COURT OF APPEAL FOR ONTARIO

CITATION: Varriano v. Allstate Insurance Company of Canada, 2023 ONCA 78
DATE: 20230206
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Simmons, Huscroft and Coroza JJ.A.

BETWEEN

Nunzio Varriano

Appellant (Respondent)

and

Allstate Insurance Company of Canada

Respondent (Appellant)

Sophia Chaudri and Brittanny Tinslay, for the appellant

Ryan Naimark and Nergiz Sinjari, for the respondent

Heard: November 30, 2022

On appeal from the order of the Divisional Court (Justices Harriet E. Sachs, Nancy L. Backhouse, and Renu J. Mandhane) dated December 14, 2021, with reasons reported at 2021 ONSC 8242 overturning a decision of the Licence Appeal Tribunal, dated January 6, 2020.

Coroza J.A.:

I. INTRODUCTION

[1] Nunzio Varriano was injured in a motor vehicle accident on September 30, 2015. He applied to his insurer, Allstate Insurance Company of Canada ("Allstate") for income replacement benefits ("IRBs") pursuant to the *Statutory Accident*

Benefits Schedule – Effective September 1, 2010, O. Reg. 34/10 (the "*SABS*"). Allstate paid him IRBs between October 7, 2015, and December 2, 2015. On December 30, 2015, Allstate notified Mr. Varriano that his IRBs would stop effective December 2, 2015, because Mr. Varriano had returned to full-time work ("Benefits Letter").

[2] On September 28, 2018, Mr. Varriano filed an application before the Licence Appeal Tribunal ("LAT") disputing the decision to terminate his benefits. Before the adjudicator, Allstate took the position that Mr. Varriano's application was time-barred, having been filed more than two years after the December 30, 2015 Benefits Letter. The LAT adjudicator agreed with Allstate on an initial hearing, as well as on a reconsideration hearing. He found that Allstate's Benefits Letter met the legislative requirements under s. 37(4) of the *SABS* and accordingly, the limitation period was triggered on December 30, 2015.

[3] The Divisional Court overturned the decision of the LAT adjudicator, finding that Mr. Varriano's application was not time-barred because Allstate's Benefits Letter did not meet the legislative requirements under s. 37(4) of the *SABS*. The Divisional Court held that s. 37(4) required Allstate to provide medical reasons in the Benefits Letter for the stoppage of benefits.

[4] Accordingly, this appeal depends on whether Allstate's Benefits Letter complied with the legislative requirements under s. 37(4) of the *SABS*, that is,

whether Allstate was required to provide a medical reason for the stoppage of Mr. Varriano's IRBs.

[5] For the reasons that follow, I would allow the appeal. Respectfully, the Divisional Court's interpretation of s. 37(4) is incorrect. Allstate's Benefits Letter complied with the legislative requirements under s. 37(4) – it provided Mr. Varriano clear and unequivocal notice that it was terminating the IRBs and the reasons for doing so.

II. BACKGROUND

[6] Allstate paid Mr. Varriano $235.59 per week as IRBs between October 7, 2015, and December 2, 2015. However, Mr. Varriano returned to work. On December 30, 2015, Allstate sent Mr. Varriano the Benefits Letter, titled "Explanation of Benefits". Under Part 2, the Benefits Letter stated, in part:

> Your Income Replacement Benefit has been stopped on December 2, 2015, as you returned to work fulltime on December 2, 2015. No further Income Replacement will be paid after this date.
>
> Non-earner Benefit - You are not entitled to the Non-earner Benefit, as you were receiving Employment Insurance at the time of your accident and you meet the test of disability for Income Replacement Benefits, as per your Disability Certificate completed by Bibu Thomas of Med Rehab Group.
>
> Caregiver Benefit - The relating policy was not purchased with optional benefits; therefore expenses relating to caregiver benefits are not payable. This benefit is available should you be deemed to have suffered a

> catastrophic impairment as defined by the SABS. [Emphasis added.]

