



Health Insurance Act Loi sur l'assurance-santé

R.R.O. 1990, REGULATION 552

GENERAL

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DEFINITIONS

1. (1) In this Regulation,

“benefit period” means the period of time during which an insured person is entitled to insured services;

“dental surgeon” means a person entitled to practise dentistry in the place where dental services are rendered by the surgeon;

“dependant”, subject to subsection 10 (11), means, with respect to a person, a dependent child of the person who is,

(a) under 22 years of age, or

(b) 22 years of age or older, but dependent on the person due to a mental or physical disability;

“extended class nursing staff” means those registered nurses in the extended class in a hospital,

(a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat in-patients or out-patients in the hospital, and

(b) who are not employed by the hospital and to whom the governing body or authority of the hospital has granted privileges to diagnose, prescribe for or treat in-patients or out-patients in the hospital;

“hospital” means, in respect of a hospital in Ontario, any hospital that is designated under this Regulation to participate in the Plan;

“in-patient” means a person admitted to and assigned a bed in a hospital in-patient area;

“long-term care home” means a long-term care home under the *Long-Term Care Homes Act, 2007*;

“midwife” means a member of the College of Midwives of Ontario;

“mobile student” means a person who attends as a student a full-time academic program at an educational institution in Ontario and who is engaged in a component of that program that requires travel outside Ontario;

“mobile worker” means a person whose work requires frequent travel outside Ontario;

“oral and maxillofacial surgeon” means,

(a) with respect to dental services rendered in Ontario, a dental surgeon who holds a specialty certificate of registration from the Royal College of Dental Surgeons of Ontario authorizing the surgeon to practise oral and maxillofacial surgery in Ontario,

(b) with respect to dental services rendered elsewhere in Canada, a person who holds a designation from a professional regulatory body in the Canadian province or territory outside of Ontario where the services are rendered that, in the opinion of the General Manager, is equivalent to the designation referred to in clause (a), or

(c) with respect to dental services rendered outside Canada, a person who is authorized to practise oral and maxillofacial surgery in the jurisdiction outside Canada where the services are rendered and holds, in the opinion of the General Manager, a designation equivalent to the designation referred to in clause (a);

- “out-patient” means a person who receives out-patient services and is not admitted to an in-patient area;
- “physical presence requirement” means the requirement set out in paragraph 3 of subsection 1.5 (1);
- “prescribed form” means the form prescribed by the General Manager for the purpose;
- “primary place of residence” means the place with which a person has the greatest connection in terms of present and anticipated future living arrangements, the activities of daily living, family connections, financial connections and social connections, and for greater certainty a person only has one primary place of residence, no matter how many dwelling places he or she may have, inside or outside Ontario;
- “publicly funded health care insurance plan” means the province or territory’s health insurance plan that is required under the *Canada Health Act* in order for the province or territory to qualify for a full cash contribution under that Act;
- “registered nurse in the extended class” means a member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act, 1991*;
- “schedule of benefits” means the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Physician Services under the *Health Insurance Act* (October 1, 2005)”, and includes Appendix D to the document, but does not include the “[Commentary...]” portions of the document, its other Appendices, or its table of contents, alphabetic index or numeric index, and includes the following amendments to the document:
1. Amendments dated April 1, 2006.
 - 1.1 Amendments dated May 12, 2006.
 2. Amendments dated July 1, 2006.
 3. Amendments dated October 1, 2006.
 4. Amendments dated October 2, 2006 (effective as of October 1, 2006).
 - 4.0.1 Amendments dated October 1, 2006 (made in 2007).
 - 4.1 Amendments dated December 1, 2006.
 5. Amendments dated January 1, 2007.
 6. Amendments dated April 1, 2007.
 - 6.1 Amendments dated October 1, 2007.
 7. Amendments dated January 1, 2008.
 8. Amendments dated January 2, 2008 (effective as of January 1, 2008).
 9. Amendments dated November 19, 2007 (effective as of February 1, 2008).
 - 9.1 Amendments dated November 22, 2007 (effective as of February 1, 2008).
 10. Amendments dated April 1, 2008.
 11. Amendments dated April 15, 2008 (effective as of June 3, 2008).
 12. Amendments dated July 3, 2009 (effective as of October 1, 2009).

13. Amendments dated June 26, 2009 (effective as of October 1, 2009).
14. Amendments dated July 1, 2010.
15. Amendments dated October 1, 2010.
16. Amendments dated April 1, 2011.
17. Amendments dated June 1, 2011.
18. Amendments dated July 1, 2011.
19. Amendments dated September 1, 2011.
20. Amendments dated April 1, 2012.
21. Amendments dated January 1, 2013.
22. Amendments dated January 1, 2013 (effective as of April 1, 2013).
23. Amendments dated September 1, 2013 (effective as of April 1, 2013).
24. Amendments dated September 1, 2013 (effective as of October 1, 2013);
25. Amendments dated November 19, 2013 (effective as of May 1, 2014).

“schedule of laboratory benefits” means the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits for Laboratory Services”, dated April 1, 1999, together with the following documents, all of which can be accessed on the Ministry’s website www.health.gov.on.ca by clicking on the Health Care Providers link, the OHIP for Healthcare Professionals link and on the Ontario Health Insurance Schedule of Benefits and Fees link:

1. The Ministry of Health and Long-Term Care document titled “Addendum Dated April 1, 2001 to Schedule of Benefits for Laboratory Services”.
2. The Ministry of Health and Long-Term Care document titled “Addendum Dated April 1, 2004 to Schedule of Benefits for Laboratory Services”.
3. The Ministry of Health and Long-Term Care document titled “Addendum Dated August 16, 2004 to Schedule of Benefits for Laboratory Services”.
4. The Ministry of Health and Long-Term Care document titled “Addendum Dated March 1, 2006 to the Schedule of Benefits for Laboratory Services”.
5. The Ministry of Health and Long-Term Care document titled “Addendum Dated December 17, 2007 (Effective as of March 1, 2008) to the Schedule of Benefits for Laboratory Services”.
6. The Ministry of Health and Long-Term Care document titled “Addendum Dated January 14, 2008 (Effective April 1, 2008) to the Schedule of Benefits for Laboratory Services”.
7. The Ministry of Health and Long-Term Care document titled “Addendum Dated October 15, 2008 (Effective as of January 1, 2009) to the Schedule of Benefits for Laboratory Services”.
8. The Ministry of Health and Long-Term Care document titled “Addendum Dated September 28, 2010 (Effective as of December 1, 2010) to the Schedule of Benefits for Laboratory Services”.
9. The Ministry of Health and Long-Term Care document titled “Addendum Dated

December 4, 2012 (Effective as of January 1, 2013) to the Schedule of Benefits for Laboratory Services”.

10. The Ministry of Health and Long-Term Care document titled “Addendum Dated April 30, 2013 (Effective as of May 30, 2013) to the Schedule of Benefits for Laboratory Services”;

“schedule of optometry benefits” means the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits for Optometry Services (July 1, 2008)”, but does not include the “[Commentary...]” portions of the document, or any appendix to the document;

“spouse” means a person,

- (a) to whom the person is married, or
- (b) with whom the person was living, in a conjugal relationship outside marriage, if the two persons,
 - (i) have cohabited for at least one year,
 - (ii) are together the parents of a child, or
 - (iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*;

“standard ward accommodation” means,

- (a) a bed in a hospital area designated by the hospital in accordance with Regulation 794 of the Revised Regulations of Ontario, 1990 under the *Ministry of Health Act* as a standard ward.
- (b) Revoked: O. Reg. 375/93, s. 1.

“three-month waiting period” means the three-month period specified under subsection 5 (1). R.R.O. 1990, Reg. 552, s. 1; O. Reg. 616/91, s. 1 (1); O. Reg. 214/93, s. 1; O. Reg. 375/93, s. 1; O. Reg. 794/93, s. 1; O. Reg. 488/94, s. 1; O. Reg. 114/96, s. 1; O. Reg. 409/96, s. 1 (1); O. Reg. 410/96, s. 1; O. Reg. 502/97, s. 1 (1); O. Reg. 44/98, s. 1; O. Reg. 147/98, s. 1; O. Reg. 375/98, s. 1 (1); O. Reg. 376/98, s. 1; O. Reg. 378/98, s. 1; O. Reg. 478/98, s. 1; O. Reg. 178/99, s. 1 (1-5); O. Reg. 201/99, s. 1; O. Reg. 482/99, s. 1; O. Reg. 67/00, s. 1; O. Reg. 322/00, s. 1; O. Reg. 368/00, s. 1 (1); O. Reg. 617/00, s. 1; O. Reg. 66/01, s. 1; O. Reg. 250/01, s. 1 (1); O. Reg. 272/01, s. 1 (1); O. Reg. 345/01, s. 1; O. Reg. 415/01, s. 1; O. Reg. 56/02, s. 1 (1); O. Reg. 169/02, s. 1 (1); O. Reg. 302/02, s. 1 (1); O. Reg. 361/02, s. 1 (1); O. Reg. 18/03, s. 1; O. Reg. 50/03, s. 1; O. Reg. 62/03, s. 1; O. Reg. 203/03, s. 1; O. Reg. 221/03, s. 1; O. Reg. 265/03, s. 1 (1); O. Reg. 266/03, s. 1; O. Reg. 350/03, s. 1; O. Reg. 6/04, s. 1; O. Reg. 238/04, s. 1; O. Reg. 320/04, s. 1 (1, 2); O. Reg. 352/04, s. 1; O. Reg. 129/05, s. 1; O. Reg. 328/05, s. 1; O. Reg. 374/05, s. 1; O. Reg. 502/05, s. 1 (1); O. Reg. 96/06, s. 1 (1); O. Reg. 318/06, s. 1; O. Reg. 418/06, s. 1; O. Reg. 420/06, s. 1; O. Reg. 501/06, s. 1; O. Reg. 538/06, s. 1; O. Reg. 557/06, s. 1; O. Reg. 24/07, s. 1; O. Reg. 98/07, s. 1; O. Reg. 128/07, s. 1; O. Reg. 189/07, s. 1; O. Reg. 403/07, s. 1; O. Reg. 519/07, s. 1; O. Reg. 587/07, s. 1; O. Reg. 8/08, s. 1; O. Reg. 26/08, s. 1; O. Reg. 52/08, s. 1; O. Reg. 168/08, s. 1; O. Reg. 209/08, s. 1; O. Reg. 210/08, s. 1; O. Reg. 430/08, s. 1; O. Reg. 133/09, s. 1; O. Reg. 135/09, s. 1; O. Reg. 298/09, s. 1; O. Reg. 421/09, s. 1; O. Reg. 100/10, s. 1; O. Reg. 214/10, s. 1; O. Reg. 404/10, s. 1; O. Reg. 406/10, s. 1; O. Reg. 83/11, s. 1; O. Reg. 186/11, s. 1; O. Reg. 217/11, s. 1; O. Reg. 385/11, s. 1; O. Reg. 76/12, s. 1 (1); O. Reg. 8/13, s. 1; O.

Reg. 138/13, s. 1; O. Reg. 166/13, s. 1; O. Reg. 267/13, s. 1 (1, 2); O. Reg. 354/13, s. 1.

(2) A reference to the schedule of benefits or the schedule of optometry benefits in relation to a service is a reference to the relevant schedule in force at the time the service was rendered. O. Reg. 320/04, s. 1 (3).

(3) Revoked: O. Reg. 421/09, s. 1 (2).

(4) Revoked: O. Reg. 265/03, s. 1 (2).

1.1 For the purposes of subsection 11 (2.1) of the Act,

“dependant” means a dependent child who is,

(a) under 22 years of age, or

(b) 22 years of age or older, but dependent on the member of the Canadian Forces due to a mental or physical disability;

“member of the Canadian forces” means,

(a) a regular force member, or

(b) a member of the reserve force of the Canadian Forces referred to in subsection 15 (3) of the *National Defence Act* (Canada) who falls within the circumstances described in clause 50.2 (1) (a) or (b) of the *Employment Standards Act, 2000*;

“spouse” has the meaning set out in subsection 1 (1) of this Regulation. O. Reg. 133/09, s. 2.

1.2 For the purposes of the Act and any regulation made under the Act, and despite any other meaning of the term “resident”, resident means a person described in sections 1.3 to 1.14 who meets the requirements set out in this Regulation to be recognized as a resident, and for greater certainty, a person whose primary place of residence ceases to be Ontario ceases to be a resident, unless subsection 1.3 (2) applies. O. Reg. 133/09, s. 2.

1.3 (1) Upon application to be an insured person, a person must meet the following requirements in order to be considered a resident, unless subsection (2) or another provision of this Regulation provides otherwise:

1. The person must possess an eligible status set out in section 1.4. A person who has an eligible status, then loses it, is no longer a resident, but may regain resident status at a later date by meeting the necessary requirements at that time.
2. The person’s primary place of residence must be in Ontario. For this purpose, the General Manager will consider a child under 16 years old to have the primary place of residence of a person who has lawful custody of the child unless the General Manager has information to the contrary. O. Reg. 133/09, s. 2.

(2) The following persons are residents, even if they do not meet the other requirements in this Regulation, and they are not affected by any of the other rules in this Regulation regarding recognition as a resident, other than the requirements under sections 3 and 4:

1. Inmates at a correctional institution that is established or designated under Part II of the *Ministry of Correctional Services Act*.
2. Children who are in the care of a children’s aid society under the *Child and Family Services Act*.
3. Young persons who are detained in a place of temporary detention or committed to a place of secure or open custody under Part IV of the *Child and Family Services Act*.

4. People who are present in Ontario because they have a work permit issued under the program of the Government of Canada known as the “Seasonal Agricultural Worker Program”. O. Reg. 133/09, s. 2; O. Reg. 253/09, s. 1.

1.4 A person cannot be recognized as a resident, unless the person has one of the following eligible statuses:

1. Being a Canadian citizen.
2. Being a landed immigrant under the former *Immigration Act* (Canada), or a permanent resident under the *Immigration and Refugee Protection Act* (Canada).
3. Being registered as an Indian under the *Indian Act* (Canada).
4. Being a “protected person”, as that term is used in the *Immigration and Refugee Protection Act* (Canada).
5. Being a person who has submitted an application for permanent residence in Canada to the proper federal government authority, even if the application has not yet been approved, as long as Citizenship and Immigration Canada has confirmed that the person meets the eligibility requirements to apply for permanent residency in Canada, and the application has not yet been denied.
6. Being a person who holds a valid work permit or other document issued under the *Immigration and Refugee Protection Act* (Canada) that permits the person to work in Canada, if the person also has a formal agreement in place to work full-time for an employer in Ontario and is working under that agreement, and if the work permit or other document issued under that Act or a letter provided by the employer or other document provided by the employer,
 - i. sets out the employer’s name,
 - ii. states the person’s occupation with the employer, and
 - iii. states that the person will be working for the employer for no less than six consecutive months.
7. Being a person who holds a valid work permit or other document issued under the *Immigration and Refugee Protection Act* (Canada) that permits the person to work at an occupation in Canada while self-employed, if the person is self-employed full-time in that occupation in Ontario and will continue to be so for no less than six consecutive months.
8. Being a member of the clergy of a religious denomination, if the member has finalized an agreement to minister to a religious congregation or group in Ontario for at least six months, as long as the member is legally entitled to stay in Canada. The main duties of ministering to the congregation or group must be preaching doctrine, performing functions related to gatherings of the congregation or group or providing spiritual counselling.
9. Being the spouse or a dependant of a person who meets the requirements under paragraph 6 or 7 or of a member of the clergy who meets the requirements provided for in paragraph 8, as long as the spouse or dependant is legally entitled to stay in Canada.
10. Having a valid “temporary resident permit” under the *Immigration and Refugee Protection Act* (Canada), if the permit is for a member of an “inadmissible class”,

with a “case type” of 86, 87, 88, 89, 90, 91, 92, 93, 94 or 95, or, if the permit is issued for the purpose of adoption to a child mentioned in subsection 6 (2), (3) or (4), “case type 80”.

11. Being a person who has submitted an application for Canadian citizenship under section 5.1 of the *Citizenship Act* (Canada) to the proper federal government authority, even if the application has not yet been approved, as long as Citizenship and Immigration Canada has confirmed that the person meets the eligibility requirements to apply for citizenship under that section and the application has not yet been denied.
12. Having a valid work permit under the Government of Canada program known as “Live-in Caregiver Program”.
13. Being a child born out of country to a mother who is receiving insured services referred to in section 1.9, if at the time the mother left Ontario to receive those insured services she was pregnant with that child and if at the time of the child’s birth the mother was receiving the insured services out of country. O. Reg. 133/09, s. 2; O. Reg. 253/09, s. 2.

1.5 (1) The following requirements must be met for a person to be continued to be recognized as a resident:

1. The person must be in Ontario for at least 153 of the first 183 days after becoming a resident, except for,
 - i. a person who has moved to Ontario directly from another province or territory of Canada where he or she was insured under a publicly funded health care insurance plan,
 - ii. a mobile student or a mobile worker,
 - iii. a child to whom section 6 applies, or
 - iv. a person who is exempt from the waiting period under subsection 11 (2.1) of the Act.
2. Except for those persons listed in subsection 1.3 (2), the person must continue to maintain his or her primary place of residence in Ontario.
3. Subject to sections 1.6 to 1.14, the person must be physically present in Ontario for at least 153 days in any given 12-month period.
4. The person must continue to hold an eligible status as listed in section 1.4. However, in order to maintain their eligible status as a resident, a person referred to in paragraph 13 of section 1.4 must be legally entitled to remain in Canada and will only maintain their eligible status under that paragraph as long as reasonable efforts are being made for the person to obtain one of the other eligible statuses under section 1.4. O. Reg. 133/09, s. 2.

(2) For the purposes of subsection (1), the General Manager will consider a child under 16 years old to be physically present with and have the primary place of residence of a person who has lawful custody of the child unless the General Manager has information to the contrary. O. Reg. 133/09, s. 2.

