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INCOME REPLACEMENT, REHABILITATION AND NO-FAULT BENEFIT MEMORANDUM

People injured in motor vehicle accidents are entitled to various statutory benefits under the *Insurance Act*. These benefits are provided from either their insurance company, if they have motor vehicle insurance, or from someone else's insurance company, if they do not have motor vehicle insurance. The main benefits available to you are divided into two categories. They are as follows:

1. Income Replacement Benefits which are to replace a portion of the income an injured party loses as a result of the injuries sustained in the motor vehicle accident in question; and

2. Medical and Rehabilitation Benefits which are necessary to assist an individual injured in a motor vehicle accident to recover from their injuries.

This Memorandum summarizes what you are entitled to under the Statutory Accident Benefits Schedule of the *Insurance Act*. **Keep in mind that you must apply for the benefits set out below within 7 days or as soon as is practical.**

INCOME REPLACEMENT BENEFITS (Part II, ss. 4-11)

The first level of entitlement is for the first 104 weeks, with payment beginning 7 days after the date of the accident (s. 5(2)(a)). There are two-104 week periods. The first is the entitlement period: the impairment must commence within 104 weeks following the accident (s. 4.1). The second is the payment period, which is 104 weeks from the commencement of the impairment. For accidents after April of 2004, there are limits on how long you are entitled to these benefits if you suffer a WAD I or WAD II type injury.

A. Entitlement

Entitlement for the first period is based on a "substantial inability to perform the essential tasks of one's own employment" (s. 5).

Entitlement for the second period (post-104 weeks) is "a complete inability to engage in any employment, for which her or she is reasonably suited by education, training or experience"(s. 5(2)(b)).

Entitlement is predicated upon impairment being suffered. Impairment is defined in s. 2 of the Regulation:

"a loss or abnormality of a psychological, physiological or anatomical structure or function".

Elsewhere in the legislation, particularly in the definition of catastrophic impairment, an additional criterion is available – that of "behavioral disorder". This is a form of behavioral or psychological abnormality. We will discuss this with you further if you qualify for such benefits.

Entitlement to income replacement benefits exists if you were:

(a) employed on the date of the accident; or

(b) not employed but either worked 26 or the 52 weeks before the accident or was on UIC at the time of the accident, was over 16 or excused from attending school, and unable to perform the job you spent the most time at; or

(c) entitled to start work within one year under a legitimate written contract of employment that was made before the accident (this entitlement may not apply after April of 2004).

B. Quantum

The amount of the benefit is 80% of net weekly income for the first 104 weeks. Thereafter, it is the greater of 80% of net and $185.00. The maximum basic benefit is $400.00, although additional coverage can be purchased to increase that amount from $400.00 to $1,000.00 per week. It is based on either the last 4 or 52 weeks preceding the date of the accident. If you were self-employed, it is the last 52 weeks or the last fiscal year completed before the accident.

You should be aware of the issue of collateral benefits. These consist of sources of income which pay you for a portion of your lost wages while you are unable to work (disability insurance, employer wage continuation plans) because of the injuries you sustained in the motor vehicle accident. These will be deducted from any amount your insurance company owes you based on the above. In essence, you can't get double indemnity for lost wages. If there is entitlement to such income, but not actual receipt, they are not deducted (s. 7(2)(b)). EI payments are not deducted. WSIB payments that would be paid except for the fact that the insured has elected to start an action are not deducted. Net income is determined according to either the Income Tax Acts of Canada and Ontario, or the Guide, at the option of the insurer. Only payments received as a result of the accident are deductible.

C. Duration

The post-104 week benefit is payable for life with an adjustment on a graduated basis at age 65. If the accident happened after you turned 65 but you were working at that date, it will be paid on a reduced basis for up to 208 weeks. Your insurance company must give you 14 days notice before it can terminate your income replacement benefits. You can dispute your loss of this benefit within that 14 day period.

NON-EARNER BENEFITS (Part III, s. 12)

A. Entitlement

This applies to you if you were not working on the date of the accident. It is payable if there is a complete inability to carry on a normal life.

B. Quantum

This benefit is $185.00 per week. It increases to $320.00 per week after 104 weeks if you were a student at the time of the accident or finished school within one year of the accident. Collateral benefits received in respect of injuries sustained in the accident are deducted.

C. Duration

It is not payable during the first 26 weeks of disability nor before the insured turns 16.

FUTURE CARE, REHABILITATION BENEFITS AND THE CATASTROPHIC INJURY

A. Outline of the Benefit Scheme

There are three categories of main benefits and some incidental benefits you may be entitled to. The main benefits are medical, rehabilitation and Attendant Care Benefits. The incidental benefits you may be entitled to include reimbursement of lost educational expenses, the services of a case manager, housekeeping and home maintenance expenses, reasonable expenses to pay you for damage to your property and/or expenses of visitors who come to visit or stay with you while you recover from your injuries. Please call us if you want any further information on the above listed incidental benefits. They are not discussed in any detail in this Memo. You may lose your entitlement to the above benefits if you don't obtain treatment and participate in rehabilitation that is reasonable, available and necessary.

