Province of Alberta
Order in Council

O.C. 284 /2026
JUL 30 2026

ORDER IN COUNCIL

Approved and ordered:

Lieutenant Governor
or
Administrator

The Lieutenant Governor in Council makes the Benefits, Treatment and Care Regulation set out in the attached Appendix.

CHAIR

FILED UNDER
THE REGULATIONS ACT
as ALBERTA REGULATION 204/2026
ON July 30 20 26
REGISTRAR OF REGULATIONS

For Information only

Recommended by: President of Treasury Board and Minister of Finance

Authority: Automobile Insurance Act
(section 101)

APPENDIX

Automobile Insurance Act

BENEFITS, TREATMENT AND CARE REGULATION

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Part 1
Interpretation

Interpretation

1(1) In this Regulation,

(a) "care-and-treatment request" means a request made by a health care practitioner that sets out the health care services the health care practitioner proposes to provide to an insured to treat the insured's bodily injury;

(b) "initial assessment", in respect of an insured, means the first assessment a health care practitioner conducts, for the

purposes of this Regulation, to diagnose and evaluate the insured's bodily injury;

(c) "nurse practitioner" means a regulated member of the College of Registered Nurses of Alberta under the *Health Professions Act* who is on the regulated members register in the nurse practitioner register category;

(d) "physician" means a regulated member of the College of Physicians and Surgeons of Alberta under the *Health Professions Act*;

(e) "program of care" means the body of rules, established under section 10.1 of the Act and incorporated by reference into this Regulation under section 2, for the diagnosis and treatment of particular bodily injuries.

(2) For the purposes of the Act and this Regulation, "health care practitioner" means

(a) a person who is a regulated member of a college of a regulated profession under the *Health Professions Act*,

(b) a person who is authorized to practice a health profession in another jurisdiction under legislation that governs health professions in that jurisdiction, if the scope of practice is substantially similar to that of a regulated profession under the *Health Professions Act*, or

(c) a person, other than a person referred to in clause (a) or (b), who has a certificate of competency from a professional body that establishes standards of competence and conduct for the profession and who is acting within the scope of that certificate.

(3) A reference in this Regulation to an amount established by the Minister, including a maximum or minimum amount, is a reference to the amount established for that purpose by the Minister under section 94 of the Act.

(4) For the purposes of this Regulation, a bodily injury falls within the program of care if the program of care

(a) identifies the bodily injury, and

(b) establishes authorized treatments for the bodily injury.

Incorporation of guideline

2 As authorized by section 101(3) of the Act, the *Care-First Program of Care (PoC) Guideline* published by the Minister's department, as amended or replaced from time to time, is incorporated into and forms part of this Regulation.

Annual adjustment of benefit amount

3(1) In this section,

(a) "adjustment date" means April 1;

(b) "Alberta escalator" means the Alberta escalator as defined in section 44.2 of the *Alberta Personal Income Tax Act*.

(2) An amount established by the Minister respecting the payment or reimbursement of an expense described in this Regulation, including a maximum or minimum amount, is subject to an annual adjustment in accordance with subsection (3).

(3) The Minister shall, as of the adjustment date in each year, adjust each amount referred to in subsection (2) by an amount equal to

(a) the amount established for the period prior to the adjustment date

multiplied by

(b) the Alberta escalator.

(4) The Minister shall, before the adjustment date in each year, publish each adjusted amount on the website of the Minister's department.

Part 2
Health Care

Health care services

4 For the purpose of section 10(a) of the Act, an insured who sustains bodily injury is entitled to the payment or reimbursement of an expense incurred for a health care service received in respect of their bodily injury in accordance with this Part.

Initial assessment — eligibility

5(1) In this section,

(a) "chiropractor" means a regulated member of the College of Chiropractors of Alberta under the *Health Professions Act*;

(b) "physiotherapist" means a regulated member of the College of Physiotherapists of Alberta under the *Health Professions Act*.

(2) An insured who sustains bodily injury and who, under section 10(a) of the Act, seeks the payment or reimbursement of an expense incurred for a health care service received in respect of their bodily injury, shall, as soon as practicable after sustaining bodily injury, undergo an initial assessment conducted by a health care practitioner in accordance with this section.

(3) An insured referred to in subsection (2) may, within 12 weeks after the date of an accident, undergo an initial assessment conducted by any of the following health care practitioners without obtaining an insurer's approval for the assessment in advance:

(a) a chiropractor;

(b) a nurse practitioner;

(c) a physician;

(d) a physiotherapist.

(4) The fee, if any, in respect of an initial assessment conducted by a health care practitioner referred to in subsection (3)

(a) is payable under section 10(a) of the Act, and

(b) shall be paid directly to the health care practitioner by the insurer.

(5) An initial assessment is required to be approved in advance by an insurer if it is conducted

(a) more than 12 weeks after the date of the accident, or

(b) by a health care practitioner not referred to in subsection (3).

(6) The fee, if any, in respect of an initial assessment approved in advance by an insurer under subsection (5)

(a) is payable under section 10(a) of the Act, and

(b) shall be paid directly to the health care practitioner by the insurer.

(7) If an insurer's approval of an initial assessment in advance is required under subsection (5) and an insured has not, prior to undergoing the initial assessment, obtained the insurer's approval, the insurer may pay or reimburse the fee, if any, in respect of the initial assessment.

Initial assessment — conduct

6(1) A health care practitioner who conducts an initial assessment of an insured's bodily injury shall

(a) use

(i) the form, if any, established under section 96 of the Act for the health care practitioner's use, or

(ii) a form acceptable to the insurer, if no assessment form has been established under section 96 of the Act for the health care practitioner's use,

and

(b) submit the completed form to the insurer.

(2) A health care practitioner may conduct an initial assessment only in respect of a bodily injury that is within the practitioner's scope of practice.

Program of care

7(1) Subject to subsections (2) to (4), if, following an initial assessment, a health care practitioner determines that an insured's bodily injury falls within the program of care, the insured is entitled to the payment or reimbursement of an expense incurred for a health care service authorized under the program of care.

(2) A health care practitioner who conducts an initial assessment of an insured's bodily injury may determine that the bodily injury falls within the program of care only if

(a) the initial assessment is conducted within 12 weeks of the date of the accident, and

(b) the insured will begin treatment under the program of care within 12 weeks of the date of the accident.

(3) A health care practitioner may, for the purposes of this Regulation, determine that an insured's bodily injury falls within the program of care only if the insured is 18 years of age or older at the time the health care practitioner conducts the initial assessment.

(4) Only a health care practitioner referred to in section 5(3) may, for the purposes of this Regulation, do the following:

(a) determine that an insured's bodily injury falls within the program of care;

(b) subject to subsection (5)(b), provide an insured a health care service authorized under the program of care.

(5) If a health care service is authorized under the program of care, an expense incurred for the health care service is payable or reimbursable only if the health care service is provided by one of the following:

(a) the health care practitioner who conducted the initial assessment;

(b) a health care practitioner to whom the health care practitioner referred to in clause (a) refers the insured, provided that the health care service is within the scope of practice of the health care practitioner to whom the insured is referred.