(3) Despite subsection (1), a resident who leaves Ontario permanently to reside in another province or territory of Canada remains a resident, even though he or she is not physically present in Ontario or does not have Ontario as his or her primary place of residence, as long as

he or she continues to have an eligible status, but only until the end of the last day of the second full month after leaving Ontario. O. Reg. 133/09, s. 2.

1.6 (1) A resident is considered to meet the physical presence requirement for up to 12 full months, if he or she temporarily goes to another province or territory of Canada. O. Reg. 133/09, s. 2.

(2) A person mentioned in subsection (1) ceases to be a resident on the last day of his or her 12th consecutive month of absence from Ontario, or, if the move becomes permanent, the last day of the second full month after the move becomes permanent, whichever occurs first. O. Reg. 133/09, s. 2.

(3) This section only applies if the resident meets any of the following requirements, or any combination of the following requirements, for at least 153 days out of the 12 months immediately before he or she leaves Ontario:

1. Being physically present in Ontario.
2. Being a mobile student or mobile worker. O. Reg. 133/09, s. 2.

(4) This section does not apply if subsection 1.8 (1) applies to the person. O. Reg. 133/09, s. 2.

1.7 (1) A resident is considered to meet the physical presence requirement during a maximum of five 12-month periods if he or she leaves Canada in order to either work full-time for payment for an employer with whom he or she has a contract of employment, or to serve full-time for a charity that is registered under the *Income Tax Act* (Canada). O. Reg. 133/09, s. 2.

(2) Subsection (1) only applies if the resident meets any of the following requirements, or any combination of the following requirements, for at least 153 days in each of the two consecutive 12-month periods immediately before he or she leaves Canada to work or serve:

1. Being physically present in Ontario.
2. Being a mobile student or mobile worker. O. Reg. 133/09, s. 2.

1.8 (1) A resident who goes to another province or territory of Canada to attend as a student one or more full-time academic programs in an educational institution in that province or territory is considered to meet the physical presence requirement as long as he or she maintains continuous full-time enrolment. O. Reg. 133/09, s. 2.

(2) Subsection (1) only applies if the resident meets any of the following requirements, or any combination of the following requirements, for at least 153 days in the 12 months immediately before going to the other province or territory:

1. Being physically present in Ontario.
2. Being a mobile student or mobile worker.
3. Remaining a resident by virtue of subsection (3). O. Reg. 133/09, s. 2.

(3) A resident who goes to another jurisdiction outside Canada to attend as a student one or more full-time academic programs in an educational institution in that jurisdiction is considered to meet the physical presence requirement as long as he or she maintains continuous full-time enrolment. O. Reg. 133/09, s. 2.

(4) Subsection (3) only applies if the resident meets any of the following requirements, or any combination of the following requirements, for at least 153 days in each of the two consecutive 12-month periods immediately before going to the other jurisdiction:

1. Being physically present in Ontario.
2. Being a mobile student or mobile worker.
3. Remaining a resident by virtue of subsection (1). O. Reg. 133/09, s. 2.

1.9 A resident who leaves Ontario is considered to meet the physical presence requirement during the time that he or she is out of Ontario receiving insured services for which an application for approval for payment by the General Manager is required to be submitted by this Regulation, and for which payment has been approved. O. Reg. 133/09, s. 2.

1.10 A resident who is a member of the Canadian Forces or Royal Canadian Mounted Police or who is a Canadian diplomat and who was a resident immediately before leaving for a posting outside Canada is considered to meet the physical presence requirement during the time he or she is posted outside of Canada. O. Reg. 133/09, s. 2.

1.11 (1) In addition to the other circumstances in which a resident is also considered to meet the physical presence requirement, a resident who travels outside Ontario is considered to meet the physical presence requirement for a maximum of two 12-month periods if the resident meets any of the following requirements, or any combination of the following requirements, for at least 153 days in each of the two consecutive 12-month periods immediately before he or she leaves Ontario:

1. Being physically present in Ontario.
2. Being a mobile student or mobile worker. O. Reg. 133/09, s. 2.

(2) Subsection (1) does not apply to a person more than once unless he or she has been physically present in Ontario or a mobile student or mobile worker for at least 153 days in each of at least five consecutive 12-month periods before each subsequent time that subsection (1) applies. O. Reg. 133/09, s. 2.

1.12 (1) A resident who is the spouse or a dependant of someone who continues to be a resident under sections 1.7 or 1.8 and who accompanies that person while they are in another province, territory or jurisdiction, as the case may be, is considered to meet the physical presence requirement while they are accompanying the person to whom section 1.7 or 1.8 applies, if they met the applicable requirements under those sections that applied to the person they are accompanying immediately before going to the other province, territory or jurisdiction. O. Reg. 133/09, s. 2.

(2) A resident who is the spouse or a dependant of someone who continues to be a resident under section 1.9 and who accompanies that person while they are out of Ontario is considered to meet the physical presence requirement while they are accompanying the person. O. Reg. 133/09, s. 2.

(3) A resident who is the spouse or a dependant of a member of the Canadian Forces or Royal Canadian Mounted Police who continues to be a resident under section 1.10 or of a Canadian diplomat who continues to be a resident under that section and who accompanies that member or diplomat while they are out of Canada is considered to meet the physical presence requirement while they are accompanying the person. O. Reg. 133/09, s. 2.

1.13 A resident is considered to meet the physical presence requirement during any period of time where that person is unable to return to Ontario as a result of activity by another person that would be considered to be unlawful in Canada. O. Reg. 133/09, s. 2.

1.14 A resident is considered to meet the physical presence requirement during any

period of time where he or she is out of Ontario because he or she is a mobile student or a mobile worker. O. Reg. 133/09, s. 2.

HEALTH CARD

2. (1) The General Manager shall issue a health card to each insured person. R.R.O. 1990, Reg. 552, s. 2 (1); O. Reg. 177/95, s. 1 (2).

(2) A health card is nontransferable. R.R.O. 1990, Reg. 552, s. 2 (2); O. Reg. 177/95, s. 1 (3).

(3) An insured person shall present his or her health card upon the request of the hospital, physician or practitioner from whom the person receives insured services. R.R.O. 1990, Reg. 552, s. 2 (3); O. Reg. 177/95, s. 1 (4).

(4) A health card shall be in the form approved by the Minister. O. Reg. 177/95, s. 1 (5).

2.1 Revoked: O. Reg. 172/98, s. 1.

2.2 The following information is prescribed as personal information that may be collected, used or disclosed under clause 2 (3) (b) of the Act:

1. A photograph of the insured person.

2. A copy of an insured person's signature. O. Reg. 177/95, s. 2.

2.3 (1) An insured person shall surrender his or her health card to the General Manager upon ceasing to be a resident. O. Reg. 218/95, s. 1.

(2) An insured person who intends to surrender a card under subsection (1) by mailing it or by delivering it to the General Manager in a way other than by personal delivery shall deface the card in the manner approved by the General Manager before mailing or otherwise delivering the card. O. Reg. 218/95, s. 1.

ESTABLISHING STATUS

3. (1) Where any one asserts that he or she is a resident, or is entitled to any exemption from the requirements to be recognized as a resident, or in any other way is entitled to payment from the Plan, it is the obligation of the person making the assertion to prove to the General Manager that he or she meets the requirements to be an insured person. O. Reg. 133/09, s. 3.

(2) The General Manager may require a person to submit any information, evidence or documents that the General Manager considers necessary to make a decision, whether the person is applying to be an insured person for the first time or seeking to re-establish coverage, and may either require the submission of original material, or permit the submission of copies. O. Reg. 133/09, s. 3.

3.1 Revoked: O. Reg. 133/09, s. 3.

APPLICATION

4. (1) An application to be an insured person must be in the form approved by the General Manager. O. Reg. 133/09, s. 3.

(2) A person must submit his or her application in person, unless subsection (3) applies. O. Reg. 133/09, s. 3.

(3) The following are the rules about submitting an application on someone else's behalf:

1. If a person is under 16 years old, a parent who has legal custody, a children's aid

society, or anyone else who is legally authorized to act for the person may submit an application.

2. If there are reasonable grounds to believe that a person is incapable of consenting to the collection, use and disclosure of personal health information under the *Personal Health Information Protection Act, 2004*, a person who would be able to act for the person under section 26 of that Act may submit an application, and the rules of that section apply for the purposes of making the application, subject to any necessary modification.
3. In the case of a dead person, the person's estate trustee may submit an application, or, if there is no estate trustee, the person who has assumed the responsibility for looking after the estate may submit the application.
4. A person who is legally authorized to act for another person for this purpose under a law of Ontario or Canada may submit an application. O. Reg. 133/09, s. 3.

(4) When a person is applying on someone else's behalf, the General Manager may require them to attend in person to submit that application and to submit anything a person applying on their own behalf would have been required to submit. O. Reg. 133/09, s. 3.

WAITING PERIODS

5. (1) Subject to subsection (2) and sections 6 to 6.3, and to subsection 11 (2.1) of the Act, a person shall only start receiving insured services once the General Manager is satisfied that he or she has been a resident for three full consecutive months, and has not stopped being a resident since meeting that three-month waiting period requirement. O. Reg. 133/09, s. 3.

(2) Subject to section 6.1, and to subsection 11 (2.1) of the Act, a person who takes up residence in Ontario immediately after residing in another province or territory of Canada where he or she was insured under a publicly funded health care insurance plan is subject to a waiting period that ends at the end of the last day of the second full month after he or she becomes a resident. O. Reg. 133/09, s. 3.

6. (1) A newborn, who, on the date of his or her birth, meets the requirements to be a resident is exempt from the three-month waiting period for the three months immediately following the date of birth. O. Reg. 133/09, s. 3.

(2) A child under 16 years old whose adoptive parent or prospective adoptive parent received approval of a Director under subsection 5 (4) of the *Intercountry Adoption Act, 1998* is exempt from the three-month waiting period, or from completing it if it has already begun, but only for the three months immediately following the first time the child meets the requirements to be a resident. O. Reg. 253/09, s. 3.

(3) A child under 16 years old who is the subject of a proposed placement for adoption that has been approved by a Director under subsection 142 (2) of the *Child and Family Services Act* is exempt from the three-month waiting period, or from completing it if it has already begun, but only for the three months immediately following the first time the child meets the requirements to be a resident. O. Reg. 253/09, s. 3.

(4) A child under 16 years old to whom subsections (2) and (3) do not apply who is the subject of an adoption order under section 146 of the *Child and Family Services Act* and who, on the date the adoption order is made, meets the requirements to be a resident, is exempt from the three-month waiting period, or from completing it if it has already begun, for the three months immediately following the date the adoption order is made. O. Reg. 253/09, s. 3.

6.1 If a person takes up residence in Ontario immediately after moving to Ontario from another province or territory of Canada where he or she was insured under a publicly funded health care insurance plan and is admitted to and moves into a long-term care home, the person,

- (a) is exempt from the waiting period under subsection 5 (2), if he or she is admitted to and moves into that home immediately upon taking up residence in Ontario; or
- (b) is exempt from completing the remainder of the waiting period, if applicable, when he or she is admitted to and moves into that home. O. Reg. 133/09, s. 3; O. Reg. 100/10, s. 2.

6.2 A person is exempt from the three-month waiting period if he or she is a Canadian citizen, a landed immigrant under the former *Immigration Act* (Canada) or a permanent resident under the *Immigration and Refugee Protection Act* (Canada) who, after July 20, 2006 comes to Ontario promptly after leaving a foreign country where an evacuation effort is being undertaken or facilitated by the Government of Canada. O. Reg. 133/09, s. 3.

6.3 A person is exempt from the three-month waiting period if he or she is a “protected person” as that term is used in the *Immigration and Refugee Protection Act* (Canada). O. Reg. 133/09, s. 3.

INSURED HOSPITAL SERVICES IN CANADA

7. Subject to section 10, the in-patient services to which an insured person is entitled without charge are all of the following services:

1. Accommodation and meals at the standard or public ward level.
2. Necessary nursing service, except for the services of a private duty nurse who is not engaged and paid by the hospital.
3. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.
4. Drugs, biologicals and related preparations that are prescribed by an attending physician, oral and maxillofacial surgeon, midwife or registered nurse in the extended class in accordance with accepted practice and administered in a hospital, but not including any proprietary medicine as defined from time to time by the regulations made under the *Food and Drugs Act* (Canada).
5. Use of operating room, obstetrical delivery room and anaesthetic facilities, including necessary equipment and supplies. R.R.O. 1990, Reg. 552, s. 7; O. Reg. 794/93, s. 2; O. Reg. 345/01, s. 2; O. Reg. 217/11, s. 2.

8. (1) The out-patient services to which an insured person is entitled without charge are all of the following services:

1. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations.
2. The use of radiotherapy facilities where available in a hospital in Canada when prescribed by a physician.
- 2.1 The use of occupational therapy and physiotherapy facilities where available in a hospital in Canada when prescribed by a physician or a registered nurse in the extended class.

3. The use of speech therapy facilities where available in a hospital in Canada when prescribed by a physician, by an oral and maxillofacial surgeon or by a registered nurse in the extended class.
4. The use of diet counselling services when prescribed by a physician or a registered nurse in the extended class.
5. The hospital component of all other out-patient services, including the use of an operating room and anaesthetic facilities, surgical supplies, necessary nursing service, meals required during a treatment program and the supplying of drugs, biologicals and related preparations that are prescribed in accordance with accepted practice by a physician on the medical staff, a midwife on the midwifery staff, an oral and maxillofacial surgeon on the dental staff or a registered nurse in the extended class on the extended class nursing staff of the hospital and that are administered in the hospital, but not including,
 - i. the provision of any proprietary medicine as defined from time to time by the regulations made under the *Food and Drugs Act* (Canada),
 - ii. the provisions of medications for the patient to take home,
 - iii. diagnostic services performed to satisfy the requirements of third parties such as employers and insurance companies, and
 - iv. visits solely for the administration of drugs, vaccines, sera or biological products.
6. Use of home renal dialysis medications where available in a hospital in Canada and prescribed by a physician on the medical staff of that hospital.
- 6.1 Use of home renal dialysis equipment and supplies where available in a hospital in Canada and prescribed by a physician on the medical staff of that hospital or by a registered nurse in the extended class on the extended class nursing staff of that hospital.
7. Use of home hyperalimentation medications where available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital.
- 7.1 Use of home hyperalimentation equipment and supplies where available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital or by a registered nurse in the extended class on the extended class nursing staff of that hospital.
8. The provision to haemophiliac patients, for use in the home, of equipment and supplies for the emergency treatment of, or the prevention of, haemorrhage where the equipment and supplies are available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital.
- 8.1 The provision to haemophiliac patients, for use in the home, of equipment and supplies other than blood products where the equipment and supplies are available in a hospital in Ontario and prescribed by a registered nurse in the extended class on the extended class nursing staff of that hospital.

9.-16. Revoked: O. Reg. 175/95, s. 1 (2).

R.R.O. 1990, Reg. 552, s. 8; O. Reg. 794/93, s. 3; O. Reg. 175/95, s. 1 (1, 2); O. Reg. 345/01, s. 3; O. Reg. 62/03, s. 2 (1-6).

(1.1) Despite paragraph 1 of subsection (1), a radiological or other diagnostic procedure ordered by a registered nurse in the extended class is not an out-patient service to which an insured person is entitled without charge unless it is a radiological or diagnostic procedure described in subsection (1.2). O. Reg. 217/11, s. 3.

(1.2) For the purposes of subsection (1.1), the following radiological and diagnostic procedures are, when ordered by a registered nurse in the extended class who is on the extended nursing staff of a hospital, out-patient services to which an insured person is entitled without charge:

1. A mammogram.
2. An X-ray of a chest, ribs, arm, wrist, hand, leg, ankle or foot.
3. A diagnostic ultrasound of the abdomen, pelvis or breast. O. Reg. 217/11, s. 3.

(1.3) Revoked: O. Reg. 62/03, s. 2 (8).

(2) Despite subparagraph ii of paragraph 5 of subsection (1), the provision of a medication listed in Column 1 of the Table to this subsection to an out-patient, for use in the home, is an out-patient service to which an insured person is entitled without charge if the medication is provided in the circumstances described in Column 2 of the Table:

TABLE

Item	Column 1 Medication Provided	Column 2 Condition of Insured Service
1.	A medication for the emergency treatment of, or the prevention of, a haemorrhage	1. The medication must be available in a hospital in Ontario.
		2. The medication must be prescribed by a physician on the medical staff of that hospital.
		3. The medication must be provided to a patient with haemophilia.
2.	cyclosporine	1. The medication must be prescribed by a physician on the medical staff of a hospital graded, under the <i>Public Hospitals Act</i> , as a Group O hospital.
		2. The medication must be provided to a solid organ or bone marrow transplant patient.
3.	zidovudine, commonly called "AZT"	1. The medication must be prescribed by a physician.
		2. The medication must be provided to a patient with HIV infection.
4.	A biosynthetic human growth hormone	1. The medication must be prescribed by a physician on the medical staff of a hospital graded, under the <i>Public Hospitals</i>

		<i>Act</i> , as a Group S hospital.
		2. The medication must be provided to a patient with endogenous growth hormone deficiency.
5.	A medication for treatment of cystic fibrosis that is listed in Schedule 17	1. The medication must be prescribed by a physician on the medical staff of a hospital graded, under the <i>Public Hospitals Act</i> , as a Group T hospital.
6.	A medication for the treatment of thalassemia that is listed in Schedule 18	1. The medication must be prescribed by a physician on the medical staff of a hospital graded, under the <i>Public Hospitals Act</i> , as a Group U hospital.
7.	erythropoietin	1. The medication must be prescribed by a physician on the medical staff of a hospital.
		2. The medication must be provided to a patient with anaemia of end-stage renal disease.
8.	alglucerase	1. The medication must be prescribed by a physician.
		2. The use of the medication must be recommended by the Gaucher Disease Review Committee.
		3. The medication must be provided to a patient with Gaucher disease.
9.	clozapine	1. The medication must be prescribed by a physician on the medical staff of a hospital.
		2. The use of the medication must be recommended by a regional co-ordinator of a provincial psychiatric hospital.
		3. The medication must be provided to a patient with treatment-resistant schizophrenia.
10.	didanosine, commonly called “ddI”	1. The medication must be prescribed by a physician.
		2. The medication must be provided to a patient with HIV infection.

