COURT OF APPEAL FOR ONTARIO

CITATION: Morrissey v. Wawanesa Insurance Company, 2024 ONCA 602
DATE: 20240806
DOCKET: COA-23-CV-0534

Lauwers, van Rensburg and Thorburn JJ.A.

BETWEEN

Steven Morrissey

Applicant/Appellant
(Appellant)

and

Wawanesa Insurance Company and Licence Appeal Tribunal

Respondents
(Respondents)

Nicholaus de Koning, for the appellant

Amanda Lennox, for the respondent Wawanesa Insurance Company

Douglas Lee and Valerie Crystal, for the respondent Licence Appeal Tribunal

Heard: January 31, 2024

On appeal from the order of the Divisional Court (Justices Michael R. Dambrot, Elizabeth M. Stewart and George W. King), dated July 29, 2022, with reasons reported at 2022 ONSC 4398, allowing in part an appeal from the decision and order of Adjudicator Sandeep Johal of the Licence Appeal Tribunal, dated January 7, 2020, with reasons reported at 2020 CanLII 14420 (Ont. LAT).

van Rensburg J.A.:

A. OVERVIEW

[1] Mr. Morrissey was catastrophically injured in a motor vehicle accident in 2000 and has been receiving attendant care benefits ("ACBs" or "benefits") from Wawanesa Insurance Company since shortly after the accident. These benefits are payable under the no-fault statutory accident benefits scheme of the *Insurance Act*, R.S.O. 1990, c. I.8.

[2] On April 9, 2018, Mr. Morrissey submitted a claim to Wawanesa for increased benefits from October 2015 onward to cover additional attendant care expenses that he asserts he incurred and is continuing to incur.[1] Wawanesa refused the claim, which Mr. Morrissey then submitted for dispute resolution to the Licence Appeal Tribunal (the "LAT").[2] Adjudicator Sandeep Johal (the "Adjudicator") granted Mr. Morrissey's claim in part after concluding that he was entitled to some of the additional ACBs claimed, and only on a go-forward basis from April 9, 2018. The Divisional Court allowed Mr. Morrissey's appeal in part, but

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[1] It is unclear from the record the precise date in October 2015 from which increased ACBs were sought. A copy of Mr. Morrissey's claim was not included in the appeal materials. The reasons below and the factums variously state the date as October 14, 15, and 20. I accordingly refer to the claim as simply being from "October 2015" onward.

[2] On June 1, 2016, the LAT assumed jurisdiction under the *Insurance Act* to adjudicate statutory accident benefits disputes. Previously, between 1997 and 2016, such disputes were determined by the Financial Services Commission of Ontario ("FSCO"). FSCO had two levels of decision-makers: an arbitrator at first instance and a Director's Delegate if a party sought review of the arbitrator's decision. The LAT has a similar structure: an adjudicator at first instance and an opportunity to submit a reconsideration request, which may be heard by the same adjudicator or assigned to a different tribunal member at the LAT's discretion.

not on the issue of his entitlement to increased ACBs from October 2015 to April 9, 2018. Mr. Morrissey appeals to this court with leave.[3]

[3] The appeal involves the interpretation of O. Reg. 403/96, *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996* (the "1996 Schedule") and O. Reg. 34/10, *Statutory Accident Benefits Schedule – Accidents on or After September 1, 2010* (the "2010 Schedule"), including their transitional provisions.

[4] For the reasons that follow, I would allow the appeal. The Adjudicator and the Divisional Court erred in their interpretation and application of the Schedules.

[5] In allowing the appeal, I note that Mr. Morrissey accepts the findings of fact of the Adjudicator with respect to his eligibility for ACBs. That is, he accepts the Adjudicator's decision that he is entitled to only an additional 30 minutes per day of intermittent care. Further, the parties agree that the applicable monthly ACB allowance based on the Adjudicator's decision is $451.50.

[6] Accordingly, I would order that (1) the $451.50 monthly allowance is retroactive to October 2015 if the parties agree that the increased ACBs allowed by the LAT were "reasonable and necessary" within the meaning of s. 16(2) of the

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[3] The LAT, although a respondent to the appeal, takes no position on the merits of the decisions below or the outcome of the appeal. The LAT's submissions were limited to providing statutory context and highlighting that, pursuant to s. 11(6) of the *Licence Tribunal Act, 1999*, S.O. 1999, c. 12, Sched. G, the appeal is restricted to questions of law only, with the standard of review being correctness.

1996 Schedule for the period from October 2015 to April 9, 2018, failing which this question will be remitted to the LAT for determination; and (2) Mr. Morrissey is not required to substantiate that he "incurred" attendant care expenses in accordance with s. 3(7)(e) of the 2010 Schedule as that provision is not applicable to his claim.

B. THE ISSUES

[7] On appeal to this court Mr. Morrissey contends that the Adjudicator and the Divisional Court:

1. Erred in law in interpreting s. 42(5) of the 2010 Schedule as requiring him to meet a test of "urgency, impossibility, or impracticability" as a precondition to submitting a Form 1 for retroactive ACBs; and
2. Erred in law in concluding that the definition of "incurred" in the 2010 Schedule requires Mr. Morrissey to substantiate the attendant care expenses.

[8] Before addressing these issues, I lay out the more detailed facts, key provisions of the Schedules and the rulings that led to this appeal.

C. THE FACTS

[9] Mr. Morrissey was catastrophically injured in a motor vehicle accident on January 13, 2000. He applied for and received statutory accident benefits ("SABs") from Wawanesa, including ACBs. His entitlement to ACBs was determined under the 1996 Schedule, which applies to accidents occurring on or after November 1,

1996, and was the schedule in place when the accident occurred. The panel was advised that Mr. Morrissey's ACBs were adjusted from time to time, although the details were not in the record.

[10] On April 9, 2018, Mr. Morrissey applied for increased benefits pursuant to s. 16(2) of the 1996 Schedule. At the time of the application, he was receiving $346.15 per month for intermittent care of 90 minutes per day, and for 60 minutes per week for assistance with financial affairs. He submitted a Form 1 (Assessment of Attendant Care Needs), prepared by an occupational therapist, claiming ACBs from October 2015 onward for the cost of 24/7 supervisory care, intermittent care for 120 minutes per day, help with exercise for 60 minutes per day and 60 minutes per week for assistance with financial affairs.