(6) A health care practitioner who both conducts an initial assessment of an insured and provides a health care service to the insured under the program of care shall provide the insurer a report in relation to the status of the insured's recovery from bodily injury at the following times:

(a) the insured reaching the midpoint of the program of care;

(b) the insured completing or otherwise ending the program of care.

Care-and-treatment request

8(1) In this section, "evidence-based care" means the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions.

(2) If a health care practitioner is, under section 7(2), unable to determine that an insured's bodily injury falls within the program of care or, following an initial assessment, a health care practitioner determines that an insured's bodily injury does not fall within the program of care or that the program of care is not suitable to treat the insured's bodily injury, the health care practitioner may

(a) develop a care-and-treatment request for the insured, and

(b) submit the care-and-treatment request to an insurer for approval.

(3) Subject to subsection (6), an insurer shall, within 5 business days of receiving a care-and-treatment request, respond in writing to the request.

(4) An insurer's response under subsection (3) shall be sent to

(a) the health care practitioner who submitted the care-and-treatment request for approval, and

(b) the insured to whom the care-and-treatment request relates.

(5) An insurer shall approve a care-and-treatment request to the extent that the health care services set out in the care-and-treatment request meet the following criteria:

(a) the health care services will be provided by a health care practitioner using evidence-based care;

(b) the health care services are expected to

(i) facilitate the insured's recovery from bodily injury, or

(ii) address a decline in the insured's physical or mental function caused by their bodily injury;

(c) the cost of the health care services is reasonable relative to

(i) the benefits achieved from the health care services, and

(ii) the cost of alternative health care services;

(d) no other health care services provide a similar benefit to the insured at a lower cost.

(6) If an insurer does not respond to a care-and-treatment request within 5 business days of receipt of the care-and-treatment request, the insurer is deemed to have approved the request.

(7) If an insurer denies a care-and-treatment request, a health care practitioner may revise and resubmit the request.

(8) Subject to subsection (9), if an insurer approves a care-and-treatment request under subsection (5) or is deemed to have approved it under subsection (6), the insured is entitled to the payment or reimbursement of an expense incurred for a health care service authorized under the care-and-treatment request.

(9) A health care service authorized under a care-and-treatment request is payable or reimbursable only if the health care service is provided by the health care practitioner who developed and submitted the care-and-treatment request.

(10) If a health care practitioner determines, in the course of providing a health care service to an insured under a care-and-treatment request, that a modification to the care-and-treatment request is required to support the insured's recovery from bodily injury, the health care practitioner may submit a request to modify the care-and-treatment request to the insurer for approval.

(11) Subsections (3) to (9) apply, with necessary modifications, to a request to modify a care-and-treatment request under subsection (10).

(12) A health care practitioner who, under a care-and-treatment request, provides a health care service to an insured shall provide an insurer information in relation to the status of the insured's recovery from bodily injury whenever the insurer requests it.

(13) A health care practitioner who, under a care-and-treatment request, provides a health care service to an insured shall, once the number of approved visits in respect of the health care services authorized under the care-and-treatment request has been reached, provide an insurer a report in relation to the status of the insured's recovery from bodily injury.

Bodily injury under both program of care and care-and-treatment request

9 If an insured sustains, in the same accident, both a bodily injury that falls within the program of care and a bodily injury that does not

fall within the program of care, as determined by a health care practitioner following an initial assessment conducted in accordance with this Part, the insured is entitled,

(a) in respect of the bodily injury that falls within the program of care, to the payment or reimbursement of an expense incurred for a health care service received in respect of that injury in accordance with section 7, and

(b) in respect of the bodily injury that does not fall within the program of care, to the payment or reimbursement of an expense incurred for a health care service received in respect of that injury in accordance with section 8.

Treatment for minors

10(1) This section only applies to an insured who is a minor when the insured undergoes an initial assessment.

(2) Subject to subsections (3) to (5), if, following an initial assessment, a health care practitioner determines that an insured's bodily injury would fall within the program of care if the insured were eligible under section 7(3), the insured is entitled to the payment or reimbursement of an expense incurred for a health care service received within the 12 weeks following the date of the initial assessment.

(3) An insured is entitled to the payment or reimbursement of an expense incurred for a health care service under subsection (2) only if

(a) the initial assessment is conducted within 12 weeks of the date of the accident, and

(b) the insured begins treatment within 12 weeks of the date of the accident.

(4) Only a health care practitioner referred to in section 5(3) may, for the purpose of subsection (2), determine that an insured's bodily injury would fall within the program of care if the insured were eligible under section 7(3).

(5) An expense incurred for a health care service is payable or reimbursable under subsection (2) only if the health care service is provided by one of the following:

(a) the health care practitioner who conducted the initial assessment;

(b) a health care practitioner to whom the health care practitioner referred to in clause (a) refers the insured, provided that the health care service is within the scope of practice of the health care practitioner to whom the insured is referred.

(6) An insured who, under subsection (2), is entitled to the payment or reimbursement of an expense incurred for a health care service received in the 12 weeks following the date of the initial assessment is not entitled to the payment or reimbursement of an expense incurred for a health care service received after those 12 weeks unless the health care service is approved by an insurer through a care-and-treatment request developed for the insured and submitted by a health care practitioner.

(7) If an insured is not entitled to the payment or reimbursement of an expense incurred for a health care service under subsection (2), or if, following an initial assessment, a health care practitioner determines that an insured's bodily injury would not fall within the program of care if the insured were eligible under section 7(3), the health care practitioner may

(a) develop a care-and-treatment request for the insured, and

(b) submit the care-and-treatment request to an insurer for approval.

(8) If an insured sustains, in the same accident, both a bodily injury that would fall within the program of care if the insured were eligible and a bodily injury that would not fall within the program of care if the insured were eligible, as determined by a health care practitioner following an initial assessment conducted in accordance with this Part, the insured is entitled,

(a) in respect of the bodily injury that would fall within the program of care if the insured were eligible, to the payment or reimbursement of an expense incurred for a health care service received in respect of that injury in accordance with subsections (2) to (6), and

(b) in respect of the bodily injury that would not fall within the program of care if the insured were eligible, to the payment or reimbursement of an expense incurred for a health care

service received in respect of that injury in accordance with subsection (7).

(9) Section 8(3) to (13) apply, with necessary modifications, to a care-and-treatment request developed and submitted under subsection (6) or (7).

Change of health care practitioner

11(1) An insured may request to change the health care practitioner who, under the program of care or a care-and-treatment request, is providing a health care service to the insured.

(2) An insured's request to change a health care practitioner

(a) shall be submitted to the insurer, and

(b) is subject to the insurer's approval.

(3) If an insurer approves an insured's request to change a health care practitioner, the insured is not entitled to the payment or reimbursement of an expense incurred for a health care service provided by the replacement health care practitioner unless

(a) the insured first undergoes, in accordance with sections 5 and 6, an initial assessment conducted by the replacement health care practitioner, and

(b) the replacement health care practitioner

(i) determines that the insured's bodily injury falls within the program of care, and the health care service is authorized under the program of care, or

(ii) develops and submits a care-and-treatment request for the insured that

(A) includes the health care service, and

(B) is approved by the insurer.