11.	zalcitabine, commonly called “ddC”	1. The medication must be prescribed by a physician.
		2. The medication must be provided to a patient with HIV infection.
12.	pentamidine	1. The medication must be prescribed by a physician.
		2. The medication must be provided to a patient with HIV infection.

O. Reg. 175/95, s. 1 (3); O. Reg. 253/00, s. 1; O. Reg. 322/01, s. 1.

(2.1) Despite subparagraph 5 ii of subsection (1), the provision of verteporfin to an out-patient on or after June 15, 2002, for use in the home, is an out-patient service to which an insured person is entitled without charge if the verteporfin is provided in the following circumstances:

1. The verteporfin is provided in the course of ocular photodynamic therapy for the treatment of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
2. The area of classic subfoveal choroidal neovascularization is equal to or greater than 50 per cent of the total lesion, as determined by fluorescein angiography.
3. The first treatment is commenced within 30 months after the initial diagnosis of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
4. The patient's visual acuity is 20/40 or worse. O. Reg. 169/02, s. 2.

(3) Despite subparagraph iv of paragraph 5 of subsection (1), the following visits to a hospital are out-patient services to which an insured person is entitled without charge:

1. A visit that is solely for the administration of a rabies vaccine.
2. A visit that is solely for the administration of a medication listed in Column 1 of the Table to subsection (2) if the conditions listed in Column 2 of the Table are satisfied. O. Reg. 175/95, s. 1 (3).

8.1 (1) Despite paragraph 3 of section 7 and paragraph 1 of subsection 8 (1), a laboratory, radiological or other diagnostic procedure ordered by an oral and maxillofacial surgeon and rendered in a hospital is not an in-patient or out-patient service to which an insured person is entitled without charge unless,

- (a) in the case of a radiological or diagnostic procedure, it is a procedure described in subsection (2); and
- (b) the laboratory, radiological or other diagnostic procedure is rendered,
 - (i) in connection with a dental surgical procedure provided by an oral and maxillofacial surgeon in a hospital and it is medically necessary for the person to receive the dental surgical procedure in a hospital, or
 - (ii) on the order of an oral and maxillofacial surgeon who has reasonable grounds to believe that a dental surgical procedure, performed by an oral and maxillofacial surgeon, will be required in connection with the laboratory, radiological or

other diagnostic procedure and that it will be medically necessary for the person to receive the dental surgical procedure in a hospital. O. Reg. 345/01, s. 4.

(2) The following radiological and diagnostic procedures are the procedures to which an insured person is entitled without charge for the purposes of clause (1) (a):

1. Nuclear medicine bone and labeled leukocyte scintigraphy.
2. Plain X-ray of the head, neck, chest, pelvis and tibia.
3. Computed tomography of the head.
4. Fistula or sinus radiology examination.
5. Radiology sialograms.
6. Ultrasound of the face and sinuses.
7. Pulmonary function studies.
8. Electrocardiograms. O. Reg. 345/01, s. 4.

9. (1) Subject to section 10 and subsection 11 (1), an insured person is entitled to in-patient services and out-patient services in the following hospitals, without paying any charge to the hospital for such services:

1. A hospital listed in Schedule 2.
2. A hospital graded, under the *Public Hospitals Act*, as a Group A, B, C, E, F, G, J or R hospital.
3. Revoked: O. Reg. 322/01, s. 2 (1).

O. Reg. 253/00, s. 2 (1); O. Reg. 322/01, s. 2 (1).

(2) Subject to section 10 and subsection 11 (1), an insured person is entitled to receive, in a hospital listed in Schedule 1, such in-patient and out-patient services as are available in the hospital without paying any charge to the hospital for the services. R.R.O. 1990, Reg. 552, s. 9 (2).

(3) Subject to section 10, where the attending physician, oral and maxillofacial surgeon or midwife certifies in writing that an insured person's condition is such that the person requires immediate admission as an in-patient, and standard ward accommodation in an approved hospital is not available because all such accommodation is occupied or where the attending physician, oral and maxillofacial surgeon or midwife certifies in writing that an insured person's condition is such that for the person's own good or for the good of other patients it is necessary that the person be supplied with private or semi-private accommodation, the person shall be provided by the hospital with private or semi-private accommodation without paying any charge to the hospital for such services. R.R.O. 1990, Reg. 552, s. 9 (3); O. Reg. 794/93, s. 4; O. Reg. 496/96, s. 2; O. Reg. 345/01, s. 5.

(4) Subject to section 10 and to subsection 11 (1), an insured person is entitled to receive, in a hospital listed in Schedule 4, those insured services that are in accordance with the type of care and treatment designated in the Schedule for that hospital without paying any charge for such services. R.R.O. 1990, Reg. 552, s. 9 (4); O. Reg. 111/98, s. 1.

(5) Subject to subsection 11 (2), an insured person is entitled to receive, as an out-patient in a rehabilitation centre or crippled children's centre listed in Schedule 6, the insured services indicated in the Schedule without paying any charge to the centre for such services. R.R.O. 1990,

Reg. 552, s. 9 (5).

(6) Subject to subsection 11 (1), an insured person is entitled to receive computerized axial tomography scanning services in a hospital graded, under the *Public Hospitals Act*, as a Group M hospital without paying any charge to the hospital for such services. O. Reg. 322/01, s. 2 (2).

(7) Revoked: O. Reg. 253/00, s. 2 (3).

(8) It is a condition of payment by the Plan to a hospital for the performance of a computerized axial tomography scan that the scan be performed by and on the premises of a hospital graded, under the *Public Hospitals Act*, as a Group M hospital. O. Reg. 322/01, s. 2 (3).

10. (1) A co-payment for accommodation and meals that are insured services shall be made by or on behalf of an insured person who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution. O. Reg. 496/96, s. 3.

(2) This section applies only with respect to an insured person receiving,

- (a) insured in-patient services provided in a hospital listed in Part II of Schedule 1, Part II of Schedule 2 or Part II of Schedule 4 or a hospital graded, under the *Public Hospitals Act*, as a Group F, G or R hospital; or
- (b) insured in-patient services provided in a hospital graded, under the *Public Hospitals Act*, as a Group A, B or C hospital if the insured person is awaiting placement in a hospital referred to in clause (a) or another institution. O. Reg. 322/01, s. 3.

(3) Co-payments shall be paid to the hospital providing the services. O. Reg. 496/96, s. 3.

(4) The amount of the co-payment is the amount charged by the hospital subject to the following restrictions:

- 1. The amount charged may not exceed the maximum amount of the co-payment under subsections (6) to (9).
- 2. The amount charged may not be increased unless the hospital has given the insured person at least 30 days written notice of the increase. O. Reg. 496/96, s. 3.

(5) Paragraph 2 of subsection (4) does not apply to an increase in the amount of a co-payment that was reduced pursuant to an application under subsection (7), if the increase results from,

- (a) a determination under subsection (8) pursuant to a reapplication under subsection (7); or
- (b) a failure to reapply under subsection (7) at the end of the period for which the reduction was in effect. O. Reg. 496/96, s. 3.

(6) Subject to subsections (7) to (9), the maximum amount of the co-payment is,

- (a) for each calendar month that services are received on every day of the month by a person in a category set out in Column 2 of Table 2, the amount prescribed opposite in Column 3 for the period the services are received in Column 1; and
- (b) for each day, other than a day that is part of a month referred to in clause (a), that services are received by a person in a category set out in Column 2 of Table 2, the amount prescribed opposite in Column 4 for the period the services are received in Column 1. O. Reg. 496/96, s. 3.

- (7) The insured person or the insured person's spouse may make an application to the hospital for a reduction in the maximum amount of the co-payment if,
- (a) the insured person has a spouse who was cohabiting with the insured person immediately before the insured person was admitted to the hospital where he or she is receiving insured in-patient services or, if the insured person has been in more than one hospital or institution continuously, immediately before the insured person was first admitted to such a hospital or institution;
 - (b) the spouse is receiving benefits under the *Old Age Security Act* (Canada) or the *Ontario Guaranteed Annual Income Act*; and
 - (c) the spouse lives outside a long-term care home or a hospital or other facility that is government-funded. O. Reg. 496/96, s. 3; O. Reg. 67/00, s. 4 (1); O. Reg. 328/05, s. 4 (1-4); O. Reg. 100/10, s. 3.
- (8) If an application is made under subsection (7), the amount of the reduction shall be determined in accordance with the Application for Reduction of Assessed Co-Payment Fees dated June 2008 and published by and available from the Ministry of Health and Long-Term Care. O. Reg. 496/96, s. 3; O. Reg. 67/00, s. 4 (2); O. Reg. 314/06, s. 1; O. Reg. 209/07, s. 1 (1); O. Reg. 192/09, s. 1.
- (9) A reduction determined under subsection (8) shall take effect on the first day of the month in which the application for the reduction was made and ends on the earliest of the following dates:
- 1. The first June 30 following the first day of the month in which the application for the reduction was made.
 - 2. The last day of the month immediately preceding the month in which the next application is made under subsection (7) in respect of the same insured person. O. Reg. 496/96, s. 3.
- (10) This section does not apply with respect to,
- (a) a child who is under 18 years of age;
 - (b) a person who was receiving benefits under the *General Welfare Assistance Act* or the *Family Benefits Act*, income support under the *Ontario Disability Support Program Act, 1997*, or income assistance under the *Ontario Works Act, 1997* on the day before the insured person was admitted to the hospital where they are receiving insured in-patient services. O. Reg. 496/96, s. 3; O. Reg. 221/03, s. 2.
- (11) In this section, and in Table 2,
- “dependant” means,
- (a) a spouse who is not receiving benefits under the *Old Age Security Act* (Canada) or the *Ontario Guaranteed Annual Income Act* and who was cohabiting with the insured person immediately before the insured person was admitted to the hospital where they are receiving insured in-patient services or, if the insured person has been in more than one hospital or institution continuously, immediately before they were first admitted to such a hospital or institution, or
 - (b) a child who is under 18 years of age;
- “estimated income” means the average monthly income of any nature or kind whatsoever, so long as it is taxable under the *Income Tax Act* (Canada), of an insured person or of a

dependant of an insured person, as estimated by the insured person or the insured person's representative, and including,

- (a) payments made under an Act of the Parliament of Canada, except for payments made under the *Universal Child Care Benefit Act* (Canada),
- (a.1) payments made by Ontario,
- (b) income from salaries and wages,
- (c) income from an interest in or operation of a business, less expenses incurred in earning such gross income, and
- (d) income from investments, less expenses incurred in earning such income. O. Reg. 496/96, s. 3; O. Reg. 197/97, s. 1; O. Reg. 67/00, s. 4 (3, 4); O. Reg. 328/05, s. 4 (5); O. Reg. 209/07, s. 1 (2).

(12) Despite the definition of "estimated income" in subsection (11), payments from a registered disability savings plan, as defined in subsection 146.4 (1) of the *Income Tax Act* (Canada), shall not be included in estimated income. O. Reg. 131/09, s. 1.

11. (1) An insured person is not entitled to insured services in a hospital unless the person has been,

- (a) admitted as an in-patient on the order of a physician or a registered nurse in the extended class;
- (b) received in the hospital and examined as an out-patient by a physician and treated as an out-patient, if necessary;
- (c) referred to the hospital as an out-patient by,
 - (i) a physician, for any of the services designated in section 8,
 - (ii) an osteopath, for X-rays, or
 - (iii) an oral and maxillofacial surgeon, for any laboratory, radiological or diagnostic procedure described in section 8.1;
- (c.1) admitted as an in-patient or registered as an out-patient on the order or under the authority of an oral and maxillofacial surgeon;
- (d) admitted as an in-patient or registered as an out-patient on the order or under the authority of a midwife; or
- (e) registered as an out-patient on the order or under the authority of a registered nurse in the extended class. R.R.O. 1990, Reg. 552, s. 11 (1); O. Reg. 794/93, s. 5; O. Reg. 44/98, s. 3; O. Reg. 345/01, s. 6; O. Reg. 62/03, s. 3; O. Reg. 352/04, s. 2; O. Reg. 217/11, s. 4.

(2) An insured person is not entitled to receive insured services in a centre listed in Schedule 6 unless he or she has been,

- (a) received in the centre, and examined as an out-patient by a physician; or
- (b) referred to the centre as an out-patient by a physician. R.R.O. 1990, Reg. 552, s. 11 (2).

12. Revoked: O. Reg. 375/93, s. 3.

13. Revoked: O. Reg. 253/09, s. 4.

14. Revoked: O. Reg. 493/00, s. 1.

INSURED AMBULANCE SERVICES

15. (1) Ambulance services are insured services if,

- (a) the ambulance services are provided to an insured person by an ambulance service operator that holds a certificate issued by the certifying authority in accordance with the *Ambulance Act*;
- (b) the ambulance crew of the operator transports the insured person to or from a hospital as defined in the *Public Hospitals Act* or a private hospital as defined in the *Private Hospitals Act*; and
- (c) the insured person pays a co-payment of \$45 to the hospital. O. Reg. 528/10, s. 1.

(2) Where ambulance services are provided by air or by rail, including where applicable any ambulance service required to connect with the air or rail facilities, an insured person shall pay as his or her share of the ambulance charges an amount of \$45 a trip by way of co-payment. R.R.O. 1990, Reg. 552, s. 15 (2); O. Reg. 329/92, s. 1 (2).

(3) An ambulance service is not an insured service if it is not medically necessary. O. Reg. 329/92, s. 1 (3).

(4), (5) Revoked: O. Reg. 329/92, s. 1 (4).

(6) The co-payment prescribed in subsections (1) and (2) does not apply to a person,

- (a) who receives benefits under the *Family Benefits Act*, income support under the *Ontario Disability Support Program Act, 1997*, or income assistance under the *Ontario Works Act, 1997*;
 - (b) who is transferred from a hospital to another hospital;
 - (c) who is transferred from a hospital to a facility listed in Schedule 6;
 - (d) who is transferred from a hospital to a facility listed in Schedule 8;
 - (e) who is transferred from a hospital to a medical laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act*;
 - (f) who is transferred from a hospital to a facility registered under the *Healing Arts Radiation Protection Act* for the purpose of radiological examination or treatment;
 - (g) who is transferred from one part of a hospital to any other part of the same hospital;
 - (h) who is receiving a professional service referred to in paragraph 1, 2, 3, 4, 5, 6, 8 or 9 of subsection 2 (7) of the *Home Care and Community Services Act, 1994* that is provided or arranged by a community care access centre as defined in subsection 1 (1) of Ontario Regulation 386/99 (Provision of Community Services) made under that Act;
 - (i) who is residing in an approved home under section 12 of the *Mental Hospitals Act*;
 - (j) who is a resident of a home for special care licensed under the *Homes for Special Care Act*; or
 - (k) who is a resident of a long-term care home.
- (l), (m) Revoked: O. Reg. 100/10, s. 4 (3).

R.R.O. 1990, Reg. 552, s. 15 (6); O. Reg. 375/93, s. 5; O. Reg. 221/03, s. 3; O. Reg. 253/09, s. 5; O. Reg. 100/10, s. 4.

SPECIFIED HEALTH CARE SERVICES

16. (1) The services rendered by dental surgeons that are prescribed as insured services are the services set out in Column 1 of Parts I, II and III of the schedule of dental benefits. O. Reg. 86/03, s. 2.

(2) It is a condition for the performance and for payment of the insured services set out in the schedule of dental benefits that the insured services be performed in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D by a dental surgeon who has been appointed to the dental staff by the public hospital on the recommendation of the chief of the surgical staff and the agreement of the Medical Advisory Committee of the public hospital. O. Reg. 172/05, s. 1 (1).

(3) It is a condition for the performance and for payment of the insured services set out in Part II of the schedule of dental benefits that they be performed in conjunction with one or more of the insured services set out in Part I or III of that schedule. O. Reg. 86/03, s. 2.

(4) It is a condition for the performance and for payment of the insured services set out in Part III of the schedule of dental benefits that,

- (a) hospitalization in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D is medically necessary; and
- (b) there is prior approval by the General Manager of the provision of the service. O. Reg. 86/03, s. 2; O. Reg. 172/05, s. 1 (2).

(5) The amount payable by the Plan for a service set out in Column 1 of Part I, II or III of the schedule of dental benefits is the amount set out opposite the service in Column 2 where the service is performed by a dental surgeon or the amount set out opposite the service in Column 3 where the service is performed by an oral and maxillofacial surgeon. O. Reg. 86/03, s. 2.

(5.1) The amount that would otherwise be payable by the Plan for an insured service is increased by,

- (a) 1 per cent if the service was rendered on or after April 1, 2002, but before April 1, 2003; and
- (b) 3 per cent if the service was rendered on or after April 1, 2003, but before January 1, 2004. O. Reg. 442/03, s. 1 (1).

(5.2) Each dental surgeon who provided insured services during the period that commenced on April 1, 2002 and ended on March 31, 2003 is entitled to a payment calculated using the formula,

$$P = (A/B) \times \$300,000$$

in which,

“P” = the amount of the payment,

“A” = the total amount otherwise paid by the Plan to the dental surgeon for insured services rendered on or after April 1, 2002 but before April 1, 2003, and

“B” = the total amount paid by the Plan for all dental services rendered on or after April 1, 2002 but before April 1, 2003.

(5.3) Each dental surgeon who provided insured services during the period that commenced on April 1, 2003 and ended on December 31, 2003 is entitled to a payment calculated using the formula,

$$P = (A/B) \times \$225,000$$

in which,

“P” = the amount of the payment,

“A” = the total amount otherwise paid by the Plan to the dental surgeon for insured services rendered on or after April 1, 2003 but before January 1, 2004, and

“B” = the total amount paid by the Plan for all dental services rendered on or after April 1, 2003 but before January 1, 2004.

