The insurer took the position that the insured's predominant injury was a minor injury as defined in s. 3 of the *Statutory Accident Benefits Schedule* ("*SABS*"), so that he was entitled to claim a maximum of $3,500 in medical and rehabilitation benefits pursuant to s. 18(1) of *SABS* and would not be entitled to claim for attendant care benefits pursuant to s. 14. The parties applied for arbitration. As a preliminary issue, the insurer brought a motion for an order that the insured was suffering from minor injuries and was therefore limited in the benefits he could claim. The arbitrator determined that the insured did not fall under the *Minor Injury Guideline — Superintendent's Guideline No. 2/10* and was entitled to medical and rehabilitation benefits beyond the maximum prescribed in s. 18 of the *SABS*. The director's delegate allowed the insurer's appeal. The insured brought an application for judicial review of that decision.

Held, the application should be allowed.
The standard of review of the director's delegate's decision was reasonableness.

The director's delegate reasonably, and in fact correctly, concluded that the arbitrator erred in finding that ss. 14 and 18 of the *SABS* provide for exclusion of coverage, so that the onus was on the insurer to establish that the insured was bound by the $3,500 limit. The burden remained on the insured throughout to establish entitlement to the appropriate level of benefits.

The director's delegate's finding that the *Minor Injury Guideline* is as binding as the *SABS* was not reasonable. To be incorporated by reference into a statute or regulation, material must be referred to expressly in the statute or regulation, and required for the proper interpretation of that part of the statute or regulation which expressly refers to it. There is no provision in the *SABS* which expressly incorporates by reference the entirety of the guideline. In each instance in which the guideline is expressly referred to, one must undertake an analysis of the extent to which, if at all, the guideline is required to enable a proper interpretation of the section in question. It is only to that extent that the guideline is incorporated by reference.

The director's delegate reasonably found that the insurer was denied procedural fairness because the arbitrator conducted his own research and raised his own arguments for the first time while rendering his decision without first giving counsel an opportunity to make submissions.

Background :
Sec 14 of SABS: insurer is liable to pay medical/rehab benefits and AC for non-minor injuries and Sec 14 is for insurer liable to pay medical/rehab benefits under MIG

Standard of Review
[12] As provided in *Dunsmuir v. New Brunswick*, [2008] 1 S.C.R. 190, [2008] S.C.J. No. 9, the process for determining the appropriate standard of review on judicial review involves two steps: (1) a determination of whether the jurisprudence has already determined in a satisfactory manner the degree of deference to be accorded with regard to a particular category of question;and
(2) where the first inquiry proves unfruitful, an analysis of the factors making it possible to identify the proper standard of review.

[13] In *Pastore v. Aviva Canada Inc*. (2012), 112 O.R. (3d) 523, [2012] O.J. No. 4508 (C.A.), the Ontario Court of Appeal undertook the *Dunsmuir* analysis while examining a decision of the director's delegate of the Financial Services Commission of Ontario and concluded that the correct standard of review is reasonableness. I see no reason to depart from this decision.

Analysis

Issue #1 — Do the SABS provide for exclusions of coverage in ss. 14 and 18(1)?

[20] The issue is of importance because it informs the decision of who has the burden of proof. That is, although it is fundamental to insurance law that the burden of proof rests on the insured to establish a right to recover under the terms of the policy, so too is it fundamental that when an insurer relies upon an exclusion in the policy to avoid payment, the onus of proving that the loss falls within the exclusion generally lies upon the insurer.

[21] The director's delegate found that there was no exclusion created by either ss. 14 or 18 of the *SABS*. For the following reasons, I am of the view that his decision was not only reasonable, but correct.

[22] Section 14 of the *SABS* defines the liability of the insurer. It requires the insurer to pay the medical and rehabilitation benefits set out under ss. 15 and 17 and, if the impairment is not a minor injury, attendant care benefits under s. 19.

[24] Section 18 of the *SABS* does not create an exclusion to liability, it creates limits on that liability….