(4) If an insurer approves an insured's request to change a health care practitioner, the fee, if any, in respect of an initial assessment conducted by the replacement health care practitioner

(a) is payable under section 10(a) of the Act, and

(b) shall be paid directly to the health care practitioner by the insurer.

Reports

12(1) When a health care practitioner is required to provide a report to an insurer under this Part, the health care practitioner shall prepare the report using

(a) the form, if any, established under section 96 of the Act for the health care practitioner's use, or

(b) a form acceptable to the insurer, if no form has been established under section 96 of the Act for the health care practitioner's use.

(2) A health care practitioner may charge a fee for providing a report to an insurer under subsection (1), provided that the fee does not exceed the maximum fee, if any, established by the Minister.

(3) The fee, if any, charged under subsection (2)

(a) is payable under section 10(a) of the Act, and

(b) shall be paid directly to a health care practitioner by the insurer.

Communication

13(1) A health care practitioner who provides a health care service to an insured under the program of care or a care-and-treatment request shall communicate with and keep the insurer informed of the insured's condition and the status of the insured's recovery from bodily injury.

(2) A health care practitioner may charge a fee for communicating with an insurer under subsection (1), provided that the fee does not exceed the maximum fee, if any, established by the Minister.

(3) The fee, if any, charged under subsection (2)

(a) is payable under section 10(a) of the Act, and

(b) shall be paid directly to a health care practitioner by the insurer.

Exceptional expenses

14 Despite anything to the contrary in this Part, an insured is entitled, under section 10(a) of the Act, to the payment or reimbursement of an expense incurred for a health care service the insured receives in respect of their bodily injury, even if the health care service to which the expense relates is not authorized under a care-and-treatment request, if

(a) it was not reasonable for the insured to obtain an insurer's authorization for the expense under a care-and-treatment request prior to incurring it, and

(b) the health care service to which the expense relates meets the criteria set out in section 8(5).

Failure to comply

15(1) For the purpose of section 47(i) of the Act, each of the following is a requirement:

(a) attending treatment visits, in accordance with the program of care or a care-and-treatment request, as applicable, and participating in the treatment provided;

(b) following the advice and recommendations of a health care practitioner who, under the program of care or a care-and-treatment request, is providing a health care service to the insured.

(2) If an insured fails, without reasonable excuse, to comply with a requirement described in subsection (1), an insurer may, under section 47(i) of the Act, suspend payment of a benefit to which the insured is entitled under Part 2, Divisions 3 and 4 of the Act.

(3) An insurer shall give to an insured notice of a decision to suspend the payment of a benefit under subsection (2).

(4) A suspension of the payment of a benefit under subsection (2) takes effect on an insured's receipt of notice of the insurer's decision.

(5) If the payment of a benefit is suspended under subsection (2), the suspension shall be cancelled and payment of the benefit shall resume if

(a) the insured resumes compliance with the requirement, or

(b) the insured provides a reasonable excuse for the failure.

(6) When

(a) subsection (5)(a) applies, the insurer shall make a payment to the insured retroactive to the date the insured resumes compliance with the requirement, and

(b) subsection (5)(b) applies, the insurer shall make a payment to the insured retroactive to the initial date of the suspension in the amount that was suspended.

Part 3
Medical Assessments

Medical assessment

16(1) In this section, "designated medical assessment service provider" means an entity with whom the Minister has entered into an agreement to

(a) provide a roster of health care practitioners who may conduct medical assessments, and

(b) administer the process for arranging and carrying out medical assessments.

(2) For the purpose of section 57(1) of the Act, only a health care practitioner referred to in section 1(2)(a) or (b) is authorized to conduct a medical assessment.

(3) For the purpose of section 57(4) of the Act, on receiving an application, the Superintendent shall refer the application to a designated medical assessment service provider.

(4) After reviewing the application, a designated medical assessment service provider shall recommend to the Superintendent, in accordance with criteria approved by the Superintendent, one or more health care practitioners to act as the medical assessor and conduct the medical assessment in respect of the application received.

(5) The Superintendent shall, based on the designated medical assessment service provider's recommendation, select one or more health care practitioners to act as the medical assessor and conduct the medical assessment.

(6) For the purpose of section 57(8) of the Act, an insurer must

(a) accept the medical assessor's findings set out in the medical assessor's report respecting the diagnosis and prognosis of the claimant's bodily injury, and

(b) use the report in making decisions related to the claimant's entitlement to compensation.

(7) If, following a medical assessment, an insurer disagrees with a medical assessor's findings, the insurer may not, under section 57(2) of the Act, require the claimant to undergo another medical assessment in respect of the same bodily injury for the purpose of challenging the medical assessor's findings.

Attendance at medical assessment

17(1) For the purpose of section 47(i) of the Act, each of the following is a requirement:

(a) attending and undergoing a medical assessment when required by an insurer;

(b) not obstructing a medical assessor from conducting a medical assessment.

(2) If a claimant fails, without reasonable excuse, to comply with a requirement described in subsection (1), an insurer may, under section 47(i) of the Act, suspend payment of a benefit to which the claimant is entitled under Part 2, Divisions 3 and 4 of the Act.

(3) An insurer shall give to a claimant notice of a decision to suspend payment of a benefit under subsection (2).

(4) A suspension of the payment of a benefit under subsection (2) takes effect on a claimant's receipt of notice of the insurer's decision.

(5) If the payment of a benefit is suspended under subsection (2), the suspension shall be cancelled and payment of the benefit shall resume if

(a) the claimant undergoes a medical assessment satisfactory to the insurer, or

(b) the claimant provides a reasonable excuse for the failure.

(6) When

(a) subsection (5)(a) applies, the insurer shall make a payment to the claimant retroactive to the date the claimant undergoes a medical assessment satisfactory to the insurer, and

(b) subsection (5)(b) applies, the insurer shall make a payment to the claimant retroactive to the initial date of the suspension in the amount that was suspended.

Part 4
Equipment, Medication and Supplies

Prosthesis and orthosis

18(1) An expense in respect of a prosthesis or orthosis is payable or reimbursable under section 10(b) of the Act only if the insured has a prescription for the prosthesis or orthosis from a health care practitioner.

(2) Subject to subsection (3), if an insured did not wear a prosthesis or orthosis before the accident, the following expenses are payable or reimbursable in respect of the prosthesis or orthosis:

(a) an expense for the initial purchase, rental, fitting or adjustment of the prosthesis or orthosis;

(b) an expense for the subsequent repair, replacement, fitting or adjustment of the prosthesis or orthosis, if the expense is incurred

(i) because of a change in the physical or mental condition of the insured caused by their bodily injury,

(ii) because of the ordinary use of the prosthesis or orthosis, or

(iii) to enhance the performance of the prosthesis or orthosis.

