross annual employment income the amount of his or her gross employment income during the last fiscal year of the business that ended on or before the day of the accident.

(3) A self-employed person's weekly income or loss from self-employment at the time of the accident is the amount that would be 1/52 of the amount of the person's income or loss from the business for the last completed taxation year as determined in accordance with Part I of the *Income Tax Act* (Canada).

(4) A self-employed person's loss from self-employment after an accident is determined in the same manner as losses from the business in which the person was self-employed would be determined under subsection 9 (2) of the *Income Tax Act* (Canada) without making any deductions for,

- (a) any expenses that were not reasonable or necessary to prevent a loss of revenue;
- (b) any salary expenses paid to replace the self-employed person's active participation in the business, except to the extent that the expenses are reasonable in the circumstances; and
- (c) any non-salary expenses that are different in nature or greater than the non-salary expenses incurred before the accident, except to the extent that those expenses are reasonable in the circumstances and necessary to prevent or reduce any losses resulting from the accident.

(5) If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident shall be determined for the purposes of this Part without reference to any income the person has failed to report contrary to that Act or legislation.

(6) The amount of a person's gross annual employment income and the amount of the person's income or loss from self-employment may be adjusted for the purposes of this Part to reflect any subsequent change in the amount determined by the Canada Revenue Agency under the *Income Tax Act* (Canada) or by the relevant government or agency under the legislation of another jurisdiction that imposes a tax calculated by reference to income.

Eligibility criteria

5. (1) The insurer shall pay an income replacement benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies one or both of the following conditions:

1. The insured person,

- i. was employed at the time of the accident and, as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of that employment, or
- ii. was not employed at the time of the accident but,
 - A. was employed for at least 26 weeks during the 52 weeks before the accident or was receiving benefits under the *Employment Insurance Act* (Canada) at the time of the accident,
 - B. was at least 16 years old or was excused from attending school under the *Education Act* at the time of the accident, and
 - C. as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident.

2. The insured person,

- i. was a self-employed person at the time of the accident, and
- ii. suffers, as a result of and within 104 weeks after the accident, a substantial inability to perform the essential tasks of his or her self-employment.

(2) Despite subsection (1), an insured person is not eligible to receive income replacement benefits if he or she is eligible to receive and has elected under section 35 to receive either a non-earner benefit or a caregiver benefit under this Part.

Period of benefit

6. (1) Subject to subsection (2), an income replacement benefit is payable for the period in which the insured person suffers a substantial inability to perform the essential tasks of his or her employment or self-employment.

(2) The insurer is not required to pay an income replacement benefit,

- (a) for the first week of the disability; or
- (b) after the first 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience.

Amount of weekly income replacement benefit

7. (1) The weekly amount of an income replacement benefit payable to an insured person who becomes entitled to the benefit before his or her 65th birthday is the lesser of “A” and “B” where,

“A” is the weekly base amount determined under subsection (2) less the total of all other income replacement assistance, if any, for the particular week the benefit is payable, and

“B” is \$400 or, if an optional income replacement benefit referred to in section 28 has been purchased and applies to the person, the amount fixed by the optional benefit.

(2) For the purposes of subsection (1), the weekly base amount in respect of an insured person is determined as follows:

1. Determine whichever of the following amounts is applicable:

- i. 70 per cent of the amount, if any, by which the sum of the insured person’s gross weekly employment income and weekly income from self-employment exceeds the amount of the insured person’s weekly loss from self-employment, if the weekly income replacement benefit is for one of the first 104 weeks of disability, or
- ii. the greater of the amount determined for the purposes of subparagraph i and \$185, if the weekly income replacement benefit is for a week for which the person is entitled to receive an income replacement benefit after the first 104 weeks of disability.

2. To the amount determined under paragraph 1, add 70 per cent of the amount of the insured person’s weekly loss from self-employment that he or she incurs as a result of the accident.

(3) The insurer may deduct from the amount of an income replacement benefit payable to an insured person,

- (a) 70 per cent of any gross employment income received by the insured person as a result of being employed after the accident and during the period in which he or she is eligible to receive an income replacement benefit; and
- (b) 70 per cent of any income from self-employment earned by the insured person after the accident and during the period in which he or she is eligible to receive an income replacement benefit.

(4) The insurer shall pay an expense incurred by or on behalf of an insured person for the preparation of a report for the purpose of calculating the person’s income from employment or self-employment if all of the following conditions are satisfied:

1. The insured person is applying for an income replacement benefit under this Part that is based on the employment or self-employment considered in the report.
2. The report is prepared by an accountant licensed under the *Public Accounting Act, 2004* or comparable legislation of the jurisdiction in which the accountant practises.
3. The expense is reasonable and necessary for the purpose of determining the insured person’s entitlement to an income replacement benefit.

(5) The insurer is not required to pay more than a total of \$2,500 for the preparation of one

or more reports under subsection (4) in respect of an insured person.

Adjustment after age 65

8. (1) If a person is receiving an income replacement benefit immediately before his or her 65th birthday, the weekly amount of the benefit is adjusted, on the later of the day of the person's 65th birthday and the second anniversary of the day the person began receiving the benefit, to the amount determined in accordance with the following formula:

$$C \times 0.02 \times D$$

in which,

“C” is the weekly amount of the income replacement benefit that the person was entitled to receive immediately before the adjustment, before any deductions permitted by subsection 7 (3),

“D” is the lesser of,

(a) 35, and

(b) the number of years during which the person qualified for the income replacement benefit before the adjustment is made.

(2) Despite section 6, an income replacement benefit that has been adjusted under subsection (1) is payable, without any deductions under clause 7 (3) (a) or (b), until the person dies.

If entitlement first arises on or after 65th birthday

9. (1) If an insured person becomes entitled to receive an income replacement benefit on or after his or her 65th birthday,

(a) subject to clause 6 (2) (a) and despite clause 6 (2) (b), the insured person is entitled to an income replacement benefit for not more than 208 weeks after becoming entitled to the benefit; and

(b) the weekly amount of the benefit is the weekly amount of the income replacement benefit otherwise determined under section 7 before any deductions permitted by subsection 7 (3), multiplied by the factor set out in Column 2 of the Table to this subsection opposite the number of weeks that have elapsed since the person became entitled to receive the benefit.

TABLE

Column 1	Column 2
Number of weeks since Entitlement Arose	Factor
Less than 52 weeks	1.0
52 weeks or more but less than 104 weeks	0.8
104 weeks or more but less than 156 weeks	0.6
156 weeks or more but less than 208 weeks	0.3

(2) No deduction may be made under clause 7 (3) (a) or (b) from an income replacement benefit determined under subsection (1).

No violation of *Human Rights Code*

10. The age distinctions in sections 8 and 9 apply despite the *Human Rights Code*.

Temporary return to employment

11. A person receiving an income replacement benefit may return to or start employment or self-employment at any time during the first 104 weeks for which he or she is receiving the benefit without affecting his or her entitlement to resume receiving any benefits to which he or she is entitled under this Part if, as a result of the accident, he or she is unable to continue the employment or self-employment.

NON-EARNER BENEFITS

Non-earner benefit

12. (1) The insurer shall pay a non-earner benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies any of the following conditions:

1. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and does not qualify for an income replacement benefit.
2. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and,
 - i. was enrolled on a full-time basis in elementary, secondary or post-secondary education at the time of the accident, or
 - ii. completed his or her education less than one year before the accident and was neither employed nor a self-employed person after completing his or her education and before the accident, in a capacity that reflected his or her education and training.

(2) Subject to subsection (3), the amount of a non-earner benefit is \$185 for each week during the period that the insured person suffers a complete inability to carry on a normal life, less the total of all other income replacement assistance, if any, for the same week.

(3) If a person qualifies for a non-earner benefit under paragraph 2 of subsection (1) and more than 104 weeks have elapsed since the onset of the disability, the amount of the non-earner benefit is \$320 for each week that the insured person suffers a complete inability to carry on a normal life, less the total of all other income replacement assistance, if any, for the same week.

(4) The insurer is not required to pay a non-earner benefit,

- (a) for the first 26 weeks after the onset of the complete inability to carry on a normal life;
- (b) before the insured person is 16 years of age; or
- (c) if the insured person is eligible to receive and has elected under section 35 to receive either an income replacement benefit or a caregiver benefit under this Part.

(5) Sections 8 and 9 apply with necessary modifications for the purposes of determining the amount of a non-earner benefit and, in the application of those sections,

- (a) the reference in the definition of “C” in subsection 8 (1) to “the weekly amount of the income replacement benefit that the person was entitled to receive immediately before the adjustment, before any deductions permitted by subsection 7 (3)” is to be read as a reference to the amount referred to in subsection (2); and
- (b) the reference in clause 9 (1) (b) to “the weekly amount of the income replacement benefit otherwise determined under section 7 before any deductions permitted by

subsection 7 (3)” is to be read as a reference to the amount referred to in subsection (2).

CAREGIVER BENEFITS

Caregiver benefit

13. (1) The insurer shall pay a caregiver benefit to or for an insured person who sustains a catastrophic impairment as a result of an accident if, as a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she was engaged at the time of the accident and if, at the time of the accident,

- (a) the insured person was residing with a person in need of care, and
- (b) the insured person was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiving activities.

(2) The caregiver benefit shall pay for reasonable and necessary expenses incurred as a result of the accident in caring for a person in need of care, but shall not exceed,

- (a) \$250 per week for the first person in need of care; and
- (b) \$50 per week for each additional person in need of care.

(3) Despite subsection (1), no caregiver benefit is payable to an insured person if he or she is eligible to receive and has elected under section 35 to receive either an income replacement benefit or a non-earner benefit under this Part.

(4) Despite subsection (1), no caregiver benefit is payable for any period longer than 104 weeks of disability unless, as a result of the accident, the insured person is suffering a complete inability to carry on a normal life.

PART III

MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

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.

Medical benefits

15. (1) Subject to section 18, medical benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

- (a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;
- (b) chiropractic, psychological, occupational therapy and physiotherapy services;
- (c) medication;
- (d) prescription eyewear;
- (e) dentures and other dental devices;
- (f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;

- (g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant;
 - (h) other goods and services of a medical nature that the insured person requires, other than goods or services for which a benefit is otherwise provided in this Regulation.
- (2) Despite subsection (1), the insurer is not liable to pay medical benefits,
- (a) for goods or services that are experimental in nature;
 - (b) for expenses related to professional services described in clause (1) (a), (b) or (h) rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines; or
 - (c) for transportation expenses other than authorized transportation expenses.

Rehabilitation benefits

16. (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market.

(2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,

- (a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or
 - (b) lead as normal a work life as possible.
- (3) The activities and measures referred to in subsection (1) are,
- (a) life skills training;
 - (b) family counselling;
 - (c) social rehabilitation counselling;
 - (d) financial counselling;
 - (e) employment counselling;
 - (f) vocational assessments;
 - (g) vocational or academic training;
 - (h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;
 - (i) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;
 - (j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the

needs of the insured person than to modify an existing vehicle;

(k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant;

(l) other goods and services that the insured person requires, except,

(i) services provided by a case manager,

(ii) housekeeping and caregiver expenses, and

(iii) any goods or services for which a benefit is otherwise provided in this Regulation.

