COURT OF APPEAL FOR ONTARIO

CITATION: Baker v. Blue Cross Life Insurance Company of Canada, 2023 ONCA 842
DATE: 20231220
DOCKET: COA-22-CV-0046

Hourigan, Zarnett and George JJ.A.

BETWEEN

Sara Baker

Plaintiff (Respondent)

and

Blue Cross Life Insurance Company of Canada

Defendant (Appellant)

Paul J. Pape and Mitchell McGowan, for the appellant

Geoffrey Adair and Stephen Birman, for the respondent

Linda M. Plumpton and J. Toshach Weyman, for the intervener Canadian Life & Health Insurance Association Inc.

Heard: November 15, 2023

On appeal from the judgment of Justice Susan Vella of the Superior Court of Justice, dated August 12, 2022, sitting with a jury, and the order for costs, dated March 22, 2023, with reasons reported at 2023 ONSC 1891.

Hourigan J.A.:

A. OVERVIEW

[1] The respondent, Sara Baker, suffered a stroke while exercising in October 2013. At the time of the incident, she was 38 years old and was the Director of

Food Services, Environmental, and Porter or Transport Services at Humber River Hospital as an employee of Compass Group Canada. Ms. Baker had a disability insurance policy through her employer. The appellant, Blue Cross Life Insurance Company of Canada ("Blue Cross"), is the insurer under that policy.

[2] After the incident, Ms. Baker was paid short-term disability benefits until January 2014, when she was cut off by Blue Cross. After an internal appeal, Blue Cross reinstated the benefits on March 7, 2014. After 30 weeks, when her eligibility for short-term disability benefits had elapsed, Ms. Baker sought long-term disability benefits.

[3] In order to obtain long-term disability benefits under Blue Cross' policy, an insured had to demonstrate that they satisfied the definition of "total disability." The policy had two provisions defining "total disability." The first was the "own occupation" provision, which applied for the first two years of receipt of long-term disability benefits. This provision defined "total disability" as "the complete and continuous inability of the Covered Employee to perform the regular duties of his own occupation as a result of illness or injury."

[4] After that, the second applicable provision was the "any occupation" provision, which defined a "total disability" as a:

> state of continuous incapacity, resulting from illness or injury, which wholly prevents the Covered Employee from performing the regular duties of any occupation for which he:

- would earn 60% or more of his Pre-disability Earnings and
- is reasonably qualified, or may so become, by training, education, or experience.

[5] Ms. Baker was paid two years of long-term "own occupation" benefits. During this period, Blue Cross stopped the payment of long-term disability benefits in August 2015 and reinstated it on March 23, 2016, after Ms. Baker went through an internal appeal. Ms. Baker was then denied long-term "any occupation" benefits. She participated in two levels of internal appeals of the decision but was unsuccessful in obtaining these benefits.

[6] Having exhausted Blue Cross' appeal process, Ms. Baker commenced this action for "any occupation" benefits, along with aggravated and punitive damages. Blue Cross served a jury notice and successfully resisted a motion to strike it due to the COVID-19 pandemic. The trial took 22 days, and the jury returned a verdict in favour of Ms. Baker as follows: (a) a declaration that she was totally disabled within the meaning of Blue Cross' long-term disability benefits policy; (b) retroactive benefits to the date of the trial in the amount of $220,604.00; (c) aggravated damages for mental distress of $40,000; and (d) punitive damages in the sum of $1,500,000.00.

[7] The trial judge found that full indemnity costs were appropriate in this case and fixed those costs at $1,083,953.50, all-inclusive. She did so on the basis that, as a matter of public policy, Ms. Baker should not have her disability insurance

benefits, of which she was wrongfully deprived, eroded by unrecoverable legal expenses.

[8] Blue Cross does not appeal the declaration that Ms. Baker is totally disabled, the award of damages equivalent to the benefits owed, or the order for aggravated damages. It appeals the punitive damages award, but does not take issue with the trial judge's instructions to the jury concerning the law of punitive damages. Instead, Blue Cross asserts that a contextual and fair reading of the entire record demonstrates that Ms. Baker's claim was handled in a balanced and reasonable manner. Blue Cross also seeks leave to appeal the costs award.

[9] For the reasons discussed below, I would dismiss the appeal and grant leave to appeal costs but deny the costs appeal. In summary, the evidence at trial raised serious concerns regarding the manner in which several disability claim examiners and reviewers at Blue Cross processed Ms. Baker's file. At best, it shows reckless indifference to its duty to consider the respondent's claim in good faith and to conduct a good faith investigation, and at worst, a deliberate strategy to wrongfully deny her benefits.