(3) An expense related to the purchase, fitting or adjustment of the following prostheses or orthoses is payable or reimbursable only if an insured did not wear the prosthesis or orthosis before the accident:

(a) contact lenses;

(b) a denture;

(c) eyeglasses;

(d) a hairpiece;

(e) an ocular prosthesis.

(4) An expense for the purchase, fitting or adjustment of a fixed dental prosthesis resting on an implant is payable or reimbursable for an insured who did not wear a denture before the accident only if a fixed dental prosthesis not resting on an implant would not be medically effective.

(5) The following expenses are payable or reimbursable in relation to a prosthesis or orthosis an insured wore before the accident:

(a) an expense for the initial repair, replacement, fitting or adjustment of the prosthesis or orthosis;

(b) an expense for the subsequent repair, replacement, fitting or adjustment of the prosthesis or orthosis, if the expense is incurred because of a change in the physical or mental condition of the insured caused by the insured's bodily injury.

(6) An expense for the repair of a prosthesis or orthosis is payable or reimbursable to the extent that the cost of repair does not exceed 80% of the original purchase price of the prosthesis or orthosis.

Medical equipment

19(1) For the purpose of section 10(c) of the Act, an expense is payable or reimbursable in respect of only the following medical equipment:

(a) bowel and bladder equipment;

(b) clothing;

(c) a communication aid;

(d) a hospital-style bed;

(e) a mobility aid;

(f) personal hygiene and self-care equipment;

(g) transfer equipment;

(h) a ventilator;

(i) a wheelchair.

(2) An expense in respect of medical equipment referred to in subsection (1) is payable or reimbursable under section 10(c) of the Act only if the insured has a prescription for the medical equipment from a health care practitioner.

(3) If an insured did not use any of the medical equipment referred to in subsection (1) before the accident, the following expenses are payable or reimbursable in respect of the medical equipment:

(a) an expense for the initial purchase, rental, fitting or adjustment of the medical equipment;

(b) an expense for the subsequent repair, replacement, fitting or adjustment of medical equipment, if the expense is incurred

(i) because of a change in the physical or mental condition of the insured caused by the insured's bodily injury,

(ii) because of the ordinary use of the medical equipment, or

(iii) to enhance the performance of the medical equipment.

(4) The following expenses are payable or reimbursable in relation to medical equipment referred to in subsection (1) that an insured used before the accident:

(a) an expense for the initial repair, replacement, fitting or adjustment of the medical equipment;

(b) an expense for the subsequent repair, replacement, fitting or adjustment of the medical equipment, if the expense is incurred because of a change in the physical or mental condition of the insured caused by the insured's bodily injury.

(5) An expense for the repair of medical equipment referred to in subsection (1) is payable or reimbursable to the extent that the cost of repair does not exceed 80% of the original purchase price of the medical equipment.

Medication and supplies

20 For the purpose of section 10(d) of the Act, an expense is payable or reimbursable in respect of only the following medication and supplies:

(a) prescription medication;

(b) non-prescription medication recommended by a health care practitioner;

(c) medical supplies.

Part 5
Accessibility Supports

Eligible expenses

21(1) For the purpose of section 11 of the Act, an expense is payable or reimbursable in respect of only the following accessibility supports:

(a) the acquisition or adaptation of an automobile for use by an insured as a driver or passenger, in accordance with section 22;

(b) the relocation of an insured's residence or an alteration to a residence for the insured's benefit, in accordance with section 23;

(c) attendant care to enable an insured to hold employment, in accordance with section 24.

(2) Nothing in this section prevents an insurer from paying or reimbursing an expense related to an accessibility support not referred to in subsection (1) under section 16.1 of the Act.

Automobile acquisition and adaptation

22(1) For the purpose of section 11 of the Act and subject to subsections (2) to (4), the following expenses are payable or reimbursable:

(a) an expense relating to the acquisition of an automobile equipped as necessary for and appropriate to its use by an insured as a driver or passenger, with the choice of make or model of automobile to be in the discretion of an insurer;

(b) an expense relating to the adaptation of an automobile to equip it as necessary for and appropriate to its use by an insured as a driver or passenger;

(c) an expense relating to the adaptation of an automobile to equip it as necessary for and appropriate to its use by an insured, as a driver or passenger, in the course of the insured's employment.

(2) An expense relating to the replacement of an automobile acquired in accordance with subsection (1)(a) is not payable or reimbursable more than once within a 10-year period.

(3) An insurer's liability to pay or reimburse an automobile acquisition or adaptation expense referred to in subsection (1) is limited to the following:

(a) in the case of the replacement of an automobile acquired in accordance with subsection (1)(a), the difference between the cost of replacement and the fair market value of the automobile at the time of replacement;

(b) in the case of the adaptation of an automobile referred to in subsection (1)(b) or (c), the cost attributable to adapting the automobile to accommodate the insured's needs.

(4) An insurer is not liable to pay or reimburse insurance or operating costs, including repair and maintenance costs, related to an automobile acquired or adapted for use by the insured as a driver or passenger in accordance with subsection (1).

Relocation and residential alterations

23(1) For the purpose of section 11 of the Act and subject to subsections (3) to (6), the following expenses are payable or reimbursable:

(a) an expense relating to an alteration to the insured's existing principal residence;

(b) if an alteration referred to in clause (a) is not practicable, an expense relating to the relocation of the insured to a new principal residence;

(c) if at the time of the accident a new principal residence for the insured is planned or is under construction, an expense

relating to an alteration to the plan for or the construction of the principal residence;

(d) if the insured is a minor whose principal residence is not the same as a parent of the minor, an expense relating to an alteration to the parent's principal residence;

(e) if the insured is relocating from their existing principal residence to a new principal residence for one or more of the following reasons, an expense relating to an alteration to the insured's new principal residence:

(i) to engage in a retraining or educational program approved by the insurer;

(ii) because of changes affecting the insured's health or family circumstances;

(iii) in the case of an insured who, at the time of the accident, was a minor, to move from their family home.

(2) Subject to subsections (3) to (6), if an insured has sustained a catastrophic injury, the following expenses are payable or reimbursable in addition to the applicable payments or reimbursements under subsection (1):

(a) an expense relating to an alteration to a secondary residence owned by the insured or the insured's spouse or adult interdependent partner;

(b) if an alteration referred to in clause (a) is not practicable, an expense relating to the relocation of the insured to a new secondary residence;

(c) if at the time of the accident a new secondary residence, to be owned by the insured or the insured's spouse or adult interdependent partner, is planned or is under construction, an expense relating to an alteration to a plan for or the construction of the new secondary residence;

(d) if the insured is a minor, an expense relating to an alteration to a secondary residence of the insured's parent;

(e) if the insured is relocating in order to engage in a retraining or educational program approved by the insurer, an expense relating to an alteration to a temporary residence to be used

by the insured while engaged in the retraining or education program.

(3) An expense referred to in subsection (1)(d) or (2)(a) to (d) is payable or reimbursable only if the insured regularly uses the residence.

