<u>NOVA SCOTIA COURT OF APPEAL</u>

Citation: ***Wright v. Nova Scotia (Public Service Long Term Disability Plan Trust Fund)***, 2006 NSCA 101

Date: 20060817
Docket: CA 260409
Registry: Halifax

Between:

The Nova Scotia Public Service Long Term
Disability Plan Trust Fund

Appellant

v.

Robert Bruce Wright

Respondent

Judges: Cromwell, Oland and Hamilton, JJ.A.

Appeal Heard: May 15, 2006, in Halifax, Nova Scotia

Held: **Appeal dismissed per reasons for judgment of Cromwell, J.A.; Oland and Hamilton, JJ.A. concurring.**

Counsel: Colin D. Bryson and Amad Al-Sharief, Articled Clerk, for the appellant
Jamie MacGillivray and Joshua Martin, for the respondent

Reasons for judgment:

I. INTRODUCTION:

[1] The respondent, Mr. Wright, sued in the Supreme Court for disability insurance benefits. The insurer claimed that Mr. Wright's action was barred by his earlier, unsuccessful appeal to a medical appeal board set up under the terms of his disability insurance plan. The trial judge, MacLellan, J., disagreed. He found that Mr. Wright's medical appeal did not bar his court action and that he was entitled to continuing disability benefits. The insurer appeals, challenging both of these conclusions.

[2] While I cannot subscribe to all of the judge's reasons, I agree with both of his fundamental conclusions: it would be unjust to hold that the medical appeal bars Mr. Wright's court action in the circumstances of this case and he proved at trial that he was entitled to continuing benefits. I would dismiss the insurer's appeal.

II. FACTS AND DECISION AT TRIAL:

[3] There are three important aspects of the factual context for the appeal: the history of Mr. Wright's claim for disability insurance benefits; the provisions of the disability plan under which Mr. Wright claimed; and, the facts concerning Mr. Wright's medical appeal under the plan. I will review each in turn and then provide a brief summary of the trial judge's resolution of the key issues raised on appeal.

A. Mr. Wright's Illness and Claims History:

[4] To understand Mr. Wright's claim for disability benefits, it is first necessary to know that there are two sorts of disability covered by the Nova Scotia Public Service Long Term Disability Plan ("Plan"). During the first 30 months (following a one hundred day elimination period of short term disability), a claimant is considered disabled within the meaning of the Plan if s/he is completely unable to perform the "... regular duties of his/her occupation." (I will refer to this as the "own occupation" definition of disability.) Thereafter, the claimant is considered disabled if s/he is "... unable to engage in any occupation for remuneration or profit

for which the employee is or may become fit through education, training, experience or rehabilitation, which occupations pays (sic) not less than 80% of the current rate...” of the position held before the claimant became disabled. (I will refer to this as the “any occupation” definition of disability.) The insurer’s refusal to continue Mr. Wright’s benefits came at the point this second, “any occupation” definition of disability applied to his claim.

[5] Mr. Wright was a family benefits case worker with the Department of Community Services. Starting in the early 1990's, he found his work becoming more and more demanding and frustrating as a result of the nature and range of his duties, the case load and the large amount of travel. In early 1995, his family doctor found that Mr. Wright was unable to work as a result of “stress reaction with probable endogonous (sic) depression.”

[6] Mr. Wright filed a claim for disability benefits under the Plan in late May or early June of 1995. At that time, his attending psychiatrist, Dr. Sheard, reported a diagnosis of “major depression – job burn out”. Mr. Wright’s application for benefits was approved on July 7, 1995, retroactive to June 10.

[7] The claim was reviewed in the late autumn of 1995. At that time, Dr. Sheard described Mr. Wright as having a prevailing mood of depression and heightened anxiety. He opined that Mr. Wright needed at least a year without working and that it was “most unlikely” that he would return to his former job. The Plan continued to pay benefits with a review set for the late spring of 1996.

[8] As part of the Plan’s review of the claim, Dr. Sheard provided another report in August of 1996. It indicated that Mr. Wright would not be able to return to his former job in a three month time horizon but that within that time period he could be considered fit to return to suitable employment. Attempts were made to find a suitable position, but without success.

[9] Benefits continued. A further report from Dr. Sheard was obtained in June of 1997 which stated that Mr. Wright was “indefinitely disabled.” The Plan administrators then referred the file to Dr. Rubens, a psychiatrist. At the time, the administrators noted that there did not appear to be “... a lot of supportive evidence for this man to be on claim ...” but that “ ... [i]t is very obvious he cannot do his own job.” Dr. Rubens opined that “[t]his claim has been highly suspect from the start”. He noted that Dr. Sheard had at no point given a clear diagnosis or

described any significant symptoms. He recommended that the claim be denied on the grounds of no evidence of a disabling psychiatric condition. Dr. Rubens recognized that Mr. Wright would soon have to meet the "any occupation" test for disability, noting that as a result, the specific circumstances of Mr. Wright's former job would be irrelevant. Dr. Rubens concluded that the problem was occupational, not psychiatric. The change of definition came into effect on December 1997. At that point, Mr. Wright's eligibility depended on whether he met the "any occupation" definition of disability.

[10] The previous July, after reviewing Dr. Rubens' report, the Plan administrators had advised Mr. Wright that his benefits would terminate on December 10. They stated:

> ... It is our opinion that the medical documentation on file does not support a claim of total disability after the 30 months as described above. Maritime Life's Rehabilitation Coordinator, Noelle Baldwin, has been contacted to approach your employer for an alternate position; however, please note that availability of alternate work is not a consideration regarding termination of benefits as per this Plan.

[11] The letter also advised Mr. Wright of the appeal provisions under the Plan.

B. <u>The Terms of the Plan</u>:

[12] The Plan was established by the Province of Nova Scotia and the Nova Scotia Government Employees Union ("NSGEU") in 1985. They established a trust fund (the "LTD Fund") from monies held by the Province and the ongoing premium contributions by the Province and the Plan members, with the LTD Fund to be administered by a Board of Trustees, four of whom were to be appointed by the Province, and four by the NSGEU. The principal role of the Trustees was to administer the LTD Fund and the Plan. The Plan was the product of negotiations between the Province and the NSGEU. The trustees hired Maritime Life Assurance Company to carry out the day-to-day administration of the Plan, including the processing and the adjudication of claims.

[13] The Plan provided for benefits when "... illness or injury results in the disability of an employee." (s. 7(1)). As noted earlier, disability within the

meaning of the Plan was defined in two ways. For the first 30 months (following an elimination period), an "own occupation" definition applied and thereafter, an "any occupation" definition came into effect.