[10] Given the claim for punitive damages, Blue Cross was on notice that how it handled this file would be a significant part of the trial. Yet, it elected to call only the last appeals specialist as a witness, whose involvement was limited to a review of the final decision not to reinstate benefits at the time of the change of the

applicable definition of “total disability.” She was unable to explain several of the actions of her predecessors on the file.

[11] Because punitive damages are not at large, the jurisprudence permits appellate courts a greater scope and discretion when reviewing jury awards of punitive damages than an ordinary award of damages. However, Blue Cross must still demonstrate that the punitive damages award does not serve a rational purpose. In the instant case, Blue Cross elected not to call the most relevant witnesses to counter the evidence that it acted in bad faith. One of the consequences of this litigation strategy is that it does not have the evidence to meet its onus on the appeal.

[12] Further, there is nothing about the quantum of the award that warrants appellate interference. It was open to the jury to conclude that Blue Cross engaged in systemic and deliberate misconduct in handling Ms. Baker’s claim and that a significant punitive damages award was necessary to deter Blue Cross from conducting themselves in that fashion in the future.

[13] Concerning the motion for leave to appeal the costs award, I am satisfied that the trial judge erred in finding entitlement to costs on a full indemnity scale on the basis that disability insurance policies as a class should automatically attract such an award. That error warrants the granting of leave to appeal. Given this incorrect approach, it falls to this court to determine the issue of costs. In my view,

as a result of Blue Cross' misconduct and the existence of the respondent's generous offer to settle, an award of full indemnity costs is warranted. Thus, I reach the same result as the trial judge on the issue of costs, but my decision is made differently.

B. ANALYSIS

(1) Punitive Damages Award

(a) Standard of Review

[14] During his oral submissions, counsel for Blue Cross submitted that the appropriate standard of review when considering a jury's award of punitive damages on appeal is correctness. This submission was not in Blue Cross' factum, and counsel conceded that it finds no support in Canadian jurisprudence. It is unpersuasive. However, it is essential to consider the standard of review before examining the evidence in the instant case.

[15] As in many cases where the defendants are insurance companies, or they insure named defendants, Blue Cross served a jury notice. Insurance companies often seek to have cases tried by juries. The thinking behind this strategy is that a jury may be more inclined than a judge to decline to award damages or, at least, will likely award less damages than a judge. A plaintiff who chooses a jury is making an opposite assessment. At its essence, then, the choice of a civil jury is a strategy that aims to improve a party's odds of achieving a favourable outcome.

In making that choice, a party is also taking certain calculated risks. The first and most obvious risk is that the jury might render a verdict more generous to the other side than a judge would. A second risk – one that arises if the jury's verdict is unfavourable – is that an appellate court has less scope to interfere than it would with a judge's reasons. It is this second risk that I will discuss next.

[16] Because juries do not provide reasons, an appellate court generally has a more limited basis to interfere with their verdicts. We are not in a position where we can carefully scrutinize the jury's chain of reasoning. That is why, generally, appellate courts take a deferential approach to reviewing jury verdicts. In explaining the rationale underlying this approach, I can do no better than to cite the comments of Chief Justice Laskin in his dissent in *Wade v. C.N.R.*, [1978] 1 S.C.R. 1064, at pp. 1069-1070:

> Appeal Courts do not fine-comb jury answers but accord them the respect of a common sense interpretation even where there may be some ambiguity in the answers.… It is always timely to be reminded that juries do not write reasons for judgment, and their answers must be taken against the background of the evidence from which they are entitled to select, without manifesting their selection, what is credible, what is significant, what is persuasive to them. It is very often easy for an appellate Court, in the leisurely scrutiny of the transcript, to find significance in pieces of evidence to contradict jury findings, and in so doing to usurp the jury's function. What an appellate Court may believe from a reading of the transcript may be the very things which a jury disbelieved or believed in part only. It is one thing to interfere with a jury's verdict where there is simply no evidence to support its findings or to support a critical one; it is a different thing, and not

> to be encouraged, to interfere with its findings where there is evidence, however slight, on which they may be based, but where because of offsetting evidence a question of credit and weight arises. These are matters for the jury alone.