(6) The following services are prescribed as insured services under the Plan:

1. All services rendered by a hospital in connection with dental surgical procedures not specified in subsection (1), (3) or (5). O. Reg. 86/03, s. 2.

(7) It is a condition for the performance and for payment of insured services prescribed under subsection (6) that hospitalization in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D is medically necessary. O. Reg. 172/05, s. 1 (3).

(8) In this section,

“schedule of dental benefits” means,

- (a) the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2003)”, if the service is performed on or after April 1, 2003 and before January 1, 2004,
- (b) the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Dental Services under the *Health Insurance Act* (January 1, 2004)”, if the service is performed on or after January 1, 2004 and before April 1, 2004,
- (c) the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2004)”, if the service is performed on or after April 1, 2004 and before April 1, 2005,
- (d) the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2005)”, but does not include the “[Commentary...]” portions of the document, if the service is performed on or after April 1, 2005 and before April 1, 2006,
- (e) the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2006)”, but does not include the “[Commentary...]” portions of the document, if the service is performed on or after April 1, 2006 but before October 1, 2012,
- (f) the document published by the Ministry of Health and Long-Term Care titled

“Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2012)”, but does not include the “[Commentary...]” portions of the document, if the service is performed on or after October 1, 2012. O. Reg. 172/05, s. 1 (3); O. Reg. 105/06, s. 1 (1); O. Reg. 76/12, s. 2.

(8.1) Despite subsection (1), the following services described by the following codes in the “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2006) are prescribed services only if they are performed on or after March 1, 2007:

1. T456 — Excision, subtotal, parotid gland.
2. T457 — Excision, total, parotid gland.
3. T458 — Parotid biopsy. O. Reg. 105/06, s. 1 (2).

(8.2) Despite subsection (5), the premiums described by the following codes in the “Schedule of Benefits — Dental Services under the *Health Insurance Act* (April 1, 2006) are payable only if the prescribed services to which they relate are rendered on or after March 1, 2007:

1. T811 — Premium for consultation or visit between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday.
2. T812 — Premium for any consultation or visit to a patient in an intensive care facility.
3. T813 — Premium for a consultation or visit between midnight and 7:00 a.m. O. Reg. 105/06, s. 1 (2).

(9) This section, as it read immediately before April 1, 2003, continues to apply with respect to payments for services rendered before April 1, 2003. O. Reg. 86/03, s. 2.

17. (1) A service rendered by an optometrist in Ontario is an insured service if it is referred to in the schedule of optometry benefits and is rendered in the circumstances or under the conditions referred to in the schedule of optometry benefits. O. Reg. 320/04, s. 2.

(2) The basic fee payable by the Plan for an insured service prescribed under subsection (1) is the fee payable under the schedule of optometry benefits. O. Reg. 320/04, s. 2.

(3) Despite anything in this Regulation as it existed at any time before February 9, 2007, the fees set out in paragraphs 1 and 2 are, and shall be deemed to have always been, payable under the Plan for the insured services described in those paragraphs in respect of the time periods described in those paragraphs:

1. For periodic oculo-visual assessment rendered to an insured person 65 years of age or older (fee schedule code V406),
 - i. \$43.05 for services rendered after March 31, 2004 and before April 1, 2006, and
 - ii. \$44.30 for services rendered on or after April 1, 2006 and before February 9, 2007.
2. For minor assessment (fee schedule code V402),
 - i. \$23.15 for services rendered after March 31, 2005 and before April 1, 2006, and
 - ii. \$25.15 for services rendered on or after April 1, 2006 and before February 9, 2007. O. Reg. 493/07, s. 2.

(4) Despite anything else in this Regulation, the fees set out in paragraphs 1, 2 and 3 are, and shall be deemed to have always been, payable under the Plan for the insured services

described in those paragraphs in respect of the time periods described in those paragraphs:

1. For periodic oculo-visual assessment rendered to an insured person 65 years of age or older (fee schedule code V406),
 - i. \$46.50 for services rendered after March 31, 2007 and before April 1, 2009, and
 - ii. \$47.00 for services rendered on or after April 1, 2009.
2. For periodic oculo-visual assessment rendered to an insured person 19 years of age or younger (fee schedule code V404), \$42.50 for services rendered on and after April 1, 2009.
3. For oculo-visual minor assessment rendered to an insured person older than 19 years of age and younger than 65 years of age (fee schedule code V408), \$25.15 for services rendered after March 31, 2007. O. Reg. 210/08, s. 2.

18. Revoked: O. Reg. 352/04, s. 3.

19. (1) The following services rendered by osteopaths are prescribed as insured services under the Plan:

1. Initial service (office or institutional).
2. Subsequent service.
3. Home service.
4. Radiographic examination. R.R.O. 1990, Reg. 552, s. 19 (1).

(2) The amount payable by the Plan for the services prescribed in subsection (1) is, where the services are provided to an insured person on or after the 1st day of July, 1989, as follows:

1.	Initial service (office or institutional)	\$12.00
2.	Subsequent service	9.00
3.	Home service	15.00
4.	Radiographic examination	10.00

R.R.O. 1990, Reg. 552, s. 19 (2).

(2.1) Despite paragraph 2 of subsection (2), where a subsequent service is provided to an insured person on or after the 1st day of July, 1990, the amount payable by the Plan is \$9.50. O. Reg. 42/91, s. 1.

(3) The maximum amount payable by the Plan for the radiographic services prescribed in subsection (1) is, in respect of each insured person, \$25 per twelve-month period. R.R.O. 1990, Reg. 552, s. 19 (3).

(4) The maximum amount payable by the Plan for the services prescribed in subsection (1) is, where the insured services are provided to an insured person on or after the 1st day of July, 1989, in respect of each insured person, \$155 per twelve-month period. R.R.O. 1990, Reg. 552, s. 19 (4).

(5) For the purposes of subsections (3) and (4), the 12-month period to which the maximum amount applies is, with respect to insured services rendered on or after July 1, 1989 and before July 1, 1993, the period beginning on July 1 of each year and ending on June 30 of the following year. O. Reg. 589/94, s. 2.

(6) For the purposes of subsections (3) and (4), the period beginning on July 1, 1993 and ending on March 31, 1994 shall be deemed to be a 12-month period and the maximum amounts

prescribed in subsections (3) and (4) apply to services rendered within that period. O. Reg. 589/94, s. 2.

(7) For the purposes of subsections (3) and (4), the 12-month period to which the maximum amount applies is, with respect to insured services rendered on or after April 1, 1994, the period beginning on April 1 in any year and ending on March 31 of the following year. O. Reg. 589/94, s. 2.

20. (1) The following are insured services:

1. Chiropody services rendered by a member of the College of Chiropodists of Ontario who is a podiatrist.
2. Podiatrist services rendered by a podiatrist who practises outside Ontario. O. Reg. 787/94, s. 1.

(2) The amounts payable by the Plan for services prescribed as insured services in subsection (1) and rendered on or after the 1st day of February, 1990 are as follows:

1.	Initial office visit	\$16.40
2.	Subsequent office visit	11.45
3.	Home visit	14.00
4.	Institution visit	7.00
5.	X-ray of foot — antero-posterior and lateral views	11.00
6.	X-ray of feet, including one view of each foot	11.00
7.	Oblique or special view of foot	5.50

R.R.O. 1990, Reg. 552, s. 20 (2).

(3) The maximum amount payable by the Plan for the services set out in subsection (2), excluding radiographic examinations, and rendered in a 12-month period in respect of an insured person is \$135. O. Reg. 589/94, s. 3.

(4) The maximum amount payable by the Plan for radiographic examinations set out in subsection (2) and carried out in a 12-month period in respect of an insured person is \$30. O. Reg. 589/94, s. 3.

(5) For the purposes of subsections (3) and (4), the 12-month period to which the maximum amount applies is, with respect to services rendered on or after July 1, 1990, the period beginning on July 1 of each year and ending on June 30 of the following year. O. Reg. 589/94, s. 3.

21, 21.1 Revoked: O. Reg. 138/13, s. 2.

22. (1) A laboratory service is an insured service where the laboratory service is a test

within the meaning of section 5 of the *Laboratory and Specimen Collection Centre Licensing Act* and,

- (a) the test is specifically authorized, on a form approved by the Minister, by a physician, midwife or registered nurse in the extended class who has clinically assessed the patient to whom the test relates; and
- (b) the test is performed in a laboratory, other than a hospital laboratory, licensed under the *Laboratory and Specimen Collection Centre Licensing Act* to perform the test for which payment is claimed. R.R.O. 1990, Reg. 552, s. 22 (1); O. Reg. 794/93, s. 6 (1); O. Reg. 44/98, s. 4 (1); O. Reg. 217/11, s. 5.

(2) Laboratory services are insured services,

- (a) if the services are authorized by a medical director of a laboratory;
- (b) if the results of the tests authorized by a physician, midwife or registered nurse in the extended class who has clinically assessed a patient yield abnormal findings or information that, without the laboratory services, would be incomplete or insufficient or meaningless to the physician, midwife or registered nurse in the extended class; and
- (c) if the services are performed in a laboratory, other than a hospital laboratory, licensed under the *Laboratory and Specimen Collection Centre Licensing Act* to perform the laboratory services for which payment is claimed. R.R.O. 1990, Reg. 552, s. 22 (2); O. Reg. 794/93, s. 6 (2); O. Reg. 44/98, s. 4 (2).

(3) A laboratory service is not an insured service unless, in addition to meeting the requirements of subsection (1) or (2), the service is listed in the schedule of laboratory benefits. O. Reg. 511/00, s. 1.

(4) The amount payable by the Plan for an insured service rendered by a medical laboratory on or after the 1st day of October, 1989 is 51.7 cents multiplied by the applicable individual unit value for such service set out opposite the service in the schedule of laboratory benefits. R.R.O. 1990, Reg. 552, s. 22 (4); O. Reg. 2/98, s. 1 (2); O. Reg. 201/99, s. 2 (1).

(5) Despite subsection (4), the amount payable by the Plan for an insured service rendered by a medical laboratory in a time period set out in Column 1 of Table 4 is,

- (a) where the service is authorized by a physician who has clinically assessed the patient; and
- (b) Revoked: O. Reg. 2/98, s. 1 (4).
- (c) where the total individual unit values for the services authorized by the physician during the period set out opposite thereto in Column 2 of Table 4 are greater than 150,000 but less than 200,001,

the amount arrived at by multiplying the applicable individual unit value for such service set out opposite the service in the schedule of laboratory benefits by the amount calculated by,

- (d) multiplying the first 150,000 individual unit values by the amount set out opposite thereto in Column 3 of Table 4;
- (e) multiplying the excess by the amount set out opposite thereto in Column 4 of Table 4;
- (f) adding the amounts arrived at under clauses (d) and (e); and
- (g) dividing the amount arrived at under clause (f) by the total individual unit values.

R.R.O. 1990, Reg. 552, s. 22 (5); O. Reg. 291/91, s. 1 (2); O. Reg. 2/98, s. 1 (3, 4); O. Reg. 201/99, s. 2 (2).

(6) Despite subsection (4), the amount payable by the Plan for an insured service rendered by a medical laboratory in a time period set out in Column 1 of Table 5 is,

- (a) where the service is authorized by a physician who has clinically assessed the patient; and
- (b) Revoked: O. Reg. 2/98, s. 1 (6).
- (c) where the total individual unit values for the services authorized by the physician during the period set out opposite thereto in Column 2 of Table 5 are greater than 200,000,

the amount arrived at by multiplying the applicable individual unit value for such service set out opposite the service in the schedule of laboratory benefits by the amount calculated by,

- (d) multiplying the first 150,000 individual unit values by the amount set out opposite thereto in Column 3 of Table 5;
- (e) multiplying the next 50,000 individual unit values by the amount set out opposite thereto in Column 4 of Table 5;
- (f) multiplying the excess by the amount set out opposite thereto in Column 5 of Table 5;
- (g) adding the amounts arrived at under clauses (d), (e) and (f); and
- (h) dividing the amount arrived at under clause (g) by the total individual unit values.

R.R.O. 1990, Reg. 552, s. 22 (6); O. Reg. 291/91, s. 1 (3); O. Reg. 2/98, s. 1 (5, 6); O. Reg. 201/99, s. 2 (3).

(7) Revoked: O. Reg. 2/98, s. 1 (7).

(8) Despite subsection (4), if the amount paid by the Plan for insured services rendered by a medical laboratory during the period set out in Column 1 of Table 6 is less than the product obtained by multiplying the total individual unit values for insured services rendered by the medical laboratory during the period set out in Column 1 by 51.7 cents, the amount payable by the Plan for an insured service rendered by the medical laboratory during the period set out in Column 2 of Table 6 is the amount arrived at according to the following formula:

$$a = (b/c) d$$

where,

- a = the amount payable by the Plan,
- b = the amount paid by the Plan for insured services rendered by the medical laboratory during the period set out in Column 1 of Table 6,
- c = the product obtained by multiplying the total individual unit values for insured services rendered by the medical laboratory during the period set out in Column 1 of Table 6 by 51.7 cents,
- d = the product obtained by multiplying the applicable individual unit value for the insured service set out opposite the service in the schedule of laboratory benefits by 51.7 cents.

O. Reg. 126/92, s. 1; O. Reg. 2/98, s. 1 (8); O. Reg. 201/99, s. 2 (4).

(9) Revoked: O. Reg. 291/91, s. 1 (4).

(10) Payment for an insured service provided by a medical laboratory is subject to the following conditions:

1. The medical laboratory shall not accept payment for the service from any other person.
2. The medical laboratory must be a party to a written verification agreement with the General Manager at the time the service was rendered. O. Reg. 676/00, s. 1.

(11) In subsection (10),

“verification agreement” means an agreement between a medical laboratory and the General Manager in which the medical laboratory authorizes the General Manager or a person designated by the General Manager to examine records in the medical laboratory’s possession, on such terms as the parties may agree to, in order to verify that,

- (a) all insured services for which accounts were submitted to the Plan were in fact performed by the medical laboratory,
- (b) all insured services performed by the medical laboratory were authorized by a physician, midwife or registered nurse in the extended class, and
- (c) the Plan has not paid more for an insured service performed by the medical laboratory than the amount payable for the service under the Plan. O. Reg. 676/00, s. 1.

22.1 (1) In sections 22.2 to 22.11,

“base year amount” means, in relation to a medical laboratory, the amount calculated in accordance with section 22.5;

“fiscal year” means the 12-month period beginning on April 1;

“over-threshold laboratory” means a medical laboratory that has a threshold amount for a fiscal year (determined without regard to the operation of section 22.4) that is less than the total amount payable to it under section 22 for insured services provided during the year;

“receiving laboratory” means a medical laboratory that performs tests referred to it by a referring laboratory;

“referring laboratory” means a medical laboratory that refers to a receiving laboratory tests that it is not licensed to perform;

“threshold amount” means, in relation to a medical laboratory, the amount calculated in accordance with section 22.3;

“under-threshold laboratory” means a medical laboratory that has a threshold amount for a fiscal year (determined without regard to the operation of section 22.4) that is greater than the total amount payable to it under section 22 for insured services provided during the year. O. Reg. 2/98, s. 2.

(2) Two or more medical laboratories are jointly engaged in providing insured services if they provide the services as a joint undertaking on a fully-integrated basis, whether as partners or otherwise. O. Reg. 2/98, s. 2.

(3) Sections 22.2 to 22.11 do not apply with respect to hospital laboratories. O. Reg. 2/98, s. 2.

22.2 (1) For the purposes of subsections 17.1 (6) and 17.2 (4) of the Act,

- (a) all insured services provided by a medical laboratory are prescribed insured services;
- (b) the prescribed period for a medical laboratory is a fiscal year; and
- (c) the prescribed amount for a medical laboratory is its threshold amount for the fiscal year. O. Reg. 2/98, s. 2.

(2) If the total amount payable under section 22 for insured services provided by a medical laboratory during a fiscal year equals or exceeds its threshold amount, the fee payable for each insured service it performs during the fiscal year is decreased by the percentage that is calculated as follows:

1. Calculate the medical laboratory's threshold amount for the fiscal year.
2. Subtract the threshold amount from the total amount payable to the medical laboratory for the fiscal year.
3. Express the amount calculated under paragraph 2 as a percentage of the total amount payable to the medical laboratory for the fiscal year. O. Reg. 2/98, s. 2.

22.3 (1) A medical laboratory's threshold amount for a fiscal year is the amount calculated as follows:

1. Calculate the medical laboratory's base year amount.
2. Express the base year amount as a percentage of the base year amounts of all medical laboratories.
3. Multiply the provincial cap for the fiscal year by the percentage calculated under paragraph 2.
4. Add the amounts, if any, calculated under section 22.4. O. Reg. 2/98, s. 2.

(2) The provincial cap applicable for the purposes of calculating threshold amounts for medical laboratories is,

- (a) \$660,004,368 for the 2012/13 fiscal year;
- (b) \$649,004,368 for the 2013/14 fiscal year; and
- (c) \$638,004,368 for the 2014/15 fiscal year and subsequent fiscal years. O. Reg. 269/13, s. 1.

22.4 (1) This section applies if one or more medical laboratories are under-threshold laboratories for a fiscal year. O. Reg. 2/98, s. 2.

(2) For each over-threshold laboratory that is jointly engaged in providing insured services with an under-threshold laboratory, the threshold amount for the fiscal year is increased in accordance with subsection (4). O. Reg. 2/98, s. 2.

(3) The threshold amount for a fiscal year for each over-threshold laboratory is increased in accordance with subsection (5). Increases under this subsection are calculated after any increases required by subsection (2) are made. O. Reg. 2/98, s. 2.

(4) The amount of the increase described in subsection (2) for an over-threshold laboratory is calculated as follows:

1. Subtract the total amount payable to the under-threshold laboratory under section 22 for insured services provided during the fiscal year from its threshold amount for the year.