[25] I would also note that Part VII of the *SABS*, entitled "GENERAL EXCLUSIONS", defines the circumstances in which certain benefits, otherwise payable by the insurer, are not payable. In my view, it is these types of exclusion from coverage that will result in a shift of the onus to the insurer to establish that there is no coverage.

Issue #2 — The meaning of "compelling evidence"

[26] Section 18(2) of the *SABS* allows an individual who is suffering from a minor injury to claim medical and rehabilitation expenses in excess of $3,500 provided their own health care practitioner determines and provides compelling evidence that the insured's pre-existing medical condition prevents him from achieving maximal recovery if subject to the $3,500 limit and to the goods and services authorized under the *MIG*.

[27] The applicant argued that Director's Delegate Evans altered the civil standard of proof by finding that the requirement for "compelling" evidence goes beyond a requirement that the evidence be credible. I do not agree that he did so. A fair reading of his decision reveals no indication that the standard of proof was elevated beyond a balance of probabilities. Rather, he properly recognized (1) that the word "compelling" is directed at the sufficiency of the evidence required to satisfy that standard; and (2) that whether the evidence in a particular case is sufficient to meet the test of "compelling" must be determined on the facts of each individual case having regard to what is reasonable in all of the circumstances.

Issue #3 — Is the minor injury guideline binding?

[28] The manner in which this issue has been framed is somewhat misleading. Although Director Delegate Evans did hold that the *Minor Injury Guideline* "is as binding as the *SABS*", the real issue is whether the *MIG* has been incorporated into the *SABS* by reference, and if so, to what extent.

[30] However, a distinction must be drawn between material which is simply referred to in a statute or regulation and material which, by that reference, is thereby incorporated. Furthermore,

one must be careful in defining the breadth of the material which is to be incorporated. This is particularly so when the material in question, like the *MIG*, is a combination of commentary, policy statement, guideline and definition.
[31] In my view, to be incorporated by reference into a statute or regulation, material must be
(1) referred to expressly in the statute or regulation; and
(2) required for the proper interpretation of that part of the statute or regulation which expressly refers to it.
[33] There is no provision in the *SABS* which expressly incorporates by reference the entirety of the *MIG*. Accordingly, in my view it is necessary to examine each reference to the *MIG* to determine if it is an express reference thereto, and if so, what part of the *MIG* is required for the proper interpretation of the *SABS* provision in question.
[34] For example, s. 18(1) provides that the sum of the medical and rehabilitation expenses 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 in accordance with the *MIG*. Clearly, the *MIG* is expressly referred to in this section. Just as clearly, reference to the *MIG* is required to determine if amounts paid in respect of the insured were paid in accordance with it. However, this cannot mean that unrelated commentary and policy in the *MIG* is also incorporated by virtue of that reference. Such material is not required to understand or interpret s. 18(1).
[35] Similarly, s. 18(2) of the *SABS* refers to an insured being "limited to the goods and services authorized under the Minor Injury Guideline". Again, the *MIG* is expressly referred to, and one must refer to the goods and services authorized by the *MIG* to understand and interpret the meaning of the section. However, the remainder of the *MIG* is not necessary to understand and interpret the section, and therefore is not incorporated by reference.

Issue #4 — Was there a breach of the principles of procedural fairness?
[38] Director's Delegate Evans found that Belair was denied procedural fairness because Arbitrator Wilson, when rendering his decision, raised argument of his own for the first time, conducted research of his own, and inappropriately applied s. 233 of the *Insurance Act*, all without first raising the matters with counsel and allowing an opportunity for submissions to be made.
[39] The basic principle underlying the duty of procedural fairness is that parties affected by a decision should have the opportunity to present their case fully and fairly, and have decisions affecting their rights, interests or privileges made using a fair, impartial and open process…In my view, this duty of procedural fairness would include providing interested parties a reasonable opportunity to address case law, statutory provisions and lines of argument which the arbitrator wishes to consider but which were not raised at the arbitration.