[14] The Plan provides for an appeal in the event that the administrator decides that an employee is not eligible for benefits:

> 6. (2) When the Administrator rules that an employee is not eligible for benefits hereunder, the employee may appeal to the Board of Trustees, who shall arrange a medical hearing, in accordance with Letter of Understanding #6, attached hereto.

[15] While this section of the Plan contemplates an appeal whenever an employee is found ineligible, the letter of understanding restricts the appeal to a medical appeal board to "medical grounds only":

> LETTER OF UNDERSTANDING #6
>
> MEDICAL APPEAL SYSTEM
>
> The parties agree that the Board of Trustees be instructed to establish a medical appeal system.
>
> (a) Such appeal system shall be on medical grounds only.

(Emphasis added)

[16] There are appeal rules which govern this medical appeal process. I have appended them as Annex A to my reasons. Briefly, they provide that the appeal board is to consist of one or more qualified medical doctors, that there is to be a full exchange of medical information and that the appellant is permitted to present medical evidence. The appeal board is to have a written decision within 14 days after it has heard all the evidence and it is not required to give reasons for its decision. The rules stipulate that the board's decision is final and binding and not open to judicial review.

C. Mr. Wright's Medical Appeal:

[17] Mr. Wright appealed the termination of benefits. Dr. Sheard wrote a further report (dated August 31, 1997) which provided a diagnosis of "major depression severe without psychotic features". The report concluded that Mr. Wright's "cognitive difficulties preclude working at any employment".

[18] The Plan administrator referred the file to Dr. Rubens for further review. In a memo to Dr. Rubens, the administrator stated: "I decided to terminate benefits after at the 30 month mark as information certainly did not support disability for any occupation." This memo shows that the administrator was applying the "any occupation" branch of the definition of disability.

[19] Dr. Rubens provided a follow-up report (dated September 17, 1997). His view was that the "... claim should be denied on the grounds both that there is insufficient evidence of a disabling psychiatric condition ...". He added that the recent diagnosis of major depression of severe proportion was inconsistent with the symptoms that had been reported and treatment provided. Dr. Rubens also suggested that the claim could be denied on the grounds of insufficient treatment.

[20] The Plan advised Mr. Wright that the denial of benefits was being maintained.

[21] Dr. Sheard wrote a further report (dated October 30, 1997) in which he described an enhanced treatment plan. The administrators of the Plan once again referred the matter to Dr. Rubens, indicating that the administrator "... had advised the claimant benefits would terminate in December as this was his definition change date. <u>I could have terminated a bit earlier but I felt it would be easier to maintain a termination based on his inability to perform any occupation</u>." This memo quite clearly indicates that while the administrator may have had doubts about whether Mr. Wright continued to suffer from any disabling condition, the basis of her decision to terminate was her view that he was not disabled under the "any occupation" definition.

[22] Dr. Rubens once again provided comments on Dr. Sheard's report.

[23] The matter was then scheduled for an appeal hearing with Dr. Byron Reid sitting as the medical appeal board. Mr. Wright's union representative was provided with a copy of the medical appeal file. Present at the hearing were Mr.

Wright, his union representative, a representative of the LTD Fund, and the claims' examiner.

[24] The only evidence of what took place at the hearing was from Mr. Wright, evidence the trial judge found to be "vague and not helpful." There was no evidence as to any consideration at the hearing of what jobs, if any, Mr. Wright was thought able to do.

[25] There is brief reference to a couple of potential jobs in the Maritime Life file (but not the medical appeal file) – specifically, a job of Case Aid - Service Navigator and a possible Gaming Commission job referred to in Dr. Sheard's reports. In his direct evidence at trial, Mr. Wright referred to an intake or input worker for family benefits job that he was offered, stating that the salary was well below 80% of his former salary. It is not clear whether this was the Case Aid - Service Navigator job referred to in the documents. There was no other evidence about how the qualifications for these jobs matched Mr. Wright's "education, training or experience" or about what they paid.

[26] There was nothing in the medical appeal board file concerning specific jobs which it was alleged Mr. Wright could do, about their requirements, how they related to Mr. Wright's "education, training [or] experience" or their rates of pay. So far as one can tell from the claims' file and the trial record, the administrator of the Plan never identified a single job or type of job for which it claimed Mr. Wright was "fit through education, training [or] experience" and which paid the requisite wage. For that matter, the current salary in 1997 for his former position is not found in the claims file or the medical appeal file.

[27] The medical appeal board released his decision in a letter dated March 12, 1998. It said this:

> I am writing to inform you that your Appeal has been denied.
>
> I agree with the staff of Maritime Life that <u>your medical problems do not support a claim for Long Term Disability as defined under the Plan</u>.
>
> I feel that your condition is primarily related to job stress and <u>alternate employment should be considered</u>. (emphasis added)

D. <u>The Trial Judge's Decision</u>:

[28] Following his unsuccessful medical appeal, Mr. Wright started an action in the Supreme Court to recover the disability benefits he claimed under the Plan. The Plan defended the action, in part on the basis that the appeal board ruling barred the suit under the issue estoppel branch of *res judicata*. The appeal board, said the Plan, had decided the issue of whether Mr. Wright was disabled and he could not relitigate it in court.

[29] The trial judge rejected this defence and found that the Plan should continue to pay disability benefits to Mr. Wright.

[30] On the issue estoppel defence raised by the Plan, the judge, as I read his reasons, reached three conclusions.

[31] First, the judge found that the appeal board had not been acting within jurisdiction because its decision was not based solely on "medical grounds" as required by the terms of the Plan. An issue under the "any occupation" definition of disability concerned Mr. Wright's ability to perform an occupation that would pay at least 80% of the current rate of his pre-disability position. This, the judge concluded, was not a pure "medical ground" and therefore not within the jurisdiction of the appeal board. For this view of the jurisdiction of the appeal board, the judge relied on the decision of this Court in **Braithwaite v. Nova Scotia Public Service Long Term Disability Plan Trust Fund** (1999), 176 N.S.R. (2d) 173 (C.A.). Issue estoppel could not operate because the issue raised in the court action was outside the jurisdiction of the medical appeal board.

[32] Second, the judge found that, in any event, the appeal board had not in fact decided whether Mr. Wright could perform some occupation for which he was suited and which paid at least 80% of the current pay for his pre-disability position. Issue estoppel could not operate because the board had not decided the question now before the court. The judge reached this conclusion because there was no evidence before the board which would have permitted it to decide that question.

[33] Third, the judge held, in the alternative, that even if the board had finally decided the issue, he would exercise his discretion to allow the case to proceed "... considering the importance of the issues to the plaintiff and the informal procedure used at the appeal hearing along with the lack of reasons given."

[34] Turning to the merits of Mr. Wright's claim for benefits under the Plan, the judge reviewed the medical reports and the oral evidence and concluded that Mr. Wright was disabled within the meaning of the Plan. He accordingly ordered the Plan to restore benefits effective the date of their termination.