[7] Part 6 of the Benefits Letter outlined an applicant's right to dispute the insurer's determination of their claim to statutory accident benefits.

[8] On July 1, 2018, Mr. Varriano stopped working again. He sought to resume his IRBs and applied to Allstate. Allstate denied the resumption of his benefits by another "Explanation of Benefits" letter dated July 30, 2018. Allstate's letter stated:

> Income Replacement Benefits & Non Earner Benefits - Please refer to our explanation of benefits dated December 30 2015. Our position remains unchanged.

[9] On September 28, 2018, Mr. Varriano filed an application with the LAT disputing Allstate's decision to deny his IRBs. As a preliminary issue, Allstate argued that Mr. Varriano's application was time-barred pursuant to s. 56 of the *SABS* – specifically, that the limitation period on Mr. Varriano's application began to run from the date of the Benefits Letter and accordingly, his application in September 2018 was 10 months over the two-year limitation period.

III. RELEVANT LEGISLATIVE PROVISIONS

[10] Under the *SABS*, an insurer is permitted to discontinue an insured's benefits for specified reasons under s. 37(2). One of those reasons includes the fact that the insured person has returned to their pre-accident employment duties:

> **Determination of continuing entitlement to specified benefits**

> **37. (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. [Emphasis added.]

[11] If the insurer determines that it will discontinue paying a benefit because an insured is ineligible on any one or more grounds, the insurer, pursuant to s. 37(4) is required to provide a notice to the insured containing the reasons for their determination:

> **37. (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. [Emphasis added.]

[12] The insured may dispute the insurer's decision. If they do so, the insured is required to bring an application to the LAT within two years from the insurer's refusal to pay an amount claimed:

> **56.** An application under subsection 280 (2) of the Act in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed.[1]

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[1] For the sake of completeness, s. 280 of the *Insurance Act*, R.S.O. 1990, c. I.8, provides:

> 280 (1) This section applies with respect to the resolution of disputes in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled.
>
> (2) The insured person or the insurer may apply to the Licence Appeal Tribunal to resolve a dispute described in subsection (1).
>
> (3) No person may bring a proceeding in any court with respect to a dispute described in subsection (1), other than an appeal from a decision of the Licence Appeal Tribunal or an application for judicial review.
>
> (4) The dispute shall be resolved in accordance with the *Statutory Accident Benefits Schedule*.
>
> (5) The regulations may provide for and govern the orders and interim orders that the Licence Appeal Tribunal may make and may provide for and govern the powers and duties that the Licence Appeal Tribunal shall have for the purposes of conducting the proceeding.
>
> (6) Without limiting what else the regulations may provide for and govern, the regulations may provide for and govern the following:
>
> 1. Orders, including interim orders, to pay costs, including orders requiring a person representing a party to pay costs personally.
>
> 2. Orders, including interim orders, to pay amounts even if those amounts are not costs or amounts to which a party is entitled under the *Statutory Accident Benefits Schedule*.

[13] In sum, an insurer is permitted to stop benefits under the *SABS* for any one or more of the reasons set out in s. 37(2). When such decision is taken, the insurer is required to provide notice to the insured under s. 37(4) and state the reason for its determination. A valid notice under s. 37(4) commences the applicant's two-year limitation period to bring an application before the LAT disputing the decision.

IV. DECISIONS BELOW

A. Licence Appeal Tribunal Decision

[14] The sole issue before Adjudicator Boyce was whether Mr. Varriano's application was time-barred. Adjudicator Boyce found that Allstate's Benefits Letter accorded with the requirements under the *SABS* and the principles established by the Supreme Court of Canada in *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129 – that the notice contain straightforward language and be directed towards an unsophisticated person. Adjudicator Boyce found that the notice clearly stated the reason for Mr. Varriano's ineligibility, outlined the dispute resolution process, and stated the relevant time periods. Finally, he found that returning to work was a valid "other" reason per s. 37(2) of the *SABS*, and Allstate did not have to provide a medical reason to satisfy the requirements of the *SABS* or *Smith*.