(4) Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,

(a) for expenses related to professional services described in any of clauses (3) (a) to (g) or (3) (l) rendered to the insured person that exceed the maximum rate or amount of expenses established under the Guidelines;

(b) for expenses incurred to renovate the insured person's home if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living;

(c) for the purchase of a new home in excess of the value of the renovations to the insured person's existing home that would be required to accommodate the needs of the insured person;

(d) for expenses incurred to purchase or modify a vehicle to accommodate the needs of the insured person that are incurred within five years after the last expenses incurred for that purpose in respect of the same accident;

(e) for the purchase of a new vehicle in excess of the amount by which the cost of the new vehicle exceeds the trade-in value of the existing vehicle;

(f) for transportation expenses other than authorized transportation expenses.

Case manager services

17. (1) Subject to subsection (2), medical or rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of the accident for services provided by a qualified case manager in accordance with a treatment and assessment plan under section 38,

(a) if the insured person sustains a catastrophic impairment as a result of the accident; or

(b) if the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) is available to the insured person.

(2) The insurer is not liable to pay expenses for case manager services that exceed the maximum rate or amount of expenses established under the Guidelines.

(3) In this section,

“qualified case manager” means a person who provides services related to the co-ordination of goods or services for which payment is provided by a medical or rehabilitation benefit.

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

for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.

(2) Despite subsection (1), the \$3,500 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 will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

(3) The sum of the medical and rehabilitation benefits paid in respect of an insured person who is not subject to the financial limit in subsection (1) shall not exceed, for any one accident,

(a) \$50,000; or

(b) if the insured person sustained a catastrophic impairment as a result of the accident, \$1,000,000.

(4) The maximum amounts set out subsection (3) apply unless modified by any optional benefits that are available under paragraph 3 or 5 of subsection 28 (1).

(5) For the purposes of subsections (1) and (3), medical and rehabilitation benefits payable in respect of an insured person include all fees and expenses for conducting assessments and examinations and preparing reports in connection with any benefit or payment to or for an insured person under this Regulation, other than,

(a) fees in connection with any examination required by an insurer under section 44; and

(b) expenses in respect of a report referred to in subsection 7 (4).

Attendant care benefit

19. (1) Attendant care benefits shall pay for all reasonable and necessary expenses,

(a) that are incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant or by a long-term care facility, including a long-term care home under the *Long-Term Care Homes Act, 2007* or a chronic care hospital; and

(b) that, to the extent any of the expenses referred to in clause (a) are for transportation, are authorized transportation expenses for which no medical benefit described in clause 15 (1) (g) is payable, no rehabilitation benefit described in clause 16 (3) (k) is payable and no amount is payable under subsection 25 (4).

(2) Subject to subsection (3), the amount of a monthly attendant care benefit is determined in accordance with the version of the document entitled “Assessment of Attendant Care Needs” that is required to be submitted under section 42 and is calculated by,

(a) multiplying the total number of hours per month of each type of attendant care listed in the document that the insured person requires by an hourly rate that does not exceed the maximum hourly rate, as established under the Guidelines, that is payable in respect of that type of care; and

(b) adding the amounts determined under clause (a), if more than one type of attendant care is required.

(3) The amount of the attendant care benefit payable in respect of an insured person shall not exceed the amount determined under the following rules:

1. If the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) has not been purchased and does not apply to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,
 - i. \$3,000 per month, if the insured person did not sustain a catastrophic impairment as a result of the accident, or
 - ii. \$6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident.
2. Unless increased by any optional benefits available to the insured person in accordance with paragraph 4 or 5 of subsection 28 (1), the amount of the attendant care benefits paid in respect of the insured person shall not exceed, for any one accident,
 - i. \$1,000,000, if the insured person sustained a catastrophic impairment as a result of the accident, or
 - ii. \$36,000 in any other case.
3. If the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) has been purchased and applies to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed the monthly limit under subsection 28 (6).

Duration of medical, rehabilitation and attendant care benefits

20. (1) Subject to subsection (3), no medical or rehabilitation benefit is payable for expenses incurred,

- (a) more than 10 years after the accident, in the case of an insured person who was at least 15 years of age at the time of the accident; or
- (b) after the insured person's 25th birthday, in the case of an insured person who was under 15 years of age at the time of the accident.

(2) Subject to subsection (3), no attendant care benefit is payable for expenses incurred more than 104 weeks after the accident.

(3) The time limits set out in subsections (1) and (2) do not apply in respect of an insured person,

- (a) who sustains a catastrophic impairment as a result of the accident; or
- (b) who is entitled to the optional medical, rehabilitation and attendant care benefit under paragraph 5 of subsection 28 (1).

PART IV PAYMENT OF OTHER EXPENSES

Lost educational expenses

21. (1) The insurer shall pay for up to \$15,000 for lost educational expenses incurred by or on behalf of an insured person who sustains an impairment as a result of an accident if,

- (a) at the time of the accident, the insured person was enrolled in a program of elementary, secondary, post-secondary or continuing education; and
- (b) as a result of the accident, the insured person is unable to continue the program.

(2) The insurer may require a person who applies for or is receiving benefits under this section to furnish a disability certificate as often as is reasonably necessary.

(3) If an insurer requires a disability certificate, the person shall furnish a new disability certificate, completed as of a date after the date of the insurer's request, within 15 business days after receiving the insurer's request.

(4) If the person fails to comply with subsection (3), no amount is payable for lost educational expenses until the person furnishes the completed disability certificate.

(5) In this section,

“lost educational expenses” means expenses incurred before the accident for tuition, books, equipment or room and board in respect of the program term or program year in which the insured person was enrolled at the time of the accident, if the expenses are related to the program that the insured person is unable to continue.

Expenses of visitors

22. (1) If an insured person sustains an impairment as a result of an accident, the insurer shall pay for reasonable and necessary expenses incurred not more than 104 weeks after the accident by the following persons as a result of the accident in visiting the insured person during his or her treatment or recovery:

1. The spouse, children, grandchildren, parents, grandparents, brothers and sisters of the insured person.
2. An individual who was living with the insured person at the time of the accident.
3. An individual who has demonstrated a settled intention to treat the insured person as a child of the individual's family.
4. An individual whom the insured person has demonstrated a settled intention to treat as a child of the insured person's family.

(2) The time limit of 104 weeks does not apply if the insured person sustained a catastrophic impairment as a result of the accident.

Housekeeping and home maintenance

23. The insurer shall pay up to \$100 per week for reasonable and necessary additional expenses incurred by or on behalf of an insured person as a result of an accident for housekeeping and home maintenance services if, as a result of the accident, the insured person sustains a catastrophic impairment that results in a substantial inability to perform the housekeeping and home maintenance services that he or she normally performed before the accident.

Damage to clothing, glasses, hearing aids, etc.

24. The insurer shall pay for all reasonable expenses incurred by or on behalf of an insured person in repairing or replacing the following:

1. Clothing worn by the insured person at the time of the accident that was lost or damaged as a result of the accident.
2. Prescription eyewear, dentures, hearing aids, prostheses and other medical or dental devices that were lost or damaged as a result of the accident.

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 in accordance with sections 279 to 283 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.

(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.

(3) The insurer is not liable under subsection (1) for expenses related to professional services rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines.

(4) The insurer shall pay reasonable expenses incurred by or on behalf of an insured person for authorized transportation expenses incurred in transporting the insured person to and from an assessment or examination referred to in subsection (1), including transportation expenses for an aide or an attendant.

- (5) Despite any other provision of this Regulation, an insurer shall not pay,
- (a) more than \$2,000 in respect of fees for any one assessment or examination, whether conducted at the instance of the insured person or the insurer; or
 - (b) any amount in respect of fees for preparing a future care plan, a life care plan or a similar plan or for any assessment or examination conducted in connection with the preparation of the plan.

PART V DEATH AND FUNERAL BENEFITS

Death benefit

- 26.** (1) The insurer shall pay a death benefit in respect of an insured person who dies as result of an accident,
- (a) within 180 days after the accident; or
 - (b) within 156 weeks after the accident, if during that period the insured person was continuously disabled as a result of the accident.
- (2) The death benefit shall provide the following payments:
- 1. A payment to the insured person's spouse of,
 - i. \$25,000, or
 - ii. if the optional death and funeral benefit referred to in section 28 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.
 - 2. A payment to each of the insured person's dependants and to each person to whom the insured person had an obligation at the time of the accident to provide support under a domestic contract or court order of,
 - i. \$10,000, or
 - ii. if the optional death and funeral benefit referred to in section 28 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.
 - 3. If no payment is required by paragraph 1, an additional payment to the insured person's dependants and the persons, other than a former spouse of the insured person, to whom the insured person had an obligation at the time of the accident to provide support under a domestic contract or court order, to be divided equally among the persons entitled, of,
 - i. \$25,000, or
 - ii. if the optional death and funeral benefit referred to in section 28 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.
 - 4. A payment of \$10,000 to each former spouse of the insured person to whom the insured person was obligated at the time of the accident to provide support under a domestic contract or court order.
 - 5. A payment of \$10,000 to,
 - i. a person in respect of whom the insured person was a dependant at the time of the accident,
 - ii. the spouse of a person in respect of whom the insured person was a dependant at the time of the accident, if the spouse was the insured person's primary caregiver at the time of the accident and the person in respect of whom the insured person was a dependant at the time of the accident dies before the insured person or within 30 days after the insured person, or
 - iii. the dependants of a person in respect of whom the insured person was a dependant at the time of the accident, if no payment is required by subparagraph i

or ii, to be divided equally among the persons entitled.

(3) No payment shall be made under this section to a person who dies before the insured person or within 30 days after the insured person.

(4) If at the time of the accident the insured person had more than one spouse who is entitled to a payment under this section, the payment shall be divided equally among them.

(5) If at the time of the accident the insured person was a dependant in respect of more than one person who is entitled to a payment under this section, the payment shall be divided equally among the persons in respect of whom the insured person was a dependant.

(6) If requested by the insurer, a person who conducts an autopsy of the insured person shall provide a copy of his or her report to the insurer.

Funeral benefit

27. (1) The insurer shall pay a funeral benefit in respect of an insured person who dies as a result of an accident.

(2) The funeral benefit shall pay for funeral expenses incurred in an amount not exceeding,

(a) \$6,000; or

(b) if the optional death and funeral benefit referred to in section 28 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.

PART VI OPTIONAL BENEFITS

Description of optional benefits

28. (1) Every insurer shall offer the following optional benefits:

1. An optional income replacement benefit that increases the maximum weekly amount of \$400 referred to in the definition of "B" in subsection 7 (1) to \$600, \$800 or \$1,000, as selected by the named insured under the policy.
2. An optional caregiver, housekeeping and home maintenance benefit that,
 - i. provides caregiver benefits payable in the circumstances described in section 13 if, as a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she engaged at the time of the accident even if the impairment sustained by the insured person is not a catastrophic impairment, but not for any period longer than 104 weeks of disability unless, as a result of the accident, the insured person is suffering a complete inability to carry on a normal life, and
 - ii. provides a housekeeping and home maintenance benefit payable in the circumstances described in section 23 even if the impairment sustained by the insured person is not a catastrophic impairment, but not for expenses incurred more than 104 weeks after the onset of the disability.
3. An optional medical and rehabilitation benefit of up to \$100,000 in respect of an insured person for any one accident in which the impairment sustained by the insured person is not a catastrophic impairment, instead of the maximum amount specified in clause 18 (3) (a).
4. An optional attendant care benefit of up to \$72,000 in respect of an insured person for

any one accident in which the impairment sustained by the person is not a catastrophic impairment, instead of the maximum amount specified in subparagraph 2 ii of subsection 19 (3).