2. Allocate the amount calculated under paragraph 1 among the over-threshold laboratories jointly engaged with the under-threshold laboratory in providing insured services during the fiscal year. The allocation is to be made in proportion to their respective threshold amounts for the year (determined without regard to the operation of this section).
3. Increase the threshold amount of each over-threshold laboratory by the lesser of,
 - i. the amount allocated to the laboratory under paragraph 2, or
 - ii. the amount that results in the threshold amount being equal to the total amount payable to the laboratory under section 22 for insured services provided by it during the fiscal year.
4. If the threshold amount of one or more over-threshold laboratories is increased by the amount described in subparagraph ii of paragraph 3, for each such laboratory subtract the amount of the increase from the amount allocated to the laboratory under paragraph 2.
5. Add the amounts calculated under paragraph 4.
6. Allocate the amount calculated under paragraph 5 among the over-threshold laboratories whose threshold amount was increased by the amount described in subparagraph i of paragraph 3, in proportion to their respective threshold amounts (determined without regard to the operation of this section).
7. Paragraphs 3 to 6 apply, with necessary modifications, with respect to the allocation of amounts calculated under paragraph 5 until,
 - i. all such amounts are allocated, or
 - ii. the threshold amount of every over-threshold laboratory equals the total amount payable to the laboratory under section 22 for insured services provided by it during the fiscal year. O. Reg. 2/98, s. 2.

(5) The amount of the increase described in subsection (3) for an over-threshold laboratory is calculated as follows:

1. For each under-threshold laboratory that is not jointly engaged in providing insured services with an over-threshold laboratory, subtract the total amount payable to it under section 22 for insured services provided during the fiscal year from its threshold amount for the year.
2. Add all amounts calculated under paragraph 5 of subsection (4) that remain unallocated under paragraph 7 of that subsection.
3. Add the amounts calculated under paragraphs 1 and 2.
4. Allocate the amount calculated under paragraph 3 among the over-threshold laboratories that are entitled to an increase under subsection (3), in proportion to their respective threshold amounts (determined without regard to the operation of this subsection).
5. Increase the threshold amount of each over-threshold laboratory by the lesser of,
 - i. the amount allocated to the laboratory under paragraph 4, or
 - ii. the amount that results in the threshold amount being equal to the total amount payable to the laboratory under section 22 for insured services provided by it

during the fiscal year.

6. If two or more over-threshold laboratories that are entitled to an increase under subsection (3) were jointly engaged with each other in providing insured services during the fiscal year and the threshold amount of one or more of them is increased by the amount described in subparagraph ii of paragraph 5, for each such laboratory subtract the amount of the increase from the amount allocated to the laboratory under paragraph 4.
7. Add the amounts calculated under paragraph 6.
8. Allocate the amount calculated under paragraph 7 among the over-threshold laboratories who were jointly engaged with a laboratory described in paragraph 6 and whose threshold amounts were increased by the amount described in subparagraph i of paragraph 5, in proportion to their respective threshold amounts (determined without regard to the operation of this subsection).
9. Paragraphs 5 to 8 apply, with necessary modifications, until,
 - i. all amounts calculated under paragraph 7 are allocated, or
 - ii. the threshold amount of each laboratory receiving an allocated amount under paragraph 8 equals the total amount payable to the laboratory under section 22, whichever occurs first.
10. If the threshold amount of every jointly engaged over-threshold laboratory to which amounts are allocated under paragraph 8 equals its total amount payable under section 22, determine the amount, if any, that remains unallocated.
11. If the threshold amount of one or more over-threshold laboratories, other than a jointly engaged over-threshold laboratory described in paragraph 6, is increased by an amount described in subparagraph ii of paragraph 5, for each such laboratory subtract the amount of the increase from the amount allocated to the laboratory under paragraph 4.
12. Add the amounts calculated under paragraph 11 and any amount determined under paragraph 10.
13. Allocate the amount calculated under paragraph 12 among the over-threshold laboratories whose threshold amounts were increased by the amount described in subparagraph i of paragraph 5, other than any jointly engaged over-threshold laboratory that ceases to be over-threshold as a result of an allocation under paragraph 8, in proportion to their respective threshold amounts (determined without regard to the operation of this subsection).
14. Paragraphs 5 and 11 to 13 apply, with necessary modifications, until all such amounts are allocated. O. Reg. 2/98, s. 2.

22.5 (1) The base year amount for a medical laboratory is calculated as follows:

1. For each physician who authorized insured services that were performed by the medical laboratory during the 1995/96 fiscal year, calculate the total amount payable under section 22 to all laboratories for insured services authorized by the physician for that fiscal year.
2. Express the total amount payable to the medical laboratory for insured services authorized by each physician as a percentage of the amount calculated under

paragraph 1 in respect of the physician.

3. For each physician, calculate the total individual unit values of all insured services authorized by him or her and performed by all laboratories during the 1995/96 fiscal year.
4. For each physician, reduce the amount calculated under paragraph 3 by 8.5737 per cent.
5. For each physician, calculate the amount that would have been payable under section 22 for all insured services authorized by him or her and performed by all medical laboratories during the 1995/96 fiscal year. The calculation is to be based upon the total individual unit values for the insured services, as reduced under paragraph 4.
6. For each physician, multiply the amount calculated under paragraph 5 by the percentage calculated under paragraph 2 for the physician.
7. Add the amounts calculated under paragraph 6 for every physician that authorized the insured services that the medical laboratory performed during the 1995/96 fiscal year.
8. For the following medical laboratories, add the amount indicated:
 - i. Canadian Medical Laboratories Ltd., \$397,922.
 - ii. Flemington Medical Laboratories, \$1,537,136.
 - iii. Hospital-In-Common Laboratory Inc., \$182,750.
 - iv. MDS Inc., \$2,108,864.
 - v. Med-Chem Health Care Ltd., \$922,003.
9. Add or subtract (as the case may be) the amounts, if any, calculated under sections 22.6 to 22.12. O. Reg. 2/98, s. 2.

(2) Despite subsection (1), if no amount was payable under the Plan to the medical laboratory for performing insured services before January 1, 1997, the base year amount for the medical laboratory is calculated as follows:

1. Multiply by four an amount equal to 85 per cent of the total individual unit values for insured services, if any, performed by the medical laboratory from January 1 to March 31, 1997.
2. Add or subtract (as the case may be) the amounts, if any, calculated under sections 22.6 to 22.11. O. Reg. 2/98, s. 2.

(3) Except where otherwise provided, a change in a medical laboratory's base year amount made under sections 22.6 to 22.11 applies with respect to the calculation of the threshold amount for the fiscal year in which the change is made and for every subsequent fiscal year. O. Reg. 2/98, s. 2.

22.6 (1) This section applies if one or more medical laboratories are under-threshold laboratories for a fiscal year after the 1996/97 fiscal year. O. Reg. 2/98, s. 2.

(2) The base year amount of each under-threshold laboratory is decreased by the amount calculated using the formula,

$$\frac{A \times B}{C}$$

in which,

“A” equals the total of the base year amounts of all medical laboratories for the fiscal year (calculated without regard to the operation of this section),

“B” equals the amount by which the threshold amount for the laboratory in the fiscal year exceeds the total amount payable under section 22 to the laboratory for insured services provided during the fiscal year, and

“C” equals the provincial cap set out in subsection 22.3 (2) for the fiscal year.

O. Reg. 2/98, s. 2.

(3) The base year amount of each medical laboratory that is an over-threshold laboratory for the fiscal year is increased by the amount calculated using the formula,

$$\frac{A \times D}{C}$$

in which,

“A” and “C” have the same meaning as in subsection (2), and

“D” equals the amount by which the threshold amount for the fiscal year for the over-threshold laboratory is increased under section 22.4.

O. Reg. 2/98, s. 2.

(4) A change in base year amounts made under this section applies with respect to the calculation of threshold amounts for the fiscal year following the year in which the circumstance described in subsection (1) exists, and for every subsequent fiscal year. O. Reg. 2/98, s. 2.

22.7 (1) The base year amount for a medical laboratory is increased by the amount calculated under subsection (2) if the laboratory becomes licensed to perform, and begins to perform, one or more of the following tests during the 1995/96 or 1996/97 fiscal year:

1. Antithrombin III assay (L373).
2. C-peptide Immunoreactivity (L346).
3. Dehydroepiandrosterone Sulphate (L347).
4. Free T-3 (L607).
5. Free Testosterone (L608).
6. 1,25 Dihydroxy Vitamin D (L605).
7. 25 Hydroxy Vitamin D (L606).
8. Immunoperoxidase technique (L731).
9. Leukocyte phenotyping by monoclonal antibodies (L685 or L686).
10. Methenalbumin (L171).
11. Oxalic Acid — U (L184).
12. Plasminogen assay (L433).
13. Total Haemolytic complement (CH 50 non-kit) (L530).
14. Thyroglobulin (L609). O. Reg. 2/98, s. 2.

(2) The amount of the increase is calculated using the formula,

$$A \times B \times 0.43945$$

in which,

“A” is the total individual unit values (based on the unit values in effect on April 1, 1997) for all the tests listed in subsection (1) that were performed by or on behalf of the Hospital-in-Common Laboratory Inc. during the 1995/96 fiscal year, and

“B” is the total individual unit values of the tests listed in subsection (1) performed by the medical laboratory from April 1 until June 30, 1997 expressed as a percentage of the total individual unit values of the tests performed during that period by all medical laboratories entitled to an increase under subsection (1).

O. Reg. 2/98, s. 2.

22.8 (1) This section applies with respect to a referring laboratory and a receiving laboratory,

(a) if during the 1995/96 fiscal year the referring laboratory referred certain tests to the receiving laboratory; and

(b) if during the 1995/96 or 1996/97 fiscal year,

(i) the referring laboratory becomes licensed to perform those tests and begins to perform them instead of referring them to the receiving laboratory, or

(ii) the referring laboratory begins referring the tests to a related laboratory instead of the receiving laboratory. O. Reg. 2/98, s. 2.

(2) The base year amount for the referring laboratory is increased, and the base year amount for the receiving laboratory is decreased, by 85 per cent of the total amount that would have been payable under subsection 22 (4) for tests referred by the referring laboratory that were performed by the receiving laboratory during the 1995/96 fiscal year. O. Reg. 2/98, s. 2.

(3) A change in the base year amount made under this section applies with respect to the calculation of threshold amounts for the 1996/97 fiscal year and for every subsequent fiscal year. O. Reg. 2/98, s. 2.

(4) For the purposes of subsection (1), two medical laboratories are related if they are controlled (within the meaning of subsection 1 (5) of the *Business Corporations Act*) by the same person. O. Reg. 2/98, s. 2.

22.9 (1) This section applies with respect to a referring laboratory and a receiving laboratory,

(a) if, during the 1995/96 fiscal year, the receiving laboratory performed tests that were referred by the referring laboratory;

(b) if, on or after April 1, 1997, the receiving laboratory ceases to perform some or all of the tests referred by the referring laboratory; and

(c) if neither the referring laboratory nor a related laboratory is licensed to perform the tests when the receiving laboratory ceases to perform some or all of them. O. Reg. 2/98, s. 2.

(2) The base year amount for the receiving laboratory is decreased, and the base year amount for all of the medical laboratories described in subsection (3) is increased, by the

amount calculated as follows:

1. With respect to the type of test that the receiving laboratory ceases to perform, determine the total amount that would have been payable under subsection 22 (4) for tests of that type referred by the referring laboratory that were performed by the receiving laboratory during the 1995/96 fiscal year.
2. Multiply the amount calculated under paragraph 1 by 85 per cent. O. Reg. 2/98, s. 2.
- (3) The increase is apportioned among the following medical laboratories as follows:
 1. If the referring laboratory refers the tests to other medical laboratories and one receiving laboratory performs all the tests referred, the base year amount for the receiving laboratory is increased by the amount calculated under subsection (2).
 2. If the referring laboratory refers the tests to other medical laboratories and two or more medical laboratories perform the tests, the amount calculated under subsection (2) is allocated between them, and the base year amount of each is increased, in proportion to the total amount payable to each of them respectively for the tests. O. Reg. 2/98, s. 2.

22.10 (1) This section applies if a written agreement in effect between two medical laboratories provides that,

- (a) one of them (the “managing laboratory”) will manage and operate all or part of the laboratory business of the other of them (the “contracting laboratory”); or
- (b) one of them (the “managing laboratory”) will perform insured services referred by the other of them (the “contracting laboratory”). O. Reg. 2/98, s. 2.

(2) The agreement must have been in effect on March 31, 1996 or it must replace such an agreement, although the replacement agreement may involve a different managing laboratory than the one that was a party to the agreement in effect on March 31, 1996. O. Reg. 2/98, s. 2.

(3) If the agreement terminates on March 31, upon its termination the base year amount for the managing laboratory that was a party to the agreement in effect on March 31, 1996 is decreased in the fiscal year after the agreement is terminated, and the base year amount for the contracting laboratory is increased, by the amount calculated as follows:

1. Calculate 85 per cent of the total amount that would have been payable under subsection 22 (4) to the managing laboratory for insured services performed during the 1995/96 fiscal year by the managing laboratory under the agreement then in effect.
2. Calculate 85 per cent of the total amount that would have been payable under subsection 22 (4) to the contracting laboratory for all insured services performed by it during the 1995/96 fiscal year.
3. If the amount calculated under paragraph 1 is greater than or equal to the amount calculated under paragraph 2, the amount calculated under paragraph 1 is the amount of the increase or decrease, as the case may be, in the base year amount. O. Reg. 2/98, s. 2.

(4) If the agreement terminates on a date other than March 31, upon its termination the base year amount for the managing laboratory that was a party to the agreement in effect on March 31, 1996 is decreased in the fiscal year in which the agreement is terminated and in the following fiscal year, and the base year amount for the contracting laboratory is increased in

each of those years, by the amounts calculated as follows:

1. Calculate the amount of the increase or decrease that would be payable if the agreement terminated on March 31.
2. Multiply the amount calculated under paragraph 1 by the following fraction:

$$\frac{\text{number of days remaining in the fiscal year}}{\text{number of days in the fiscal year}}$$

The resulting amount is the amount of the increase or decrease, as the case may be, in the fiscal year in which the agreement is terminated.

3. Subtract the amount calculated under paragraph 2 from the amount calculated under paragraph 1. The resulting amount is the amount of the increase or decrease, as the case may be, in the following fiscal year. O. Reg. 2/98, s. 2.

(5) Despite subsections (3) and (4), if the contracting party enters into an agreement with another medical laboratory within 60 days after the expiry of the agreement referred to in subsection (1),

- (a) the base year amount for the contracting laboratory shall not be increased as provided by subsection (3) or (4); and
- (b) the base year amount for the other medical laboratory shall be increased by the amount that the base year amount for the contracting laboratory would have been increased under subsection (3) or (4). O. Reg. 2/98, s. 2.

(6) Upon the termination of an agreement described in subsection (5), the base year amount for the contracting laboratory is increased and the base year amount for the other medical laboratory is decreased as provided by subsection (3) or (4). O. Reg. 2/98, s. 2.

22.11 (1) This section applies,

- (a) when one medical laboratory (the “transferring laboratory”) transfers its interest in one or more laboratories (the “transferred facilities”) licensed under the *Laboratory and Specimen Collection Centre Licensing Act* to another medical laboratory (the “acquiring laboratory”) and ceases to hold a licence under that Act for the transferred facilities;
- (b) when one medical laboratory becomes controlled (within the meaning of subsection 1 (5) of the *Business Corporations Act*) by another medical laboratory or two medical laboratories become controlled by the same person;
- (c) when two or more medical laboratories amalgamate; or
- (d) when the trustee in bankruptcy or receiver and manager appointed over a medical laboratory (the “trustee”) sells assets of the medical laboratory. O. Reg. 2/98, s. 2; O. Reg. 232/99, s. 1 (1).

(2) In the circumstances described in subsection (1) (a) and only if both medical laboratories agree, the base year amount for the acquiring laboratory is increased and the base year amount for the transferring laboratory is decreased by the amount calculated as follows:

1. Calculate 85 per cent of the total amount payable under subsection 22 (4) to the transferring laboratory for insured services performed at the transferred facilities in the fiscal year before the transfer of interest in the facilities occurs.
2. Calculate 85 per cent of the total amount payable under subsection 22 (4) to the

transferring laboratory for the same fiscal year.

3. Express the amount calculated under paragraph 1 as a percentage of the amount calculated under paragraph 2.
4. Multiply the base year amount of the transferring laboratory by the percentage calculated under paragraph 3. O. Reg. 2/98, s. 2.

(3) In the circumstances described in clause (1) (b) and only if both medical laboratories agree,

- (a) the base year amount for one of the medical laboratories is increased by the amount of the base year amount for the other medical laboratory; and
- (b) the base year amount for the other medical laboratory is reduced to zero. O. Reg. 2/98, s. 2.

(4) When two or more medical laboratories amalgamate and only if the amalgamating laboratories agree,

- (a) the base year amount for the amalgamated laboratory is increased by the base year amount for each of the amalgamating laboratories; and
- (b) the base year amount for each of the amalgamating laboratories is reduced to zero. O. Reg. 2/98, s. 2.

(4.1) In the case of the sale of assets described in clause (1) (d),

- (a) the base year amount for the medical laboratory whose base year amount is to be increased under the terms of the agreement of purchase and sale is increased by an amount equal to the base year amount of the medical laboratory whose assets are being sold; and
- (b) the base year amount for the medical laboratory whose assets are being sold is reduced to zero. O. Reg. 232/99, s. 1 (2).

(5) The base year amount is transferred as of April 1 in the fiscal year in which the event described in subsection (2), (3), (4) or (4.1) occurs. O. Reg. 232/99, s. 1 (3).

(6) Subsection (2) does not apply to the transfer of interests in facilities that are part of a sale of assets described in clause (1) (d). O. Reg. 232/99, s. 1 (3).

23. (1) In this section,

“birth centre” means a place where one or more members of the public receive labour and delivery care;

“labour and delivery care” includes the post-partum care given to a woman and the care of her newborn during their stay at the birth centre immediately following delivery. O. Reg. 486/94, s. 1.