(4) An expense relating to an alteration to a residence referred to in subsection (1) or (2) is payable or reimbursable only if the alteration is necessary to make the residence accessible to and usable by the insured.

(5) An insurer's liability to pay or reimburse an expense relating to the relocation of an insured or an alteration to a residence referred to in subsection (1) or (2) is limited to the cost attributable to the insured's bodily injury.

(6) An insurer is not liable to pay or reimburse insurance or operating costs, including repair and maintenance costs, relating to a residence to which an insured is relocated or that is altered for the insured in accordance with this section.

Attendant care for employment

24 For the purpose of section 11 of the Act, an expense relating to attendant care for employment is payable or reimbursable only if the insured is, because of their bodily injury, unable to hold employment without an attendant's care.

Part 6
Transportation, Lodging and Other Expenses

Transportation expenses

25(1) For the purpose of section 12 of the Act, the following transportation expenses are payable or reimbursable:

(a) an expense related to transportation by private automobile;

(b) an expense related to transportation by public transportation;

(c) a parking or toll expense related to the use of a private automobile referred to in clause (a).

(2) For the purpose of section 12 of the Act, a transportation expense related to the use of an ambulance is payable or reimbursable only if the transportation is required

(a) by any of the following:

(i) a physician;

(ii) a nurse practitioner;

(iii) a person entitled in another jurisdiction to practice in a capacity equivalent to a physician or nurse practitioner in Alberta,

or

(b) to provide the insured with first aid or other health care without delay to

(i) preserve the insured's life,

(ii) prevent or alleviate serious physical or mental harm, or

(iii) alleviate severe pain.

(3) For the purpose of section 12 of the Act, a transportation expense related to the use of an aircraft is payable or reimbursable only if other means of transport are

(a) inadequate or dangerous because of travel time or road or weather conditions, or

(b) more expensive.

(4) For the purpose of section 12 of the Act, a transportation expense is not payable or reimbursable if the distance travelled is less than 25 km.

(5) Subsection (4) does not apply to

(a) a parking expense related to the use of a private automobile, or

(b) a transportation expense related to the use of an ambulance under subsection (2).

(6) A transportation expense referred to in this section is payable or reimbursable in accordance with the rates and maximum amounts, if any, established by the Minister.

Lodging expenses

26(1) For the purpose of section 12(1) of the Act, a lodging expense is payable or reimbursable only if lodging is necessary because of

(a) the distance between the insured's residence and the place where the insured

(i) receives or obtains a service or thing referred to in section 12(1)(a) or (b) of the Act,

(ii) attends a medical assessment referred to in section 12(1)(c) of the Act, or

(iii) submits or receives a document referred to in section 12(1)(d) of the Act,

or

(b) the insured's state of health.

(2) For the purpose of section 12(2) of the Act, a lodging expense is payable or reimbursable only if lodging is necessary because of

(a) the distance between the accompanying person's residence and the place where the insured whom the person is accompanying

(i) receives a service or thing referred to in section 12(1)(a) or (b) of the Act,

(ii) attends a medical assessment referred to in section 12(1)(c) of the Act, or

(iii) submits or receives a document referred to in section 12(1)(d) of the Act,

or

(b) the accompanying person's state of health.

(3) For the purpose of section 12 of the Act, a lodging expense is not payable or reimbursable if the distance travelled is less than 25 km.

(4) For the purpose of section 12 of the Act, a lodging expense is payable or reimbursable in accordance with the rates and maximum amounts, if any, established by the Minister.

Meal expenses

27(1) For the purpose of section 12 of the Act, a meal expense is payable or reimbursable only if the meal expense is incurred in conjunction with a lodging expense that is payable or reimbursable under section 26.

(2) For the purpose of section 12 of the Act, a meal expense is payable or reimbursable in accordance with the rates and maximum amounts, if any, established by the Minister.

Expenses beyond 100 km

28(1) In this section, "care services destination" means a place where an insured

(a) receives or obtains a service or thing referred to in section 12(1)(a) or (b) of the Act,

(b) attends a medical assessment referred to in section 12(1)(c) of the Act, or

(c) submits or receives a document referred to in section 12(1)(d) of the Act.

(2) For the purpose of section 12(1) and (2) of the Act and in addition to the conditions, restrictions, requirements and exclusions set out in sections 25 to 27, if

(a) an insured travels more than 100 km from their residence to a care services destination, for a purpose set out in section 12(1)(a) to (d) of the Act, when the insured could have attended a care services destination within 100 km of their residence, the insurer is liable to pay or reimburse only a transportation, lodging or meal expense that would have been incurred by the insured if the care services destination had been within 100 km, and

(b) an accompanying person transports the insured from the insured's residence to a care services destination, the insurer is, subject to subsection (3), liable to pay or reimburse only a transportation, lodging or meal expense incurred in relation to the round trip between the insured's residence and the care services destination.

(3) For the purpose of subsection (2)(b), if the care services destination to which the accompanying person is transporting the

insured is more than 100 km from the insured's residence, and the insured could have attended a care services destination within 100 km of the insured's residence, the insurer is liable to pay or reimburse only a transportation, lodging or meal expense that would have been incurred by the accompanying person if the care services destination had been within 100 km of the insured's residence.

Critical care expenses

29(1) For the purpose of section 12(3) of the Act, an insured is considered to require critical care because of their bodily injury if the insured is admitted to and required to remain in a hospital because of their bodily injury and

(a) is under 16 years of age, or

(b) as a result of the accident,

(i) is in intensive care,

(ii) is recommended to undergo or has undergone a surgical procedure requiring general anaesthesia or an invasive or high-risk examination, or

(iii) has sustained a life-threatening bodily injury.

(2) For the purpose of section 12(3) of the Act, an expense is payable or reimbursable only if the person attending to the insured is a parent, grandparent, guardian, spouse, adult interdependent partner, fiancé, fiancée, adult child or sibling of the insured.

(3) For the purpose of section 12(3) of the Act, an expense is payable or reimbursable only if an insurer considers that the insured's need for a person to attend to them is necessary or advisable for one of the following reasons:

(a) to authorize treatment for the insured;

(b) to assist the insured in deciding whether to undergo a surgical procedure requiring general anaesthesia or an invasive or high-risk examination;

(c) to assist in the treatment of the insured's bodily injury;

(d) to assist the insured on other medical or compassionate grounds.

(4) For the purpose of section 12(3) of the Act, an expense is payable or reimbursable

(a) for up to 2 persons attending to an insured at the same time while the insured receives critical care,

(b) in accordance with the rates for transportation, lodging and meals established by the Minister for the purposes of sections 25 to 27, and

(c) up to the maximum amount, if any, established by the Minister.

(5) The maximum amount an insurer is liable to pay or reimburse a person under section 12(3) of the Act is the amount, if any, established by the Minister.

Part 7
Daily Living Assistance Expenses

Definitions

30(1) In this Part,

(a) "activity of daily living", in respect of an insured, means an activity, including a functional, cognitive, behavioural or emotional activity, that the insured normally performs on a daily basis to maintain their health and well-being;

(b) "daily living assistance assessment" means an assessment conducted under section 33(2).