5. An optional medical, rehabilitation and attendant care benefit of up to the following maximum amounts, instead of the maximum amounts specified in subsection 18 (3) and paragraph 2 of subsection 19 (3), and that does not limit the period of time for which expenses are to be paid by the insurer for medical, rehabilitation and attendant care benefits:
 - i. The sum of the medical and rehabilitation benefits paid in respect of an insured person shall not exceed, for any one accident,
 - A. \$1,100,000 if the insured person did not sustain a catastrophic impairment as a result of the accident, or
 - B. \$2,000,000 if the insured person sustained a catastrophic impairment as a result of the accident.
 - ii. The amount of the attendant care benefit paid in respect of an insured person shall not exceed, for any one accident,
 - A. \$1,072,000 if the insured person did not sustain a catastrophic impairment as a result of the accident,
 - B. \$2,000,000 if the insured person sustained a catastrophic impairment as a result of the accident, or
 - C. nil, if the insured person's impairment is a minor injury.
 - iii. Despite the limits established by subparagraphs i and ii, the sum of all medical, rehabilitation and attendant care benefits paid in respect of an insured person for any one accident shall not exceed,
 - A. \$1,172,000 if the insured person did not sustain a catastrophic impairment as a result of the accident, or
 - B. \$3,000,000 if the insured person sustained a catastrophic impairment as a result of the accident.
6. An optional death and funeral benefit that,
 - i. fixes the amount payable under paragraph 1 of subsection 26 (2) at \$50,000, instead of the amount specified in subparagraph 1 i of subsection 26 (2),
 - ii. fixes the amount payable under paragraph 2 of subsection 26 (2) at \$20,000, instead of the amount specified in subparagraph 2 i of subsection 26 (2),
 - iii. fixes the amount payable under paragraph 3 of subsection 26 (2) at \$50,000 instead of the amount specified in subparagraph 3 i of subsection 26 (2), and
 - iv. fixes the maximum payment for funeral expenses at \$8,000 instead of the amount specified in clause 27 (2) (a).
7. An optional dependant care benefit, as described in section 29.
8. An optional indexation benefit, as described in section 30.

(2) The optional benefits referred to in subsection (1) are applicable only to,

- (a) the named insured;
- (b) the spouse of the named insured;
- (c) the dependants of the named insured and of the named insured's spouse; and
- (d) the persons specified in the policy as drivers of the insured automobile.

(3) An optional benefit may be purchased at any time before an accident in respect of which an application for benefits is made.

(4) If a person purchases an optional benefit referred to in subsection (1), the insurer shall issue to the person the endorsement set out in Ontario Policy Change Form 47 (OPCF 47), as approved by the Commissioner of Insurance on December 3, 1996 under section 227 of the Act.

(5) For the purposes of paragraphs 3 and 5 of subsection (1), the medical and rehabilitation benefits payable in respect of an insured person include all fees and expenses for conducting assessments and examinations and preparing reports in connection with any benefit or payment to or for an insured person under this Regulation, other than,

- (a) fees in connection with any examination required by an insurer under section 44; and
- (b) expenses in respect of a report referred to in subsection 7 (4).

(6) For the purpose of paragraph 5 of subsection (1),

- (a) the maximum monthly attendant care benefit payable in respect of an insured person shall not exceed \$6,000; and
- (b) the medical and rehabilitation benefits payable in respect of an insured person include any amount paid in respect of the insured person for services provided by a qualified case manager as authorized under section 17.

Optional dependant care benefit

29. (1) The optional dependant care benefit shall pay for reasonable and necessary additional expenses incurred by or on behalf of an insured person as a result of an accident in caring for the insured person's dependants, if the insured person satisfies the following conditions:

1. The insured person sustained an impairment as a result of the accident.
2. The insured person was employed at the time of the accident.
3. The insured person is not receiving a caregiver benefit.

(2) Despite subsection (1), the amount of optional dependant care benefits shall not exceed \$75 per week for the first dependant and \$25 per week for each additional dependant, to a maximum amount of \$150 per week.

(3) No optional dependant care benefit is payable in respect of an expense incurred after the insured person dies.

Optional indexation benefit

30. (1) The optional indexation benefit shall provide that the following amounts are subject to annual indexation in accordance with subsections (2) and (3):

1. The weekly amount of any income replacement or non-earner benefit payable under this Regulation, determined without regard to any other income replacement assistance, within the meaning of subsection 4 (1), that is received by the insured person.

2. The following amounts:
 - i. The amounts specified in the definition of “B” in subsection 7 (1).
 - ii. The amounts specified in subsections 12 (2) and (3).
 - iii. The amounts specified in subsection 13 (2).
 - iv. The amounts specified in paragraphs 1 and 3 of subsection 19 (3).
3. If the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) was purchased and is applicable to the insured person, the following amounts:
 - i. The outstanding balance with respect to medical and rehabilitation benefits, as calculated under subsection (4).
 - ii. The outstanding balance with respect to attendant care benefits, as calculated under subsection (5).
 - iii. The outstanding balance with respect to medical, rehabilitation and attendant care benefits, as calculated under subsection (6).
4. If paragraph 3 does not apply, the following amounts:
 - i. The outstanding balance with respect to medical and rehabilitation benefits, as calculated under subsection (7).
 - ii. The outstanding balance with respect to attendant care benefits, as calculated under subsection (8).

(2) The indexation shall be performed on January 1 of every year following an accident to which the optional indexation benefit applies by adjusting the amount to be indexed by the percentage change in the Consumer Price Index for Canada (All Items), as published by Statistics Canada under the authority of the *Statistics Act* (Canada), for the period from September in the year immediately preceding the previous year to September of the previous year.

(3) Subsection (2) is subject to the Optional Indexation Benefit Guidelines published in *The Ontario Gazette* by the former Ontario Insurance Commission or the Financial Services Commission of Ontario, as they may be amended from time to time by the Financial Services Commission of Ontario, except that those guidelines shall not provide an adjustment of the amount to be indexed by a percentage greater than the percentage change in the applicable Consumer Price Index.

(4) For the purpose of subparagraph 3 i of subsection (1), the outstanding balance with respect to medical and rehabilitation benefits is the amount calculated using the formula,

$$E - F$$

in which,

“E” is the indexation balance for the year equal to,

- (a) the amount specified in sub-subparagraph 5 i A or B, as the case may be, of subsection 28 (1), if the year is the first year the optional indexation benefit applies, or
- (b) the outstanding balance for the previous year as calculated under this subsection and indexed under subsection (2), if the year is the second or a subsequent year

the optional indexation benefit applies, and

“F” is the total of medical and rehabilitation benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies.

(5) For the purpose of subparagraph 3 ii of subsection (1), the outstanding balance with respect to attendant care benefits is the amount calculated using the formula,

$$G - H$$

in which,

“G” is the indexation balance for the year equal to,

(a) the amount specified in sub-subparagraph 5 ii A or B, as the case may be, of subsection 28 (1), if the year is the first year the optional indexation benefit applies, or

(b) the outstanding balance for the previous year as calculated under this subsection and indexed under subsection (2), if the year is the second or a subsequent year the optional indexation benefit applies, and

“H” is the total of attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies.

(6) For the purpose of subparagraph 3 iii of subsection (1), the outstanding balance with respect to medical, rehabilitation and attendant care benefits is calculated using the formula,

$$I - J$$

in which,

“I” is the indexation balance for the year equal to,

(a) the amount specified in sub-subparagraph 5 iii A or B, as the case may be, of subsection 28 (1), if the year is the first year the optional indexation benefit applies, or

(b) the outstanding balance for the previous year as calculated under this subsection and indexed under subsection (2), if the year is the second or a subsequent year the optional indexation benefit applies, and

“J” is the total of medical, rehabilitation and attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies.

(7) For the purpose of subparagraph 4 i of subsection (1), the outstanding balance with respect to medical and rehabilitation benefits is calculated using the formula,

$$K - L$$

in which,

“K” is the indexation balance for the year equal to,

(a) the amount specified in clause 18 (3) (a) or (b), as the case may be, if the year is the first year the optional indexation benefit applies, or

(b) the outstanding balance for the previous year as calculated under this subsection and indexed under subsection (2), if the year is the second or a subsequent year

the optional indexation benefit applies, and

“L” is the total of medical and rehabilitation benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies.

(8) For the purpose of subparagraph 4 ii of subsection (1), the outstanding balance with respect to attendant care benefits is calculated using the formula,

$$M - N$$

in which,

“M” is the indexation balance for the year equal to,

- (a) the amount specified in subparagraph 2 i or ii of subsection 19 (3), as the case may be, if the year is the first year the optional indexation benefit applies, or
- (b) the outstanding balance for the previous year as calculated under this subsection and indexed under subsection (2), if the year is the second or a subsequent year the optional indexation benefit applies, and

“N” is the total of attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies.

PART VII GENERAL EXCLUSIONS

Circumstances in which certain benefits not payable

31. (1) The insurer is not required to pay an income replacement benefit, a non-earner benefit or a benefit under section 21, 22 or 23,

- (a) in respect of a person who was the driver of an automobile at the time of the accident,
 - (i) if the driver knew or ought reasonably to have known that he or she was operating the automobile while it was not insured under a motor vehicle liability policy,
 - (ii) if the driver was driving the automobile without a valid driver’s licence,
 - (iii) if the driver is an excluded driver under the contract of automobile insurance, or
 - (iv) if the driver knew or ought reasonably to have known that he or she was operating the automobile without the owner’s consent;
- (b) in respect of any person who has made, or who knows of, a material misrepresentation that induced the insurer to enter into the contract of automobile insurance or who intentionally failed to notify the insurer of a change in a risk material to the contract;
- (c) in respect of an occupant of an automobile at the time of the accident who knew or ought reasonably to have known that the driver was operating the automobile without the owner’s consent;
- (d) in respect of a person who, at the time of the accident,
 - (i) was engaged in an act for which the person is convicted of a criminal offence, or
 - (ii) was an occupant of an automobile that was being used in connection with an act for which the person is convicted of a criminal offence; or
- (e) in respect of a person who is convicted of an offence under section 254 of the *Criminal*

Code (Canada) of failing to comply with a lawful demand to provide a breath sample in connection with the accident.

(2) Clause (1) (c) does not prevent an excluded driver or any other occupant of an automobile driven by the excluded driver from recovering accident benefits under a motor vehicle liability policy in respect of which the excluded driver or other occupant is a named insured.

(3) The insurer shall hold in trust any amounts payable as an income replacement benefit, a non-earner benefit or a benefit under section 21, 22 or 23 to a person who sustains an impairment as a result of an accident if,

(a) at the time of the accident, the person was engaged in, or was an occupant of an automobile that was being used in connection with, an act for which the person is charged with a criminal offence; or

(b) the person is charged with an offence under section 254 of the *Criminal Code* (Canada) of failing to comply with a lawful demand to provide a breath sample in connection with the accident.

(4) On the final disposition of all charges described in clause (3) (a) or (b), the amounts and any income on the amounts described in subsection (3),

(a) shall be returned to the insurer, if the person is found guilty of the offence or an included offence; or

(b) shall be paid to the person entitled to the payment, if the person is not found guilty of the offence and an included offence.

(5) In this section,

“criminal offence” means,

(a) operating an automobile while the ability to operate the automobile is impaired by alcohol or a drug,

(b) operating an automobile while the concentration of alcohol in the operator’s blood exceeds the limit permitted by law,

(c) failing to comply with a lawful demand to provide a breath sample, or

(d) any other criminal offence, whether or not the offence is related to the operation of an automobile.