[17] Despite the foregoing, the role of an appellate court is different when it comes to reviewing an award of punitive damages. These damages are not at large, and consequently, it has been held that courts have greater scope to interfere with such awards. The leading cases on this point are *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130 and *Whiten v. Pilot Insurance Co.,* 2002 SCC 18, [2002] 1 S.C.R. 595, which provide guidance regarding the appropriate standard of review.

[18] In discussing appellate review of punitive damages awards, Cory J. in *Hill*, at para. 197, stated:

> [C]ourts have a much greater scope and discretion on appeal. The appellate review should be based on the court's estimation as to whether the punitive damages serve a rational purpose. In other words, was the misconduct of the defendant so outrageous that punitive damages were rationally required to act as deterrence?

[19] This rationality test applies to whether an award of punitive damages should be made and to the issue of its quantum: *Whiten*, at para. 101. The focus is on whether the award is the product of reason and rationality, and the question is "whether the court's sense of reason is offended rather than on whether its conscience is shocked": *Whiten*, at para. 108.

[20] Regarding the quantum of a punitive damages award, in *Whiten*, Binnie, J. built on the dicta from *Hill*, stating, at para. 107:

> In *Hill*…Cory J., while emphasizing the overriding obligation of rationality, also recognized that the jury must be given some leeway to do its job. The issue of punitive damages, after all, is a matter that has been confided in the first instance to their discretion. Thus, to be reversed, their award of punitive damages must be "so inordinately large as obviously to exceed the maximum limit of a reasonable range within which the jury may properly operate" (para. 159). Putting these two notions together, the test is whether a reasonable jury, properly instructed, could have concluded that an award in that amount, and no less, was rationally required to punish the defendant's misconduct.

[21] Although the standard of review is different when it comes to a punitive damages award compared to other jury damages awards, in considering whether the jury's decision is the product of reason and rationality, this court is faced with the same realities described by Chief Justice Laskin. We must consider the evidence before the jury without knowing with precision what weight it gave to it, what it found to be credible, what it thought was most relevant, and what it drew from the failure of a party to provide evidence. Thus, by necessity, we cannot conduct the type of detailed review that we undertake when reviewing a judge's reasons for decision. Instead, we must consider whether there was an evidentiary basis that would rationally lead to a punitive damages award and, if so, whether the quantum awarded was also rationally connected to the evidence and the

purposes of punitive damages. It is this review of the evidence that I will turn to next.

(b) Entitlement to Punitive Damages

[22] The evidentiary review includes an analysis of the evidence before the jury and the lack of evidence on critical aspects of Blue Cross' conduct. Before examining that evidence, I turn first to a consideration of what the jury understood about punitive damages. As noted, the appellant takes no issue with the instructions given to the jury about punitive damages. Nonetheless, it is helpful to consider that instruction in determining whether the jury's award of punitive damages is rationally connected to the evidence and the purposes of punitive damages.

[23] The instruction largely tracks the suggested elements of the charge outlined in *Whiten*, at para. 94. It states that such damages are "only to be awarded in exceptional circumstances ... to address the objectives of retribution, deterrence, and denunciation." The jurors were also instructed that punitive damages should be imposed only "if there has been high-handed, malicious, arbitrary, or highly reprehensible misconduct that departs to a marked degree from ordinary standards of decent behaviour." With regard to quantum, they were told that "punitive damages are given in an amount [that] is no greater than necessary to rationally accomplish these objectives" and that "judges and juries in our system

have usually found that moderate awards of punitive damages which inevitably carry a stigma in the broader community, are generally sufficient."

[24] Based on this instruction, the jurors understood the nature of punitive damages, when they were available, what they were meant to achieve, and the restraint that should be exercised in determining the quantum of the damages.

[25] Blue Cross' primary submission is that it acted in good faith despite its erroneous assessment of whether the respondent met the definition of "total disability" under the policy. In other words, it has a right to be incorrect without being liable for punitive damages.

[26] The second part of this submission is a strawman argument, as it is unassailable and is not an issue on the appeal. No one is suggesting that an error regarding the entitlement to long-term benefits automatically leads to an award of punitive damages. The problem with the submission is its factual premise that all that occurred was a good faith error. The actual issue is whether Blue Cross' actions in dealing with the respondent's claim meet the test for punitive damages. Its position, that the disability claim examiners sought out medical advice from Blue Cross' medical experts and relied on that advice in good faith in handling the respondent's file, is essentially a factual assertion. So is its assertion that its conduct cannot result in punitive damages because nothing was high-handed, malicious, arbitrary, or highly reprehensible in its conduct.