III. ANALYSIS:

A. Standard of Appellate Review:

[35] The standard of appellate review is not contentious. The judge's statement of legal principle is reviewed for correctness. Findings of fact, including inferences drawn from the evidence, are reviewed for clear and determinative error: **Housen v. Nikolaisen**, [2002] 2 S.C.R. 235 at paras. 1 - 5. The application of legal principles to the facts is reviewed on the same standard unless it appears that an incorrect principle has been applied. The exercise by the trial judge of his judicial discretion is reviewed for error in principle and to determine whether the result he reached is so clearly wrong that it is manifestly unjust.

B. Issue Estoppel:

[36] The principle of issue estoppel bars a subsequent claim if the same issue has been finally decided in a prior judicial proceeding between the same parties. There is a discretion, however, to relax this rule to prevent injustice.

[37] The judge found that the requirements of issue estoppel had not been met in this case and that, even if they were, he would disallow the defence as a matter of discretion. The appellant challenges both of these conclusions. I will address each in turn, but it will be helpful first to set out a brief summary of the applicable legal principles.

1. Issue estoppel: general principles:

[38] The general principle is that once a dispute has been judged with finality, it is not subject to relitigation. Thus, prior adjudication bars the reassertion of the same claim (estoppel *per rem judicatum*) or the relitigation of any of the "...constituent issues or material facts necessarily embraced therein..." (issue

estoppel): **Danyluk v. Ainsworth Technologies Inc.**, [2001] 2 S.C.R. 460 at para. 20. The present case is concerned with whether a prior tribunal decision (the medical appeal board), not a court decision, bars Mr. Wright's action. The discussion which follows relates to that sort of claim of issue estoppel.

[39] A claim, such as the appellant's, that issue estoppel bars the court's determination of an issue must be considered in two steps. At the first, the appellant must establish all three of the requirements of a plea of issue estoppel: that the same question was decided between the same parties in a previous, final judicial decision: see **Danyluk** at para. 25. A decision is "judicial" if it is made by a tribunal capable of exercising adjudicative authority which is required to and did act in a judicial manner within its jurisdiction: **Danyluk** at para. 35. If all of these requirements are established, the court must go on to the second step and decide whether, as a matter of discretion, it should disallow the plea of issue estoppel: **Danyluk** at para. 33.

2. The same issue?

[40] The first requirement for issue estoppel is that there has been a prior decision on the same question as is advanced in the proceeding: **Danyluk** at para. 25.

[41] Mr. Wright's court action was based on his contention that he was disabled within the meaning of the Plan. The appellant's submission is that this was the precise issue decided by the medical appeal board and therefore, the "same issue" element of issue estoppel was established. The appellant submits that the judge erred in finding that this was not the issue which the appeal board decided and in basing that conclusion on material other than the Plan documents and the board's decision.

[42] Turning to the second point first, I am not persuaded that the judge erred in considering the material he did in his attempt to determine what the appeal board had actually decided. In making that determination, " ... the court may look to the documentation behind the formal judgment to determine what was decided for the purpose of *res judicata*. It is the substance of the matter actually decided which should control whether *res judicata* applies, not the form of the judgment.": Donald J. Lange, **The Doctrine of *Res Judicata* in Canada**, 2nd ed., (Ontario: Butterworths, 2004) at pp. 14-15 In this case, we have in the record the full disability Plan claims file, the medical appeal board file, the board's decision and

the trial evidence. Contrary to the appellant's submission, I do not think that the trial judge was restricted to examining only the Plan documents and the appeal board's written decision in order to determine what issue or issues the appeal board decided.

[43] With great respect, however, I am of the view that the judge erred in the way he applied the "same issue" requirement. As I read his reasons, he looked at the *basis* of the board's decision rather than at the *issue* the board decided. In my respectful view, this was the wrong question and asking it led the judge into error. The question for the judge was whether the board had purported to decide an issue on which Mr. Wright's court action depended, not on what basis it did so or whether there was evidence to support its conclusion.

[44] Approached in this way, the question is quite straight-forward. The Plan claimed that Mr. Wright was estopped from relitigating the issue of whether he was disabled. What the judge had to determine was whether the Plan had shown this issue had been decided in the medical appeal process. Had the judge limited his enquiry in this way, he would inevitably have concluded on this record that the board had indeed purported to decide that Mr. Wright was not disabled within the meaning of the Plan.

[45] The only issue in contention before the appeal board was whether Mr. Wright was disabled within the meaning of the Plan and, at the relevant time, the applicable definition of disability was the "any occupation" definition. While, as the judge rightly observed, the board's decision does not much enlighten one as to the basis for its conclusion, it is, with respect, clear that the board found Mr. Wright was not entitled to continued benefits because he was not disabled within the meaning of the Plan. I do not know what other meaning could be ascribed to the appeal board's words that Mr. Wright's "... medical problems do not support a claim for Long Term Disability as defined under the Plan." Whether the appeal board's determination was right or wrong or inside or outside its jurisdiction does not matter for the "same issue" element of the issue estoppel analysis. (These factors are, of course, relevant with respect to other aspects of the analysis.) On some basis or another, rightly or wrongly, within its jurisdiction or not, the board clearly decided that Mr. Wright was not disabled within the meaning of the Plan. That is the same issue raised in Mr. Wright's law suit.

[46] In my view, the judge erred in finding that the appellant had failed to establish the "same issue" element of its plea of issue of estoppel.

3. Jurisdiction of the appeal board:

[47] The judge found that the appeal board did not have jurisdiction to decide whether Mr. Wright met the "any occupation" definition of disability. This is one aspect of the requirement that the decision giving rise to the estoppel be "judicial". The appellant says the judge erred in doing so. Respectfully, I agree. Before turning to the specific submissions, it will be helpful to situate them within the Plan documents, Mr. Wright's position and the principles relating to issue estoppel.

(a) The Plan documents:

[48] As noted earlier, the medical appeal system is created by letter of understanding between the parties. When the administrator rules that an employee is not eligible for benefits, s. 6 of the Plan provides that he or she may appeal to the board of trustees. However, the trustees are then to arrange for a medical appeal as set up under the letter of understanding. Such appeals are restricted to "medical grounds only". There are, as noted, medical appeal rules which further underline the medical focus of the process. The appeal board is to consist of one or more qualified medical doctors, there is to be full exchange of medical information and the appellant is permitted to present medical evidence. The board is to have a written decision within 14 days after it has heard or received all evidence and it is not required to give reasons for its decision. The rules stipulate the board's decision is final and binding and not open to judicial review.