[11] Mr. Morrissey had received payment of ACBs for years under the 1996 Schedule, which, although requiring an expense for goods or services to have been "incurred", did not contain a definition of "incurred". Interpretations in case law had accepted that, in order to "incur" an expenditure within the meaning of the 1996 Schedule, the insured need not actually receive the items or services. Rather, it is sufficient that the services or items are reasonably necessary, and the amount of the expenditure can be determined with certainty: see *Belair Insurance Co. v. McMichael* (2007), 86 O.R. (3d) 68 (Div. Ct.), at paras. 21-26; *Monks v. ING Insurance Company of Canada*, 2008 ONCA 269, 90 O.R. (3d) 689, at paras. 46-

52; and *Pucci v. The Wawanesa Mutual Insurance Company*, 2020 ONCA 265, at paras. 35-36.

[12] Wawanesa denied Mr. Morrissey's claim on May 10, 2018, relying on an examination of Mr. Morrissey under s. 44 of the Schedule[4] and a document review performed by Wawanesa's assessor, an occupational therapist, who supported only the current level of attendant care based on her perception of Mr. Morrissey's level of functioning.

D. KEY PROVISIONS OF THE SCHEDULES

[13] Two provisions of the 2010 Schedule are central to this appeal: s. 42(5) (which is virtually identical to s. 39(3) of the 1996 Schedule) and s. 3(7)(e).

[14] Section 42(5) provides as follows:

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

[15] Section 3(7)(e) sets out the following definition of "incurred":

> 3(7) For the purposes of this Regulation,
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> ...

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[4] Section 44 of the 2010 Schedule allows an insurer to, at its expense, require an insured person to be examined by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation. The purpose of a s. 44 examination is for an insurer to determine "if an insured person is or continues to be entitled to a benefit" under the SABs scheme. If a s. 44 examination relates to ACBs, the examination report must include an assessment of attendant care needs in accordance with s. 42 (that is, a Form 1).

> (e) … an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,
>
> (i) the insured person has received the goods or services to which the expense relates,
>
> (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
>
> (iii) the person who provided the goods or services,
>
> (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
>
> (B) sustained an economic loss as a result of providing the goods or services to the insured person …[5]

[16] While the appeal centres on these provisions, I will also refer to other provisions of the Schedules as the need arises.

E. THE RULINGS THAT LED TO THIS APPEAL

(i) The initial LAT decision

[17] Mr. Morrissey applied to the LAT for the determination of his dispute with Wawanesa. The issues before the Adjudicator were as follows: (1) whether Mr. Morrissey was entitled to ACBs in the amount of $5,263.20 per month or some

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[5] Section 19(3) of the 2010 Schedule was amended on February 1, 2014, pursuant to O. Reg. 347/13, which limited the amount of ACBs in respect of non-professional attendant care providers such as friends and family members, to the economic loss sustained by the attendant care provider during the period and as a direct result of providing attendant care. On June 1, 2016, by O. Reg. 251/15, s. 19(3) was amended to add the qualification that the ACBs which an insurer must pay in respect of a person providing attendant care for remuneration are limited to the quantum of actual incurred attendant care expenses. These amendments are not contained s. 3(7)(e).

other increased amount for the period from October 2015; (2) whether Mr. Morrissey was entitled to submit a retroactive Form 1 for ACBs; (3) whether s. 3(7)(e) of the 2010 Schedule, dealing with "incurred" expenses, applied to Mr. Morrissey's claim; (4) if it did not apply, whether Mr. Morrissey must establish that the services were rendered; (5) the applicable rate of interest; (6) whether Wawanesa was liable to pay an award because it unreasonably withheld or delayed the payment of benefits; and (7) whether Mr. Morrissey was entitled to interest on any overdue payment of benefits. I focus my discussion on the second and third issues given that they form the basis of this appeal.

[18] The Adjudicator granted Mr. Morrissey ACBs for an additional 30 minutes of intermittent care per day plus interest on a go-forward basis from April 9, 2018, the date of submission of the Form 1. He concluded that Mr. Morrissey was not entitled to submit a retroactive Form 1 for ACBs, and that he was not entitled to 24/7 supervisory care or 60 minutes per day of assistance with exercise and stretching. As a result, Mr. Morrissey was entitled to an additional amount of $105.35 per month from April 9, 2018 onward, plus interest at the rate of 1 per cent per month on amounts owing (the rate prescribed under the 2010 Schedule).

[19] The Adjudicator began by observing, correctly, that because Mr. Morrissey claimed benefits after September 1, 2010 in relation to an accident that occurred before then, he was required to consider both the 1996 Schedule and the 2010 Schedule.

[20] On the first issue raised in this appeal, whether Mr. Morrissey was entitled to submit a retroactive Form 1 for ACBs, that is a claim for a period that had already passed, the Adjudicator accepted Wawanesa's position that the effect of s. 42(5) of the 2010 Schedule is that in order for a retroactive claim to be considered by an insurer, an applicant is required to explain the urgency of their care needs and/or the impossibility or impracticability of compliance with s. 42(5) of the Schedule. The Adjudicator followed *T.K. v. Unica Insurance Inc.*, 2017 CanLII 15835 (Ont. LAT), where Adjudicator Jeffrey Shapiro stated that s. 42 of the Schedule details the procedures for claiming ACBs, including the form to be used and the timing of its submission; that retroactive Form 1s are allowed in certain circumstances (such as where a claimant is neither physically nor legally capable of instituting the Form 1 process or where other factors or arguments are present); and that to allow all retroactive claims would render s. 42(5) meaningless.[6]

[21] The Adjudicator stated that, since Mr. Morrissey had not provided any submissions or evidence on why a retroactive Form 1 was required, he was not satisfied on a balance of probabilities that Mr. Morrissey required the ACBs to be retroactive to October 2015, or as to why he could not have complied with s. 42(5).