The scheme of the regulation is relatively straightforward. They are as follows:

B. Definitions

(a) *Health Care Expenses:*

Defined in the Act (s.14, 15 and 16) to be all goods and services for which payment is provided by the medical, rehabilitation and Attendant Care Benefits provided for in the SABS.

(b) *Catastrophic impairment:*

Defined in the regulations in s. 2:

(a) Paraplegia or quadriplegia;

(b) Amputation or other impairment causing the total and permanent loss of use of both arms or both legs;

(c) Amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;

(d) Total loss of vision in both eyes;

(e) Brain impairment that results, in respect of an accident,

i. More than six months after the accident, results in a score of 2 or 3 on the Glasgow Outcome Scale or a score of less than 9 according to a test administered within a reasonable time after the accident;

(f) Subject to ss (2) or (3), any impairment or combination of impairments that, in accordance with the AMA Guides to the Evaluation of Permanent Impairment….results in 55% or more impairment of the whole person; or

(g) Subject to ss (2) or (3) any impairment that, in accordance with the AMA Guides to the Evaluation of Permanent Impairment…results in a Class 4 or 5 impairment due to mental or behavioral disorder.

The relevant Sections provide as follows:

A. *Medical Benefit* (Part IV, s.14)

s.14 (1) The insurer shall pay…….a medical benefit.

(2) The medical benefit 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 eye wear;

(e) dentures and other dental devices;

(f) hearing aids, wheelchairs or other mobility devices;

(g) transportation expenses….; and

(h) other goods and services of a medical nature that the insured person requires.

B. *Rehabilitation Benefit* (Part IV, s.15)

s. 15 (1) The insurer shall pay……a rehabilitation benefit.

(2) The rehabilitation benefit shall pay for reasonable and necessary measures undertaken by an insured person to reduce or eliminate the effects of any disability resulting form the impairment or to facilitate the insured person's reintegration into his or her family, the rest of society and the labour market.

(3) Measures to reintegrate an insured person into the labour market include measures that are reasonable and necessary to enable the person to,

(a) engage in employment that is as similar as possible to employment in which he or she engaged before the accident; or

(b) lead as normal a work life as possible.

(4) In determining whether a measure is reasonable and necessary for the purpose of subsection (3), the insurer shall consider the insured person's personal and vocational characteristics.

(5) The rehabilitation benefit 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 purpose referred to in subsection (2) for,

(a) family counseling;

(b) social rehabilitation counseling;

(c) financial counseling;

(d) employment counseling;

(e) vocational assessments;

(f) vocational or academic training;

(g) workplace modifications and workplace devices, including communication aids, to accommodate the needs of the insured person;

(h) 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 the insured person's existing home;

(i) 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;

(j) transportation for the insured person to and from counseling sessions, training sessions and assessments, including transportation for an aide or attendant; and

(k) other goods and services that the insured person requires, except services provided by a case manager. Get pre-approval from your insurance company before purchasing any ancillary goods or services or you will not be reimbursed for these expenses.

C. *Personal and Vocational Characteristics*

"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.

D. *Attendant Care Benefit*

s.16 (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident an Attendant Care Benefit. This benefit will not apply to those who suffer a WAD I or WAD II type injury after April of 2004. The Attendant Care Benefit 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) services provided by an aide or attendant; or

(b) services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital.

(2) The amount of the Attendant Care Benefit payable in respect of an insured person shall not exceed,

(a) $3,000.00 per month (or up to $6,000.00 per month if optional coverage is purchased), in the case of an insured person who did not sustain a catastrophic impairment as a result of the accident; or

(b) $6,000.00 per month, in the case of an insured person who sustained a catastrophic impairment as a result of the accident.

C. Duration of benefits

Health care expenses (medical and rehabilitation) benefits are available in a non-catastrophic case for ten years or up to age 25 if the insured is under age 15 on the date of the accident. Catastrophic benefits are available for life subject to certain maximums.

D. Quantum of benefits

There is an overall limit of $100,000.00 for medical and rehabilitation benefits. Attendant care is limited to 104 weeks and $72,000.00. In a catastrophic case, the quantum of benefits is limited to $1,000,000.00 for attendant care and an additional one million dollars for medical and rehabilitation expenses combined. In the case of a catastrophic impairment, there is a mandatory requirement for the appointment of a case manager under s. 17.

OTHER BENEFITS

CAREGIVER BENEFITS

A. Entitlement

These benefits are available if you reside with a person in need of care, and you were that person's primary caregiver. It is a "substantial inability" test to qualify for such benefits.