(b) Mr. Wright's position:

[49] Mr. Wright's fundamental point, accepted by the trial judge, is that the determination of whether he is able to perform "any occupation", in the circumstances of this case, is not a "medical ground" and therefore not within the jurisdiction of the medical appeal board.

(c) Issue estoppel and "jurisdiction":

[50] Issue estoppel requires that there has been a final judicial decision of the issue raised in the subsequent proceedings: **Danyluk** at para. 25. There is no

dispute here that the appeal board's decision was "final". The issue is whether it was "judicial".

[51] In order to be considered a "judicial" decision for issue estoppel purposes, three conditions must be present: the tribunal issuing the decision must be capable of receiving and exercising adjudicative authority, it must be a decision that was required to be made in a "judicial" manner and the decision must have been made in that manner: **Danyluk** at para. 35. In order to be made in a "judicial manner", the tribunal must have been acting within its jurisdiction. There is no dispute here that the board was capable of receiving and exercising judicial authority and was required to act in a judicial manner. The dispute concerns whether the appeal board was acting within its jurisdiction.

[52] In this context, the term "jurisdiction" is used in a very narrow sense. To have "jurisdiction", the tribunal must have had the authority to undertake the inquiry presented to it. As the Court put it in **Danyluk**, the requirement is that "... the conditions precedent to the exercise of ... jurisdiction are satisfied ..." : para. 47; the tribunal must not have lacked jurisdiction "from the outset": para. 51. This (for good or ill) is reminiscent of the concepts of jurisdiction *stricto sensu* and collateral and preliminary questions as discussed in cases such as **U.E.S., Local 298 v. Bibeault,** [1988] 2 S.C.R. 1048 at 1083 - 4 and **Dayco (Canada) Ltd. v. CAW-Canada**, [1993] 2 S.C.R. 230 at 258 - 9. In **Danyluk**, the Court distinguished between jurisdiction in this sense and errors made in the course of the proceedings such as, for example, denials of natural justice: at para. 47. In other words, the matter is within jurisdiction for the purposes of the "judicial decision" requirement of issue estoppel in this context if the tribunal was entitled to engage in the particular decision-making function on which it embarked.

[53] As explained in **Danyluk**, this narrow approach to defining jurisdiction is necessary in order to avoid gutting restraints which limit "collateral attacks" on a final decision or which may deny judicial review of a tribunal decision where there was some other adequate, alternate remedy: paras. 47 - 51.

(d) Analysis of the appellant's submissions:

[54] The judge held that, in the circumstances of this case, the board had no jurisdiction to address the issue of whether Mr. Wright could perform "any occupation". It followed, in the judge's view, that the board's decision could not

support an estoppel because it had no jurisdiction to decide the issue. The appellant attacks this conclusion on three grounds which I will address in turn.

(i) Is jurisdiction relevant?

[55] First, the appellant says that jurisdictional issues are not relevant to the question of whether the requirements of issue estoppel have been met. I do not agree.

[56] As discussed earlier, the second requirement of issue estoppel – that there be a final judicial decision – includes a requirement that the tribunal have jurisdiction. However, as I have explained, jurisdiction in this context has a limited meaning. As Binnie, J. put it in **Danyluk**, "... Where arguments can be made that an administrative officer or tribunal <u>initially possessed the jurisdiction to make a decision in a judicial manner but erred in the exercise of that jurisdiction</u>, the resulting decision is nevertheless capable of forming the basis of an estoppel. Alleged errors in carrying out the mandate are matters to be considered by the court in the exercise of its discretion. ...": at para. 51 (emphasis added).

[57] I conclude that the jurisdiction of the board, in the narrow sense I have described, is relevant to the issue estoppel analysis.

(ii) Did the board have jurisdiction?

[58] The appellant says that the judge erred in finding that the board lacked jurisdiction. I agree. In my view, the appeal board had jurisdiction in the narrow sense required for the operation of issue estoppel in this context. The judge, with respect, erred in finding otherwise.

[59] I emphasize again that we are here concerned with jurisdiction over the parties and the subject-matter. We are not at this stage of the analysis concerned with other questions such as whether there was evidence to support the board's conclusion or whether the board was empowered to decide the issue of whether there were other jobs Mr. Wright could do. I mention this because the trial judge found that the appeal board could not have decided whether Mr. Wright was disabled under the "any occupation" definition of disability because there was no evidence before it in relation to the issue of "whether there were jobs available to Mr. Wright which would enable him to earn 80% of what he used to earn." In my

view, this is irrelevant at this stage of the analysis. I repeat: in looking at the "judicial decision" element of issue estoppel in this context, we are concerned only with whether the appeal board had jurisdiction in the narrow sense I have described earlier.

[60] Mr. Wright's complaint is not that the appeal board lacked jurisdiction over him or the subject-matter of his appeal. His complaint is that the appeal board decided an issue that it should not have addressed in the course of dealing with his appeal. This complaint, in my respectful view, is that the appeal board, to use the words of Binnie, J., made " ... errors in carrying out the mandate ...": **Danyluk** at para. 51. This does not show that the board lacked jurisdiction to embark on hearing the appeal. As the Court decided in **Danyluk**, alleged errors in carrying out the mandate are matters to be considered by the court in the exercise of its discretion, not in determining whether the tribunal had jurisdiction in the narrow sense required to support a plea of issue estoppel: para. 51.

*(iii) The **Braithwaite** decision*:

[61] The judge relied on our decision in **Braithwaite** for the proposition that the application of the "any occupation" definition of disability was not a purely medical ground and, therefore, not within the jurisdiction of the medical appeal board. I agree with the appellant that he erred in doing so.

[62] **Braithwaite** did not finally determine anything about the jurisdiction of the medical appeal board. The case was an appeal in a pleadings motion and the issue therefore was whether the pleading was obviously unsustainable, not whether it was correct. As I said on behalf of the majority at para. 61, "I emphasize that I have not attempted to rule definitively on what constitutes a medical ground, the application of res judicata or any of the other issues raised other than to say they are triable issues."

[63] I therefore respectfully conclude that the trial judge in this case erred when he held that **Braithwaite** decided that the medical appeal board has no jurisdiction for the purposes of issue estoppel to deal with the non-medical aspects of whether a person is disabled within the meaning of the "any occupation" branch of the Plan's definition of disability.

4. Conclusion on issue estoppel requirements:

[64] In my respectful view, the judge erred in finding that the "same issue" and "jurisdiction" requirements of issue estoppel had not been established in this case. There is no dispute that the other requirements are met. I would therefore hold that the appellant established each of the three requirements for issue estoppel.

5. Discretion:

(a) The judge's decision and the appellant's position:

[65] The judge's reasons on this aspect of the case are very brief. He refers to the "importance of the issues to [Mr. Wright], the informal procedure used at the appeal hearing along with the lack of reasons given" as providing a basis for the exercise of his discretion not to apply the issue estoppel defence.