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[6] The Adjudicator also cited *C.W. v. Jevco Insurance Company*, 2019 CanLII 22200 (Ont. LAT); *E.E. v. Aviva Insurance Company*, 2018 CanLII 81909 (Ont. LAT), at para. 39; and *G.J. v. Coachman Insurance Company*, 2018 CanLII 81882 (Ont. LAT), as other LAT decisions that followed the reasoning in *T.K.*

[22] On the second issue raised in this appeal, the Adjudicator held that the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule applied to Mr. Morrissey's claim. He did not expressly consider Mr. Morrissey's argument that the transitional provisions of the 2010 Schedule specifically excluded s. 3, which is the "definitions and interpretation" section. Instead, the Adjudicator accepted as a general proposition that the benefits a party may be entitled to are determined at the time of the claim and not at the date of the accident. He reached this conclusion by relying on s. 268(1) of the *Insurance Act*, which provides:

> Every contract evidenced by a motor vehicle liability policy, including every such contract in force when the *Statutory Accident Benefits Schedule* is made or amended, shall be deemed to provide for the statutory accident benefits set out in the *Schedule* and any amendments to the *Schedule*, subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule*.

[23] The Adjudicator also relied on the decision in *J.M. v. Certas Home and Auto Insurance Company*, 2018 CanLII 132564 (Ont. LAT), which in turn relied on s. 268(1) of the *Insurance Act* and *Motor Vehicle Accident Claim Fund v. Barnes*, [2017] O.F.S.C.D. No. 99 (FSCO App.)[7] to conclude that an insured's rights do not crystallize based on the date of the accident, but are based on what is set out in the *Insurance Act* and the regulations at the time of a claim.

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[7] Although the insured in *Barnes* sought judicial review of the FSCO appeal decision in the Divisional Court, her application was dismissed as moot: *Barnes v. Motor Vehicle Accident Claims Fund*, 2019 ONSC 1782.

[24] The Adjudicator also considered himself bound by the decision of this court in *Beattie v. National Frontier Insurance Co.* (2003), 68 O.R. (3d) 60 (C.A.), where the court concluded that an application for SABs was properly made under the Schedule then in force (the 1996 Schedule) even though the insurance policy was purchased before that schedule came into force. Borins J.A. explained that the effect of s. 268(1) was that the insured's policy had been amended to incorporate the benefits and exclusions contained in the regulation.

[25] Accordingly, the Adjudicator concluded that the definition of "incurred" in the 2010 Schedule applied to Mr. Morrissey's case.

[26] The result was that Mr. Morrissey's request for increased ACBs was partially granted (for the additional half hour per day of supervisory care) on a go-forward basis from April 9, 2018, after the Adjudicator concluded on the evidence that it was reasonable and necessary for Mr. Morrissey to receive an additional 30 minutes per day for intermittent attendant care in addition to what he was already receiving. The parties agree that the applicable monthly ACB allowance based on the Adjudicator's decision is $451.50. The Adjudicator also determined that the required payments were subject to interest at the rate of 1 per cent per month under the 2010 Schedule rather than 2 per cent per month under the 1996 Schedule.

(ii) The LAT reconsideration decision

[27] The Adjudicator refused Mr. Morrissey's request for reconsideration. He saw no legal error in his conclusions that Mr. Morrissey must meet a standard of "urgency, impossibility, or impracticability" in regard to claiming entitlement to a retroactive Form 1, and that the definition of "incurred" in the 2010 Schedule applied to Mr. Morrissey's claim. He also rejected other arguments with respect to the applicable interest rate, and his factual determinations as to the amount of attendant care that was required.

(iii) The decision of the Divisional Court

[28] Mr. Morrissey appealed to the Divisional Court. He did not seek to disturb the Adjudicator's factual findings about the amount of attendant care or to pursue the full $5,263.20 per month amount. Rather his appeal was restricted to three issues: whether he was entitled to submit a Form 1 for payment of retroactive ACBs; whether the definition of "incurred" in the 2010 Schedule applied to his claim; and the applicable rate of interest.

[29] The Divisional Court upheld the Adjudicator's decision that Mr. Morrissey was not permitted to submit a Form 1 for payment of retroactive benefits, since the decision was discretionary, and Mr. Morrissey gave no reason for the delay. Furthermore, whether he was entitled to claim such benefits was a question of mixed law and fact, and thus beyond the scope of the appeal (which was restricted

to questions of law). In the alternative, the court concluded that the Adjudicator's interpretation of the Schedule was correct.

[30] The court accepted as correct the Adjudicator's determination that Mr. Morrissey's claim for retroactive ACBs failed because he had not provided an explanation for his failure to comply with s. 42, which was consistent with the requirement recognized in many LAT decisions that a retroactive Form 1 is considered payable if it is reasonable and necessary, and only where there is evidence of urgency of a need and/or impossibility or impracticability of compliance with the requirements of s. 42(5), which in turn requires an applicant to provide a satisfactory explanation for non-compliance.

[31] On the second issue, the Divisional Court agreed with Wawanesa that the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule applied to the continuing requirement that benefits be "incurred" before they are payable by an insurer because that requirement is essentially procedural and not substantive. Further, the automatic amendment of an insured's policy of insurance resulting from the enactment of a Schedule change would produce the same result.

[32] The Divisional Court allowed Mr. Morrissey's appeal regarding the interest rate and found that the 1996 Schedule's rate of 2 per cent per month applied even in respect of periods after September 1, 2010.

F. ANALYSIS

[33] This appeal requires the interpretation of dense and difficult text in a changing and complex statutory scheme. As noted earlier, the appeal involves the interpretation of O. Reg. 403/96, *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996* (the "1996 Schedule") and O. Reg. 34/10, *Statutory Accident Benefits Schedule – Accidents on or After September 1, 2010* (the "2010 Schedule"), including their transitional provisions.

[34] I therefore begin with several contextual observations to set the groundwork.

[35] The task of interpretation requires the court to consider the text of the legislation, the context within which it operates, and the particular purpose of the provisions at issue. As the Supreme Court has noted: "[t]hose who draft and enact statutes expect that questions about their meaning will be resolved by an analysis that has regard to the text, context and purpose": *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at para. 118.