(2) The following services rendered by a member of the College of Midwives of Ontario are prescribed as insured services under the Plan:

1. Pre-natal care rendered during visits to a birth centre during pregnancy.
2. Labour and delivery care at a birth centre.
3. Post-partum care of a woman during visits to a birth centre after labour and delivery.
4. Care to the newborn that is ancillary to the birth and received during visits of a newborn

to a birth centre after birth. O. Reg. 486/94, s. 1.

(3) No amount shall be payable by the Plan for any of the services prescribed as insured services under subsection (2). O. Reg. 486/94, s. 1.

(4) The provision of premises, equipment, supplies and personnel incidental to the provision of insured services prescribed under subsection (2) are deemed not to be part of the insured services. O. Reg. 486/94, s. 1.

EXCLUSIONS

24. (1) The following services rendered by physicians or practitioners are not insured services and are not part of insured services unless, in the case of services rendered by physicians, they are specifically listed as an insured service or as part of an insured service in the schedule of benefits or, in the case of services rendered by optometrists, they are specifically listed as an insured service or as part of an insured service in the schedule of optometry benefits:

1. Travelling to visit an insured person outside the usual geographical area of practice of the person making the visit.
2. Toll charges for long distance telephone calls.
3. Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes unless,
 - i. the device is used to permit or facilitate a procedure or examination, or
 - ii. the device is a cast for which there is a fee listed in the schedule of benefits.
4. Preparing or providing,
 - i. a drug, antigen, antiserum or other substance used for treatment that is not used to facilitate a procedure or examination, or
 - ii. a drug to promote ovulation.
5. Advice given by telephone to an insured person at the request of the person or the person's representative.
6. An interview or case conference in respect of an insured person that,
 - i. lasts more than 20 minutes,
 - ii. includes a professional, none of whose services are insured services, and
 - iii. occurs at a place other than a hospital.
7. The preparation and transfer of an insured person's health records when this is done because the care of the person is being transferred at the request of the person or the person's representative.
8. A service, including an annual health or annual physical examination, received wholly or partly for the production or completion of a document or the transmission of information to which paragraph 8.1 or 8.2 applies regardless of whether the document or information was requested before, at the same time as or after the service was received.
- 8.1 The production or completion of a document, or the transmission of information to any person other than the insured person, if the document or transmission of

information is required by legislation of any government or is to be used to receive anything under, or to satisfy a condition under, any legislation or program of a government.

- 8.2 The production or completion of a document, or the transmission of information to any person other than the insured person, if the document or the transmission of the information relates to,
- i. admission to or continued attendance in a day care or pre-school program or a school, community college, university or other educational institution or program,
 - ii. admission to or continued attendance in a recreational or athletic club, association or program or a camp,
 - iii. an application for, or the continuation of, insurance,
 - iv. an application for, or the continuation of, a licence,
 - v. entering or maintaining a contract,
 - vi. an entitlement to benefits, including insurance benefits or benefits under a pension plan,
 - vii. obtaining or continuing employment,
 - viii. an absence from or return to work,
 - ix. legal proceedings.
9. The providing of a prescription to an insured person if the person or the person's personal representative requests the prescription and no concomitant insured service is provided.
10. A service that is solely for the purpose of altering or restoring appearance.
11. An anaesthetic service rendered by a physician in connection with,
- i. a service rendered by a practitioner that is provided outside a hospital, or
 - ii. a dental service that is not insured, is provided in a hospital and involves only the removal of impacted teeth.
12. The fitting of contact lenses other than for,
- i. aphakia,
 - ii. myopia greater than 9 dioptries,
 - iii. irregular astigmatism resulting from post corneal grafting or corneal scarring from disease, or
 - iv. keratoconus.
13. An acupuncture procedure.
14. Psychological testing.
15. Revoked: O. Reg. 295/04, s. 1 (1).
16. An examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program.

17. Treatment for a medical condition that is generally accepted within Ontario as experimental.
18. Psychotherapy that is a requirement for the patient to obtain a diploma or degree or to fulfil a course of study.
19. A missed appointment or procedure.
20. Destruction of hair follicles.
21. Circumcision, except if medically necessary.
22. Reversal of sterilization.
23. *In vitro* fertilization other than the first three treatment cycles of *in vitro* fertilization that are intended to address infertility due to complete bilateral anatomical fallopian tube blockage that did not result from sterilization.
24. Counselling, therapy or any other service rendered for the purpose of weight loss for the benefit of a patient other than a patient,
 - i. who has a medical condition that is attributable to, or aggravated by, excess weight, or
 - ii. who suffers from obesity and whose obesity puts the patient at an increased risk of developing a medical condition that is attributable to, or aggravated by, excess weight.
25. A service or treatment, including immunization or the administration of any drug, rendered to an insured person in connection with, and for the sole purpose of, travelling to a country outside Canada.
26. Revoked: O. Reg. 168/08, s. 2 (1).
27. The fitting or evaluation of hearing aids and tinnitus maskers.
28. A service rendered to a person who is 20 or more years of age and less than 65 years of age that is rendered solely for the purpose of refraction. R.R.O. 1990, Reg. 552, s. 24 (1); O. Reg. 617/91, s. 1; O. Reg. 785/92, s. 1 (1); O. Reg. 488/94, s. 2 (1, 2); O. Reg. 790/94, s. 1; O. Reg. 176/95, s. 1 (1); O. Reg. 146/98, s. 1 (1, 2); O. Reg. 377/98, s. 1 (1); O. Reg. 528/98, s. 2 (1); O. Reg. 617/00, s. 2; O. Reg. 250/01, s. 2 (1); O. Reg. 272/01, s. 2 (1, 2); O. Reg. 295/04, s. 1 (1); O. Reg. 320/04, s. 3 (1, 2); O. Reg. 96/06, s. 2; O. Reg. 168/08, s. 2 (1).

(1.0.1) Subparagraph 4 i of subsection (1) does not apply with respect to the preparation or provision of verteporfin on or after June 15, 2002 if all of the following conditions exist:

1. The verteporfin is provided in the course of ocular photodynamic therapy for the treatment of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
2. The area of classic subfoveal choroidal neovascularization is equal to or greater than 50 per cent of the total lesion, as determined by fluorescein angiography.
3. The first treatment is commenced within 30 months after the initial diagnosis of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
4. The patient's visual acuity is 20/40 or worse. O. Reg. 169/02, s. 3.

(1.1) Paragraphs 8, 8.1 and 8.2 of subsection (1) do not apply to:

1. Keeping or maintaining appropriate physician or practitioner records.
2. Conferring with or providing advice, direction, information or records to physicians or other professionals concerned with the health of the insured person.
3. Producing or completing documents or transmitting information,
 - i. required to satisfy a condition of being admitted to, or receiving health services in, a hospital, a facility within the meaning of the *Developmental Services Act* or a long-term care home,
 - ii. required in relation to an annual health or annual physical examination of a patient or resident of any facility mentioned in subparagraph i,
 - iii. required to receive anything under a program administered by the Minister of Health,
 - iv. required to receive welfare or social assistance benefits provided by a government or employment supports under Part III of the *Ontario Disability Support Program Act, 1997*,
 - v. required by or for a health facility as defined in the *Independent Health Facilities Act*,
 - vi. respecting the health status of a child who,
 - A. is in the supervision, or under the care, custody or control of a children's aid society,
 - B. resides in a place of secure custody, a place of open custody or a place of temporary detention, within the meaning of Part IV of the *Child and Family Services Act*, or
 - C. resides in a children's residence licensed under Part IX of the *Child and Family Services Act*,
 - vii. required, as evidence of immunization status, for admission to or continued attendance in a day care or pre-school program or a school, community college, university or other educational institution or program,
 - viii. required as evidence of disability, for the purposes of eligibility for a benefit, related to transportation, under any legislation or program of a government, or
 - ix. to obtain consents to the performance of insured services.
4. A service received wholly or partly for the production or completion of a document or the transmission of information to which paragraph 3 applies.
5. An examination rendered and documents produced or completed or information transmitted under the *Mental Health Act*.
6. An examination rendered and documents produced or completed or information transmitted for the purpose of an investigation or confirmation of an alleged sexual assault in accordance with the requirements of the Ministry of the Attorney General and the Ministry of the Solicitor General. O. Reg. 785/92, s. 1 (2); O. Reg. 502/05, s. 2; O. Reg. 100/10, s. 6.

(1.2) Paragraph 8 of subsection (1) does not apply to a service that is, in the opinion of

the physician or practitioner, medically necessary and that is received wholly or partly for the production or completion of a document or the transmission of information that relates to any of the following:

1. The receipt of disability or sickness benefits or the satisfaction of a condition relating to disability or sickness benefits.
2. A return to a day care or pre-school program after a temporary absence.
3. A condition relating to fitness to continue employment other than a condition that requires an examination or assessment to be conducted on an annual or other periodic basis.
4. An absence from or return to work.
5. Legal proceedings. O. Reg. 785/92, s. 1 (2).

(1.3) For the purpose of subparagraph ii of paragraph 24 of subsection (1), a person, other than a person referred to in subsection (1.4), suffers from obesity if the person's body mass index is equal to or greater than 27. O. Reg. 146/98, s. 1 (3).

(1.4) For the purpose of subparagraph ii of paragraph 24 of subsection (1), the following persons suffer from obesity if it is the opinion of the physician who renders the service referred to in paragraph 24 that they suffer from obesity:

1. A pregnant or lactating female.
2. A person of muscular build.
3. A person who is under the age of 20 or over the age of 65. O. Reg. 146/98, s. 1 (3).

(1.5) In subsection (1.3),

“body mass index” means, with respect to a person, the ratio of the person's mass (measured in kilograms) to the square of his or her height (measured in metres). O. Reg. 146/98, s. 1 (3).

(2) The following are deemed not to be insured services:

1. Revoked: O. Reg. 111/96, s. 1.
2. A service provided by a laboratory, physician or hospital that supports a service that is deemed under paragraph 8, 8.1, 8.2, 10, 13, 16, 17, 21, 22, 23, 25, 27 or 28 of subsection (1) not to be an insured service.
3. A service provided by a laboratory and ordered by a dental surgeon. R.R.O. 1990, Reg. 552, s. 24 (2); O. Reg. 785/92, s. 1 (3); O. Reg. 488/94, s. 2 (3); O. Reg. 176/95, s. 1 (2); O. Reg. 111/96, s. 1; O. Reg. 377/98, s. 1 (2); O. Reg. 528/98, s. 2 (2); O. Reg. 250/01, s. 2 (2); O. Reg. 272/01, s. 2 (3, 4); O. Reg. 345/01, s. 8; O. Reg. 295/04, s. 1 (2), O. Reg. 320/04, s. 3 (3); O. Reg. 352/04, s. 4; O. Reg. 168/08, s. 2 (2).

(3) Revoked: O. Reg. 168/08, s. 2 (3).

(4) The following services rendered by physicians are deemed not to be insured services:

1. Physical therapy and therapeutic exercise, including thermal therapy, light therapy, ultrasound therapy, hydrotherapy, massage therapy, electrotherapy, magnetotherapy, transcutaneous nerve stimulation and biofeedback. O. Reg. 272/01, s. 2 (6).

25. (1) The following services rendered outside of Ontario by physicians shall be deemed

not to be insured services in respect of insured persons who are under the age of sixteen years:

1. Ligation, cauterization or removal of vas deferens — uni or bilateral (vasectomy).
2. Hysterectomy or ligation, cauterization or removal of fallopian tubes — uni or bilateral by abdominal or vaginal approach, including laparoscopy, culdoscopy, or hysteroscopy — for sterilization (any method). R.R.O. 1990, Reg. 552, s. 25 (1).

(2) All services rendered outside of Ontario by hospitals in connection with the services specified in subsection (1) shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years. R.R.O. 1990, Reg. 552, s. 25 (2).

(3) Subsections (1) and (2) do not apply where the surgeon or the attending physician believes that the surgical operation is medically necessary for the protection of the physical health of the insured person. R.R.O. 1990, Reg. 552, s. 25 (3).

26. (1) In this section,

“patient” means a patient as defined in section 1 of the *Mental Health Act*;

“psychiatric facility” means a psychiatric facility as defined in section 1 of the *Mental Health Act*;

“psychiatrist” means a psychiatrist as defined in section 1 of the *Mental Health Act*. R.R.O. 1990, Reg. 552, s. 26 (1).

(2) The following services are not insured services under the Plan:

1. Any service or examination for the purpose of legal requirements or proceedings, other than an examination rendered,
 - i. by a psychiatrist, who is not a member of the medical staff of a psychiatric facility in which a patient is detained, for the purpose of clause 49 (4) (b) of the *Mental Health Act*,
 - ii. and documentation prepared by a physician for the purpose of an investigation or confirmation of an alleged sexual assault. R.R.O. 1990, Reg. 552, s. 26 (2).

26.1 Services rendered by a podiatrist are prescribed for the purposes of clause 14 (1) (c) of the Act. O. Reg. 339/96, s. 1; O. Reg. 352/04, s. 5.

PREFERRED PROVIDER ARRANGEMENTS

27. (1) For the purposes of section 28,

- (a) a preferred provider arrangement is a written agreement between the Minister and the operator of a hospital outside Ontario but within Canada for the delivery of specified insured services to insured persons; and
- (b) a reference to the preferred provider is a reference to the operator. O. Reg. 135/09, s. 2.

(2) For the purposes of section 28.0.1,

- (a) a preferred provider arrangement is a written agreement between the Minister and the operator of a health facility outside Ontario but within Canada for the delivery of specified insured services to insured persons; and
- (b) a reference to the preferred provider is a reference to the operator. O. Reg. 135/09, s. 2.

- (3) For the purposes of section 28.4, except paragraph 3 of subsection 28.4 (7),
 - (a) a preferred provider arrangement is a written agreement between the Minister and the operator of a hospital or health facility outside Canada for the delivery of specified insured services to insured persons; and
 - (b) a reference to the preferred provider is a reference to the operator. O. Reg. 135/09, s. 2; O. Reg. 83/11, s. 2.
- (4) For the purposes of section 29,
 - (a) a preferred provider arrangement is a written agreement between the Minister and a physician or practitioner outside Ontario for the delivery of specified insurance services to insured persons; and
 - (b) a reference to the preferred provider is a reference to the physician or practitioner. O. Reg. 135/09, s. 2.

SERVICES OUTSIDE ONTARIO

28. (1) In-patient or out-patient services rendered in a hospital outside Ontario but within Canada are prescribed as insured services if,

- (a) the hospital that supplied the service is approved by the General Manager for the purpose of the Plan;
- (b) the hospital that supplied the service is licensed or approved as a hospital by the governmental hospital licensing authority in whose jurisdiction the hospital is situated;
- (c) the service, if performed in Ontario, is one to which the insured person would be entitled without charge pursuant to section 7 in the case of an in-patient service or section 8 in the case of an out-patient service;
- (d) in the case of an in-patient service, in Ontario, the insured person would ordinarily have been admitted as an in-patient of a public hospital to receive the service;
- (e) the hospital or the insured person provides to the General Manager such information and records as the General Manager may require for the purpose of assessing and verifying the claim; and
- (f) the services received, including accommodation, do not constitute, in the opinion of the General Manager, the domiciliary type of care provided in a long-term care home, an infirmary or other institution of a similar character. O. Reg. 135/09, s. 3; O. Reg. 100/10, s. 7.

(2) An insured person may be reimbursed by the Plan for the receipt of insured services prescribed by subsection (1) on presentation to the General Manager of an account, including a detailed receipt, from the hospital for payment made by the person to the hospital, or the General Manager may cause reimbursement to be made directly to the hospital. O. Reg. 135/09, s. 3.

- (3) The amount to be reimbursed under subsection (2) is determined as follows:
 - 1. If the insured services are rendered in a hospital whose operator is a preferred provider, the amount payable is the amount provided in the preferred provider arrangement.

2. If the insured services are covered by a preferred provider arrangement in the province in which the services are rendered, but the insured person receives services performed by an identical or equivalent procedure in a hospital in that province whose operator is not a preferred provider, the amount payable is the lesser of the following:
 - i. The amount provided in the preferred provider arrangement.
 - ii. The amount actually paid by the insured person.
3. If the insured services are not covered by a preferred provider arrangement in the province in which the services are rendered, the amount payable is the amount payable in accordance with the applicable interprovincial reciprocal billing agreement entered into by the Minister under clause 2 (2) (b) of the Act, and if there is no such agreement, the lesser of the following:
 - i. The usual and customary amount charged under similar circumstances by similar facilities in the jurisdiction where the insured services are rendered.
 - ii. The amount actually paid by the person. O. Reg. 135/09, s. 3.

(4) If an insured person receives in-patient or out-patient services in a hospital outside Ontario but within Canada for an acute attack of tuberculosis, the Plan may reimburse the insured person for the cost of the treatment for a period not exceeding 60 days and subsection (3) applies. O. Reg. 135/09, s. 3.

(5) Subsection (3) applies, and is deemed to have always applied, with respect to services rendered on or after June 3, 2008. O. Reg. 135/09, s. 3.

28.0.1 (1) In-patient or out-patient services rendered in a health facility outside Ontario but within Canada are prescribed as insured services if the Minister has entered into a preferred provider arrangement with the operator of that facility for the delivery of those services and the services are rendered in accordance with the preferred provider arrangement. O. Reg. 135/09, s. 3.

(2) On application by the health facility or by or on behalf of the insured person, the General Manager may cause reimbursement to be made to the health facility for the rendering of insured services prescribed under subsection (1). O. Reg. 135/09, s. 3.

(3) The amount to be reimbursed under subsection (2) is the amount provided in the preferred provider arrangement. O. Reg. 135/09, s. 3.

(4) No amount shall be reimbursed if the Minister has entered into a preferred provider arrangement with the operator of a health facility outside Ontario but within Canada for the delivery of services where,

- (a) a person receives services from that health facility that are covered by the preferred provider arrangement, but the services are not rendered in accordance with the preferred provider arrangement;
- (b) a person receives services from that health facility that are not covered by the preferred provider arrangement; or
- (c) a person receives services performed by an identical or equivalent procedure in another health facility outside Ontario but within Canada whose operator is not a preferred provider for those services. O. Reg. 135/09, s. 3.