PART VIII PROCEDURES FOR CLAIMING BENEFITS

GENERAL

Notice to insurer and application for benefits

32. (1) A person who intends to apply for one or more benefits described in this Regulation shall notify the insurer of his or her intention no later than the seventh day after the circumstances arose that give rise to the entitlement to the benefit, or as soon as practicable after that day.

(2) The insurer shall promptly provide the person with,

- (a) the appropriate application forms;
- (b) a written explanation of the benefits available;
- (c) information to assist the person in applying for benefits; and
- (d) information on the election relating to income replacement, non-earner and caregiver benefits, if applicable.

(3) If an insurer that is subject to a Guideline referred to in subsection 64 (7) determines, acting reasonably, that there is a likelihood that the person may, in connection with the accident, deliver one or more documents referred to in that subsection, the insurer shall provide the following information to the central processing agency referred to in that subsection:

1. The name, address, gender and date of birth of the person.
2. The date of the accident.
3. Particulars of the automobile insurance policy under which the person asserts he or she is entitled to a benefit or benefits, including,
 - i. the name of the insurer,
 - ii. the policy number, and
 - iii. the name of the person to whom the policy was issued.
4. The claim number assigned by the insurer.
5. Any other information reasonably required by the central processing agency to enable it to carry out its obligations to the insurer under this Regulation.

(4) An insurer's obligation to provide the information referred to in subsection (3) may be discharged by,

- (a) providing the information to the central processing agency; or
- (b) confirming, correcting or supplementing the information previously provided to the central processing agency.

(5) The applicant shall submit a completed and signed application for benefits to the insurer within 30 days after receiving the application forms.

(6) If an insurer receives an incomplete or unsigned application, the insurer shall notify the applicant within 10 business days after receiving the application and shall advise the applicant of the missing information that is required or that the applicant's signature is missing, as appropriate.

- (7) The insurer shall not give a notice under subsection (6) unless,
- (a) the insurer, after a reasonable review of the incomplete application, is unable to determine, without the missing information, whether a benefit is payable; or
 - (b) the application has not been signed by the applicant.

(8) If subsection (6) applies in respect of an incomplete application, no benefit is payable before the applicant provides the missing information or signs the application, as the case may be.

- (9) If an applicant is required by an insurer to submit an additional application in respect of

a benefit that the applicant is receiving or may be eligible to receive, the applicant shall submit the additional application to the insurer within 30 days after receiving the additional application forms from the insurer.

(10) Despite any shorter time limit in this Regulation, if an applicant fails without a reasonable explanation to notify an insurer under subsection (1) within the time required under that subsection, the insurer may delay determining if the applicant is entitled to a benefit and may delay paying the benefit until the later of,

- (a) 45 days after the day the insurer receives the completed and signed application; or
- (b) 10 business days after the day the applicant complies with any request made by the insurer under subsection 33 (1) or (2).

Duty of applicant to provide information

33. (1) An applicant shall, within 10 business days after receiving a request from the insurer, provide the insurer with the following:

- 1. Any information reasonably required to assist the insurer in determining the applicant's entitlement to a benefit.
- 2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.
- 3. The number, street and municipality where the applicant ordinarily resides.
- 4. Proof of the applicant's identity.

(2) If requested by the insurer, an applicant shall submit to an examination under oath, but is not required,

- (a) to submit to more than one examination under oath in respect of matters relating to the same accident; or
- (b) to submit to an examination under oath during a period when the person is incapable of being examined under oath because of his or her physical, mental or psychological condition.

(3) An applicant is entitled to be represented at his or her own expense at an examination under oath by such counsel or other representative of his or her choice as the law permits.

(4) The insurer shall make reasonable efforts to schedule the examination under oath for a time and location that are convenient for the applicant and shall give the applicant reasonable advance notice of the following:

- 1. The date and location of the examination.
- 2. That the applicant is entitled to be represented in the manner described in subsection (3).
- 3. The reason or reasons for the examination.
- 4. That the scope of the examination will be limited to matters that are relevant to the applicant's entitlement to benefits.

(5) The insurer shall limit the scope of the examination under oath to matters that are relevant to the applicant's entitlement to benefits described in this Regulation.

(6) The insurer is not liable to pay a benefit in respect of any period during which the insured person fails to comply with subsection (1) or (2).

- (7) Subsection (6) does not apply in respect of a non-compliance with subsection (2) if,
- (a) the insurer fails to comply with subsection (4) or (5); or
 - (b) the insurer interferes with the applicant's right to be represented as described in subsection (3).

(8) If an applicant who failed to comply with subsection (1) or (2) subsequently complies with that subsection, the insurer,

- (a) shall resume payment of the benefit, if a benefit was being paid; and
- (b) shall pay all amounts that were withheld during the period of non-compliance, if the applicant provides a reasonable explanation for the delay in complying with the subsection.

Result if fail to comply with time limits

34. A person's failure to comply with a time limit set out in this Part does not disentitle the person to a benefit if the person has a reasonable explanation.

Election of income replacement, non-earner or caregiver benefit

35. (1) If an application indicates that the applicant may qualify for two or more of the income replacement benefit, the non-earner benefit and the caregiver benefit under Part II, the insurer shall, within 10 business days after receiving the application, give a notice to the applicant advising the applicant that he or she must elect, within 30 days after receiving the notice, the benefit he or she wishes to receive.

(2) If an applicant is determined to have sustained a catastrophic impairment as a result of an accident, the insurer shall, within 10 business days of the date of the determination, give a notice to the applicant advising the applicant that, despite any election previously made under subsection (1), he or she may elect, within 30 days after receiving the notice, to receive a caregiver benefit if the applicant would otherwise qualify for a caregiver benefit.

(3) The applicant's election under subsection (1) is final and can be subsequently changed only if permitted under subsection (2).

CLAIM FOR INCOME REPLACEMENT BENEFIT, NON-EARNER BENEFIT, CAREGIVER BENEFIT OR PAYMENT FOR HOUSEKEEPING OR HOME MAINTENANCE SERVICES

Application

36. (1) In this section and section 37,

“specified benefit” means an income replacement benefit, non-earner benefit, caregiver benefit or a payment for housekeeping or home maintenance services under section 23.

(2) An applicant for a specified benefit shall submit a completed disability certificate with his or her application under section 32.

(3) An applicant who fails to submit a completed disability certificate is not entitled to a specified benefit for any period before the completed disability certificate is submitted.

(4) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,

- (a) pay the specified benefit;
- (b) give the applicant a notice explaining the medical and any other reasons why the

insurer does not believe the applicant is entitled to the specified benefit and, if the insurer requires an examination under section 44 relating to the specified benefit, advising the applicant of the requirement for an examination; or

(c) send a request to the applicant under subsection 33 (1) or (2).

(5) If the insurer sends a request to the applicant under subsection 33 (1) or (2), the insurer shall, within 10 business days after the applicant complies with the request,

(a) pay the specified benefit; or

(b) give the applicant a notice described in clause (4) (b).

(6) If the insurer fails to comply with subsection (4) or (5) within the applicable time limit, the insurer shall pay the specified benefit for the period starting on the day the insurer received the application and completed disability certificate and ending, if the insurer subsequently gives a notice described in subsection (4) (b), on the day the insurer gives the notice.

(7) If the insurer requires the applicant to undergo an examination under section 44, the insurer shall, within 10 days after receiving the report of the examination,

(a) give a copy of the report to the applicant and to the person who completed the disability certificate submitted with the application; and

(b) provide the applicant with a notice indicating the amount, if any, that the insurer agrees to pay in respect of the specified benefit, the amount, if any, the insurer refuses to pay in respect of the specified benefit and the medical and any other reasons for the insurer's decision.

(8) Within 10 business days after delivering the notice under clause (7) (b), the insurer shall pay the amount, if any, that the insurer agrees to pay in respect of the specified benefit.

(9) Every income replacement benefit, non-earner benefit or caregiver benefit shall be paid at least once every second week, subject to any prepayment of the benefit by the insurer.

Determination of continuing entitlement to specified benefits

37. (1) If an insurer wishes to determine if an insured person is still entitled to a specified benefit, the insurer may, but not more often than is reasonably necessary,

(a) request that the insured person submit, within 15 business days, a new disability certificate completed as of a date on or after the date of the request;

(b) notify the insured person that the insurer requires an examination under section 44; or

(c) do both.

(2) An insurer shall not discontinue paying a specified benefit to an insured person unless,

(a) the insured person fails or refuses to submit a completed disability certificate if requested to do so under subsection (1);

(b) the disability certificate submitted on behalf of the insured person does not support the insured person's continuing entitlement to the benefit;

(c) the insurer has received the report of the examination under section 44, if the insurer required an examination under that section, and has determined that the insured person is not entitled to the benefit;

(d) the insurer is entitled under subsection (7) to refuse to pay the specified benefit;

- (e) the insured person has resumed his or her pre-accident employment duties;
- (f) the insurer is no longer required to pay the specified benefit by reason of subsection (7), paragraph 2 of subsection 28 (1), subsection 33 (6) or section 57 or 58; or
- (g) the insured person is not entitled to the specified benefit for a reason unrelated to whether he or she has an impairment that entitles the insured person to receive the specified benefit.

(3) If an insured person fails to submit a completed disability certificate as required under subsection (1), no specified benefits are payable for the period commencing the 15th business day after the day the insured person received the insurer's request and ending, if the insured person subsequently submits a completed disability certificate, the day the insurer receives the completed disability certificate.

(4) If the insurer determines that an insured person is not entitled or is no longer entitled to receive a specified benefit on any one or more grounds set out in subsection (2), the insurer shall advise the insured person of its determination and the medical and any other reasons for its determination.

(5) Within 10 business days after receiving the report of an examination under section 44, the insurer shall give a copy of the report to the insured person and to the person who completed the disability certificate, if one was provided in accordance with subsection (1).

(6) Within 10 business days after receiving the report of an examination under section 44, the insurer shall provide the insured person with a notice of determination setting out,

- (a) the specified benefits the insurer agrees to pay;
- (b) the specified benefits the insurer refuses to pay;
- (c) the medical and any other reasons for the insurer's decision; and
- (d) if the insurer determines that the insured person is not entitled to a specified benefit, the date that payment of the benefit will be stopped.

(7) If the insured person fails or refuses to comply with subsection 44 (9), the insurer may,

- (a) make a determination that the insured person is no longer entitled to the specified benefit; and
- (b) refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with that subsection and before the insured person complies with that subsection.

(8) If the insured person subsequently complies with subsection 44 (9), the insurer shall,

- (a) reconsider the insured person's entitlement to the specified benefit; and
- (b) if the insurer determines that the insured person is still entitled to the specified benefit,
 - (i) resume payment of the specified benefit, and
 - (ii) pay all amounts, if any, that were withheld during the period of non-compliance if the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with that subsection.

CLAIM FOR MEDICAL OR REHABILITATION BENEFITS

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

38. (1) This section applies to,

- (a) medical and rehabilitation benefits other than benefits payable in accordance with the Minor Injury Guideline; and
- (b) all applications for approval of assessments or examinations.

(2) An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirements of subsection (3) unless,

- (a) the insurer gives the insured person a notice under subsection 39 (1) stating that the insurer will pay the expense without a treatment and assessment plan;
- (b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates; or
- (c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,
 - (i) drugs prescribed by a regulated health professional, or
 - (ii) goods with a cost of \$250 or less per item.

(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 will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 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,

(A) that the expenses contemplated by the treatment and assessment plan are reasonable and necessary for the insured person's treatment or

rehabilitation, and

(B) that the impairment sustained by the insured person does not come within a *Pre-approved Framework Guideline* referred to in the Old Regulation.