[27] The appellant also argues that this court has the complete record and is, therefore, in a position to evaluate the jury's decision to award punitive damages. We indeed have all of the evidence that was before the jury. However, there are significant gaps in that evidence. As noted above, Blue Cross elected not to call as witnesses all but one of the appeals specialists. The result is that the jury never had evidence regarding why the representatives of Blue Cross acted the way they did and whether they considered other courses of action.

[28] There was ample evidence to support an award of punitive damages. Set out below are some examples in the record that would justify such an award:

- Blue Cross stopped the payment of benefits on three separate occasions. On each occasion, it denied benefits first and then asked for additional documentation instead of first warning Ms. Baker of a potential cut-off and requesting additional documentation.
- Blue Cross relied on opinions from its contracted general practitioners, which it knew or ought to have known were incorrect. For example, on June 12, 2015, Blue Cross sent a Medical Consultant Referral Form to Dr. Knox, a contracted general practitioner, to provide a medical opinion on Ms. Baker's condition. Blue Cross populated a section on the form summarizing Ms. Baker's "History" based on her submitted medical documentation before sending it to Dr. Knox for review. Dr. Knox's completed referral form, dated July 7, 2015, contained several misstatements of Ms. Baker's condition contrary to the information Dr. Knox had been provided by Blue Cross. Blue Cross did not seek to clarify or address the flaws in this report. Instead, it relied on it as an accurate statement of her condition.
- Blue Cross selectively relied on evidence that supported the denial of benefits and ignored conflicting medical evidence. For example, when Ms. Baker's benefits were denied on August 5, 2015, this decision was based on Dr. Knox's July 2015 report rather than the evidence submitted by Ms. Baker's doctors, which included the opinion, "I don't believe she can

return to work at this time, even on a part-time basis." This opinion should have at least been addressed in Blue Cross' decision to cut off benefits. Another example is in Blue Cross' notes in Ms. Baker's file on the level one review of her claim, dated October 12, 2016. These notes were also selective in the interpretation of Ms. Baker's medical documentation. They reference conclusions from the reports completed by Dr. Bauman, dated August 2, 2016, that supported a denial of benefits and ignored evidence in the report that militated in favour of the payment of benefits.

- In the face of conflicting medical evidence, Blue Cross delayed obtaining an independent medical exam of Ms. Baker. It only sent Ms. Baker for a neuropsychological assessment with Dr. Kane in March 2016, over two and a half years after she suffered the stroke.

- Blue Cross distorted Dr. Kane's neuropsychological assessment report in a way that supported the denial of benefits. Dr. Kane's report stated:

> [I]t is expected that Ms. Baker would be able to return to a role as a Nutritionist in which she could meet with clients individually in a quiet environment and provide feedback individually or in written format and with minimal need for decision-making or feedback in speeded situations or amidst large groups. Whether such a role exists will need to be determined by her employer. Whether Ms. Baker would be able to perform such a role on a full-time basis in terms of fatigue and/or headache will need to be determined by her Physicians and/or Physiotherapist.

Blue Cross repeatedly omitted the caveats in Dr. Kane's report in their internal files and communications and in communications with Ms. Baker. For example, Blue Cross' notes from January 2017, which supported the denial of the level two appeal, read:

> After reviewing all the information on file, we conclude that the [claimant] has the ability to perform the previously identified alternate occupations, as confirmed by the medical consultant. According to the neuropsychologist's assessment, the [claimant] would even have the ability to do her previous job, with some modifications. As the [claimant] would be able to do her previous job with modifications and also the alternative occupation of dietician and nutritionist, which meets the

> commensurate salary, the [claimant] does not meet the definition of total disability for any occupation.

Dr. Kane did not identify that Ms. Baker could do her previous job with modifications. Rather, she indicated that even the potential to perform the work of a nutritionist was subject to significant qualifications.

- Blue Cross misread Ms. Kresak's Transferable Skills Analysis report ("TSA") in a way that supported the denial of benefits. On several occasions, Blue Cross misinterpreted the TSA, which identified only one suitable alternative occupation that satisfied the requirement of compensating Ms. Baker at least 60% of her pre-disability salary. For example, an email from Blue Cross to one of its medical consultants, dated December 21, 2016, stated that "6 alternative occupations were identified for the claimant." Blue Cross later conceded that the average income depictions of five of the six occupations in the report were not commensurate with 60% of Ms. Baker's pre-disability income.