(5) This section applies, and is deemed to have always applied, with respect to services

rendered on and after June 3, 2008. O. Reg. 135/09, s. 3.

28.0.2 (1) A therapeutic laboratory service or diagnostic laboratory test that is performed outside Ontario but within Canada for an insured person is prescribed as an insured service if that kind of service or test is not performed in Ontario but the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person. O. Reg. 27/14, s. 1.

(2) Despite subsection (1), a service or test is not prescribed as an insured service if,

(a) the service or test is experimental or the service or test is performed for research purposes; or

(b) the service or test does not constitute a test as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*. O. Reg. 27/14, s. 1.

(3) Subject to subsection (4), an amount is payable for an insured service prescribed by subsection (1) if the service is provided to an insured person and an application for approval of payment is submitted to the General Manager on behalf of the insured person by a physician who practises medicine in Ontario and,

(a) the application includes written confirmation from the physician that, in his or her opinion, the conditions in subsection (1) are satisfied; and

(b) written approval of payment of the amount for the service is granted by the General Manager before the service is rendered and the service is rendered within the time limit set out in the written approval. O. Reg. 27/14, s. 1.

(4) Where an insured service prescribed by subsection (1) is a genetic service or test, an amount is not payable for the insured service unless the application under subsection (3) includes written confirmation from an Ontario physician who is a specialist, as defined in the schedule of benefits, in treating the medical condition to which the test or service for which approval of payment is sought relates that, in that specialist's opinion, the conditions in subsection (1) are satisfied. O. Reg. 27/14, s. 1.

(5) The amount payable by the Plan for a service or test prescribed by subsection (1) is the amount determined by the General Manager. O. Reg. 27/14, s. 1.

(6) An insured person may be reimbursed by the Plan for an amount paid for insured services prescribed by subsection (1) on presentation to the General Manager of an account, including a detailed receipt, from the laboratory that performed the service for payment made by the person to the laboratory, or the General Manager may cause reimbursement to be made directly to the laboratory. O. Reg. 27/14, s. 1.

28.0.3 In the case of any service prescribed under sections 28 to 29, the General Manager may require information and records to be provided in order to assess and verify the claim for payment, and where such information and records are not provided to the satisfaction of the General Manager, the amount payable for the insured service is nil. O. Reg. 27/14, s. 1.

OUT OF COUNTRY SERVICES

28.1 Licensed facilities outside Canada where medical or surgical services are rendered are prescribed as health facilities for the purposes of the Act. O. Reg. 31/92, s. 3.

28.2 (1) Out-patient services described in the Table to this section and rendered outside Canada are prescribed as insured services if,

- (a) they are medically necessary;
- (b) they are rendered by persons other than physicians, dental surgeons, optometrists, osteopaths or podiatrists;
- (c) they are rendered,
 - (i) in a hospital that is licensed or approved as a hospital by the government in whose jurisdiction the hospital is situated, or
 - (ii) in a health facility that is licensed by the government in whose jurisdiction the health facility is situated and in which medical or surgical services are routinely rendered on an out-patient basis; and
- (d) they are rendered for the purpose of treating an illness, disease, condition or injury that,
 - (i) is acute and unexpected,
 - (ii) arose outside Canada, and
 - (iii) requires immediate treatments. O. Reg. 31/92, s. 3; O. Reg. 596/93, s. 1 (1); O. Reg. 345/01, s. 9 (1); O. Reg. 76/12, s. 5 (1, 2).

(2) Subsection (1) does not apply to an out-patient service that is,

- (a) the provision of a drug or other substance for the insured person to take away from the hospital or facility;
- (b) a visit solely to administer a drug or other substance;
- (c) a physiotherapy, radiotherapy, speech therapy, occupational therapy or diet counselling service; or
- (d) a laboratory service. O. Reg. 31/92, s. 3.

(3) The Table to this section sets out the amounts payable by the Plan for insured services prescribed in subsection (1). O. Reg. 31/92, s. 3.

(4) The amounts in the Table are daily amounts that cover all the out-patient services rendered during the day by persons other than physicians, dental surgeons, optometrists, osteopaths or podiatrists. O. Reg. 76/12, s. 5 (3).

(5) An amount payable under this section for out-patient services shall be reduced by any amount paid or payable under section 28.3 for in-patient services rendered to the insured person on the same day. O. Reg. 31/92, s. 3.

(6) If the amount payable under this section is more than the amount that would be payable under the Act and this Regulation if the services were rendered in Ontario, then only that latter amount is payable. O. Reg. 31/92, s. 3.

(7) Subsection (6) does not apply if no amount would be payable under the Act and this Regulation if the services were rendered in Ontario. O. Reg. 31/92, s. 3.

(8) The amount payable under this section for renal dialysis rendered outside of Canada on or after the 1st day of October, 1991 but before the 1st day of May, 1992 is the cost of the dialysis to the patient and subsections (2) to (7) do not apply with respect to such dialysis. O. Reg. 343/92, s. 1.

TABLE OUT OF COUNTRY OUT-PATIENT RATES

1.	Services not described below that are,	
	(a) rendered in a hospital; or	
	(b) rendered in a health facility and that are necessary for the provision of a service that is set out in the schedule of benefits and preceded in the schedule by the symbol “#”	\$50.00
2.	Services that include Magnetic Resonance Imaging (one scan) prescribed by a physician	50.00
3.	Services that include renal dialysis	210.00
4.	Services that include cancer chemotherapy prescribed by a physician	50.00
5.	Services that support a surgical procedure that is ordinarily rendered in an operating room and ordinarily requires the services of an anaesthetist	50.00
6.	Services that include a Computerized Axial Tomography scan prescribed by a physician	50.00
7.	Services that include either lithotripsy or Magnetic Resonance Imaging (more than one scan), prescribed by a physician	50.00
Note: If a day's services are described by more than one item, the applicable amount is the highest amount payable.		

O. Reg. 489/94, s. 1.

28.3 (1) In-patient services rendered outside Canada in an eligible hospital or health facility are prescribed as insured services if,

- (a) the services are medically necessary;
- (b) it is medically necessary that the services be provided on an in-patient basis;
- (c) in Ontario, the insured person would ordinarily have been admitted as an in-patient of a public hospital to receive the services; and
- (d) the services are rendered for the purpose of treating an illness, disease, condition or injury that,
 - (i) is acute and unexpected,
 - (ii) arose outside Canada, and
 - (iii) requires immediate treatment. O. Reg. 31/92, s. 3; O. Reg. 596/93, s. 2; O. Reg. 76/12, s. 6.

(2) In subsection (1),

“eligible hospital or health facility” means,

- (a) a hospital licensed or approved as a hospital by the government in whose jurisdiction the hospital is situated in which complex medical and complex surgical procedures are routinely performed, or
- (b) a health facility licensed by the government in whose jurisdiction the health facility is situated in which complex medical and complex surgical procedures are routinely performed. O. Reg. 31/92, s. 3.

(3) Despite subsection (1), if all the services rendered during a day are part of a domiciliary type of care that, in Ontario, would ordinarily be provided in a long-term care home,

the services are not prescribed as insured services. O. Reg. 31/92, s. 3; O. Reg. 375/93, s. 7; O. Reg. 100/10, s. 8.

(4) The amount payable by the Plan for in-patient services prescribed in subsection (1) is the amount actually billed to a maximum of,

- (a) \$400 per day for the higher level of care described in subsection (5); or
- (b) \$200 per day for any other kind of care. O. Reg. 392/95, s. 1.

(5) The higher level of care referred to in subsection (5) is care for a condition for which the primary treatment ordinarily provided in Ontario is provided in a public hospital in any of the following:

- 1. A coronary care unit.
- 2. An intensive care unit.
- 3. A neonatal or paediatric special care unit.
- 4. An operating room. O. Reg. 392/95, s. 1.

(6) An amount payable under this section covers all the in-patient services rendered during the day including diagnostic procedures or interpretations rendered by physicians but not including any other kind of service rendered by a physician. O. Reg. 31/92, s. 3.

(7) The amount payable under this section for renal dialysis rendered outside of Canada on or after the 1st day of October, 1991 but before the 1st day of May, 1992 is the cost of the dialysis to the patient and subsections (3) to (6) do not apply with respect to such dialysis. O. Reg. 343/92, s. 2.

28.4 (1) In this section,

“emergency circumstances” means medical circumstances in which an insured person faces immediate risk of,

- (a) death, or
- (b) medically significant irreversible tissue damage;

“emergency patient referral service” means a person, agency or organization operating in Ontario that,

- (a) is approved by the General Manager, and
- (b) provides information to physicians, hospitals or health facilities about health services available in emergency circumstances;

“health facility” means,

- (a) a health facility licensed as a health facility by the government in whose jurisdiction the health facility is situated in which complex medical and complex surgical procedures are routinely performed,
- (b) whether or not described in clause (a), a facility licensed by the government in whose jurisdiction the facility is situated with whose operator the Minister has entered into a preferred provider arrangement;

“hospital” means a hospital licensed or approved as a hospital by the government in whose jurisdiction the hospital is situated in which complex medical and complex surgical procedures are routinely performed;

“urgent circumstances” means emergency circumstances in which it would be impossible or so impractical as to be impossible for a hospital or health facility in which services are rendered to give notice to the General Manager before the services are rendered. O. Reg. 135/09, s. 4.

(2) Services that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

- (a) the service is generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person;
- (b) the service is medically necessary;
- (c) either,
 - (i) the identical or equivalent service is not performed in Ontario, or
 - (ii) the identical or equivalent service is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage;
- (d) in the case of a hospital service or a service rendered in a health facility, the service, if performed in Ontario, is one to which the insured person would be entitled without charge pursuant to section 7 in the case of an in-patient service or section 8 in the case of an out-patient service; and
- (e) in the case of a service performed for an insured person who is admitted as an in-patient at a hospital or for an overnight stay at a health facility in Ontario, the insured person would ordinarily have been admitted to a public hospital as an in-patient. O. Reg. 135/09, s. 4; O. Reg. 76/12, s. 7 (1).

(3) Services that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

- (a) the conditions in clauses (2) (a), (b), (d) and (e) are satisfied; and
- (b) the service is rendered in urgent circumstances in order to treat medical complications resulting or arising from services,
 - (i) that are insured services under subsection (2),
 - (ii) that are rendered in circumstances that are not emergency circumstances, and
 - (iii) for which written approval of payment was granted before the services are rendered, in accordance with subparagraph 1 i of subsection (4). O. Reg. 135/09, s. 4.

(3.1) Despite anything in this section, this section does not apply to a service that is a therapeutic laboratory service or a diagnostic laboratory test, unless the therapeutic laboratory service or diagnostic laboratory test is necessary for the purpose of rendering a service that is insured under this section and that is not a therapeutic laboratory service or diagnostic laboratory test. O. Reg. 83/11, s. 3 (1).

(4) Despite anything in this section as it read before April 1, 2009, a service is not, and is deemed never to have been, an insured service under this section unless the following conditions are satisfied:

1. For services rendered in circumstances that are not emergency circumstances,

i. written approval of payment of the amount for the services is granted by the General Manager before the services are rendered, and

ii. the services are rendered within the time limit set out in the written approval.

2. For services rendered in emergency circumstances, written approval of payment of the amount for the services is granted by the General Manager, either before or after the services are rendered. O. Reg. 135/09, s. 4.

(5) For the purposes of clause (2) (c), a service is performed in Ontario if the service can be legally obtained by an insured person in Ontario and includes,

(a) services that are prescribed as insured services, other than under this section;

(b) services that are publicly funded, in whole or in part;

(c) services that are for sale anywhere in Ontario to a person in the same medical circumstances as the insured person; and

(d) services that a person in the same medical circumstances as the insured person is eligible to receive in Ontario under or through any program or policy, including a program or policy permitting special or extraordinary access to the services. O. Reg. 135/09, s. 4.

(6) The amount payable for insured services prescribed by subsections (2) and (3) is determined as follows:

1. If the services are rendered in a hospital whose operator is a preferred provider, the amount payable is the amount provided in the preferred provider arrangement.

2. If the services are covered by one or more preferred provider arrangements, but the insured person receives identical or equivalent services in or from a hospital or health facility whose operator is not a preferred provider, the amount payable is nil.

3. If the services are not covered by a preferred provider arrangement, the amount payable is the usual and customary amount charged by similar facilities under similar circumstances to major insurers for services rendered, to persons they insure, in facilities located in the jurisdiction where the insured services are rendered. O. Reg. 135/09, s. 4.

(7) An amount is payable for insured services prescribed by subsection (2) if the following conditions are met:

1. An application for approval of payment is submitted to the General Manager on behalf of the insured person,

i. by a physician who practises medicine in Ontario, or

ii. by an emergency patient referral service, but only in emergency circumstances.

2. The application mentioned in paragraph 1 includes written confirmation that the conditions set out in clauses (2) (a) and (b) and one of the conditions set out in clause (2) (c) are satisfied, from,

i. a physician who is a specialist, as defined in the schedule of benefits, in the type of service for which approval of payment is sought,

ii. a general practitioner, if the type of service for which approval of payment is sought is within the general practitioner's scope of practice, or

- iii. in emergency circumstances, a physician who practises medicine in Ontario or an emergency patient referral service.
- 3. In circumstances that are not emergency circumstances, a service that is identical or equivalent to the service for which payment is sought is not covered by a preferred provider arrangement entered into,
 - i. between the Minister and the operator of a hospital outside Ontario but within Canada under subsection 27 (1),
 - ii. between the Minister and the operator of a health facility outside Ontario but within Canada under subsection 27 (2), or
 - iii. between the Minister and a physician or practitioner outside Ontario but within Canada under subsection 27 (4).
- 4. For a service that consists primarily of the administration of a drug, including the provision of the drug that is administered, there is a recommendation from the executive officer appointed under the *Ontario Drug Benefit Act* for payment for the drug for a person in the same medical circumstances as the insured person. O. Reg. 135/09, s. 4; O. Reg. 83/11, s. 3 (2, 3).

(7.1) For the purposes of subclause (2) (c) (i), if there is a physician in Ontario who has provided written confirmation that he or she is available to provide the service that is the subject of an application under subsection (7) and the service is within the physician's scope of practice, the service is deemed to be identical or equivalent to the service that is the subject of the application. O. Reg. 83/11, s. 3 (4).

(7.2) For the purposes of paragraph 3 of subsection (7), if there is a physician in Canada who has provided written confirmation that he or she is available to provide the service that is the subject of an application under subsection (7) and the service is within the physician's scope of practice, the service is deemed to be identical or equivalent to the service that is the subject of the application. O. Reg. 83/11, s. 3 (4).

(8) An amount is payable for insured services prescribed by subsection (3) if the following conditions are met:

- 1. An application for approval of payment is submitted to the General Manager by or on behalf of the insured person.
- 2. The application includes written confirmation from the hospital or health facility in which the service is rendered that, in the opinion of the hospital or health facility,
 - i. the service is rendered in urgent circumstances in order to treat medical complications resulting or arising from services that are insured services under subsection (2), and
 - ii. the service is medically necessary. O. Reg. 135/09, s. 4.

(9) Subject to subsection (4), this section, as it read immediately before April 1, 2014, continues to apply to applications for approval of payment for services in circumstances that are not emergency circumstances,

- (a) if the applications were mailed, faxed or otherwise delivered to the General Manager before that date; or
- (b) if the applications are in respect of the continuation or extension of the same service for which approval was granted before that date, as long as,

- (i) the service is for the same insured person,
- (ii) the service is for the same medical condition, and
- (iii) the insured person has been outside of Canada receiving the service at a hospital or health facility on a continuous basis without having returned to Ontario since before April 1, 2014. O. Reg. 76/12, s. 7 (2).

28.5 (1) A therapeutic laboratory service or diagnostic laboratory test that is performed outside Canada is prescribed as an insured service if that kind of service or test is not performed in Ontario but the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person. O. Reg. 31/92, s. 3.

(2) Despite subsection (1), a service or test is not prescribed as an insured service if the service or test is experimental or the service or test is performed for research purposes. O. Reg. 31/92, s. 3.

(3) The amount payable by the Plan for a service or test prescribed by subsection (1) is the amount determined by the General Manager. O. Reg. 31/92, s. 3.

(4) An amount is payable for an insured service prescribed by subsection (1) if the following conditions are met:

1. An application for approval of payment is submitted to the General Manager on behalf of the insured person by a physician who practises medicine in Ontario.
2. The application mentioned in paragraph 1 includes written confirmation from the physician who submits the application that, in his or her opinion, the conditions in subsection (1) are satisfied.
3. Written approval of payment of the amount for the service is granted by the General Manager before the service is rendered and the service is rendered within the time limit set out in the written approval.
4. The service is a test as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*. O. Reg. 83/11, s. 4 (1).

(4.1) Where an insured service prescribed by subsection (1) is a genetic service or test, an amount is not payable for the insured service unless, in addition to the written confirmation required under paragraph 2 of subsection (4), there is written confirmation from an Ontario physician who is a specialist, as defined in the schedule of benefits, in treating the medical condition to which the service or test for which approval of payment is sought relates that, in that specialist's opinion, the conditions in subsection (1) are satisfied. O. Reg. 267/13, s. 3.

(4.2) This section, as it read immediately before April 1, 2013, continues to apply to applications for approval of payment for services if the applications were mailed, faxed or otherwise delivered to the General Manager before that date. O. Reg. 76/12, s. 8.

(5) A payment under this section may only be made directly to the person who performed the service or test. O. Reg. 31/92, s. 3.

(6) This section, as it read immediately before April 1, 2011, continues to apply to an application for approval of payment for a service if the application was mailed, faxed or otherwise delivered to the General Manager before that date. O. Reg. 83/11, s. 4 (2).