(4) A claim for dental goods or services completed and signed by a dentist and in the form approved by the Ontario Dental Association is deemed to be a treatment and assessment plan that satisfies the requirements of subsection (3).

(5) An insurer may refuse to accept a treatment and assessment plan if the plan describes goods or services to be received or an assessment or examination to be conducted in respect of any period during which the insured person is entitled to receive goods or services under the Minor Injury Guideline in respect of the impairment.

(6) An insurer's refusal to accept a treatment and assessment plan under subsection (5) is final and is not subject to review.

(7) Nothing in subsection (5) prevents an insured person, while receiving goods or services under the Minor Injury Guideline, from submitting a treatment and assessment plan applicable to a period other than the period for which the insured person is receiving goods or services under the Minor Injury Guideline.

(8) Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical and any other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary.

(9) If the insurer believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person.

(10) If the insurer has not agreed to pay for all goods, services, assessments and examinations described in the treatment and assessment plan or believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) may notify the insured person that the insurer requires the insured person to undergo an examination under section 44.

(11) If the insurer fails to give a notice in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:

1. The insurer is prohibited from taking the position that the insured person has an impairment to which the Minor Injury Guideline applies.
2. The insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives a notice described in subsection (8).

(12) If an insurer advises an insured person that the Minor Injury Guideline applies, the insured person may submit a treatment confirmation form under section 40 and, pending the insurer's determination, may receive goods and services in accordance with the Minor Injury Guideline.

(13) Within 10 business days after receiving the report of an examination conducted under

section 44 for the purpose of the treatment and assessment plan, the insurer shall give a copy of the report to the insured person and to the regulated health professional who prepared the treatment and assessment plan.

(14) Within 10 business days after receiving the report, the insurer shall,

- (a) provide the insured person with a notice indicating the goods and services described in the treatment and assessment plan that the insurer agrees to pay for, the goods and services the insurer refuses to pay for and the medical and any other reasons for the insurer's decision; or
- (b) if the insurer determines that the Minor Injury Guideline applies, advise the insured person that the Minor Injury Guideline applies to the insured person's impairment and provide medical and any other reasons for the insurer's determination.

(15) The insurer shall pay for goods and services the insurer agreed to pay for in the notice under subsection (8) or (14) or is required to pay for under this section within 30 days after receiving an invoice for them.

If no treatment and assessment plan required

39. (1) This section applies to a claim for a medical or rehabilitation benefit or an application for approval of an assessment or examination under section 38 if the insurer gives the insured person a notice informing the insured person that the insurer will pay the expenses without the submission of a treatment and assessment plan under that section.

(2) If the insurer gives the insured person a notice under subsection (1),

- (a) the notice must describe the expenses that the insurer will pay without the submission of a treatment and assessment plan and shall specify,
 - (i) the types of expenses,
 - (ii) any restrictions on the amount of the expenses, and
 - (iii) any restrictions on when the expenses are to be incurred;
- (b) the insurer shall comply with the requirements set out in any applicable Guideline if the notice is given in connection with a proposal, recommendation or suggestion that the insured person receive goods or services from a person named by the insurer;
- (c) the insurer shall pay expenses described in the notice within 30 days after receiving an invoice for them; and
- (d) the insurer shall, if there is a dispute about whether for the purpose of subsection 15 (1) or 16 (3) an expense described in the notice is reasonable or necessary, pay the expense pending resolution of the dispute in accordance with sections 279 to 283 of the Act.

CLAIM FOR MEDICAL OR REHABILITATION BENEFITS TO WHICH MINOR INJURY GUIDELINE APPLIES

Minor Injury Guideline

40. (1) This section applies to a person if,

- (a) the person sustains, as a result of an accident, a minor injury to which the Minor Injury Guideline applies; and

(b) the person submits or intends to submit an application under section 32 for medical or rehabilitation benefits.

(2) The person shall submit, within the time specified in the Minor Injury Guideline, a treatment confirmation form that satisfies the following requirements:

1. The treatment confirmation form must be prepared and signed by a health practitioner,
 - i. who is authorized by law to treat the impairment that is the subject of the form,
 - ii. who is authorized under the Minor Injury Guideline to complete the treatment confirmation form, and
 - iii. who will be the health practitioner responsible for providing the goods and services described in the treatment confirmation form.
2. The treatment confirmation form must contain details concerning the impairment and specify the provisions of the Minor Injury Guideline that apply.
3. The treatment confirmation form must be signed by the person claiming benefits, unless the insurer waives this requirement.

(3) Within five business days after receiving a treatment confirmation form, the insurer shall send a notice to the person claiming benefits and to the health practitioner,

- (a) acknowledging receipt by the insurer of the treatment confirmation form; and
- (b) advising if the person claiming benefits is an insured person with respect to the accident.

(4) If the person also submits a completed and signed application under section 32 and the insurer accepts the claim for benefits, the insurer shall, within 30 days of receipt, pay every invoice for goods and services described in section 15 or 16 that are provided in accordance with the Minor Injury Guideline.

(5) An insured person shall submit an amended treatment confirmation form if, during the course of treatment under the Minor Injury Guideline, he or she changes the health practitioner who is responsible for providing goods and services described in the treatment confirmation form.

(6) The insurer is liable to pay for goods and services described in an amended treatment confirmation form only to the extent the goods and services have not already been provided in accordance with the Minor Injury Guideline.

(7) If goods or services available under the Minor Injury Guideline are not provided within the times specified in that Guideline, the insured person shall submit a treatment and assessment plan under section 38 if he or she wishes to obtain medical or rehabilitation benefits to which the Minor Injury Guideline would otherwise apply.

(8) If a court or arbitrator determines, in any dispute about an insured person's entitlement to medical or rehabilitation benefits or related assessments or examinations, that the Minor Injury Guideline applies to an insured person and the insured person received benefits or underwent assessments or examinations under that Guideline,

- (a) the benefits are deemed to have been reasonable and necessary for the purposes of sections 15 and 16; and

- (b) the assessments and examinations are deemed to have been reasonably required for the purposes of section 25.

If treatment confirmation form not required

41. (1) This section applies to a claim for medical or rehabilitation benefits under section 40 in respect of a minor injury,

- (a) if the insurer gives the insured person a notice informing the insured person that the insurer offers to pay for the goods and services described in the Minor Injury Guideline without the submission of a treatment confirmation form; and
- (b) if the insured person accepts the insurer's offer and does not submit a treatment confirmation form in accordance with section 40 or a treatment and assessment plan in accordance with section 38 after receiving the notice described in clause (a).

(2) If this section applies, the following rules apply:

1. If the notice is given in connection with a proposal, recommendation or suggestion that the insured person receive goods or services from a person named by the insurer, the insurer shall also comply with any applicable Guideline.
2. After the insured person submits an application under section 32 to the insurer, the insurer shall pay the expenses described in the notice within 30 days after receiving an invoice for them.

CLAIM FOR ATTENDANT CARE BENEFITS

Application for attendant care benefits

42. (1) Subject to subsection (2), an application for attendant care benefits for an insured person must be,

- (a) in the form of and contain the information required to be provided in the version of the document entitled "Assessment of Attendant Care Needs" that is approved by the Superintendent for use in connection with the claim; and
- (b) prepared and submitted to the insurer by an occupational therapist or a registered nurse.

(2) If a Guideline issued for the purpose of this section specifies conditions, restrictions or limits with respect to the preparation of an assessment of attendant care needs, the assessment of attendant care needs must be prepared in accordance with the Guideline.

(3) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that specifies the expenses described in the assessment of attendant care needs the insurer agrees to pay, the expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision.

(4) A notice under subsection (3) may require the insured person to undergo an examination under section 44 if the insurer has not agreed to pay all expenses described in the assessment of attendant care needs.

(5) An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer.

(6) The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 44 required by the insurer, shall calculate the amount of the

benefits based on the assessment of attendant care needs.

(7) If an insurer wants to determine if an insured person is still entitled to attendant care benefits, wants to determine if the benefits are being paid in the appropriate amount or wants to determine both, the insurer shall give the person a notice requesting that a new assessment of attendant care needs for the insured person be prepared in accordance with this section and submitted to the insurer within 15 business days after the insured person receives the notice.

(8) Subject to subsection (12), a notice under subsection (7) may also advise the insured person that the insurer requires an examination under section 44.

(9) Subject to subsection (12), new assessments of attendant care needs may be submitted to an insurer at any time there are changes that would affect the amount of the benefits.

(10) If a new assessment of attendant care needs indicates that it is appropriate to increase the amount of the attendant care benefits and the insurer has not already advised the insured person that the insurer requires an examination under section 44, the insurer may give a notice to the insured person advising that the insurer requires an examination under that section.

(11) If a new assessment of attendant care needs is required under subsection (7) or the insurer requires an examination under section 44, the insurer shall, subject to section 20 and paragraph 2 of subsection 19 (3), continue to pay the insured person attendant care benefits at the same rate until the insurer receives the assessment of attendant care needs or the report of the examination, as applicable.

(12) If more than 104 weeks have elapsed since the accident, the insurer shall not require an examination under section 44 to determine the insured person's entitlement to attendant care benefits and the insured person shall not submit nor be required to submit an assessment of attendant care needs to the insurer unless,

(a) the insured person is or may be entitled under section 20 to receive attendant care benefits more than 104 weeks after the accident; and

(b) at least 52 weeks have elapsed since the last examination under section 44 relating to entitlement to attendant care benefits.

(13) Within 10 business days after receiving the report of an examination under section 44, the insurer shall,

(a) give a copy of the report to the person who prepared the assessment of attendant care needs; and

(b) provide the insured person with a notice specifying the benefits and expenses the insurer agrees to pay, the benefits and expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision.

(14) If an insured person fails or refuses to comply with subsection 44 (9), the insurer may,

(a) make a determination that the insured person is not entitled to attendant care benefits; and

(b) refuse to pay attendant care benefits relating to the period after the person failed or refused to comply with that subsection and before the insured person submits to the examination and provides the material required by that subsection.

(15) If an insured person subsequently complies with subsection 44 (9), the insurer shall,

- (a) reconsider the application and make a determination under this section;
- (b) subject to the new determination, section 20 and paragraph 2 of subsection 19 (3), resume payment of attendant care benefits; and
- (c) pay all amounts, if any, that were withheld during the period of non-compliance, if the insured person provides, not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with that subsection.

(16) If an insurer determines that an insured person is not entitled by reason of section 20 to attendant care benefits for expenses incurred more than 104 weeks after the accident, the insurer shall give the insured person a notice of its determination, with reasons, not less than 10 business days before the last payment of attendant care benefits.

OTHER TYPES OF BENEFITS

Parts IV and V expenses and benefits

43. (1) If a person is entitled to a death benefit, a funeral benefit or a benefit under Part IV, the insurer shall pay the benefit within 30 days after the insurer receives an application for the benefit.

(2) If the insurer refuses to pay a benefit referred to in subsection (1), the insurer shall give the person a notice of the refusal and the medical and any other reasons for the refusal within 30 days after the insurer receives the application for the benefit.

(3) In the case of a benefit for housekeeping and home maintenance services under section 23, subsections (1) and (2) are subject to sections 36 and 37.

ADDITIONAL MATTERS

Examination required by insurer

44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, but not more often than is reasonably necessary, an insurer may require an insured person to be examined under this section by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation.