B. Reconsideration Decision

[15] Mr. Varriano requested reconsideration of the LAT Decision, arguing that Adjudicator Boyce had erred in his interpretation of s. 37(4) of the *SABS* in finding that Allstate was not required to provide a medical reason for the denial of his benefits. Adjudicator Boyce dismissed the reconsideration application. He found no basis to vary his prior decision. Specifically, he found that Mr. Varriano's interpretation, that would require Allstate to provide a medical reason to deny benefits even if there was none, would result in insurers fabricating reasons. This would result in ensuing disputes and bad faith allegations. Adjudicator Boyce further relied upon *Sietzema v. Economical Mutual Insurance Company*, 2014 ONCA 111, 118 O.R. (3d) 713, which found that as long as an insurer provided clear and unequivocal notice, a limitation period would be triggered even if the reasons provided were legally incorrect.

C. Divisional Court Appeal

[16] Mr. Varriano appealed to the Divisional Court pursuant to s. 11(6) of the *Licence Appeal Tribunal Act*, *1999*, S.O. 1999, c.12, Sched. G., which allows appeals only on questions of law in matters relating to the *Insurance Act*, R.S.O. 1990, c. I.8. The Divisional Court allowed the appeal and remitted the matter back to the LAT for reconsideration on its merits.

[17] The Divisional Court held that Adjudicator Boyce erred in his interpretation of s. 37(4) of the *SABS*. That court concluded that a plain reading of s. 37(4) supported the interpretation of the word “and” in the phrase “medical and any other reasons” as bearing a conjunctive meaning. The court further noted that prior to the amendment of the *SABS* in 2010, insurers were not required to provide reasons for the stoppage of benefits payments. The addition of language in s. 37(4) ensured robust information sharing by requiring insurers to provide both medical and other reasons. Further, the court held that an impaired person would not be able to assess the “full impact” of a stoppage decision if the insurer did not provide their position on the insured’s medical impairment. Finally, the court concluded that interpreting s. 37(4) as requiring both medical and other reasons was consistent with the proposition that insurance coverage provisions are to be interpreted broadly.

[18] The court rejected Allstate’s argument that even if the notice was deficient in failing to provide a medical reason, the limitation period had expired because a clear and unequivocal termination of the IRBs had been given. It found that, because Allstate’s Benefits Letter did not refer to Mr. Varriano’s medical condition or the specific provision of the *SABS* that it relied upon to deny benefits, the letter was insufficient to trigger the two-year limitation period as it did not allow Mr. Varriano to assess his future eligibility under the *SABS*.

V. ISSUES ON APPEAL

[19] The sole issue on appeal is whether the Divisional Court erred in its interpretation of s. 37(4) of the *SABS*. In other words, does an insurer always have to provide a medical reason when denying benefits under the *SABS*?

VI. STANDARD OF REVIEW

[20] The parties agree that the applicable standard of review is that of correctness, as only questions of law can be appealed to this court pursuant to s. 11(6) of the *Licence Appeal Tribunal Act, 1999*.

VII. ANALYSIS

[21] Allstate advances two arguments on appeal: (1) the Divisional Court erred in its approach to the interpretation of s. 37(4) and the notice provided to Mr. Varriano was not deficient; and (2) even if the notice was deficient in failing to provide a medical reason, a clear and unequivocal termination of the IRBs had triggered the limitation period which has expired.

[22] I conclude below that the Divisional Court erred in its approach to the interpretation of s. 37(4) and accordingly, there is no need to address Allstate's alternative argument. In my view, the Divisional Court made two key errors in its approach to interpreting s. 37(4). First, it improperly applied the modern principle of statutory interpretation, and secondly, it wrongly concluded that s. 37(4) was an insurance coverage provision that had to be interpreted broadly.