There is no definition of a person in need of care. Therefore, children over the age of 16, elderly parents, and others who you were providing care to at the time of the accident are to be considered for the purposes of the section.

B. Quantum

The level of benefit is $250.00 for the first dependant and $50.00 per week for each additional person in need of care.

C. Duration

The benefit continues for 104 weeks and then stops unless you are suffering a complete inability to carry on a normal life.

DEATH BENEFIT

You are entitled to certain Death Benefits if your spouse or dependent dies as a result of injuries sustained in a motor vehicle accident. The base amount you are entitled to if your spouse dies in a motor vehicle accident is $25,000.00. This sum can be increased to $50,000.00 by purchasing an optional Death and Funeral Benefit. You are entitled to $10,000.00 if one of your dependents dies in a motor vehicle accident. This sum can be increased to $20,000.00 if optional Death and Funeral Benefits are purchased.

HOW DO YOU GET YOUR BENEFITS?

THE TREATMENT PLAN

A Treatment Plan must be prepared for you by a health practitioner in order for you to be entitled to the benefits described above.

A. Who pays for the Plan? Who controls its preparation?

The Treatment Plan itself will be paid for by the Statutory Accident Benefit carrier. It is your obligation to ensure that a Treatment Plan is completed. It must be completed and submitted before you receive any of the treatment set out in the Treatment Plan or your insurance company doesn't have to pay for the services in question. You get to chose who prepares it. It is important to have such a Plan completed as soon as possible. You may have to get approval from your insurance company to have a Treatment Plan completed. Your health care practitioner, usually your family doctor, will take care of this for you. Please call us before you send a Treatment Plan to your insurance company.

B. How will the Treatment Plans work?

Plan development focuses attention of all care givers on the goals of the treatment being offered. The recommendations in such Plans may change over time. There will be emergent medical and rehabilitative problems that may take a few weeks or months to resolve. A Treatment Plan must be responsive to healing, new conditions and changing diagnosis. Treatment Plans are not necessary for those who fall within the Pre-Approved Framework Guideline. A Treatment Plan may be rejected by your insurance company. You can file for mediation and then arbitration if a Treatment Plan is rejected.

DUTY TO PROVIDE INFORMATION and CO-OPERATE WITH YOUR INSURER

Under Section 33 of the SABS you have an obligation to submit to an interview taken under oath regarding the information needed to determine entitlement to Accident Benefits. You must be provided with reasonable notice for any such examination and you have the right to have counsel present with you during that interview. Please contact us should you be advised that your insurance company wants to interview you under oath.

Under Section 42 of the SABS you may also be required to attend an Insurer's Examination. Such an Examination is often requested by an Insurance Company to determine your entitlement to any of the benefits set out in the SABS. Your Insurance Company pays for the assessment. You will be provided with no less than five (5) business days notice of when such an examination is to take place. Please call us if your insurance company intends to schedule any such examination. You are entitled to have someone do a rebuttal report to any Insurer's Examination Report. Your Insurance Company must pay for this rebuttal report. There are limits on how much they have to pay for your rebuttal report.

THE PRE-APPROVED TREATMENT FRAMEWORK

Under Bill 198 you are entitled to a specific regime of treatments if you sustain a particular kind of injury. The type of injury that entitles you to this specific treatment is a Whiplash Associated Disorder Grade I or II (WAD I or WAD II). If your health practitioner determines that you have a WAD I or WAD II injury then you will immediately be referred to health practitioners who can provide you with the pre-approved treatment in question. The treatment you are entitled to under the Pre-Approved Framework is set out in the Guideline for Whiplash Associated Disorders. Please call us if you want a copy of this Guideline.

WHAT HAPPENS IF YOU HAVE A DISPUTE WITH YOUR INSURANCE COMPANY ABOUT THE BENEFITS YOU ARE ENTITLED TO?

If your Insurance Company refuses to provide you with a benefit which you feel you are entitled to, you can challenge that position. You have the right to file for Mediation in those circumstances. If your matter is not resolved at Mediation, you can file for Arbitration or go to Court to have your matter heard by an Arbitrator or Judge. The Mediation process consists of an informal discussion with a Mediator assigned to your case by the Financial Services Commission of Ontario. The Mediation is conducted by way of teleconference. You would be

expected to attend at our office so that you can participate in that Mediation. Most matters are settled at Mediation. If your matter is not settled at Mediation, then we can proceed to file for Arbitration on your behalf. An Arbitration is like an informal trial where we have the right to present evidence either verbally through witnesses, including health practitioners, or by the submission of documentation. The Arbitrator will then make a decision which is binding on you and your insurance company. You can also go to Court if your matter doesn't resolve at Mediation. This doesn't happen very often because of the cost of going to Court.

Please read this memo several times. It is important that you understand your entitlements. If you have any questions please ask us or refer to the web site for the Financial Services Commission of Ontario.