(2) Despite subsection (1), if a Guideline specifies conditions, restrictions or limits with respect to the determination of whether an impairment is a catastrophic impairment and the purpose of the examination is to determine whether the insured person has sustained a catastrophic impairment, the determination must be made in accordance with those conditions, restrictions and limits.

(3) Subsection (1) does not apply with respect to,

- (a) a benefit payable in accordance with the Minor Injury Guideline; or
- (b) a funeral benefit or death benefit.

(4) Subject to subsection (7), an examination under this section may be limited by the insurer to an examination of material provided under subsection (9) in respect of the insured person without requiring the attendance of the insured person.

(5) If the insurer requires an examination under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,

- (a) the medical and any other reasons for the examination;
- (b) whether the attendance of the insured person is required at the examination;
- (c) the name of the person or persons who will conduct the examination, any regulated health profession to which they belong and their titles and designations indicating their specialization, if any, in their professions; and
- (d) if the attendance of the insured person is required at the examination, the day, time and location of the examination and, if the examination will require more than one day, the same information for the subsequent days.

(6) If the attendance of the insured person is required at the examination, the insurer shall give the notice required under subsection (5) not less than five business days before the examination, unless the insured person and the insurer mutually agree otherwise.

(7) If the notice under subsection (5) indicates that the attendance of the insured person is not required at the examination and it is subsequently determined by the person conducting the examination that the insured person should be in attendance and personally examined, the insurer shall give a notice to the insured person at least five business days before the examination,

- (a) notifying the insured person of the change;
- (b) requiring the attendance of the insured person at the examination; and
- (c) setting out the day, time and location of the examination and, if the examination will require more than one day, setting out the same information for the subsequent days.

(8) A notice under subsection (5) or (7) may be verbal if a written confirmation is given as soon as practicable afterwards.

(9) The following rules apply in respect of the examination:

1. If the attendance of the insured person is not required, the insured person and the insurer shall, within five business days after the day the notice under subsection (5) is received by the insured person, provide to the person or persons conducting the examination such information and documents as are relevant or necessary for the review of the insured person's medical condition.
2. If the attendance of the insured person is required,
 - i. the insurer shall make reasonable efforts to schedule the examination for a day, time and location that are convenient for the insured person,
 - ii. the insured person and the insurer shall, not later than five business days before the day scheduled for the examination, provide to the person or persons conducting the examination such information and documents as are relevant or necessary for the review of the insured person's medical condition, and
 - iii. the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination.
3. If the examination relates to an application for attendant care benefits, the report of the examination must include an assessment of attendant care needs prepared in accordance with section 42.

Determination of catastrophic impairment

45. (1) An insured person who sustains an impairment as a result of an accident may apply to the insurer for a determination of whether the impairment is a catastrophic impairment.

(2) The following rules apply with respect to an application under subsection (1):

1. An assessment or examination in connection with a determination of catastrophic impairment shall be conducted only by a physician.
2. Despite paragraph 1, if the impairment is only a brain impairment, the assessment or examination may be conducted by a neuropsychologist.
3. If a Guideline specifies conditions, restrictions or limits with respect to the determination of whether an impairment is a catastrophic impairment, the determination must be made in accordance with those conditions, restrictions and limits.

(3) Within 10 business days after receiving an application under subsection (1) prepared and signed by the person who conducted the assessment or examination under subsection (2), the insurer shall give the insured person,

- (a) a notice stating that the insurer has determined that the impairment is a catastrophic impairment; or
- (b) a notice stating that the insurer has determined that the impairment is not a catastrophic impairment and specifying the medical and any other reasons for the insurer's decision and, if the insurer requires an examination under section 44 relating to whether the impairment is a catastrophic impairment, so advising the insured person.

(4) If an application is made under this section not more than 104 weeks after the accident and, immediately before the application was made, the insured person was receiving attendant care benefits,

- (a) the insurer shall continue to pay attendant care benefits to the insured person during the period before the insurer makes a determination under this section; and
- (b) the amount of the attendant care benefits for the period referred to in clause (a) shall be determined on the assumption that the insured person's impairment is a catastrophic impairment.

(5) Within 10 business days after receiving the report of an examination under section 44, the insurer shall,

- (a) give a copy of the report to the insured person and to the person who prepared the application under this section; and
- (b) provide the insured person with a notice stating that the insurer has determined that the impairment is a catastrophic impairment or is not a catastrophic impairment and setting out the medical and any other reasons for the insurer's determination.

(6) If an insured person is determined to have sustained a catastrophic impairment as a result of an accident, the insured person is entitled to payment of all expenses incurred before the date of the determination and to which the insured person would otherwise be entitled to payment under this Regulation by virtue of having sustained a catastrophic impairment.

Conflict of interest re referrals by insurer

46. (1) This section applies if an insurer intends to refer an insured person to a person with whom the insurer has a potential conflict of interest and the referral is for the purpose of,

- (a) the insured person obtaining any goods or services referred to in section 15 or 16 from the person recommended by the insurer; or
- (b) the insured person being examined or assessed, other than under section 44, by the person recommended by the insurer.

(2) The insurer shall not refer the insured person to the person unless the insurer has first given the insured person a notice that satisfies the following and the insured person gives a written consent to obtain the goods or services from or be examined or assessed by the person:

- 1. The notice must specify the nature of the relationship between the insurer and the person, including the terms of remuneration of the person.
- 2. The notice must specify the nature, amount and duration, if applicable, of the goods or services or the assessment or examination.
- 3. The notice must inform the insured person that he or she is free to decline the proposed referral, or to revoke any consent given at any time, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits.
- 4. The notice must inform the insured person that he or she is free to choose from whom the insured person prefers to receive the goods and services, or by whom the insured person prefers to be assessed or examined, in accordance with this Regulation, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits under this Regulation.
- 5. The notice must inform the insured person of his or her rights and responsibilities with respect to the goods, services, assessments and examinations.

(3) In this section, an insurer is deemed to have a potential conflict of interest with a person if,

- (a) the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of goods or services by, on behalf of, or under the authority or supervision of the person; or
- (b) goods or services will be provided by, on behalf of, or under the authority or supervision of the person,
 - (i) pursuant to a subsisting arrangement with the insurer under which goods or services referred to in this Regulation are or will be provided at the insurer's expense, or
 - (ii) as a result of the insurer's referral, recommendation or suggestion of the person to the insured person.

PART IX PAYMENT OF BENEFITS

Deduction of collateral benefits

47. (1) The insurer may deduct the following amounts from the amount payable to an insured person as an income replacement or non-earner benefit under this Regulation:

- 1. Any temporary disability benefits being received by the insured person in respect of a

period following the accident and in respect of an impairment that occurred before the accident.

2. Any other periodic benefit being received by the insured person in respect of a period following the accident and in respect of an impairment that occurred before the accident, if the insured person was receiving that other periodic benefit at the time he or she first qualified for the income replacement or non-earner benefit and, at that time, the other periodic benefit was a temporary disability benefit.

(2) Payment of a medical, rehabilitation or attendant care benefit or a benefit under Part IV is not required for that portion of an expense for which payment is reasonably available to the insured person under any insurance plan or law or under any other plan or law.

(3) In this section,

“temporary disability benefit” means,

- (a) an income replacement or non-earner benefit paid under this Regulation or the Old Regulation, unless the benefit is paid more than 104 weeks after the onset of the disability,
- (b) a caregiver benefit paid under this Regulation or the Old Regulation,
- (c) benefits paid under Part III or IV or section 32 of Ontario Regulation 776/93,
- (d) benefits paid under section 37, subsection 43 (9) or subsection 147 (2) of the pre-1997 Act, as defined in Part IX of the *Workplace Safety and Insurance Act, 1997*, in respect of injuries that occurred before January 1, 1998, including benefits paid under those provisions as those provisions are deemed to have been amended by Part IX of the *Workplace Safety and Insurance Act, 1997*,
- (e) benefits paid under subsection 43 (3) of the *Workplace Safety and Insurance Act, 1997* in respect of injuries that occurred after December 31, 1997, or
- (f) any other periodic temporary benefit paid under an income continuation benefit plan or law, other than,
 - (i) benefits under the *Employment Insurance Act (Canada)*,
 - (ii) a non-earner benefit paid under this Regulation or the Old Regulation more than 104 weeks after the onset of the disability,
 - (iii) benefits paid under Part V of Ontario Regulation 776/93 for more than 104 weeks,
 - (iv) benefits paid under Part IV of Regulation 672 of the Revised Regulations of Ontario, 1990 for more than 156 weeks, or
 - (v) benefits paid under Part II of Subsection 2 of Schedule C to the *Insurance Act* as it existed before June 22, 1990 that have been paid for more than 104 weeks.

Method of payment

48. (1) An insurer shall pay a benefit under this Regulation,

- (a) by mailing or delivering a cheque payable to the person entitled to the benefit to the address where the person ordinarily resides; or
- (b) with the consent of the person entitled to the benefit, by electronic funds transfer to an

account in the name of the person.

(2) Despite subsection (1),

- (a) an insurer may arrange to be invoiced directly and to pay directly for goods or services provided in respect of an insured person;
- (b) an insurer may pay a benefit into court under section 271 of the Act; or
- (c) if the person entitled to the benefit has so directed in writing, an insurer shall pay the benefit directly to the person who submitted an invoice in respect of the benefit to a central processing agency in accordance with subsection 49.

Amounts payable under a Guideline

49. (1) Despite any other provision of this Regulation, if a benefit that would otherwise be payable by an insurer is payable in respect of an expense for goods or services specified in a Guideline that applies for the purposes of this section, an insurer to whom the Guideline applies shall not pay the benefit unless an invoice for the expense, in the form approved by the Superintendent and including all of the information required by the form,

- (a) is delivered to the insurer, if neither of paragraph 2 or 3 of subsection 64 (7) applies; or
- (b) is deemed to be received by the insurer under subsection 64 (8) or (9), if paragraph 2 or 3 of subsection 64 (7) applies.

(2) An insurer shall not waive the submission of an invoice for goods or services to which subsection (1) applies.

(3) If a Guideline specifies that invoices are to be delivered to a central processing agency on behalf of insurers to whom the Guideline applies, each of those insurers that receives an invoice that complies with subsection (1) shall report the following to the central processing agency in the manner and within the time required by the Guideline:

1. The date or dates on which the goods or services referred to in the invoice were delivered or rendered.
2. The names, addresses and professional college registration numbers, if applicable, of each provider of goods or services referred to in the invoice.
3. Particulars of the goods or services referred to in the invoice.
4. Particulars of the injury or injuries in respect of which the goods or services were delivered or rendered.
5. The amount, if any, paid in respect of the goods or services referred to in the invoice by any person other than the insurer.
6. The amount paid by the insurer in respect of the invoice.
7. The amount paid by the insurer in respect of each separately described component of the invoice.
8. The date on which a decision was made on payment or other disposition of the invoice.
9. Any other disposition of the invoice.
10. The information referred to in subsection 32 (3).
11. Such additional information as may be specified in the Guideline, if the invoice is in

respect of expenses described in a notice given by the insurer under subsection 39 (1) or 41 (1).

Explanation of benefit amounts

50. (1) When a benefit is first paid or the amount of a benefit is subsequently changed, the insurer shall provide the insured person with a written explanation of how the amount of the benefit was determined.

(2) While medical, rehabilitation or attendant care benefits are being claimed by or are being paid to or on behalf of an insured person, the insurer shall deliver benefit statements to the insured person in accordance with this section.