[36] I will attend to the legislative text later. In this appeal the context and purpose of the legislation play important roles that I will summarize briefly. First, automobile insurance is well understood to be a form of consumer protection: *Abarca v. Vargas*, 2015 ONCA 4, 123 O.R. (3d) 561, at para. 36, citing *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30, [2002] 2 S.C.R. 129, at para. 11.

[37] Second, it is worth recalling that the system of compensation for injuries suffered in motor vehicle accidents in Ontario is a hybrid of no-fault insurance coverage and traditional tort law. While the ability to sue for injuries is limited, injured parties have access to no-fault benefits. In *Meyer v. Bright* (1993), 15 O.R. (3d) 129 (C.A.), at p. 134, this court stated: "[t]he scheme of compensation provides for an exchange of rights wherein the accident victim loses the right to sue unless coming within the statutory exemptions, but receives more generous first-party benefits, regardless of fault, from his or her own insurer" (emphasis added).

[38] I now turn to the issues.

(1) The standard of review

[39] There is no dispute that because this appeal is concerned exclusively with questions of statutory interpretation, the standard of review is correctness: *Vavilov*, at para. 37.

(2) Mr. Morrissey's claim for retroactive benefits and s. 42(5) of the 2010 Schedule

[40] This issue engages the proper interpretation of s. 42(5) of the 2010 Schedule (which is virtually identical to s. 39(3) of the 1996 Schedule). Again, s. 42(5) provides that "[a]n insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer". Mr. Morrissey contends that the Adjudicator and the

Divisional Court erred in concluding that this provision permits an insurer to refuse a retroactive claim for ACBs (that is, ACBs in respect of a period that has already passed), where an applicant has provided no evidence of the urgency of their care needs and/or the impossibility or impracticability of submitting an assessment of attendant care needs (known as a Form 1) before the expense is incurred.[8]

[41] As I will explain, it is not a condition of eligibility for retroactive ACBs, that is for benefits in respect of a period that has already passed when the application is made, that the applicant provide an explanation for any delay in making the application. The provision relied upon by Wawanesa, s. 42(5), does not speak specifically to claims for "retroactive" ACBs, nor does it require that an insured provide a reason for any delay in submitting a retroactive Form 1 and an explanation of the urgency of their care needs and/or the impossibility or impracticability of compliance with any requirement. Construed in its proper context, s. 42(5) speaks to the timing of payment, not eligibility for benefits. The

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[8] The concept of a "retroactive" claim for ACBs has both a narrow and a broad interpretation. Narrowly, "retroactive" can be interpreted as capturing only *subsequent* Form 1s – that is, claims for revised amounts of ACBs in respect of past periods for which ACBs were already claimed through an initial Form 1, such that the insurer would already be aware that some attendant care is needed. Mr. Morrissey's claim can be characterized as "retroactive" in this narrow sense. Broadly, "retroactive" can be interpreted as capturing *any* Form 1, including an initial Form 1 – that is, *any* claim for ACBs in respect of a period that has already passed, including a period in which attendant care expenses were incurred for the first time. Mr. Morrissey's claim is also captured by the broader definition of "retroactive". I rely on the broader definition since, as I will explain, the proper interpretation of s. 42(5) of the 2010 Schedule does not differ based on whether the claim in question involves a subsequent Form 1 or an initial Form 1.

provision simply permits, but does not oblige, an insurer to make an exception to the requirement of a completed Form 1 before beginning to pay ACBs.

[42] Mr. Morrissey submits that the Adjudicator and the Divisional Court erred in their interpretation of s. 42(5) of the 2010 Schedule. He contends that the discretion provided for in s. 42(5), that an insurer "may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer", is in relation to the timing of payment of a claim. He submits that the Adjudicator and the Divisional Court misinterpreted s. 42(5), specifically the word "before", to apply to the entitlement to payment rather than the timing of payment. Neither the Adjudicator nor the Divisional Court grappled with this semantic difficulty although it is discussed in some of the FSCO cases to which they were referred. Mr. Morrissey asserts that the wording of s. 42(5) does not present any impediment to an insured submitting a new Form 1 to correct errors in an earlier Form 1.

[43] Wawanesa asserts that the Adjudicator and the Divisional Court were correct in their interpretation of s. 42(5) as applying when a retroactive Form 1 is submitted; that, by its plain meaning, s. 42(5) provides an insurer with discretion to refuse such claims; and that the requirements of urgency, impossibility or impracticability, which have been recognized by a line of LAT decisions, must be met before an insurer will consider a retroactive Form 1.

[44] In my view the Adjudicator and the Divisional Court erred in rejecting Mr. Morrissey's claim for retroactive ACBs on the basis that he had not provided any explanation for the delay in submitting a Form 1. When the relevant provisions of the Schedules are considered, it is clear that successive Form 1s can be submitted by an insured; that s. 42(5) does not have the meaning attributed by Wawanesa, but simply permits an insurer to begin paying ACBs before a Form 1 has been submitted; and that there is accordingly no basis in s. 42 for an insurer to require an insured to establish urgency, impossibility or impracticability as a condition of paying a retroactive claim for ACBs.

[45] The parties agree that s. 16 of the 1996 Schedule establishes Mr. Morrissey's entitlement to ACBs. The relevant parts of s. 16 provide as follows:

> 16(1) The insurer shall pay an insured person who sustains an impairment as a result of an accident an attendant care benefit.
>
> (1.1) [...]
>
> (2) 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) [...]
>
> (3) [...]
>
> (4) The monthly amount payable by the attendant care benefit shall be determined in accordance with Form 1.

> (5) The amount of the attendant care benefit payable in respect of an insured person shall not exceed the amount determined under the following rules:
>
> 1. If the accident occurred before October 1, 2003, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,
>
> i. [...]
>
> ii. $6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident....

[46] Accordingly, pursuant to s. 16, Mr. Morrissey, as a person who was catastrophically injured in a car accident in 2000, is entitled to "all reasonable and necessary" ACBs determined in accordance with his Form 1 up to a limit of $6,000 per month.[9]

[47] Turning to the procedure for the application for and payment of ACBs, the parties agree that s. 42 of the 2010 Schedule applies. An examination of s. 42 reveals that nowhere does the provision speak of "retroactive" claims for ACBs, or in any other way impose time limits on an insured for the initiation of a claim for ACBs.[10] Rather, s. 42 prescribes the manner in which the claim must be submitted.