(2) For the purpose of section 13 of the Act and this Part, "assistance" means

(a) providing verbal or physical aid to an insured, or

(b) supervising an insured.

Assistance expenses for persons 16 years or older

31(1) In this section, "insured" means an insured who is 16 years of age or older on the date of the accident.

(2) For the purpose of section 13 of the Act, an expense for assisting an insured with an activity of daily living is payable or reimbursable only if

(a) the assistance is provided directly to and solely for the benefit of the insured, and

(b) the insured was performing the activity of daily living before the accident, with or without modifications, assistive devices or assistance.

(3) Despite subsection (2)(b), an expense for assisting an insured with an activity of daily living that the insured was not performing before the accident is payable or reimbursable if

(a) the insured was capable of safely performing the activity of daily living, or the relevant components of the activity of daily living, before the accident, with or without modifications, assistive devices or assistance, and

(b) there is a change in circumstance that, had the accident not occurred, would require the insured to perform the activity of daily living.

(4) For the purpose of section 13 of the Act, an expense for overnight supervision assistance for an insured is payable or reimbursable only if the insured is required to receive overnight supervision for a medically necessary reason.

Assistance expenses for persons under 16 years

32(1) In this section, "insured" means an insured who is under 16 years of age on the date of the accident.

(2) For the purpose of section 13 of the Act, an expense for assisting an insured with an activity of daily living

(a) is payable or reimbursable only if the assistance is provided directly to and solely for the benefit of the insured, and

(b) is not payable or reimbursable if, in respect of the applicable activity of daily living set out in Column A of Table 2 in the Schedule, the age of the insured is not within the range of ages set out in Column B or C for that activity of daily living.

(3) For the purpose of section 13 of the Act and subject to subsection (2)(b), an expense for assisting an insured with an activity of daily living is payable or reimbursable in accordance with the following:

(a) in respect of the initial daily living assistance assessment an insured undergoes, if the insured was incapable of safely performing an activity of daily living, or the relevant components of the activity of daily living, before the accident, with or without modifications, assistive devices or assistance, an expense for assisting the insured with the activity of daily living is not payable or reimbursable;

(b) in respect of a subsequent daily living assistance assessment an insured undergoes, if the insurer is satisfied that the insured would not have been performing the activity of daily living, either partially or completely, at the age set out in Column B or C of Table 2 in the Schedule, as the case may be, for the applicable activity of daily living as set out in Column A if the accident had not occurred, an expense for assisting the insured with the activity of daily living is not payable or reimbursable.

(4) For the purpose of section 13 of the Act, an expense for additional supervision assistance is payable or reimbursable only if the insured requires supervision assistance beyond what is normal for

(a) the insured's age, and

(b) the physical and mental condition of the insured immediately before the accident.

(5) For the purpose of section 13 of the Act, an expense for overnight supervision assistance is payable or reimbursable only if the insured is required to receive overnight supervision for a medically necessary reason.

Determining assistance amount

33(1) In this section,

(a) "class 1 dependent" means an insured who is able to safely complete part of an activity of daily living or the relevant components of the activity of daily living, with modifications or assistive devices if necessary, but requires assistance with up to 25% of the activity of daily living to complete it;

(b) "class 2 dependent" means an insured who is able to safely complete part of an activity of daily living or the relevant components of the activity of daily living, with modifications

or assistive devices if necessary, but requires assistance with up to 50% of the activity of daily living to complete it;

(c) "class 3 dependent" means an insured who is able to safely complete part of an activity of daily living or the relevant components of the activity of daily living, with modifications or assistive devices if necessary, but requires assistance with up to 75% of the activity of daily living to complete it;

(d) "class 4 dependent" means

(i) an insured who is able to safely complete part of an activity of daily living or the relevant components of the activity of daily living, with modifications or assistive devices if necessary, but requires assistance with more than 75% of the activity of daily living to complete it, or

(ii) an insured who is unable to safely complete any part of an activity of daily living without assistance, with or without modifications or assistive devices.

(2) In the case of an insured who is unable to perform an activity of daily living without assistance because of their bodily injury, an insurer shall

(a) conduct a daily living assistance assessment to determine the amount of assistance the insured requires to complete the activity of daily living, and

(b) use the daily living assistance assessment tool referred to in subsection (3) to conduct the assessment.

(3) The Minister shall establish and maintain a daily living assistance assessment tool that includes

(a) a description of the components of each activity of daily living,

(b) guidelines for using the daily living assistance assessment tool, including

(i) how to use it for scoring, and

(ii) the qualifications required to use it,

and

(c) instructions for completing a daily living assistance assessment.

(4) Subject to subsection (5), an insurer shall

(a) use Table 1 in the Schedule when conducting a daily living assistance assessment, and

(b) determine an insured's score for each activity of daily living that is being assessed in accordance with the following:

(i) if the insured is class 1 dependent in respect of an activity of daily living set out in Column A of Table 1 in the Schedule, the insured's score for that activity of daily living is the score set out in Column B for that activity of daily living;

(ii) if the insured is class 2 dependent in respect of an activity of daily living set out in Column A of Table 1 in the Schedule, the insured's score for that activity of daily living is the score set out in Column C for that activity of daily living;

(iii) if the insured is class 3 dependent in respect of an activity of daily living set out in Column A of Table 1 in the Schedule, the insured's score for that activity of daily living is the score set out in Column D for that activity of daily living;

(iv) if the insured is class 4 dependent in respect of an activity of daily living set out in Column A of Table 1 in the Schedule, the insured's score for that activity of daily living is the score set out in Column E for that activity of daily living.

(5) In the case of an insured who is under 16 years of age when a daily living assistance assessment is conducted in respect of them, if the age of the insured is set out in Column B of Table 2 in the Schedule in relation to the activity of daily living set out in Column A, then

(a) an insurer shall adjust the insured's score in respect of the activity of daily living based on the following factors:

(i) the amount of assistance that the insured would normally be expected to require, based on their age;

(ii) a physical or mental condition unrelated to the insured's bodily injury that affects their ability to perform the activity of daily living;

(iii) the amount of assistance in respect of the activity of daily living that the insured required before the accident;

(iv) if the accident had not occurred, the age at which the insured would likely have been able to perform the activity of daily living;

(v) any guidelines for scoring contained in the assessment tool established under subsection (3),

and

(b) the insured's score for the activity of daily living must not exceed the score set out in Column D of Table 1 in the Schedule in relation to that activity of daily living as set out in Column A.

(6) An insured who makes a claim for the payment or reimbursement of an expense under section 13 of the Act shall, at the expense of an insurer, undergo a daily living assistance assessment as often as the insurer requires.