[66] The appellant submits that the judge erred in legal principle because he identified and relied on irrelevant factors in exercising his discretion. This, of course, is a ground on which the judge's exercise of discretion may be reviewed on appeal.

(b) Legal principles:

[67] The second stage of the issue estoppel analysis comes into play where, as here, the party claiming estoppel has established the three requirements for its operation. At this second step, "... the court must ... determine whether, as a matter of discretion, issue estoppel *ought* to be applied": **Danyluk** at para. 33, citing with approval **Braithwaite** at para. 56 (emphasis in the original). The rules governing issue estoppel should not be applied mechanically, but flexibly in light of their underlying purpose: **Danyluk** at para. 33. That purpose is to balance the important but sometimes competing goals of promoting finality in litigation while ensuring that justice is done: **Danyluk** at para. 33. Concerns about adequate alternate remedies and collateral attack have helped to shape how this discretion should be exercised, as have concerns about fairness to the parties and injustice in the result.

[68] The Supreme Court of Canada has provided seven factors as part of an open ended range of considerations: **Danyluk** at para. 67. They are:

(i) the wording of the statute from which the power to issue the administrative order derives

(ii) the purpose of the legislation

(iii) the availability of an appeal

(iv) the safeguards available to the parties in the administrative procedure, including issues concerning natural justice

(v) the expertise of the administrative decision maker

(vi) the circumstances giving rise to the prior administrative proceedings

(vii) the potential injustice

(c) Did the judge consider irrelevant factors?

[69] The judge based his decision on the importance of the issues to Mr. Wright, the informal procedure used at the appeal hearing and the lack of reasons given by the appeal board. The appellant says that these are irrelevant considerations and the judge therefore erred in principle in relying on them.

[70] I agree with the appellant in one respect. It was an error in principle to find that issue estoppel should not operate in this case simply because the parties had entrusted an important issue to an informal process. Here, two sophisticated and knowledgeable parties (the government and a very large trade union) agreed to this process. In general, the courts should respect that choice, not undermine it.

[71] This point has been made by both the Supreme Court of Canada and by this Court. In **TWU v. British Columbia Telephone Co.**, [1988] 2 S.C.R. 564, the Court adopted these words of Lambert, J.A. in the Court of Appeal ((1985), 65 B.C.L.R. 145 at 146 - 59): " The significant fact about a consensual arbitrator is that the parties have picked the arbitration process, and they have picked the arbitrator, because they want that process and that arbitrator in preference to any other process or any other decision-maker. And they want the arbitrator to do what

they ask him to do in the way they ask him to do it; and not to do something else in some other way." These words were cited with approval by Bateman, J.A., writing for the Court, in **Holt v. Nova Scotia Public Service Long Term Disability Plan Trust Fund** (1998), 172 N.S.R. (2d) 1 at para. 25.

[72] To find that the informality of the agreed process is fatal to the operation of issue estoppel undermines the parties' ability to fashion their own system of dispute resolution. Sophisticated parties may – and do – choose to entrust very important issues to informal processes of decision. Informality is no more the antithesis of justice than formality is its proxy.

[73] I conclude, therefore, that the judge erred in refusing to apply the defence because the parties entrusted an important issue to an informal process. This Court must therefore exercise the discretion that the judge had in accordance with correct legal principles.

[74] While the **Danyluk** factors are not exhaustive, they provide a convenient framework for analysis. I will consider each in turn.

(i) the wording of the statute from which the power to issue the administrative order derives

[75] There is, of course, no statutory power in this case. The medical board's authority derives from the agreement between the parties. At the root of the dispute that has led to this appeal is the interpretation of what that agreement means. In my view, it does not mean that the medical appeal board may decide all aspects of whether an employee is disabled. It may review on "medical grounds only."

[76] The role which the parties envisioned for the appeal board must be determined through the interpretation of the relevant Plan documents. In doing so, the words used should, if possible, be given a meaning that will advance the intention of the parties and not create an unrealistic result which they could not have intended.

[77] The medical appeal board provisions in the Plan are similar to contractual arbitration provisions. Such provisions must be interpreted in light of the contract (or in this case, the Plan) as a whole. The approach to interpretation should also recognize the desirability of the parties choosing their own dispute resolution

processes and be respectful of their choice. So, for example, if the language the parties have used is reasonably capable of bearing two interpretations, one of which provides for arbitration of the disagreement between the parties, the courts generally adopt that interpretation: see, for example, **Bolands Ltd. v. Ivan Smith Holdings Ltd**. (2002), 210 N.S.R. (2d) 215; N.S.J. No. 503(Q.L.)(C.A.) at para. 47; **Huras v. Primerica Financial Services Ltd**. (2001), 55 O.R. (3d) 449 (C.A.) at 18; **Canadian National Railway Co. v. Lovat Tunnel Equipment Inc.** (1999), 174 D.L.R. (4th) 385 (Ont. C.A.). As Blair, J. (as he then was) noted in **Onex Corp v. Ball Corp.**, [1994] O.J. No. 98 (Q.L.)(Gen Div) at para. 17, "Th[e] law also includes a relatively recent, and clear, shift in policy towards encouraging parties to submit their differences to consensual dispute resolution mechanisms outside of the regular court stream."

[78] However, and with respect, I cannot agree that this interpretative exercise in the present case leads to the conclusion advanced by the appellant. While the appellant says the parties intended that the medical appeal board should in all cases decide all aspects of whether an employee is disabled within the meaning of the Plan, the Plan documents do not bear this out.

[79] The appellant accepts, as the letter of understanding stipulates, that appeals to the medical appeal board are limited to "medical grounds only." The appellant also recognizes that, strictly speaking, the application of the Plan's definition of the word "disabled" to a particular case may involve a number of "sub-issues". Some of these are purely medical issues (such as whether an individual has an illness or injury). Some are clearly not purely medical issues (such as the determination of whether the person is an "employee"). Thus, the appellant recognizes the obvious: the plain meaning of the words "medical grounds only" seems to restrict appeals to purely medical issues.

[80] The appellant submits, however, that when the provisions are examined in their full context, what first appears to be the plain meaning of the words gives way to a broader, plausible interpretation. That reading of the text is that the restriction of appeals to "medical grounds only" empowers the medical appeal board to determine all aspects of whether an individual is disabled within the meaning of the Plan.

[81] The appellant supports this reading of the Plan with a number of points. With respect, I do not find any of them convincing. The text of the Plan

documents and the structure of the appeal process make it clear, in my respectful view, that the process was intended by the parties to deal only with questions about the individual's medical condition.