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[9] There is no issue that the applicable hourly ACB rates are the rates set out in the Form 1 submitted by Mr. Morrissey, and not the rates in the most recent version of Form 1 available on the Financial Services Regulatory Authority website, which applies to accidents that occurred on or after March 31, 2008.

[10] Time limits are, however, imposed under Part VIII of the 2010 Schedule. Section 32(1) requires a person who intends to apply for SABs to notify the insurer within seven days after the circumstances arose that gave rise to the entitlement to the benefit, or as soon as practicable, while s. 32(5) requires the insured to submit a completed and signed application for benefits within 30 days after receiving the forms from the insurer. Section 34 provides that a person's failure to comply with a time limit set out in that Part does not disentitle the person to a benefit if the person has a reasonable explanation. No one suggested in this appeal that Mr. Morrissey had failed to comply with the time limits in Part VIII (or its predecessor, Part X under the 1996 Schedule), or that such time limits applied to the claim he submitted in 2018 in respect of revised ACBs.

It requires an applicant for ACBs to submit a Form 1 prepared by an occupational therapist or registered nurse, which is compliant with any applicable Guideline.[11] There are, however, deadlines for the insurer to respond. The insurer must, within ten days of receipt of the Form 1, notify the applicant indicating the expenses it agrees and refuses to pay and why, and, at its option require the applicant to submit to a s. 44 examination. Section 42(6) requires the insurer to begin paying the ACBs within ten days of receiving the Form 1.

[48] The remaining subsections provide for the continued payment of ACBs at the same rate until the insurer receives its own Form 1 and/or a report on the s. 44 examination; the requirement of notice to the insured of the amounts the insurer agrees to pay and the reasons for the insurer's decision; and the consequences where an insured person does not submit to a s. 44 examination as required, or where there is subsequent compliance.

[49] It is in this context that s. 42(5) must be considered. Having regard to what precedes and follows s. 42(5), I conclude that while a Form 1 is required before an insurer must begin to pay ACBs, s. 42(5) permits the insurer, in its discretion, to start paying ACBs before a Form 1 is submitted. As Arbitrator Eban Bayefsky stated in *T.N. v. Personal Insurance Company of Canada*, 2012 ONFSCDRS 119 (FSCO Arb.), referring to s. 39(3) of the 1996 Schedule which is in substance

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[11] We were not taken to any applicable Guideline in this appeal.

identical to s. 42(5) of the 2010 Schedule, the section "simply ensures the orderly determination of a person's need for attendant care (in accordance with a proper attendant care needs assessment), and protects an insurer from having to determine what it should pay in the absence of a specific and legitimate attendant care needs assessment": at p. 19.

[50] The subsections that follow s. 42(5) support this interpretation, and weigh against the interpretation adopted by the Adjudicator and the Divisional Court in this case. The balance of s. 42 anticipates that there can be successive Form 1s, initiated by either the insurer or the insured. Section 42(7) authorizes an insurer to review ACBs by requiring the insured person to prepare and submit a new Form 1 where it wants to determine if an insured person is still entitled to attendant care benefits and/or if the benefits are being paid in the appropriate amount (and permits the insurer to require a s. 44 examination as part of this review process), while s. 42(9) provides that a new Form 1 may be submitted to an insurer at any time there are changes that would affect the amount of the benefits.

[51] Accordingly, while s. 16 of the 1996 Schedule and s. 42 of the 2010 Schedule require an application for ACBs to be initiated through a Form 1, neither section prescribes a time period in which a Form 1 must be submitted, and there is nothing in either section that states that a Form 1 cannot be submitted in respect of a period that has already passed, or that successive Form 1s are prohibited.

[52] In this case the Adjudicator erred by relying on the decision of Adjudicator Shapiro in *T.K.* to conclude that, while there is no strict bar against filing an application for ACBs on a retroactive basis, an applicant is required to provide a reason for the delay in filing a retroactive Form 1, and that reason should explain the "urgency, impossibility or impracticability" of compliance with s. 42(5). At para. 15 of his reasons, the Adjudicator stated without qualification that he agreed with and adopted the reasoning of Adjudicator Shapiro in *T.K.* With respect, the Adjudicator's reliance on *T.K.* was misplaced.

[53] A close reading of *T.K.* reveals that Adjudicator Shapiro purported to accept the reasoning in *Kelly v. Guarantee Company of North America*, 2014 ONFSCDRS 128 (FSCO Arb.). He interpreted *Kelly* as allowing a retroactive Form 1 in a specific situation – namely, "where urgency and impracticability prevented compliance with s. 42(5)". Adjudicator Shapiro then distinguished *Kelly* on the facts, finding that in the case before him "there was no urgency or impossibility or impracticability of compliance with s. 42(5)". He rejected the claim for retroactive benefits in part because the applicant had provided no reason for the "delay".

[54] While Adjudicator Shapiro correctly pointed out that the insured in *Kelly* was neither physically nor legally capable of instituting the Form 1 process, he improperly elevated that circumstance or explanation to a rule of "urgency or impossibility or impracticability of compliance with s. 42(5)".

[55] In fact, Adjudicator Shapiro's interpretation of s. 42(5) in *T.K.* is inconsistent with the reasoning in *Kelly*, where Arbitrator John Wilson stated that, while a Form 1 may be a precondition to payment of ACBs, requiring a person to complete all the paperwork including a Form 1 before incurring attendant care expenses was not congruent with the SABs scheme: at p. 6. Arbitrator Wilson expressly followed Arbitrator Bayefsky's interpretation of s. 39(3) – the predecessor to s. 42(5) (discussed below). In his view, the question once a retroactive Form 1 is filed is simply "whether the evidence prior to the receipt of the Form 1 reflects the assessment contained in the Form 1": at p. 11.

[56] Returning to the present case, while the Adjudicator listed *Kelly* as among the authorities relied on by Mr. Morrissey, he did not consider the reasoning in *Kelly* or its treatment in *T.K.* He, and later the Divisional Court, instead relied on a line of subsequent cases interpreting *T.K.* as authority for the requirement that an insured show "urgency, impossibility or impracticability" when submitting a retroactive Form 1. The Adjudicator and the Divisional Court did not consider the difficulties with the interpretation of *Kelly* in *T.K.* Nor did they address the reasoning in a line of cases decided by FSCO arbitrators that came to a different conclusion.