A. The Divisional Court's Interpretation Does Not Accord with the Modern Principle of Statutory Interpretation

[23] I begin with the observation that the modern approach to statutory interpretation requires that statutes "are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament": *Rizzo & Rizzo Shoes Ltd. (Re),* [1998] 1 S.C.R. 27, at para. 26. A statute must not be interpreted in a manner that would result in absurd consequences. An interpretation will be absurd where it leads to "ridiculous or frivolous consequences, if it is extremely unreasonable or inequitable, if it is illogical or incoherent, or if it is incompatible with other provisions or with the object of the legislative enactment": *Rizzo*, at para. 27. The modern principle of interpretation applies with equal force to regulations: *Beaudin v. Travelers Insurance Company of Canada*, 2022 ONCA 806, at para. 36.

[24] In my view, in giving a conjunctive meaning to the word "and" in the phrase "medical and any other reason" in s. 37(4), the Divisional Court failed to properly apply the modern principle of statutory interpretation. That interpretation failed to acknowledge that the grammatical and ordinary usage of the word "and" can include both the joint sense and the several sense. When the phrase "medical and any other reason" in s. 37(4) is read contextually, it becomes clear that the ordinary meaning of the word "and" was intended in its several sense. Nor does the Divisional Court's interpretation accord with the purpose of the notice provision.

(1) The grammatical and contextual meaning of "medical and any other reason"

[25] Presuming that the plain meaning of the word "and" is conjunctive reflects an incomplete appreciation of the grammatical use of the word in ordinary language. As Ruth Sullivan points out in *The Construction of Statutes*, 7th ed. (Markham: LexisNexis Canada Inc., 2022) at § 4.05, "and" is sometimes used in the joint and several sense (A and B jointly or severally) and in other circumstances is used only in the joint sense (A and B jointly, but not severally).

[26] Considering the use of "and" in a statutory provision contextually assists in determining when it should be interpreted in the joint sense as opposed to the joint and several sense: *R. v. Yadegari*, 2011 ONCA 287, 286 C.C.C. (3d) 320, at para. 62. In my view, the requirement to provide reasons in s. 37(4) is inextricably tied to the grounds for discontinuance of benefits stipulated in s. 37(2). Contextually, when the two provisions are read properly together, it is clear that the word "and" in the phrase "medical and any other reason" was intended in the joint and several sense.

[27] These two sections read together simply require the insurer to determine the basis for disqualifying the insured person under s. 37(2) from receiving specified benefits and to communicate the basis for that determination to the insured. Some

of the grounds under s. 37(2) are medical and some are not. For example, ss. 37(2)(a), (d), (f) and (g) provide for non-medical grounds to terminate benefits.

[28] Importantly, s. 37(4) states that the insurer may rely on "any one or more grounds set out in [s. 37(2)]" (emphasis added) in terminating benefits. By explicitly including those words, s. 37(4) recognizes that an insurer may rely on a single non-medical reason for termination of benefits, even though the insured might be otherwise medically entitled to the benefit. In such case, a medical ground is not a "reason" for the insurer's determination under s. 37(4). Yet, the Divisional Court's interpretation requires the insurer to state its position on the person's medical eligibility even if that is not the basis for its determination. Put differently, interpreting "and" in the joint sense conflicts with the joint and several nature of the grounds for termination.

[29] Such an interpretation is not a harmonious reading of the two sections particularly in light of s. 37(2)(g) which specifically contemplates that the disentitlement need not relate to an impairment. This subsection permits termination if the insurer determines that the insured person is not entitled to a specified benefit "for a reason unrelated to whether [the insured] has an impairment that entitles the insured person to receive the benefit" (emphasis added). The Divisional Court's interpretation would require the insurer to state its position on the insured's impairment even though it has no bearing on the insurer's determination.

[30] In support of its interpretation that s. 37(4) requires an insurer to provide its position on an insured's medical eligibility, the Divisional Court relies upon the fact that the *SABS* was amended in 2010 to specifically add the language "medical and any other reasons". However, as the Divisional Court recognizes, prior to that, the *SABS* did not require insurers to provide any reasons for their determination. In my view, the addition of language of the 2010 amendment does not indicate that the legislature intended to mandate the provision of medical reasons in all cases, as the Divisional Court suggests. It merely codified the requirement to provide a sufficient reason or reasons for the insurer's decision, by directly tying the reasons to the actual grounds for termination of benefits in s. 37(2).