(3) A benefit statement required under subsection (2) shall include a statement of,

- (a) the amount paid to the date of the benefit statement in respect of medical and rehabilitation benefits;
- (b) the additional amount remaining in respect of medical and rehabilitation benefits, taking into account the applicable maximum limits referred to in sections 18 and 28, if the insured person were to be entitled to payment of those benefits;
- (c) the amount paid to the date of the benefit statement in respect of attendant care benefits;
- (d) the additional amount remaining in respect of attendant care benefits, taking into account the applicable maximum limits referred to in sections 20 and 28, if the insured person were to be entitled to payment of attendant care benefits; and
- (e) the amount paid by the insurer to the date of the benefit statement in respect of examinations conducted under section 44.

(4) Subject to subsection (5), the benefit statements must be delivered at the following times:

1. If it has been determined that the insured person has sustained a catastrophic impairment as a result of the accident, a benefit statement must be delivered at least once a year, commencing not later than 12 months after the date the insured person was determined to have sustained the catastrophic impairment.
2. In any other case, a benefit statement must be delivered at least once every two months, commencing not later than two months after the application for the benefit was first made.

(5) Despite subsection (2), an insurer is not required to deliver a benefit statement if all of the amounts referred to in subsection (3) are unchanged from the amounts set out in the most recent benefit statement delivered in accordance with this section.

Overdue payments

51. (1) An amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Regulation.

(2) If payment of a benefit under this Regulation is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue until it is paid, at the rate of 1 per cent per month, compounded monthly.

Repayments to insurer

- 52.** (1) Subject to subsection (3), a person is liable to repay to the insurer,
- (a) any benefit described in this Regulation that is paid to the person as a result of an error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud;
 - (b) any income replacement or non-earner benefit under Part II that is paid to the person if he or she, or a person in respect of whom the payment was made, was disqualified from receiving the benefit under Part VII; or
 - (c) any income replacement, non-earner or caregiver benefit under Part II or any benefit under Part IV, to the extent of any payments received by the person that are deductible under this Regulation from the amount of the benefit.
- (2) If a person is liable to repay an amount to an insurer under this section,
- (a) the insurer shall give the person notice of the amount that is required to be repaid; and
 - (b) the insurer may, if the person is receiving an income replacement or caregiver benefit, give the person notice that the insurer intends to collect the amount by reducing each subsequent payment of the benefit by up to 20 per cent of the amount that would otherwise be the amount of the benefit.
- (3) If the notice required under subsection (2) is not given within 12 months after the payment of the amount that is to be repaid, the person to whom the notice would have been given ceases to be liable to repay the amount unless it was originally paid to the person as a result of wilful misrepresentation or fraud.
- (4) An insurer that has given a notice referred to in clause (2) (b) may obtain repayment in the manner described in the notice.
- (5) The insurer may charge interest on the outstanding balance of the amount to be repaid for the period starting on the 15th day after the notice is given under subsection (2) and ending on the day repayment is received in full, calculated at the bank rate in effect on the 15th day after the notice under subsection (2) is given.
- (6) In subsection (5),

“bank rate” means the bank rate established by the Bank of Canada as the minimum rate at which the Bank of Canada makes short term advances to the banks listed in Schedule I to the *Bank Act* (Canada).

Termination of benefits for material misrepresentation

- 53.** An insurer may terminate the payment of benefits to or on behalf of an insured person,
- (a) if the insured person has wilfully misrepresented material facts with respect to the application for the benefit; and
 - (b) if the insurer provides the insured person with a notice setting out the reasons for the termination.

Notice of right to dispute insurer’s refusal to pay or reduction of benefits

54. If an insurer refuses to pay a benefit or reduces the amount of a benefit that a person is receiving, the insurer shall provide the person with a written notice advising the person of his or her right to dispute the refusal or reduction.

Mediation proceedings

55. An insured person shall not commence a mediation proceeding under section 280 of the Act unless,

- (a) the insured person has notified the insurer of the circumstances giving rise to a claim for a benefit and has submitted an application for the benefit within the times prescribed by this Regulation; and
- (b) the insured person has complied with section 44 if the insurer provided the insured person with notice in accordance with this Regulation that it required an examination under that section.

Time limit for proceedings

56. (1) A mediation proceeding or evaluation under section 280 or 280.1 of the Act or a court proceeding or arbitration under clause 281 (1) (a) or (b) of the Act in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed.

(2) Despite subsection (1), a court proceeding or arbitration under clause 281 (1) (a) or (b) of the Act may be commenced within 90 days after the mediator reports to the parties under subsection 280 (8) of the Act or within 30 days after the person performing the evaluation provides a report to the parties under section 280.1 of the Act, whichever is later.

PART X

RESPONSIBILITY TO OBTAIN TREATMENT, PARTICIPATE IN REHABILITATION AND SEEK EMPLOYMENT OR SELF-EMPLOYMENT

Treatment and rehabilitation

57. (1) This section applies to an insured person if compliance with subsection (2) would not be detrimental to his or her treatment or recovery.

(2) An insured person who is entitled to an income replacement, non-earner or caregiver benefit shall obtain such treatment and participate in such rehabilitation as is reasonable, available and necessary to,

- (a) permit the insured person to engage in employment or self-employment in accordance with the criteria set out in subsection (3), in the case of an insured person entitled to an income replacement benefit; or
 - (b) shorten the period during which the benefit is payable, in any other case.
- (3) The criteria referred to in clause (2) (a) are:
1. The essential tasks of the employment or self-employment are of a type that the insured person,
 - i. is able and qualified to perform, or
 - ii. would be able and qualified to perform if the insured person obtained treatment and participated in rehabilitation that is reasonable, available and necessary to permit the person to engage in the employment or self-employment.
 2. The place of employment or self-employment is in the area in which the insured person lives or it is reasonable for the insured person to engage in the employment or self-employment in that area.
 3. The employment or self-employment is of a type in which it would be reasonable to expect the insured person to engage, having regard to the possibility of deterioration in

the insured person's impairment and to the insured person's personal and vocational characteristics.

(4) If the insured person is still receiving medical and rehabilitation benefits and fails to obtain treatment or participate in rehabilitation in accordance with subsection (2), the insurer may notify the insured person that the insurer intends to stop payment of the income replacement, non-earner or caregiver benefit in accordance with subsection (5).

(5) If at least 10 business days have elapsed after a notice is given under subsection (4) and the insured person has not complied with subsection (2), the insurer may stop payment of the benefit.

(6) Section 37 does not apply in respect of a stoppage of benefits, or proposed stoppage of benefits, under this section.

(7) If, after the stoppage of benefits under subsection (5), the insured person subsequently complies with subsection (2), the insurer shall resume payment of the benefit for periods after the insured person complied.

Employment and self-employment

58. (1) This section applies to an insured person who is entitled to an income replacement benefit if,

(a) returning to employment or to self-employment would not be detrimental to his or her treatment or recovery; and

(b) he or she is not participating in a vocational rehabilitation program.

(2) The insured person shall make reasonable efforts to,

(a) return to the employment or self-employment in which he or she was engaged at the time of the accident;

(b) obtain employment for which he or she is reasonably suited by education, training or experience; or

(c) engage in self-employment for which he or she is reasonably suited by education, training or experience.

(3) If the insured person fails to make reasonable efforts to comply with subsection (2), the insurer may notify the insured person that the insurer intends to stop payment of the benefit in accordance with subsection (4).

(4) If at least 10 business days have elapsed after a notice is given under subsection (3) and the insured person has not complied with subsection (2), the insurer may stop payment of the benefit.

(5) Section 37 does not apply in respect of a stoppage of benefits, or proposed stoppage of benefits, under this section.

(6) If, after the stoppage of benefits under subsection (4), the insured person subsequently complies with subsection (2), the insurer shall resume payment of the benefit for periods after the insured person complies.

PART XI INTERACTION WITH OTHER SYSTEMS

Accidents outside Ontario

59. (1) This section applies if,

- (a) as a result of an accident in another province or territory of Canada or a jurisdiction in the United States of America, a person insured in that jurisdiction within the meaning of subsection (4) dies or sustains an impairment or incurs an expense described in section 15, 16 or 19; and
- (b) no benefits are received under the law of the jurisdiction in which the accident occurred.

(2) The person, or the person claiming benefits in respect of him or her, may elect to receive either of the following, but not both:

- 1. The benefits described in this Regulation, other than the benefits referred to in paragraph 2.
- 2. Benefits in the same amounts and subject to the same conditions as if the person was a resident of the jurisdiction in which the accident occurred and was entitled to payments under the law of that jurisdiction.

(3) If an election is made under subsection (2), the insurer shall pay benefits in accordance with the election.

(4) For the purpose of this section, a person is insured in the jurisdiction in which the accident occurred if, at the time of the accident,

- (a) the person was authorized by law to be or to remain in Canada and was living and ordinarily present in Ontario;
- (b) the person met the criteria prescribed for recovery under the law of the jurisdiction in which the accident occurred;
- (c) the person was not an owner, driver or occupant of an automobile registered in the jurisdiction in which the accident occurred; and
- (d) the person,
 - (i) was an occupant of the insured automobile,
 - (ii) was the named insured, a person specified in the policy as a driver of the insured automobile, the spouse of the named insured or a dependant of the named insured or spouse and was an occupant of an automobile,
 - (iii) was the named insured, his or her spouse or a dependant of the named insured or spouse and was struck by an automobile while not an occupant of an automobile,
 - (iv) was struck by the insured automobile while not an occupant of an automobile,
 - (v) if the named insured is a corporation, unincorporated association, partnership or sole proprietorship, was a person for whose regular use the insured automobile was supplied, his or her spouse or a dependant of the person or spouse and suffered an impairment while being the occupant of an automobile or suffered an impairment caused by an automobile of which he or she was not an occupant, or
 - (vi) was struck by an automobile that was driven by a person described in subclause (i), (ii) or (v).

Social assistance payments

60. The insurer shall pay benefits described in this Regulation even though the insured person is entitled to or has received social assistance or similar payments, services or benefits under an Act of the Legislative Assembly or under similar legislation in another jurisdiction.

Workplace Safety and Insurance Act, 1997

61. (1) The insurer is not required to pay benefits described in this Regulation in respect of any insured person who, as a result of an accident, is entitled to receive benefits under the *Workplace Safety and Insurance Act, 1997* or any other workers' compensation law or plan.

(2) Subsection (1) does not apply in respect of an insured person who elects to bring an action referred to in section 30 of the *Workplace Safety and Insurance Act, 1997* if the election is not made primarily for the purpose of claiming benefits under this Regulation.

(3) If a person is entitled to receive benefits under this Regulation as a result of an election made under section 30 of the *Workplace Safety and Insurance Act, 1997*, no income replacement, non-earner or caregiver benefit is payable under this Regulation to the person in respect of any period of time before the person makes the election.

(4) If a person who would be entitled to benefits under this Regulation in the absence of subsection (1) elects to bring an action referred to in section 30 of the *Workplace Safety and Insurance Act, 1997* and there is a dispute concerning the insurer's liability to pay an expense for a vocational rehabilitation program the person was attending at the time of the election and continues to attend, the insurer shall pay the expense pending resolution of the dispute.

(5) Despite subsection (1), if there is a dispute about whether subsection (1) applies to a person, the insurer shall pay full benefits to the person under this Regulation pending resolution of the dispute if,

- (a) the person makes an assignment to the insurer of any benefits under any workers' compensation law or plan to which he or she is or may become entitled as a result of the accident; and
- (b) the administrator or board responsible for the administration of the workers' compensation law or plan approves the assignment.