[57] Most notably, the Adjudicator and the Divisional Court did not address the reasoning in *T.N.*, a prior FSCO decision that Arbitrator Wilson followed in *Kelly*. In *T.N.* Arbitrator Bayefsky rejected the insurer's argument that s. 39(3) (now s. 42(5)) precluded the submission of a retroactive Form 1. He stated at p. 19:

> [S]ection 39(3) [the predecessor to s. 42(5)] does not displace an insurer's basic obligation to pay reasonable and necessary attendant care benefits determined in accordance with a duly prepared Form 1. Section 39(3) established an insured's obligation to claim attendant care benefits in accordance with a Form 1, and an insurer's right to await a Form 1 before assessing an insured's entitlement to attendant care benefits. Section 39(3) allows an insurer to pay attendant care benefits without a Form 1. It states that an insurer is not required to pay attendant care benefits before a Form 1 is submitted. This does not, in my view, mean that an insured forfeits their right to attendant care benefits, or that an insurer is released of any obligation to pay attendant care benefits, prior to the Form 1 being submitted. In my view, significantly stronger statutory language would be required to effect this purpose. [Emphasis added.]

[58] Arbitrator Bayefsky found that an insured could be entitled to ACBs for periods prior to the submission of a Form 1, once the Form 1 was actually submitted, and that the insured's entitlement would have to be determined in a fair manner based on all the available evidence. There was no reference to any requirement of "urgency, impracticability or impossibility".

[59] Similarly, in *M.G. v. Economical Mutual Insurance Company*, 2014 ONFSCDRS 119 (FSCO App.), the Director's Delegate, David Evans, allowing an appeal from an Arbitrator's decision, accepted that an applicant could make a retroactive claim for ACBs and adopted the interpretation of s. 39(3) of Arbitrator Bayefsky in *T.N.*, that the subsection speaks more to the timing of payment rather than entitlement. The Director's Delegate also doubted that s. 39(3), which speaks

of "a" Form 1 and "an" assessment of attendant care needs, applied in any event to a subsequent claim for ACBs because there already was an assessment of attendant care needs in place when the later Form 1s were served: at p. 16.

[60] In my view, the interpretation of s. 39(3) (now s. 42(5)) in these decisions – unlike in the *T.K.* line of cases – is consistent with a plain reading of the subsection in the context of s. 42 as a whole and the SABs scheme. Accordingly, the Adjudicator and the Divisional Court erred in concluding that a retroactive Form 1 can be submitted and considered only where there is evidence of urgency of a need and/or impossibility or impracticability of compliance with the requirements of s. 42(5).

[61] It is simply not the case, as the Adjudicator observed, that a contrary interpretation would render s. 42(5), or for that matter, s. 42, meaningless. Again, the surrounding statutory scheme provides critical context. Section 42 contemplates that, in the ordinary course, no ACBs will be paid until a Form 1 is filed and the insurer has had the opportunity to assess whether ACBs should be paid and the appropriate quantum. From this context, it is clear that s. 42(5) has a distinct meaning: it permits an insurer to make an exception to the requirement of a completed Form 1 before beginning to pay ACBs. There is no basis – textual, contextual, or otherwise – for requiring "urgency, impossibility or impracticability" as a precondition to payment of ACBs. Rather, this concept should be regarded as simply reflecting the fact that some insureds have an urgent need for attendant

care and it is in fact impossible or impracticable for them to submit a Form 1 prior to incurring attendant care expenses. In such cases, where there is something that is preventing an insured from submitting a Form 1 in a prompt manner, the insurer may – at its option – wish to make a payment of ACBs prior to receiving the Form 1. This interpretation of s. 42(5) is consistent with its plain wording and the remedial purpose of the SABs scheme.

[62] Relatedly, and contrary to the Adjudicator's statement that Mr. Morrissey had failed to provide a reason for his "non-compliance with s. 42(5)" (presumably by providing a Form 1 that was not contemporaneous with his need for ACBs), there is nothing in that subsection – or elsewhere in s. 42 for that matter – that speaks to the timing of submission of a Form 1. I agree with Arbitrator Bayefsky's conclusion in *T.N.* that significantly stronger statutory language would be needed to disentitle an insured to ACBs incurred before the submission of a Form 1. And as Arbitrator Wilson stated in *Kelly*, to require an injured person in every circumstance to complete a Form 1 before incurring attendant care expenses would not be congruent with the SABs scheme. For these reasons, there was no "non-compliance" by Mr. Morrissey with any requirement imposed in s. 42.

[63] In summary, s. 42(5) was not interpreted correctly by the Adjudicator and by the Divisional Court. Section 42(5) simply confirms that an insurer has discretion to pay (or not to pay) ACBs before a Form 1 is submitted. Once a Form 1 is submitted (which can cover a period that has already passed), the insurer is

obliged to determine whether the expenses claimed in relation to that period are reasonable and necessary. Section 42(5) does not make the payment of such claims discretionary; rather, as Arbitrator Wilson observed in *Kelly*, the question is then "whether the evidence prior to the receipt of the Form 1 reflects the assessment contained in the Form 1". There is no basis in s. 42(5) for requiring as a precondition to the consideration of such a claim that the insured provide an explanation, based on urgency, impracticability, impossibility or otherwise, for why the claim is in respect of goods or services already provided.

(3) The definition of "incurred" from the 2010 Schedule does not apply to Mr. Morrissey's claim

[64] This issue engages the interaction between the 1996 and 2010 Schedules. Section 3(7)(e) of the 2010 Schedule limits the expenses claimed for ACBs to goods or services provided by a qualified provider or other person who has incurred an economic loss. The 1996 Schedule, by contrast, did not define the term "incurred", and case law interpreted "incurred" to permit ACBs to be paid when goods or services were provided by an unqualified person without evidence of an economic loss, and even if the goods or services were not actually supplied, provided that they were reasonably necessary and the amount of the expense could be determined with certainty.[12] Mr. Morrissey asserts that the Adjudicator

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[12] In addition to the applicable definition of "incurred", payment of ACBs is subject to certain monthly limits under s. 16(5) of the 1996 Schedule or s. 19(3) of the 2010 Schedule, as applicable.

and the Divisional Court erred in concluding that the definition of "incurred" under s. 3(7)(e) of the 2010 Schedule applies to his claim.