[82] I accept the appellant's point that there are many reasons a person – even an admittedly disabled person – may be denied benefits under the Plan (see section 7(3)). The clear inference is that the restriction to appeals on "medical grounds" was intended to limit appeals to those categories of denials made on medical grounds. But this does not advance the appellant's position. It begs the question of <u>which</u> denials fall into the category of denials on medical grounds.

[83] The appellant notes that the appeal provision in s. 6(2) of the Plan refers to situations in which the administrator rules that an employee is <u>not eligible for benefits</u>. The letter of understanding, however, narrows the scope of appeals to "medical grounds only". This, says the appellant, was intended to set up two categories of denials of benefits, those on medical grounds and all the others. Only those on medical grounds, the appellant submits, have access to the medical appeal board.

[84] With respect, I do not accept that the use of the very general language that an employee "is not eligible for benefits" in s. 6(2) of the Plan sheds any light on the meaning of what was intended by the term "medical grounds" in the letter of understanding. Section 6(2) of the Plan seems to contemplate an appeal to the trustees in the case of any denial on whatever grounds. It is obvious, in my view, that the choice to limit appeals to a medical appeal board on medical grounds was intended to limit the scope of those appeals to medical issues. But the appellant's submission once again simply begs the question of what that means.

[85] I accept in principle the appellant's point that an appeal on medical grounds is meant to correspond to a denial on medical grounds as opposed to a denial for some other reason, such as a failure to co-operate with a rehabilitation Plan as referred to in s. 7(2)(k) of the Plan. That leaves unanswered, however, whether the denial was on medical grounds.

[86] Whatever the merits of some different system might be, we are here concerned with the system established by the parties. It is clear from the text of the Plan and the letter of understanding that the scope of appeals to the trustees contemplated under s. 6(2) of the Plan – that is, appeals whenever the administrator

of the Plan rules that an employee is not eligible for benefits – were deliberately and significantly restricted by the letter of understanding relating to medical appeals. The letter of understanding does not indicate that such appeals should deal with the question of whether someone is disabled or address denials for primarily or mainly or fundamentally medical grounds. The letter of understanding restricts appeals to "medical grounds <u>only</u>" (emphasis added).

[87] Consistent with this limitation, the whole focus of the appeal rules is on the provision of complete medical information. The structure of the appeal board – it is to consist of "one or more qualified medical doctors" – also underlines the medical orientation of the appeal process which the parties envisioned.

[88] With respect, I see nothing in the text of the Plan, the letter of understanding or the appeal rules which supports the broader notion advanced by the appellant of what these appeals were intended to be about.

[89] At trial, extensive evidence was called from Ronald A. Pink, Q.C., a prominent labour lawyer, who acted for the union when the Plan was established. The admissibility of his evidence was not challenged on appeal and I shall say nothing more about that. Assuming that the evidence was admissible in aid of the interpretation of the Plan and the appeal provisions, it did not support the appellant's position on the point we face in this case. In fact, it did the opposite.

[90] Mr. Pink testified in chief that the medical appeal board was confined to the "very narrow grounds of whether or not the individual met the definition of disability...". He made it clear, however, that the role of the medical appeal board was to simply assess <u>from a medical perspective</u> whether the individual was capable or not of doing specific jobs. It was not the appeal board's function, on his evidence, to determine for example, whether the person "is or may become fit through education, training, experience" for particular jobs or whether those jobs pay not less than 80% of the current rate of the claimant's pre-disability position. As Mr. Pink explained it, the founders of the Plan contemplated that the appeal board would be provided with examples of jobs for which the claimant "is or may become fit through education, training, experience or rehabilitation" and which pay at the appropriate threshold. The role of the medical appeal board would be simply to make the medical judgment as to whether the claimant was able to engage in any of those occupations.

[91] In this case, the record does not establish that the medical appeal board confined itself to that question. In fact, the board's written decision and the medical appeal file do not support an inference that the board so confined itself. In my view, it is clear from the record that the appeal board had to decide, and did, whether Mr. Wright was capable of doing another job that fell within the definition of the "any occupation" branch of disability under the Plan. It is also clear to me that, in the circumstances of this case, this was not the appeal board's function and the board had no means of discharging that function on the material before it.

[92] It seems clear from the appeal board's decision that it accepted, as did the administrator in the claims file, that Mr. Wright could not do his old job: I see no other inference to be drawn from the appeal board's statement in its decision that Mr. Wright's "... condition is primarily related to job stress and alternate employment should be considered." This means that the issue for the appeal board was whether Mr. Wright could do some other job for which he was qualified (that is, fit for through education, training or experience) and which paid not less than 80% of the current rate of his former position. There was nothing in the medical appeal file about what the current rate of pay for his former position was (remember he had been off work since 1995 and the appeal hearing took place in March of 1998), about any specific jobs the requirements of which matched Mr. Wright's "education, training and experience" or about the rates of pay for such jobs. I do not understand how, in the absence of material on those matters, the board's decision could be considered to have been in relation to "medical grounds only". Moreover, with those gaps in the material, I fail to understand how the appeal board could refuse benefits on the basis of the "any occupation" definition of disability even if it was within its authority to do so.

[93] My conclusion concerning the role of the medical appeal board is not inconsistent with our decision in **Holt, supra** . That was an appeal by the trustees from a claimant's successful judicial review application of the medical appeal board's ruling. The judge at first instance had set aside the board's decision because, in the judge's view, the board had made jurisdictional errors by limiting its inquiry to whether the administrator of the Plan had followed proper procedures, by adopting a clearly wrong definition of disability and by wrongly requiring that the applicant support her claim by objective medical evidence. At issue on appeal from the judge's decision was whether he had erred in setting aside the board's ruling on these bases. The issue of what constitutes "medical grounds

only" within the terms of the letter of understanding was not before the court and was not decided by the court.

[94] I do not accept the appellant's submissions that the role of the medical appeal board, as I have interpreted it, produces a "divided, dysfunctional and eviscerated system" of medical appeals.

[95] The board's role, as I understand the parties to have defined it, permits the board to deal with the question of whether the individual is disabled within the "own occupation" definition in the Plan, provided, of course, that there is no dispute as to whether the person is an employee covered by the Plan or about what the "regular duties of his/her occupation" are. Mr. Pink made clear in his testimony that the medical appeal board was not intended to deal with those sorts of threshold issues.

[96] Similarly, the medical appeal board may deal with the question of whether a person is disabled within the "any occupation" definition of disability, provided there is no factual dispute about basic points such as the types of jobs for which the individual is "fit through education, training and experience" (i.e., the non-medical aspects of fitness) or about whether they pay "not less than 80% of the current rate of the position ... held prior to disability." These issues, as Mr. Pink made clear in his testimony, are not ones for the medical appeal board. There will frequently, however, not be any disagreement between the parties on these basic points and the medical appeal board is entitled, in my view, to apply its medical judgment to the facts on which the parties agree. It is only when the parties disagree on, or fail to provide information about, critical facts which are not part of the medical judgment within the medical expertise of the appeal board that the board will be limited in its authority to determine the issue of disability within the meaning of the Plan.