Amount for daily living assistance

34(1) In this section,

(a) "level 1 activities of daily living" means items 1 to 11 of Table 1 in the Schedule;

(b) "level 2 activities of daily living" means items 12 to 23 of Table 1 in the Schedule;

(c) "level 3 activities of daily living" means item 24 of Table 1 in the Schedule;

(d) "total score for level 1 activities of daily living" means the sum of the scores determined under section 33(4) for items 1 to 11 of Table 1 in the Schedule;

(e) "total score for level 2 activities of daily living" means the sum of the scores determined under section 33(4) for items 12 to 23 of Table 1 in the Schedule;

(f) "total score for level 3 activities of daily living" means the score determined under section 33(4) for item 24 of Table 1 in the Schedule;

(g) "total weighted score" means the number calculated under subsection (2).

(2) The total weighted score is the sum of

(a) the total score for level 1 activities of daily living,

(b) the total score for level 2 activities of daily living multiplied by 1.05,

(c) the total score for level 3 activities of daily living multiplied by 2.54, and

(d) the insured's average number of hours of supervision per day multiplied by 12.

(3) For the purpose of section 13 of the Act, the maximum amount that an insurer is liable to pay or reimburse on a per month basis for expenses to assist an insured with activities of daily living is the following:

(a) if the total weighted score is 9 or more but less than 89, the amount determined by the following formula:

$$\left(\frac{\text{total weighted score}}{89}\right) \text{ x the amount established by the Minister}$$

(b) if the total weighted score is 89 or more, the amount established by the Minister.

(4) The Minister shall, in respect of subsection (3), establish

(a) a specific amount that is applicable to an insured with a catastrophic injury, and

(b) a specific amount that is applicable to an insured without a catastrophic injury.

Location where assistance provided

35 For the purpose of section 13 of the Act, an expense for assisting an insured with an activity of daily living is payable or reimbursable in accordance with this Part regardless of the location where the assistance is provided.

Part 8
Caregiving and Family Enterprise Expenses

Caregiving expenses

36(1) For the purpose of section 14(1)(e) of the Act, each of the following is a class of persons:

(a) an insured receiving an income replacement benefit described in section 5(3) of the *Income Replacement and Monetary Benefits Regulation*, whether or not the insured is a part-time earner or non-earner;

(b) an insured receiving an income replacement benefit described in section 11(1) of the *Income Replacement and Monetary Benefits Regulation*.

(2) For the purpose of section 14 of the Act and subject to subsection (3), the maximum amount an insurer is liable to pay or reimburse an insured, on a per week basis, is the amount established by the Minister that corresponds to the number of care recipients residing with the insured in the applicable week.

(3) When determining the number of care recipients residing with an insured for the purpose of calculating the maximum amount under subsection (2), an insurer shall make the determination in accordance with the following:

(a) if a care recipient has not resided with the insured for more than 28 consecutive days for a reason that is not related to the accident, the care recipient is not considered to be residing with the insured;

(b) if a care recipient returns to reside with an insured after an absence period, the insured is considered to be residing with the insured only after the care recipient has resided with the insured for at least 14 consecutive days;

(c) if the number of care recipients that reside with the insured changes, or a circumstance described in clause (a) or (b) occurs,

(i) the maximum amount under subsection (2) shall be redetermined at the end of the week in which the number changes or the circumstance occurs, and

(ii) the redetermined maximum amount applies as of the beginning of the following week.

Family enterprise expenses

37 For the purpose of section 15(1) of the Act, the maximum amount an insurer is liable to pay or reimburse an insured is the amount per week established by the Minister.

Part 9
Miscellaneous Expenses

Prescribed expense category — clothing

38(1) For the purpose of section 16 of the Act, a clothing expense is a category of expenses.

(2) A clothing expense includes only the following expenses:

(a) an expense for cleaning, repairing or replacing clothing damaged in the accident;

(b) in the case of an insured who is permanently dependent on a wheelchair because of the insured's bodily injury, an expense for purchasing, renting, repairing, replacing, fitting or adjusting clothing;

(c) in the case of an insured who is required to use a prosthesis or orthosis because of the insured's bodily injury, an expense for purchasing, renting, repairing, replacing, fitting or adjusting clothing.

(3) A clothing expense for replacing clothing referred to in subsection (2)(a) is payable or reimbursable only if

(a) the clothing cannot be adequately cleaned or repaired, or

(b) the cost of replacement is less than the cost of cleaning or repairing.

(4) In the case of an insured referred to in subsection (2)(b) or (c), a clothing expense for the purchase, rental, repair, replacement, fitting or adjustment of clothing is payable or reimbursable in accordance with the following:

(a) if the insured did not wear the clothing before the accident, only if the expense is incurred

(i) because of the ordinary use of the clothing, or

(ii) to enhance the performance of the clothing;

(b) if the insured wore the clothing before the accident, only if the expense is incurred because of a change in the physical or mental condition of the insured because of the insured's bodily injury.

(5) For the purpose of section 16 of the Act, the maximum amount an insurer is liable to pay or reimburse an insured for an expense described in

(a) subsection (2)(a) is the amount established by the Minister,

(b) subsection (2)(b) is the amount established by the Minister, and

(c) subsection (2)(c) is,

(i) in the case of an insured who is required to use a prosthesis or orthosis for less than 6 months, the amount established by the Minister, and

(ii) in the case of an insured who is required to use a prosthesis or orthosis for 6 months or more,

(A) the amount established by the Minister for clothing worn on the upper body, and

(B) the amount established by the Minister for clothing worn on the lower body.

Prescribed expense category — volunteers

39(1) For the purpose of section 16 of the Act, each of the following is a category of expenses:

(a) an expense for cleaning, repairing or replacing clothing damaged resulting from the rendering of emergency first aid or other assistance to an insured;

(b) an expense, other than an expense described in clause (a), resulting from the rendering of emergency first aid or other assistance to an insured.

(2) An expense referred to in subsection (1) is payable or reimbursable only in respect of a person who rendered emergency first aid or other

assistance, and only if the person did so voluntarily and without expectation of compensation.

(3) An expense for replacing clothing referred to in subsection (1)(a) is payable or reimbursable only if

(a) the clothing cannot be adequately cleaned or repaired, or

(b) the cost of replacement is less than the cost of cleaning or repairing.

(4) For the purpose of section 16 of the Act, the maximum amount an insurer is liable to pay or reimburse a person for an expense referred to in subsection (1) is the amount, if any, established by the Minister.

Prescribed expense category — recreation

40(1) For the purpose of section 16 of the Act, a recreation expense is a category of expenses.

(2) For the purpose of section 16 of the Act, a recreation expense for an insured is payable or reimbursable only if the insured sustains

(a) a catastrophic injury, or

(b) a permanent impairment with a permanent impairment rating of 20% or more as determined in accordance with the *Permanent Impairment Regulation*.

(3) The permanent impairment rating referred to in subsection (2)(b) must exclude impairments related to scarring, musculotendinous disruptions, ligaments and cartilage.

(4) For the purpose of section 16 of the Act, an insurer may require an insured to provide written confirmation from a health care practitioner that a recreational activity is appropriate for the insured before paying or reimbursing the insured for the recreational activity.

(5) For the purpose of section 16 of the Act, if an insured requires another person to accompany the insured to participate in a recreational activity, an insurer shall pay or reimburse the insured for expenses incurred for the other person to accompany the insured.