[65] The Schedules, including their transitional provisions, make it clear that the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule does not apply to Mr. Morrissey's claim for ACBs. Rather, the settled case law applies to the interpretation of when an attendant care expense is incurred for the purpose of the 1996 Schedule.

[66] Mr. Morrissey asserts that the Adjudicator and the Divisional Court erred in concluding that the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule applies to his claim for ACBs despite the accident having occurred in 2000. He contends that this definition, which was not part of the 1996 Schedule, only applies to accidents that happened on or after September 1, 2010, when the 2010 Schedule came into effect and the definition was introduced. Mr. Morrissey submits that the Divisional Court and the Adjudicator did not properly consider the transitional provisions governing the two Schedules. Instead, they erred by relying on s. 268(1) of the *Insurance Act*, and the Divisional Court also erred by characterizing the definition of "incurred" as "essentially procedural in nature", after reasoning that the 2010 Schedule applied for procedural purposes, while the 1996 Schedule applied for substantive purposes.

[67] Wawanesa relies on ss. 3(1.3) and 3(1.4) of the 1996 Schedule which provide that accident benefits are to be paid under the 2010 Schedule, but in the amount determined under the 1996 Schedule. Wawanesa says that the effect of these provisions, together with s. 268(1) of the *Insurance Act* is that, while Mr. Morrissey's substantive rights are determined under the 1996 Schedule, the procedure he must follow in order to obtain benefits is prescribed under the 2010 Schedule. Wawanesa contends that the requirement that the claim for ACBs meet the definition of "incurred" in the 2010 Schedule is a procedural requirement, and as such the Adjudicator and the Divisional Court were correct to conclude that Mr. Morrissey's claim is required to meet the definition of "incurred" that is prescribed in the 2010 Schedule. Mr. Morrissey does not have a "vested right" to benefits determined in accordance with the procedure under the 1996 Schedule.

[68] I agree with Mr. Morrissey that the solution to this interpretive issue lies not in s. 268(1) of the *Insurance Act* nor in the general principle that new regulations amend existing policies, but in a careful reading of the two Schedules. There is no question that the 2010 Schedule did not fully replace the 1996 Schedule, such that parts of the 1996 Schedule continue to be in force and apply to the determination of claims in respect of accidents occurring before the 2010 Schedule came into effect. The answer to the interpretive issue is found in the transitional provisions of the two Schedules, which were not considered by the Adjudicator or the Divisional Court.

[69] For accidents that occurred on or after November 1, 1996, but before September 1, 2010, the transitional provisions of each Schedule apply to a claim for SABs.[13] The following are the relevant parts of s. 3, the transitional provisions from the 1996 Schedule (which was amended at the same time that the 2010 Schedule came into effect):

> 3 (1) In this section,
>
> "New Regulation" means Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act.
>
> (1.1) Subject to subsection (1.3), the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents that occur on or after November 1, 1996 and before September 1, 2010.
>
> (1.2) Section 24 and Parts X, XI, XII, XIII and XV do not apply after August 31, 2010.
>
> (1.3) No amount referred to in this Regulation shall be paid after August 31, 2010.
>
> (1.4) An amount that would, but for subsection (1.3), be paid under this Regulation after August 31, 2010 shall be paid under the New Regulation, but in the amount determined,
>
> (a) under this Regulation, other than section 24; or
>
> (b) under subsections 25 (1), (3), (4) and (5) of the New Regulation. [Emphasis added.]

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[13] Although the 1996 Schedule was revoked on July 3, 2020, it continues to apply by virtue of s. 68.1 of the 2010 Schedule, which states that the 1996 Schedule – as it read immediately before it was revoked – continues to apply in respect of accidents occurring on or after November 1, 1996 and before September 1, 2010.

[70] Section 2 of the 2010 Schedule is to the same effect. Of particular relevance is s. 2(2):

> 2 (2) Subsections 25 (1), (3), (4) and (5), Parts VIII and IX, other than subsections 50 (2) to (5), and Parts X, XI and XII, as they read immediately before Ontario Regulation 251/15 came into force apply with such modifications as are necessary in respect of benefits provided under the Old Regulation with respect to accidents that occurred on or after November 1, 1996 and before September 1, 2010 and, for that purpose, the following rules apply:
>
> 1. [...]
>
> 2. An amount that would, but for subsection 3 (1.3) of the Old Regulation, be paid under the Old Regulation after August 31, 2010 shall be paid under this Regulation in the amount determined,
>
> i. under the Old Regulation, other than under section 24 of that Regulation, or
>
> ii. under subsections 25 (1), (3), (4) and (5)....

[71] Wawanesa is correct that the transitional provisions mean that Mr. Morrissey's claim is to be paid under the 2010 Schedule, but in an amount determined under the 1996 Schedule, and that, generally speaking, this means that while Mr. Morrissey's substantive rights are determined under the 1996 Schedule, he is required to comply with the procedures prescribed by the 2010 Schedule for claiming SABs, including ACBs. However, that observation is not dispositive of the matter. The transitional provisions are also explicit as to what specific parts of the two Schedules apply. Pursuant to s. 3(1.2) of the 1996 Schedule, Parts X, XI, XII, XIII and XV do not apply after August 2010. And pursuant to s. 2(2) of the 2010 Schedule, Parts VIII and IX (other than ss. 50(2) to

(5)) and Parts X, XI and XII – as they read immediately before O. Reg. 251/15 came into force – "apply with such modifications as are necessary in respect of benefits provided under the [1996 Schedule] with respect to accidents that occurred on or after November 1, 1996 and before September 1, 2010 … in an amount determined under the [1996 Schedule] …".