[97] I conclude that the wording of the Plan and the letter of understanding show that the appeal board acted beyond the scope of its intended role in this case. This factor, in my view, tends in favour of disallowing the plea of issue estoppel.

(ii) The purpose of the "legislation":

[98] Once again, there is, of course, no legislation in issue here, but we can consider the purpose of the medical appeal provisions. The main issue is how

similar in purpose the medical appeal provisions are to the subject-matter of the subsequent litigation.

[99] In my view, the purposes are closely aligned and this tends against disallowing the issue estoppel defence. While the role of the medical appeal board is narrower than that of the court hearing the law suit, the basic purpose of the scheme is the same: to determine whether Mr. Wright ought to continue to receive benefits. Given that Mr. Wright initiated the appeal process in the face of the administrator's denial of benefits, a final decision on that issue must certainly have been within the contemplation of the parties.

(iii) The availability of an appeal:

[100] As noted in **Danyluk**, this factor corresponds to the "adequate alternative remedy" issue in judicial review. Here, Mr. Wright had no appeal from the medical appeal board, whose decision was stated to be final.

[101] The appellant says that Mr. Wright was protected by the availability of judicial review, limited in its submission (and according to our decision in **Holt**), to jurisdictional issues. Of course, I agree that he had that option. However, judicial review, particularly in the context of a tribunal that keeps no record of its proceedings and gives no reasons for its decisions, is not a very potent means of review. In addition, I note that Mr. Wright did not have access to the adjudication process under a collective agreement to resolve non-medical issues such as the interpretation of the Plan. In this respect, he was unlike the employees in **Holt , supra** and **Re NSGEU and Department of Human Resources (Wigginton grievance)** dated October 14, 1994 (Outhouse)(unreported). I conclude that there was no adequate alternate remedy to his taking court proceedings in this case.

[102] The absence of any adequate alternative remedy to challenge the non-medical aspects of the appeal board's decision in this case tends to favour denying the defence of issue estoppel.

(iv) The expertise of the administrative decision-maker:

[103] There is no doubt that the medical appeal board has expertise in ruling on medical grounds of appeal. It is equally clear that the board has no expertise with respect to non-medical issues that arise in the course of appeals. In such cases, of

which this case is an example, this factor tends to favour denying the defence of issue estoppel.

(v) The circumstances giving rise to the prior administrative proceedings:

[104] Mr. Wright was advised he could appeal and did so. He said that he was not told that the medical appeal would be his only recourse. If lawyers and judges cannot agree on the scope of that appeal or the effect on his other remedies of pursuing it, he can hardly be expected to have had a clearer understanding of these points. It must also be said that Mr. Wright was under psychiatric care at the time these proceedings were taken and testified that he had very little help from his union representative in preparing and presenting his case. These factors in my view tend to favour denying the defence of issue estoppel.

(vi) The potential injustice:

[105] This factor requires "... the Court ... [to] stand back and, taking into account the entirety of the circumstances, consider whether the application of issue estoppel in the particular case would work an injustice": **Danyluk** at para. 80.

[106] So far as one can tell from the record, there has never been any proper consideration by a neutral party of whether Mr. Wright was disabled within the meaning of the "any occupation" definition in the Plan. It appears that his court action was the only way that could occur. The matter did not fall squarely within either the expertise or the terms of reference of the medical appeal board and, in the circumstances of this case, there was no other adequate remedy. It is at best unclear whether Mr. Wright appreciated that the medical appeal might preclude a subsequent court action – he said he did not – and the lack of legal clarity which is evident on this point makes that lack of appreciation understandable. The stakes are large: the judge found that the Plan owed Mr. Wright well over $100, 000. And a disability plan is no "mere commercial contract", but a contract that provides for the intangible benefit of the knowledge of income security in the event of disability: **Fidler v. Sun Life Assurance Co. of Canada**, [2006] S.C.J. No. 30 (Q.L.) at paras. 56 - 58.

[107] It has been said that the principles of issue estoppel limit a litigant to "one bite at the cherry": **Danyluk** at para. 18. I am persuaded that, in the particular

circumstances of this case, it would be unfair to limit Mr. Wright to the one bite he got before the medical appeal board.

6. Conclusion on discretion:

[108] In my view, this is a case in which the court's discretion should be exercised to disallow the plea of issue estoppel. While the judge did not consider all relevant factors, he did, in my view, arrive at the appropriate and just result.

7. Conclusion on issue estoppel:

[109] I conclude that the judge erred in finding that the requirements of issue estoppel had not been established in this case. However, he did not err in his alternative holding that the defence should be disallowed as a matter of discretion.

[110] For clarity, I would add that the possible application of the principles developed in **Weber v. Ontario Hydro**, [1995] 2 S.C.R. 929 was not argued in this case and has not been considered.

C. The Merits of Mr. Wright's Action for Benefits:

[111] The judge found that Mr. Wright was disabled within the meaning of the Plan. The appellant challenges this conclusion on two main bases. First, the appellant submits that the judge failed to apply the "any occupation" test for disability and failed to assess Mr. Wright's condition at the appropriate time - that is, as of the termination of benefits on December 10, 1997. Second, the appellant says that the judge did not give adequate reasons for preferring Dr. Sheard's opinion concerning the appellant's condition over that of Dr. Rubens and that he erred by simply accepting Dr. Sheard's opinion without analysis.

[112] To start with the second point first, there is, with respect, no substance to this submission. The trial judge carefully reviewed the medical evidence as well as the evidence of the witnesses. He decided to give more weight to the opinion of the treating psychiatrist, Dr. Sheard than to the Plan's consultant, Dr. Rubens. Dr. Sheard had been treating Mr. Wright since 1995 and had seen him many times over many years. Dr. Rubens, on the other hand, had seen Mr. Wright once, for a

couple of hours in 2004, as a consultant retained by the Plan. The judge's reasons show that he did not simply accept Dr. Sheard's opinion without analysis.

[113] The appellant says that the judge accepted Dr. Sheard's evidence simply on the basis that Dr. Sheard had been treating Mr. Wright and that this was not an adequate reason. I reject both the legal and factual premises of this submission.

[114] The trial judge was entitled to give the weight he thought appropriate to the evidence. He did not misapprehend the evidence nor make any palpable and overriding error in reaching the conclusions he did. The advantage which the judge thought Dr. Sheard had over Dr. Rubens was a sufficient basis for his decision.