- Blue Cross persisted in distorting Dr. Kane's and Ms. Kresak's reports even after the respondent's lawyer wrote to it and pointed out the errors.

[29] In the face of this evidence, Blue Cross asserts that, while it reached the wrong conclusion about Ms. Baker's condition, it acted in good faith. It was open to the jury to accept this theory of the case. However, to do so, it would have had to ignore the coincidence that every time Blue Cross erred in handling the respondent's file, it was to her detriment and to the benefit of Blue Cross.

[30] Overall, we see repeated instances of the Blue Cross team ignoring information, misinterpreting experts' reports, and relying on the ill-informed advice of their contracted doctors to deny benefits. In effect, they created a closed loop of information that ignored contrary information and created a counter-narrative based on their misinterpretation of the relevant data. This is a pattern of misconduct that, at best, shows reckless indifference to its duty to consider the

respondent's claim in good faith and conduct a good faith investigation, and at worst, demonstrates a deliberate strategy to wrongfully deny her benefits, regardless of the evidence that demonstrated an entitlement.

[31] These examples or any combination offer a sufficient basis to award punitive damages. Jurors could have concluded that Blue Cross was not just cavalier in treating the respondent's claim but that it undertook a deliberate strategy to wrongfully deny her the benefits she was entitled to under the policy. The fact that Blue Cross failed to call the critical witnesses to provide the context about their handling of the file could further serve to support a finding that the conduct was deliberate.

(c) Quantum

[32] Little was said in oral argument regarding the quantum of punitive damages other than to assert that they are too high. I disagree. Punitive damages are designed to punish wrongful conduct, to denounce that misconduct, and to act as a deterrent for future misconduct.

[33] Deterrence plays an important role when dealing with claims against insurance companies. As Laskin J.A. noted in the Court of Appeal for Ontario decision in *Whiten v. Pilot Insurance Co.* (1999), 41 O.R. (3d) 641 (C.A.), at p. 659, rev'd 2002 SCC 18, [2002] 1 S.C.R. 595,

> [V]indicating the goal of deterrence is especially important in first-party insurance cases. Insurers

> annually deal with thousands and thousands of claims by their insureds. A significant award was needed to deter Pilot and other insurers from exploiting the vulnerability of insureds, who are entirely dependent on their insurers when disaster strikes.

[34] Deterrence is impossible unless the punishment is meaningful. I take judicial notice of the fact that Blue Cross is a large insurance corporation. While a punitive damages award of $1.5 million might be devastating to a personal defendant or a small business, it is little more than a rounding error for Blue Cross. Indeed, it is difficult to envision how an award of anything less than $1.5 million would even garner the attention of senior executives, let alone deter future misconduct.

[35] Another point worth emphasizing is that there was ample evidence for the jury to conclude that the problems within Blue Cross are systemic. This was not a case of a rogue disability claim examiner. The many Blue Cross employees who touched this file took the same approach, which ignored the respondent's rights under the policy. This evidence suggests that there may be many other claimants that may have been treated in the same manner by Blue Cross. The difference is that, unlike Ms. Baker, most claimants do not have the stamina to engage in long-term litigation.

[36] The fact that this appears to be a systemic approach to Blue Cross' claims handling process reinforces why a significant award of punitive damages is required. Otherwise, a small award is effectively spread over all the other cases where claimants have decided that it is not worth suing to obtain the benefits they

are legally entitled to receive. Put simply, a modest punitive damages award becomes a nominal cost of operating in a way that wrongly and systematically denies policyholders their legal right: see *Whiten*, at para. 72.

[37] There is no basis for appellate interference with the quantum of the punitive damages award. It was rationally connected to the evidence and the purposes of punitive damages. Further, it was required to deter similar misconduct by Blue Cross in the future.

(2) Costs

[38] The trial judge awarded the respondent costs of her action “on a full indemnity basis fixed in the sum of $850,000” plus HST and disbursements for a total amount awarded of $1,083,953.50. In so ruling, she relied on costs jurisprudence from duty to defend cases, where it has been held that an insured should be fully indemnified so as not to have that duty to defend benefit eroded by unrecoverable legal expenses.

[39] The trial judge eschewed any reliance on Blue Cross’ conduct, or the settlement offer made by the respondent as a basis for awarding full indemnity costs. It would appear that this was a deliberate decision by the trial judge to add a new exception to the usual costs principles on the basis that “the wrongful denial of long-term disability benefits by an insurer, given the unique character of long-

term disability insurance policies, constitutes special circumstances justifying [an award of full indemnity costs].”