[31] Accordingly, s. 37(4) requires provision of the insurer's actual reasons for determination. If the insurer relies on a medical and a non-medical reason to deny benefits, the insurer must advise the insured person of both. However, if the insurer is relying on a non-medical ground under s. 37(2), the provision requires only that the insurer provide notice of the cancellation of the benefits and to provide the insured with the non-medical reason for that determination.

(2) The purpose of the notice provision

[32] This interpretation of the 2010 amendment accords with the purpose underlying the notice provision. In *Smith*, Gonthier J. concluded that insurance notice provisions serve a consumer protection purpose by requiring insurers to

completely and clearly provide insured persons with the information they need in straightforward and understandable language to enable them to challenge a refusal to pay or a reduction of payments: at paras. 11-14. In *Turner v. State Farm Mutual Automobile Insurance Co.*, (2005) 195 O.A.C. 61 (Ont. C.A.), this court also concluded that: “[t]he purpose of the requirement to give reasons is to permit the insured to decide whether or not to challenge the cancellation.” at para. 8.

[33] Accordingly, *Smith* and *Turner* support the argument that s. 37(4) should be interpreted with this policy goal in mind. That policy goal requires reasons to be sufficiently explanatory to permit the insured to decide whether to challenge the denial of benefits.

[34] Although these cases were decided before the Legislature’s 2010 amendments to the *SABS*, those amendments did not alter that underlying purpose. Rather, those amendments enhance and reinforce that purpose by codifying the requirement to provide a sufficient reason or reasons for the insurer’s decision. However, the amendments also acknowledge that the sufficiency of the content of those reasons is determined by the grounds for termination of benefits. Where the insurer relies solely on a single non-medical ground for denying benefits, requiring the addition of a line stating, “there are no medical reasons for this denial”, would not further assist an insured in deciding whether to challenge the denial of benefits.

B. The Divisional Court Erred in Construing s. 37(4) as an Insurance Coverage Provision

[35] The Divisional Court held that its interpretation of s. 37(4) is consistent with the general principle that "insurance coverage provisions are to be interpreted broadly, while coverage exclusions or restrictions are to be construed narrowly, in favour of the insured".

[36] While I do not quarrel with this statement, the provision in question is not a coverage provision – s. 37(4) does not in anyway determine whether a person is entitled to coverage under the *SABS*. The only issue to be determined was whether that notice provision had been complied with. The correct interpretation of s. 37(4) requires an interpretation that accords with the purposes of the *SABS*, that is the timely submission and resolution of claims (*Sietzema*, at para. 16) and the purpose of the provision itself, which is to permit the insured to decide whether or not to challenge the denial of benefits (*Turner*, at para. 8). Respectfully, the Divisional Court's interpretation of this notice provision did not accord with those principles.

[37] Because I have found that the notice was not deficient and complied with the legislative requirements of s. 37(4) of the *SABS*, it is not necessary to address either Allstate's alternative argument that even if the notice was deficient in failing to provide a medical reason, it had triggered the limitation period by clearly and

unequivocally terminating Mr. Varriano's IRBs, nor Mr. Varriano's rejoinder that the termination left his eligibility for future benefits under s. 11 unclear.

VIII. DISPOSITION

[38] For these reasons, I would allow the appeal, set aside the order of the Divisional Court, and reinstate the decision of the LAT.

[39] Allstate is entitled to its costs on this appeal, before the Divisional Court, as well as its successful leave application. Those costs are fixed in the amount of $24,500 all-inclusive.

Released: February 6, 2023 "J.S."

"S. Coroza J.A."
"I agree. Janet Simmons J.A."
"I agree. Grant Huscroft J.A."