PART XII MISCELLANEOUS

Assignment of benefits

62. (1) Except as otherwise provided by subsection (2), the assignment of a benefit under this Regulation and the assignment of the right to pursue a mediation, arbitration, appeal or variation proceeding under sections 280 to 284 of the Act are void.

(2) The following assignments are not void:

1. An assignment under section 267.8 of the Act.
2. An assignment of a benefit to,
 - i. the Ministry of Community and Social Services,
 - ii. a delivery agent under the *Ontario Disability Support Program Act, 1997* or the *Ontario Works Act, 1997*, or

- iii. the Minister of Finance under subsection 6.1 (4) of the *Motor Vehicle Accident Claims Act*.

Copies of this Regulation

63. On request, the insurer shall provide a copy of this Regulation without charge to a named insured or a person entitled to benefits under this Regulation.

Notices and delivery

64. (1) Except as otherwise permitted by this Regulation, all notices required or permitted under this Regulation, other than a notice under subsection 32 (1) or (6), must be in writing.

(2) Any document, including a notice in writing, required or permitted under this Regulation to be given to a person may be delivered,

- (a) by faxing the document to the person or to the solicitor or authorized representative, if any, of the person in accordance with subsection (19);
- (b) by leaving a copy of the document with the solicitor or authorized representative, if any, of the person, or with an employee in the office of the solicitor or authorized representative;
- (c) by personal delivery to the person;
- (d) by ordinary or registered mail,
 - (i) in the case of an insurer, addressed to the insurer or its chief executive officer at the insurer's head office in Ontario as identified in the records of the Superintendent,
 - (ii) in the case of a person other than an insurer, addressed to the person at his or her last known address; or
- (e) by electronic means, if the intended recipient of the document consents to delivery by electronic means.

(3) For the purposes of clauses (2) (a) and (b), but subject to subsection (4), an authorized representative may include a regulated health professional if the document is a notice under subsection 38 (8) or 44 (5) or (7) or a report prepared under section 44.

(4) Subsection (3) does not apply unless,

- (a) the insured person is not represented at the relevant time by a solicitor or another authorized representative;
- (b) the insured person gives to the insurer a signed authorization and direction specifying which documents listed in subsection (3) that the insurer is authorized and directed to give to the regulated health professional;
- (c) the signed authorization and direction is given to the insurer before the document is given to the regulated health professional; and
- (d) the regulated health professional has agreed to act in accordance with the authorization and direction.

(5) Despite clause (2) (d), any notice or other document that must be given within fewer than five business days shall not be delivered by ordinary mail.

(6) The functional equivalency rules set out in sections 4 to 13 of the *Electronic Commerce*

Act, 2000 apply in the case of the delivery of a document by electronic means under clause (2) (e).

(7) Despite subsection (2), but subject to subsection (15), the following rules apply in the circumstances specified in a Guideline issued for the purposes of this section to a document that is listed in section 66, is specified in the Guideline and is required under this Regulation to be delivered to an insurer to whom the Guideline applies:

1. Subject to paragraphs 2 and 3, the document and any attachments to it shall be delivered to the insurer only in a manner specified in the Guideline.
2. If the Guideline specifies that a document, exclusive of attachments to it, is to be delivered to a central processing agency on behalf of the insurer,
 - i. the document shall be delivered not to the insurer but only to the central processing agency specified in the Guideline and only in a manner specified in the Guideline, and
 - ii. attachments to the document shall be delivered not to the central processing agency but only to the insurer in a manner specified in the Guideline.
3. If the Guideline specifies that a document, together with attachments to it, is to be delivered to a central processing agency on behalf of the insurer, the document and the attachments shall be delivered not to the insurer but only to the central processing agency specified in the Guideline and only in a manner specified in the Guideline.
4. A document referred to in paragraph 1, 2 or 3 shall be deemed not to have been received by the insurer to whom it is addressed, if it is delivered to the insurer otherwise than as specified in the Guideline.

(8) A document referred to in paragraph 2 of subsection (7) is deemed to be received by the insurer to whom it is addressed on the later of,

- (a) the date on which the document, delivered in a manner specified in the Guideline to the central processing agency on behalf of an insurer to whom the Guideline applies, is determined by the central processing agency to be duly completed and to contain all information required by this Regulation to be included in it; and
- (b) the date on which the last of any attachments is received by the insurer.

(9) A document referred to in paragraph 3 of subsection (7) is deemed to be received by the insurer to whom it is addressed when the document and any attachments to it are delivered in a manner specified in the Guideline to the central processing agency on behalf of an insurer to whom the Guideline applies and the document is determined by the central processing agency to be duly completed and to contain all information required by this Regulation to be included in it.

(10) For the purposes of subsections (8) and (9), the central processing agency shall be deemed to have determined, on the day the document was delivered to the central processing agency in a manner specified by the Guideline, that the document is duly completed and contains all information required by this Regulation to be included in it unless the central processing agency notifies the sender, in a manner specified in the Guideline and not later than the second business day after the document was delivered to the central processing agency, that the document is not duly completed or does not contain all information required by this Regulation to be included in it.

(11) A notice under subsection (10) must include sufficient particulars to enable the sender to remedy the deficiency.

(12) The central processing agency shall, as soon as practicable, make the contents of the document available to the insurer to whom the document is addressed.

(13) An insurer that is deemed by subsection (8) or (9) to have received a document, other than an invoice to which subsection 49 (1) applies, shall in the manner and within the time required by the Guideline provide the central processing agency with the following information, which may include personal information:

1. Particulars of the goods or services referred to in the document for which the insurer agrees to pay and the amount the insurer agrees to pay in respect of such goods or services.
2. Particulars of the goods or services referred to in the document for which the insurer does not agree to pay.

(14) Following receipt of the last of any attachments to a document in accordance with paragraph 2 of subsection (7), an insurer shall notify the central processing agency for the purpose of the application of clause (8) (b), in the manner and within the time required by the Guideline.

(15) Subsections (7) to (14) do not apply to a document if the insurer has waived the requirement that the document be submitted to the insurer in circumstances permitted by this Regulation.

(16) Nothing in this Regulation prohibits any person from delivering a document to which subsection (7) applies to the central processing agency on behalf of a person otherwise required to deliver it.

(17) If an attempt is made to personally deliver a document to a person at his or her place of residence and, for any reason, it is not possible to personally deliver the document to the person, the document may be delivered by leaving a copy, in a sealed envelope addressed to the person, at the person's place of residence with anyone who appears to be an adult member of the same household.

(18) In the absence of evidence to the contrary, a person is deemed to receive anything delivered by ordinary mail under clause (2) (d) on the fifth business day after the day the document is mailed in accordance with clause (2) (d).

(19) A document that is delivered by fax must include a cover page indicating,

- (a) the sender's name, address and telephone number;
- (b) the name of the person for whom the document is intended;
- (c) the date of the accident to which the document relates;
- (d) the name, address and telephone number of the person to whom the document relates;
- (e) the date and time the fax is sent;
- (f) the total number of pages faxed, including the cover page;
- (g) the telephone number from which the document is faxed; and
- (h) the name and telephone number of a person to contact in the event of transmission

problems with the fax.

(20) A document delivered in accordance with clause (2) (a), (b), (c) or (e) after 5 p.m. local time of the recipient shall be deemed to be delivered on the next business day.

(21) Despite subclause (2) (d) (i) and subsections (18) and (20), if the insurer provides the name and address of a contact person to whom documents are to be delivered, anything delivered to the insurer that is not addressed to the attention of the contact person at that address shall not be considered to have been delivered to the insurer until it is received by the contact person.

(22) Subject to subsection (20), subsection 22 (3) of the *Electronic Commerce Act, 2000* applies to determine when a document delivered in accordance with clause (2) (e) is deemed to be delivered to the recipient.

(23) If subsection (8) or (9) applies, the recipient for the purposes of subsection (22) is the central processing agency.

(24) A reference in this Regulation to a number of days between two events shall be read as excluding the day on which the first event happens and including the day on which the second event happens.

(25) Subject to subsection (26), if any provision of this Regulation requires a person to do anything within a time period expressed in days or business days, the time period is deemed to expire on the last day of the time period at 5 p.m. local time.

(26) If a time period in which a person is required to do anything expires on a day that is not a business day, the time period is deemed to expire on the next day that is a business day at 5 p.m. local time.

(27) For the purposes of subsections (25) and (26), if the person delivering a document or notice and the person to whom the document or notice is to be delivered are in different time zones, references to 5 p.m. local time shall be read as references to the time when it is 5 p.m. in one time zone and after 5 p.m. in the other time zone.

(28) A regulated health professional who receives a document under the authority of subsection (3) shall immediately notify the insured person by telephone of the substance of the document and send a copy of the document to the insured person by ordinary mail or fax.

(29) An insurer shall not deliver documents to a regulated health professional in reliance on an authorization under subsection (4) unless the documents are expressly specified in the authorization referred to in that subsection.

(30) In this section,

“personal information” means information that is personal information for the purposes of the *Personal Information Protection and Electronic Documents Act* (Canada) or personal health information for the purposes of the *Personal Health Information Protection Act, 2004*.

Substitute decision-makers

65. Any consent, notice or other thing to be given by or to an insured person under this Regulation may be given by or to a person exercising a power of decision on behalf of the insured person under the authority of the *Substitute Decisions Act, 1992* or as authorized under the *Health Care Consent Act, 1996*.

Forms

66. Each of the following documents shall be in a form approved by the Superintendent:

1. An application form referred to in clause 32 (2) (a).
2. A disability certificate under section 21, 36 or 37.
3. A notice under section 35.
4. A treatment and assessment plan referred to in section 38.
5. A treatment confirmation form under section 40.
6. A notice under subsection 40 (3).
7. An application for attendant care benefits under section 42 (Assessment of Attendant Care Needs).
8. An application under subsection 45 (1).
9. An invoice in respect of an expense for goods or services specified in a Guideline applicable for the purposes of section 49.

When form is considered completed

67. (1) Any document that is required by section 66 to be in a form approved by the Superintendent and to which subsection 64 (7) applies and any other document specified in a Guideline applicable for the purposes of this section is duly completed and includes all information required by this Regulation to be included in it if,

- (a) every field not identified on the form as an optional field is completed in accordance with subsection (2); and
- (b) if any field on the form that is identified as an optional field is completed, it is completed in accordance with subsection (2).

(2) If the form specifies the manner or the format in which a field is to be completed, completion of the field shall be in that manner and in that format.

**PART XIII
TRANSITIONAL PROVISIONS**

Transitional, optional benefits

68. (1) Despite any other provision of this Regulation and unless otherwise agreed in writing by the named insured and the insurer, subsection (2) applies to every motor vehicle liability policy that is in effect on September 1, 2010 until the earlier of,

- (a) the first expiry date under the motor vehicle liability policy; and
- (b) the day on which the motor vehicle liability policy is terminated by the insurer or the insured, if the policy is terminated before the day referred to in clause (a).

(2) The following benefits are deemed to be included in the motor vehicle liability policy and are applicable to an insured person in respect of the motor vehicle liability policy:

1. The optional caregiver, housekeeping and home maintenance benefit referred to in paragraph 2 of subsection 28 (1).
2. The optional medical and rehabilitation benefit referred to in paragraph 3 of subsection 28 (1).

3. The optional attendant care benefit referred to in paragraph 4 of subsection 28 (1).
4. All optional benefits referred to in subsection 27 (1) or section 28 or 29 of the Old Regulation that were purchased and still in effect on September 1, 2010.

PART XIV COMMENCEMENT

Commencement

69. This Regulation comes into force on the later of September 1, 2010 and the day it is filed.

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