[40] Leave to appeal a costs order will not be granted except in obvious cases where the party seeking leave convinces the court there are “strong grounds upon which the appellate court could find that the judge erred in exercising his discretion”: *Brad-Jay Investments Limited v. Village Developments Limited* (2006), 218 O.A.C. 315 (C.A.), at para. 21, leave to appeal refused, [2007] S.C.C.A. No. 92; *More v. 1362279 Ontario Ltd. (Seiko Homes*), 2023 ONCA 527, at para. 32. This test is designed to impose a high threshold because appellate courts recognize that fixing costs is highly discretionary and that trial judges are best positioned to understand the dynamics of a case and to render a costs decision that is just and reflective of what actually happened on the ground: *Algra v. Comrie Estate*, 2023 ONCA 811, at para. 48.

[41] I agree with the submissions of the appellant and the intervener – who was granted status only on the issue of costs – that the trial judge erred in creating a new category of cases where full indemnity costs will automatically follow. While such a category exists for duty to defend cases, it is based on the contractual language of such policies: see e.g., *E.M. v. Reed et al.* (2003), 171 O.A.C. 145 (C.A.), at para. 22.

[42] It is unwise for courts to create new classes of cases where full indemnity costs are awarded in all circumstances. It is preferable that trial judges retain their discretion to award costs based on their assessment of the dynamics of the litigation. The intervener submits, and I agree, that broad and sweeping changes to the costs regime are better left to the legislature or the Civil Rules Committee.

[43] I conclude that leave to appeal the costs award should be granted and that the basis for the award cannot stand. Under s. 134 of the *Courts of Justice Act*, R.S.O 1990, c. C.43, this court has the authority to make any order the trial judge could have made. In the case at bar, I believe that the quantum of the costs awarded was correct, but I would make that order based on the conduct of Blue Cross and the settlement offer.

[44] There was undoubtedly misconduct by Blue Cross that was worthy of sanction by the court by awarding full indemnity costs. Without repeating the specific instances referenced above, it is fair to conclude that Blue Cross has markedly disregarded its good faith obligations to Ms. Baker. Although some of that conduct is addressed in the awards of damages, not all of it is. In addition to wrongfully denying the respondent coverage in the manner that it did, Blue Cross engaged in a litigation strategy wherein it shielded its employees from appearing at trial to explain themselves. This is one of those rare cases where there has been bad faith conduct that warrants costs on this scale: see e.g., *Clarington*

(Municipality) v. Blue Circle Canada Inc., 2009 ONCA 722, 100 O.R. (3d) 66, at para. 40; *Hunt v. TD Securities Inc.* (2003), 66 O.R. (3d) 481 (C.A.), at para. 131.

[45] There is also the matter of the settlement offer made by the respondent. That offer provided for the payment of benefits owing up to October 1, 2018, in the total amount of $86,136.17, plus prejudgment interest, partial indemnity costs, and a monthly payment of $4,495 in benefits, less applicable collateral and/or CPP Disability Benefits. Counsel for Blue Cross submits that it is unclear whether this offer is more advantageous to his client than the judgment, given that the payment of benefits under the offer is indeterminate.

[46] It is hard to imagine a scenario where the proposed settlement would be more costly than what was awarded against Blue Cross at trial. In any event, in fixing costs, this court may have regard to any settlement offer, even if it does not technically meet the requirements of r. 49 of the *Rules of Civil Procedure*, R.R.O., Reg. 194: see *Rules*, r. 49.13; *König v. Hobza*, 2015 ONCA 885, 129 O.R. (3d) 57, at paras. 35, 37.

[47] The combination of Blue Cross' conduct and its decision to turn down a generous offer to settle justifies an award of full indemnity costs. As a result, I would dismiss the costs appeal and not interfere with the costs awarded by the trial judge.

C. DISPOSITION

[48] For the preceding reasons, I would dismiss the appeal of the award of punitive damages, grant leave to appeal the costs award, and dismiss the costs appeal.

[49] If the parties cannot agree on the costs of the appeal, I would direct them to each file costs submissions of no more than three pages, along with a bill of costs, within ten days of the release of these reasons.

Released: December 20, 2023 “C.W.H.”

“C.W. Hourigan J.A.”
“I agree. B. Zarnett J.A.”
“I agree. J. George J.A.”