[72] In short, the transitional provisions in both Schedules make it clear that the provisions of the 1996 Schedule establishing entitlement to benefits (except for s. 24) continue to apply to pre-September 1, 2010 accidents. This includes s. 16 of the 1996 Schedule – the provision that the parties do not dispute is the source of Mr. Morrissey's entitlement to ACBs. Pursuant to s. 16, the insurer is required to pay an insured person who sustains an impairment as a result of an accident an ACB which pays for "all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for (1) services provided by an aide or attendant …".

[73] The 1996 Schedule does not contain any criteria for an expense to be considered "incurred". The parties agree that, as per the decision of the Divisional Court in *Belair,* when expenses were "incurred" was given an expansive definition such that the insured did not have to actually receive the items or services. Rather, it was sufficient if the services or items were reasonably necessary and the amount of the expenditure could be determined with certainty: *Monks*, at paras. 46-52; *Pucci*, at paras. 35-36.

[74] Under s. 3(7)(e) of the 2010 Schedule, an expense in respect of goods or services referred to in that Schedule is not incurred by an insured person unless (i) the insured person has received the goods or services to which the expense relates, (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and (iii) the person who provided the goods or services, (a) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or (b) sustained an economic loss as a result of providing the goods or services to the insured person. Section 3(8) of the 2010 Schedule provides the LAT with the discretion to deem an expense incurred if it finds that the reason the expense was not incurred was that the insurer unreasonably withheld or delayed payment of a benefit in respect of that expense. Both of these provisions are contained in Part I of the 2010 Schedule.

[75] A careful review of the transitional provisions reveals that Part I of the 2010 Schedule – including the definition of "incurred" in s. 3(7)(e) – is not included in the list of Parts that apply to pre-September 2010 accident claims. Indeed, s. 3(7) is found in a section that begins, "For the purposes of this Regulation". By contrast, the transitional provisions make clear that Part I of the 1996 Schedule continues to apply to claims in respect of accidents occurring pre-September 2010. Part I is not listed as a part that no longer applies; indeed, Part I was amended to incorporate specific transitional provisions which clearly continue to apply.

[76] Accordingly, while the definition of "incurred" in s. 3(7)(e) would apply to claims determined under the 2010 Schedule, where, as here, the claim is determined under the 1996 Schedule, that definition does not apply. This is consistent with the transitional provisions of both Schedules to the effect that amounts paid under the 2010 Schedule for ACBs in respect of pre-September 2010 accidents are determined under the 1996 Schedule (except for certain items dealt with by s. 24 of that Schedule).

[77] I therefore agree with Mr. Morrissey that the Adjudicator and the Divisional Court erred by failing to consider that the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule does not fall into the list of provisions that apply to accidents that happened before September 1, 2010. Because Mr. Morrissey's accident occurred in 2000, his claim is governed by the word "incurred" as it appears in ss. 16 and 22 of Part V of the 1996 Schedule.

[78] I further agree with Mr. Morrissey that the Adjudicator and the Divisional Court erred in relying on s. 268(1) of the *Insurance Act* and the FSCO appeal decision in *Barnes*.

[79] First, as we have seen, s. 268(1) provides that every motor vehicle insurance policy "shall be deemed to provide for the statutory accident benefits set out in the *Schedule* and any amendments to the *Schedule*, subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule*" (emphasis

added). One must look to the specific schedules, including their transitional provisions, to understand what specific "conditions, provisions, exclusions and limits" apply. The Adjudicator erred in concluding that this court's decision in *Beattie* was relevant and binding on him with respect to the issue before him. In that case, the court determined that the effect of s. 268(1) was that a policy of insurance that was purchased before the 1996 Schedule incorporated the benefits and exclusions contained in that Schedule, because it was in force when the accident occurred. There was no question of transitional provisions or the interpretation of two schedules which were both in force. In this case, by contrast, aspects of both the 1996 and 2010 Schedules apply to Mr. Morrissey's claim, and whether a specific provision applies is then a question of interpretation.

[80] Nor does the FSCO appeal decision in *Barnes* assist in the determination of this issue. In that case, a claimant for ACBs had been injured in an accident in 2012. There was no question that the 2010 Schedule applied to his claim for ACBs; the only issue was whether the 2014 amendments to the 2010 Schedule, limiting ACBs to the amount of the economic loss of a non-professional care provider, applied to his claim for benefits after the amendment was made. There were no transitional provisions that would answer this question. While at first instance the Arbitrator had concluded that the insured had a "vested right" to attendant care determined in accordance with the pre-amendment definition in respect of periods after the amendment, ultimately this decision was overruled on appeal by a

Director's Delegate on the basis that the new provisions applied. *Barnes* stands for the proposition that where an amendment to the Schedule is silent as to whether it applies to ACB claims in respect of accidents that occurred before that day, the amended provision will apply. The reasoning in *Barnes* has no application here.

[81] In summary, I have concluded that the answer to this interpretive question is found in the transitional provisions of the Schedules. I agree with Mr. Morrissey that, on a proper reading of the provisions of the Schedules, his claim for ACBs that was made under s. 16 of the 1996 Schedule is not subject to the definition of "incurred" in s. 3(7)(e) of the 2010 Schedule.

G. CONCLUSION AND DISPOSITION

[82] For these reasons, I would allow the appeal and set aside the order of the Divisional Court. As Mr. Morrissey does not dispute the Adjudicator's factual determinations as to the amount of attendant care, and the parties have agreed that the applicable monthly ACB allowance based on the Adjudicator's decision is $451.50, I would order that (1) the $451.50 monthly allowance is retroactive to October 2015 if the parties agree that the increased ACBs allowed by the LAT were "reasonable and necessary" within the meaning of s. 16(2) of the 1996 Schedule for the period from October 2015 to April 9, 2018, failing which this question will be remitted to the LAT for determination; and (2) Mr. Morrissey is not

required to substantiate that he "incurred" attendant care expenses in accordance with s. 3(7)(e) of the 2010 Schedule as that provision is not applicable to his claim.

[83] No costs are payable by or to the respondent LAT. Costs to Mr. Morrissey are payable by Wawanesa in the amounts agreed between the parties: $7,500 for the costs of the appeal, including the motion for leave to appeal, and $4,000 for costs in the court below, both amounts inclusive of disbursements and HST.

Released: August 6, 2024 PDL

K. van Rhijgga

I agree. P. Lauwers J.A.