[115] Moreover, it is clear from the judge's reasons as a whole that he did not, as the appellant contends, favour Dr. Sheard's opinion simply because he had spent more time with Mr. Wright than had Dr. Rubens. It is clear from a fair reading of the judge's reasons that a number of factors contributed to this aspect of his decision.

[116] The judge heard the oral testimony of Mr. Wright, his former wife and his daughter. He also had the medical file from the family doctor. A good deal of this evidence related to Mr. Wright's condition and state of mind at the relevant time and, like the evidence of Dr. Sheard, was from people who had considerable first hand knowledge of his condition at that time. The judge, as he was entitled to do, accepted much of this evidence.

[117] The judge also had before him the file comments made by Dr. Rubens starting in 1997, made without the benefit of seeing Mr. Wright in person. Dr. Rubens had recommended in June of 1997 on the basis of a file review, that Mr. Wright's benefits be terminated even under the "own occupation" branch of disability because there was in his view "... no evidence of a disabling psychiatric condition." At that time, he observed that Mr. Wright's claim had been "highly suspect from the start". The judge clearly – and in my view, reasonably – decided that Dr. Rubens' assessments simply did not reflect the reality of Mr. Wright's situation as reported by people who, unlike Dr. Rubens, had been in a position to observe that condition first hand.

[118] The judge also noted that Dr. Sheard was the treating psychiatrist whereas Dr. Rubens was a hired consultant who had performed his one and only face to face assessment of Mr. Wright at the request of the Plan for the purposes of the litigation. Moreover, the judge was entitled to, and did, note the fact that although Dr. Rubens was generous throughout in his criticism of Dr. Sheard's treatment, Mr. Wright had never refused to do anything that he was asked to do by medical personnel. The judge was, of course, aware that the Plan had never requested Mr. Wright to submit to assessment or treatment by another psychiatrist other than for the purposes of this litigation.

[119] All of these considerations reasonably support the judge's decision to give more weight to Dr. Sheard's opinion than to that of Dr. Rubens.

[120] Next, the appellant says that the judge did not apply the correct definition of disability to the relevant time. It is common ground that the correct definition was the "any occupation" definition of disability and the correct time was the termination of benefits in December of 1997.

[121] A fair reading of the judge's reasons does not sustain the contention that the judge made these errors. The judge specifically referred to Mr. Wright's inability to do "any job and clearly not a job which would earn him ... [80% of his pre-disability position]". In doing so, he directed himself to the correct test for disability. The judge also made a clear and explicit finding that "... the plaintiff [had] proven entitlement to benefits since his termination date of December 10, 1997 ... " (emphasis added), thereby specifically directing himself to the correct time for making his determination.

[122] The judge, in my view, did not err either in accepting Dr. Sheard's evidence or by failing to consider the proper definition of disability as of the appropriate date.

IV. DISPOSITION:

[123] I would dismiss the appeal with costs fixed at 40% of the trial costs (i.e. 40% of $7825 = $3130) plus the disbursements on appeal as taxed or agreed.

Cromwell, J.A.

Concurred in:

Oland, J.A.

Hamilton, J.A.

Annex "A"

NOVA SCOTIA PUBLIC SERVICE

LONG TERM DISABILITY PLAN TRUST FUND

MEDICAL APPEAL RULES

1. A letter is sent from Maritime Life Assurance Company, the claims administrator, to the insured denying benefits or advising that benefits will terminate. This letter will also advise the claimant of the right to appeal and the appeal procedure.

2. The appellant is entitled to a copy of the documentation on which the decision to deny or terminate benefits is based.

3. The appellant may commence an appeal by writing to the Coordinator, LTD Benefits or the Chair of the Board of Trustees within 30 days of the date of the letter from the claims administrator, *or other date that the claims administrator may use*, advising the appellant of the denial or termination of benefits; the letter must set out the specific grounds on which the appeal is to be based.

4. The appellant must submit all pertinent medical information intended to support his/her appeal to the claims administrator for review by the claims administrator of its decision, prior to the establishment of a Medical Appeal Board. A maximum of two submissions of medical information is permitted.

5. The claims administrator shall review the appellant's case and advise the appellant of the result of its review. Following each review, the appellant will be given a further time frame for response (15 days), to advise either that further medical information will be forthcoming or to elect a medical appeal hearing.

6. The Trustees may review the appellant's file held by the claims administrator and, if there is additional information or any other reason to do so, the Trustees may ask the claims administrator to review the file and reconsider its recommendation.

7. If the Trustees do not ask the claims administrator to review the file or if the claims administrator dos not change its recommendation after a review, the claims administrator will advise the appellant of the appeal

claim status, noting that the appeal may now go to hearing, at the appellant's election, and the Trustees will appoint a Medical Appeal Board to hear and determine the appeal, on medical grounds only.

8. The date, time and place for the hearing of the appeal will be determined by the Coordinator, on behalf of the Board of Trustees, upon consultation with all parties.

9. The Medical Appeal Board may consist of one or more qualified medical doctor(s).

10. The Board of Trustees shall designate the chairperson, who will write the Appeal Board's decision.

11. The parties before the Medical Appeal Board are the appellant, the claims administrator and the Board of Trustees.

12. Notification of the hearing to the appellant shall be by certified mail at least 14 days before the date of the hearing.

13. The claims administrator shall forward all information held by it with respect to the appeal in advance of the hearing to allow for appropriate review.

14. The appellant may present medical evidence in support of his/her appeal, or may be represented by his/her union representative or legal counsel. Costs incurred on account of legal counsel, medical expert testimony or other professional services are the responsibility of the appellant, and are not reimbursed under any circumstances. If the appeal is successful, the appellant may be reimbursed for personal expenses incurred in travelling to the hearing and for costs in acquiring the medical reports/evidence submitted.

15. Medical evidence will not be considered by the Medical Appeal Board. Medical evidence submitted in support of the appeal must have regard to the appellant's disability as of the date the claims administrator decided to deny or terminate benefits, and must be put to the claims administrator before it can be considered by the Medical Appeal Board.

16. The Medical Appeal Board may request the presence of the claims administrator/Coordinator/and/or any other persons as may be determined by the Medical Appeal Board.

17. The Medical Appeal Board shall render a written decision, with a copy to the Board of Trustees and the claims administrator, within 14 days after the Medical Appeal Board has heard or received all evidence.

18. The Medical Appeal Board is not required to give reasons for its decision.

19. The Medical Appeal Board may deny an appeal on the basis of unreasonable delay, and shall deny the appeal if the appellant fails to perfect his/her appeal within 6 months of the denial or termination of benefits by the claims administrator. If prescribed time frames are not met at any time during the appeal process, the appeal may also be closed.

20. The Medical Appeal Board's decision is final and binding, and not open to judicial review.