(6) For the purpose of section 16 of the Act, an insurer's liability to pay or reimburse an expense for a recreational activity is limited to

(a) the cost attributable to the insured's bodily injury, and

(b) the following maximum amounts:

(i) in the case of an insured who sustains a catastrophic injury, the amount established by the Minister;

(ii) in the case of an insured who does not sustain a catastrophic injury but sustains a permanent impairment described in subsection (2)(b), the amount established by the Minister applicable to the insured's permanent impairment rating.

(7) The maximum amounts established under subsection (6)(b) apply to the following:

(a) an expense incurred for an insured's participation in recreational activities;

(b) an expense incurred for another person to accompany an insured to participate in recreational activities under subsection (5).

Prescribed expense category — telecommunication

41(1) For the purpose of section 16 of the Act, a telecommunication expense incurred while an insured is hospitalized because of their bodily injury is a category of expenses.

(2) For the purpose of section 16 of the Act, an insurer is not liable to pay or reimburse an insured for a telecommunication expense that the insured would have incurred if the accident had not occurred.

(3) The maximum amount an insurer is liable to pay or reimburse an insured for a telecommunication expense is the amount, if any, established by the Minister.

Prescribed expense category — personal representative

42(1) For the purpose of section 16 of the Act, if an insured is incapable of managing the insured's affairs because of their bodily injury, an expense incurred for the appointment of a person to manage the insured's affairs is a category of expenses.

(2) An expense referred to in subsection (1) is limited to

(a) a fee or disbursement for preparing documents in relation to the appointment, and

(b) a fee to file documents with a court in relation to the appointment.

(3) The maximum amount an insurer is liable to pay or reimburse an insured for an expense referred to in subsection (1) is the amount, if any, established by the Minister.

Prescribed expense category — emergency transportation

43(1) For the purpose of section 16 of the Act, an expense for emergency transportation for the insured from the scene of the accident is a category of expenses.

(2) The maximum amount an insurer is liable to pay or reimburse an insured for an expense referred to in subsection (1) is the amount, if any, established by the Minister.

Prescribed expense category — transportation from hospital

44(1) For the purpose of section 16 of the Act, an expense for transportation for the insured from a hospital following their discharge from hospital is a category of expenses.

(2) An expense referred to in subsection (1) is payable or reimbursable in accordance with the

(a) restrictions and requirements respecting the payment or reimbursement of transportation expenses under section 25, and

(b) rates and maximum amounts, if any, established by the Minister.

Prescribed expense category — loss of income re medical assessment attendance

45(1) For the purpose of section 16 of the Act, an insured's lost income due to an absence from their employment to attend a medical assessment

(a) is considered to be an expense incurred by the insured, and

(b) is a category of expenses.

(2) If an insured loses income due to an absence referred to in subsection (1), an insurer shall

(a) pay 90% of the insured's lost net income to the insured, and

(b) calculate the insured's lost net income based on

(i) the industrial average wage for the prior calendar year, determined in accordance with section 2 of the *Income Replacement and Monetary Benefits Regulation*, and

(ii) a reasonable absence period from their employment to attend the medical assessment.

Part 10
Expiry and Coming into Force

Expiry

46 For the purpose of ensuring that this Regulation is reviewed for ongoing relevancy and necessity, with the option that it may be repassed in its present or an amended form following a review, this Regulation expires on December 31, 2031.

Coming into force

47 This Regulation comes into force on the coming into force of section 101(1)(j) of the *Automobile Insurance Act*.

Schedule

Table 1
Scoring of Assessment Tool

Item	Column A Activity of Daily Living	Column B Class 1 Dependent	Column C Class 2 Dependent	Column D Class 3 Dependent	Column E Class 4 Dependent
Level 1 Activities of Daily Living					
1	Preparing personal meals: breakfast	1	2	3	4
2	Preparing personal meals: lunch	1.5	3	4.5	6
3	Preparing personal meals: dinner	2	4	6	8
4	Performing housework to maintain a place of residence in acceptable sanitary condition: light housekeeping	3	3	3	6
5	Performing housework to maintain a place of residence in acceptable sanitary condition: heavy housekeeping	0	0	0	3
6	Performing housework to	1	1	1	2

	maintain a place of residence in acceptable sanitary condition: laundry				
7	Performing yard work	0	0	0	3
8	Shopping for personal needs	0	0	0	1
9	Using private or public transportation other than transfer vehicles	0	0	0	1
10	Undertaking community outings	0	0	0	1
11	Managing personal finances or personal medication or both	0	0	0	1
Level 2 Activities of Daily Living					
12	Transferring to and from bed	1.5	1.5	1.5	3
13	Adjusting or maintaining position in bed	1.5	1.5	1.5	3
14	Using private or public transportation: vehicle transfers	2	2	2	4
15	Transfers requiring 2 or more persons or a patient lift	0	0	0	6
16	Accessing an insured's place of residence	4	4	4	7
17	Using stairs	1.5	1.5	1.5	3
18	Performing personal hygiene and self-care that relates to eating or drinking	4	4	4	16
19	Performing personal hygiene and self-care that relates to grooming or hygiene	2	2	2	3
20	Performing personal hygiene and self-care that relates to dressing or undressing	1.5	3	4.5	6
21	Performing personal hygiene and self-care that relates to prosthesis or orthosis	2	2	2	3
22	Performing personal hygiene and self-care that relates to bathing or showering	2	4	6	8
23	Performing personal hygiene and self-care that relates to toileting	6	6	6	12
Level 3 Activities of Daily Living					

24	Performing personal hygiene and self-care that relates to bowel and bladder care requiring catheters, disimpaction or diapers	8	8	8	16

Table 2
Developmental Scale

Item	Column A Activity of Daily Living	Column B Age of Insured in Years	Column C Age of Insured in Years
1	Preparing personal meals	12 to 15	16 or more
2	Transferring to and from bed	2.5 to 5	6 or more
3	Adjusting or maintaining position in bed	2.5 to 5	6 or more
4	Using public or personal transportation: vehicle transfers	2.5 to 5	6 or more
5	Transfers requiring 2 or more persons or a patient lift	N/A	0 or more
6	Using stairs	1.5 to 3.5	more than 3.5
7	Accessing place of residence other than outdoor access	9 to 12	13 or more
8	Accessing place of residence: outdoor access	2.5 to 4	5 or more
9	Performing personal hygiene and self-care that relates to eating or drinking	2.5 to 4	5 or more
10	Performing personal hygiene and self-care that relates to grooming or hygiene	4 to 6	7 or more
11	Performing personal hygiene and self-care that relates to dressing or undressing	5 to 8	9 or more
12	Performing personal hygiene and self-care that relates to prosthesis or orthosis	5 to 8	9 or more
13	Performing personal hygiene and self-care that relates to bathing or showering	4 to 6	7 or more
14	Performing personal hygiene and self-care that relates to toileting	2.5 to 6	7 or more
15	Performing personal hygiene and self-care that relates to bowel and bladder care requiring catheters, disimpaction or diapers	N/A	0 or more