28.6 (1) For in-patient services, it is a condition of the payment of any amount under section 28.3 or 28.4 that the General Manager receive, from the hospital or health facility where

the services were rendered, a written statement showing,

- (a) the day the insured person was admitted;
- (b) the diagnosis of the condition for which the insured person was admitted;
- (c) the date of discharge or death of the insured person;
- (d) the nature of any complications, if any, that warranted a stay in the hospital or health facility that was longer than the average stay of persons with the same condition or disease as the insured person;
- (e) the kind and number of any laboratory, radiological or other diagnostic tests performed;
- (f) the nature of any treatment, procedure or surgery that was performed;
- (g) the discharge diagnosis or cause of death, as the case may be; and
- (h) any other information required by the General Manager. O. Reg. 31/92, s. 3.

(2) For out-patient services, it is a condition of the payment of any amount under section 28.2 or 28.4 that the General Manager receive, from the hospital or health facility where the services were rendered, a written statement showing,

- (a) the diagnosis of the condition for which the insured person was treated;
- (b) the kind and number of any laboratory, radiological or other diagnostic tests performed;
- (c) the nature of any treatment, procedure or surgery that was performed;
- (d) the date or dates when the insured person was treated; and
- (e) any other information required by the General Manager. O. Reg. 31/92, s. 3.

(3) It is a condition of payment of any amount for services under section 28.2, 28.3 or 28.4 that the General Manager receive,

- (a) for payments to the insured person, a detailed receipt; or
- (b) for payments directly to the person billing for the services, a detailed invoice in a form specified by the General Manager and a written direction from the insured person authorizing payment to the person billing for the services. O. Reg. 31/92, s. 3.

(4) It is a condition for the payment of any amount for services under section 28.5 that the General Manager receive from the hospital or health facility where the service or test was performed,

- (a) a written statement showing the kind and number of service or test performed and any other information required by the General Manager; and
- (b) a detailed invoice in a form specified by the General Manager. O. Reg. 31/92, s. 3.

HEALTH SERVICES

29. (0.1) A service rendered by a physician outside Ontario is an insured service if it is referred to in the schedule of benefits and rendered in such circumstances and under such conditions as may be specified in the schedule of benefits. O. Reg. 135/09, s. 5 (1).

(1) The amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person is as follows:

1. If payment for the service is provided for in a preferred provider arrangement, the amount payable is the amount provided for in the preferred provider arrangement.
2. In all other cases, the amount payable is the lesser of the following:
 - i. The amount actually billed by the physician.
 - ii. The amount payable for the service in the schedule of benefits. O. Reg. 76/12, s. 9 (2).

(2) Despite subsection (1), the amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990 is, for the services Vital capacity, FEV₁, FEV₁/FVC with or without MMEFR (FEF 25-75) calculation, Repeat J301 after bronchodilator, Flow volume loop (FVC, FEV₁, FEV₁/FVC, V₅₀, V₂₅), and Repeat J304 after bronchodilator listed under the heading of “Pulmonary Function Studies” of the schedule of benefits, is the lesser of,

- (a) the amount actually billed by the physician; or
- (b) the amount calculated by adding the amount payable for the service in Column P and the amount payable for the service in Column T. R.R.O. 1990, Reg. 552, s. 29 (2); O. Reg. 178/99, s. 2 (2).

(3) Despite subsections (1) and (2), if the services Vital capacity, FEV₁, FEV₁/FVC with or without MMEFR (FEF 25-75) calculation and Flow volume loop (FVC, FEV₁, FEV₁/FVC, V₅₀, V₂₅) are rendered together by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990, the amount payable by the Plan for the services is the lesser of,

- (a) the amount actually billed by the physician; or
- (b) \$31.50. R.R.O. 1990, Reg. 552, s. 29 (3).

(4) Despite subsection (1), the amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990 and listed under the heading “Nuclear Medicine — In Vivo”, “Diagnostic Radiology”, “Diagnostic Ultrasound” or “Pulmonary Function Studies” of Schedule 16 is the lesser of,

- (a) the amount actually billed by the physician; or
- (b) the amount calculated by adding the amount payable for the service and, for a service listed under the heading,
 - (i) “Nuclear Medicine — In Vivo”,
 - (A) for visual inspection of imaging studies, the amount, or
 - (B) for visual inspection of imaging studies and quantification or data manipulation, 130 per cent of the amount,

payable for the service in Column P₁ or P₂ of the schedule of benefits, as the case may be, except for Tomography (SPECT), Myocardial wall motion studies, and Myocardial wall motion studies with ejection fraction, in which case, the amount payable for the service in Column P₁ or P₂, as the case may be, or

- (ii) “Diagnostic Radiology”, “Diagnostic Ultrasound” or “Pulmonary Function Studies”, the amount payable for the service in Column P of the schedule of benefits. R.R.O. 1990, Reg. 552, s. 29 (4); O. Reg. 178/99, s. 2 (3).

(5) Despite subsection (4), if the services Bone scintigraphy — general survey and Bone scintigraphy — single site are rendered together by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990, the amount payable by the Plan for the services is the lesser of,

- (a) the amount actually billed by the physician; or
- (b) the amount calculated by adding \$98.80 and,
 - (i) for visual inspection of imaging studies, the amount, or
 - (ii) for visual inspection of imaging studies and quantification or data manipulation, 130 per cent of the amount,payable for Bone scintigraphy — general survey in Column P₁ or P₂ of the schedule of benefits, as the case may be. R.R.O. 1990, Reg. 552, s. 29 (5); O. Reg. 178/99, s. 2 (4).

(6) Despite subsection (4), if the services Bone scintigraphy — general survey or Bone scintigraphy — single site and First transit with blood pool images are rendered together by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990, the amount payable by the Plan for the services is the lesser of,

- (a) the amount actually billed by the physician; or
- (b) the amount calculated by adding \$15.30, the amount payable for Bone scintigraphy — general survey or Bone scintigraphy — single site, as the case may be, in Schedule 16 and,
 - (i) for visual inspection of imaging studies, the amounts, or
 - (ii) for visual inspection of imaging studies and quantification or data manipulation, 130 per cent of the amounts,payable for First transit without blood pool images and Bone scintigraphy — general survey or Bone scintigraphy — single site, as the case may be, in Column P₁ or P₂ of the schedule of benefits, as the case may be. R.R.O. 1990, Reg. 552, s. 29 (6); O. Reg. 178/99, s. 2 (5).

(7) Despite subsection (4), the amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990 is for the services Brain scintigraphy, Perfusion lung scintigraphy, Ventilation lung scintigraphy, Perfusion and ventilation scintigraphy — same day, and Liver/spleen scintigraphy listed under the heading “Nuclear Medicine — In Vivo” of Schedule 16, if the service is limited to one view, the lesser of,

- (a) the amount actually billed by the physician; or
- (b) 50 per cent of the amount calculated by adding the amount payable for the service in Schedule 16 and the amount payable for the service in Column P₁ or P₂ of the schedule of benefits, as the case may be. R.R.O. 1990, Reg. 552, s. 29 (7); O. Reg. 178/99, s. 2 (6).

(8) Despite subsection (4), the amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990 and listed under the heading “Diagnostic Radiology” of Schedule 16 is, if less than the minimum number of views set out opposite the service is rendered, the lesser of,

(a) the amount actually billed by the physician; or

(b) 75 per cent of the amount calculated by adding the amount payable for the service in Schedule 16 and the amount payable for the service in Column P of the schedule of benefits. R.R.O. 1990, Reg. 552, s. 29 (8); O. Reg. 178/99, s. 2 (7).

(9) Despite subsection (4), if the services Carbon monoxide diffusing capacity by steady state at rest and Carbon monoxide diffusing capacity by single breath method are rendered together by a physician outside Ontario to an insured person on or after the 22nd day of April, 1990, the amount payable by the Plan for the services is the lesser of,

(a) the amount actually billed by the physician; or

(b) \$35.80. R.R.O. 1990, Reg. 552, s. 29 (9).

(10) Payment for insured services specified in sections 16 to 19 rendered by a practitioner outside Ontario shall be in the amounts actually billed or in the amounts prescribed under sections 16 to 19, whichever is the lesser. O. Reg. 31/92, s. 4.

(10.1) Despite subsections (1) to (10), if the insured services are rendered by a physician or practitioner who is a preferred provider, the amount payable is the amount provided in the preferred provider arrangement. O. Reg. 135/09, s. 5 (2).

(10.2) Revoked: O. Reg. 76/12, s. 9 (3).

(10.3) In the case of insured services rendered outside Ontario but within Canada that are not covered by a preferred provider arrangement in the province in which the services are rendered, the amount payable is determined in accordance with subsections (1) to (10). O. Reg. 135/09, s. 5 (2).

(10.4) Despite subsections (1) to (10), in the case of insured services rendered outside Canada that are covered by a preferred provider arrangement, if the insured person receives services performed by an identical or equivalent procedure from a physician or practitioner who is not a preferred provider, the amount payable is nil. O. Reg. 135/09, s. 5 (2).

(10.5) Subsections (10.1) to (10.4) apply, and are deemed to have always applied, with respect to services rendered on or after June 3, 2008. O. Reg. 135/09, s. 5 (2).

(11) It is a condition of payment by the Plan for an insured service rendered outside Canada by a physician or a practitioner that the service is rendered in connection with an illness, disease, condition or injury that,

(a) is acute and unexpected;

(b) arose outside Canada; and

(c) requires immediate treatment. O. Reg. 596/93, s. 3.

30. (1) Where physiotherapy services are performed in Canada but outside Ontario they are an insured service only when performed on an in-patient or out-patient basis in a hospital. R.R.O. 1990, Reg. 552, s. 30 (1).

(2) Revoked: O. Reg. 31/92, s. 5.

31., 32. Revoked: O. Reg. 76/12, s. 10.

33. Revoked: O. Reg. 31/92, s. 7.

DESIGNATED HOSPITALS AND HEALTH FACILITIES

34. No hospital or health facility in Ontario providing for the care and treatment of the sick, injured or disabled, other than a hospital or health facility designated under the Act and this Regulation, is entitled to payment by the Plan in respect of insured services provided to an insured person in or by such hospital or health facility. R.R.O. 1990, Reg. 552, s. 34.

35. (1) The following hospitals are designated for the purpose of the Plan:

1. The hospitals listed in Schedule 2.
2. The hospitals graded, under the *Public Hospitals Act*, as Group A, B, C, E, F, G, J or R hospitals.
3. Revoked: O. Reg. 322/01, s. 5 (1).

O. Reg. 253/00, s. 5 (1); O. Reg. 322/01, s. 5 (1).

(2) Each hospital listed in Schedule 1 is designated for the purpose of providing such in-patient and out-patient services to insured persons as are available in the hospital. R.R.O. 1990, Reg. 552, s. 35 (2).

(3) Each hospital graded, under the *Public Hospitals Act*, as a Group M hospital is designated for the purpose of performing computerized axial tomography scans. O. Reg. 322/01, s. 5 (2).

(4)-(7) Revoked: O. Reg. 253/00, s. 5 (3).

(8) Revoked: O. Reg. 363/02, s. 1.

(9) Each hospital listed in Schedule 4 is designated for the purpose of providing the type of care and treatment designated in the Schedule for that hospital. R.R.O. 1990, Reg. 552, s. 35 (9).

(10) Revoked: O. Reg. 138/13, s. 3.

(11) Each rehabilitation centre or crippled children's centre listed in Schedule 6 is designated as a hospital for the purpose of providing the insured services indicated in Schedule 6. R.R.O. 1990, Reg. 552, s. 35 (11).

(12) Each ambulance service operator listed in Schedule 7 is designated as a health facility for the purpose of providing insured ambulance services. R.R.O. 1990, Reg. 552, s. 35 (12).

(13) Each Public Health Laboratory listed in Schedule 8 is designated as a health facility for the purpose of providing laboratory services. R.R.O. 1990, Reg. 552, s. 35 (13).

(14) Revoked: O. Reg. 375/93, s. 8.

INFORMATION TO BE FURNISHED BY DESIGNATED HOSPITALS

36. Every hospital in Ontario designated for the purpose of the Plan shall forward to the General Manager,

- (a) within twenty-four hours after an in-patient is admitted, a notification of admission in the prescribed form and if ambulance service has been required, a notification of the name of the ambulance operator listed in Schedule 7 who provided such service, together with the amount of the ambulance service charges;
- (b) within ninety-six hours after an in-patient is discharged from or dies in the hospital, a notification of the discharge or death in the prescribed form and if ambulance service

was required when the patient was discharged, a notification of the name of the ambulance operator listed in Schedule 7 who provided such service, together with the amount of the ambulance service charges;

- (c) as required by the General Manager, a longstay report in the prescribed form;
- (d) a list of out-patients in the prescribed form, in duplicate, when the form is filled in, or not later than the twenty-fifth day of each month, whichever is the sooner;
- (e) monthly operating statements and financial and statistical returns in the prescribed forms as required by the General Manager; and
- (f) within thirty days after an in-patient is admitted as the result of an accident or at the time of discharge, whichever is earlier, and for each subsequent admission, an accident report in the prescribed form. R.R.O. 1990, Reg. 552, s. 36.

37. (1) A hospital is prescribed as an organization that must provide information to the General Manager for the purposes of subsection 37 (2) of the Act. O. Reg. 44/98, s. 5.

(2) A hospital shall give the General Manager a written statement regarding the condition of an insured person who received insured services or other treatment in the hospital and the statement shall,

- (a) be prepared by the physician, oral and maxillofacial surgeon, midwife or registered nurse in the extended class who attends the insured person in the hospital; and
- (b) set out the reasons the insured services and other treatment provided to the insured person during his or her stay in hospital were necessary. O. Reg. 44/98, s. 5; O. Reg. 345/01, s. 10 (1).

(3) The General Manager may require a hospital to obtain the written statement described in subsection (4) from the insured person's attending physician, oral and maxillofacial surgeon, midwife or registered nurse in the extended class and to forward it to the General Manager. O. Reg. 62/03, s. 4.

(4) The written statement, to be prepared by the attending physician, oral and maxillofacial surgeon, midwife or registered nurse in the extended class, is a statement regarding the condition of the insured person and must state the reason that any ambulance services provided to the insured person are necessary. O. Reg. 62/03, s. 4.

PHYSICIAN SERVICES

37.1 (1) A service rendered by a physician in Ontario is an insured service if it is referred to in the schedule of benefits and rendered in such circumstances or under such conditions as may be specified in the schedule of benefits. O. Reg. 111/96, s. 2.

(2) The basic fee payable by the Plan for an insured service prescribed under subsection (1) is the fee payable under the schedule of benefits. O. Reg. 111/96, s. 2.

(2.0.1) In this section,

“diagnostic service” means a service rendered by a physician in Ontario that is listed in the schedule of benefits with a technical and professional fee. O. Reg. 376/06, s. 1 (1).

(2.1) Despite subsection (2), the amount payable for a diagnostic service rendered on or after April 1, 2001 and before April 1, 2005 is nil if the service is an insured service rendered to an insured person who was, at the time he or she received the service,

- (a) an inpatient of a hospital;
- (b) a patient in the emergency department of a hospital; or
- (c) a patient in a hospital for the purpose of receiving day care services. O. Reg. 374/05, s. 2.

(2.2) Subsection (2.1) does not apply in respect of a diagnostic service rendered to an insured person who was, at the time he or she received the service, a patient described in clause (2.1) (b) or (c) if,

- (a) an account for the diagnostic service was submitted to the Plan for payment,
 - (i) on or before February 1, 2005 if the diagnostic service was rendered on or after April 1, 2001 and before August 1, 2004, or
 - (ii) not more than six months after the day on which the diagnostic service was rendered if the diagnostic service was rendered on or after August 1, 2004 and before April 1, 2005; and
- (b) the insured person was not, within 24 hours after receiving the diagnostic service, admitted to the same hospital as an in-patient in connection with the condition, illness, injury or disease in relation to which the diagnostic service was rendered. O. Reg. 374/05, s. 2.

(2.3) Revoked: O. Reg. 376/06, s. 1 (2).

(2.4) Despite subsection (2), the amount payable for those services rendered to an insured person on or after April 1, 2004 and no later than March 31, 2006 that are set out in the section of the General Preamble of the schedule of benefits entitled "Emergency Department Sessional Fees" is increased by 2.5 per cent. O. Reg. 318/06, s. 2 (1).

(2.5) Despite subsection (2), the amount payable for the following services rendered on or after October 1, 2005, as those services are defined in the schedule of benefits as it read on April 1, 2006, is the fee payable under that version of the schedule of benefits:

1. Subsequent visit by the most responsible physician - second day following the hospital admission assessment (C123).
2. Subsequent visit by the most responsible physician - day following the hospital admission assessment (C122). O. Reg. 318/06, s. 2 (2).

(2.5.1) Despite subsection (2), the amount payable for the professional component of a diagnostic service rendered by a physician at a department of a public hospital after the time specified in subsection (2.5.2) and before October 1, 2006 to an in-patient in the hospital is the amount payable for the same service rendered to an out-patient of the hospital. O. Reg. 376/06, s. 1 (3).

(2.5.2) The time mentioned in subsection (2.5.1) is the later of April 1, 2006 and the effective date on which the hospital and the physicians routinely practicing in the hospital department notify the General Manager in writing of the hospital's intention to decline global funding for the professional component of in-patient diagnostic services rendered in the department. O. Reg. 376/06, s. 1 (3).

(2.6) Despite subsection (2), the amount payable for the following services rendered on or after July 1, 2006 and before October 1, 2009 to an insured person who falls into the age group described in Column 2 of the following Table is increased by the percentage specified in Column 3 opposite the age group:

1. A consultation, limited consultation or repeat consultation rendered by a specialist, as those services are defined in the schedule of benefits.
2. A surgical procedure listed in Parts K to Z inclusive of the schedule of benefits.
3. Basic and time unit surgical assistant services listed in Parts K to Z inclusive of the schedule of benefits.

TABLE

Column 1 Item	Column 2 Age Group	Column 3 Percentage Increase
1.	Less than 30 days of age	30%
2.	At least 30 days but less than one year of age	25%
3.	At least one year but less than two years of age	20%
4.	At least two years but less than five years of age	15%
5.	At least five years but less than 16 years of age	10%

O. Reg. 318/06, s. 2 (3); O. Reg. 421/09, s. 2 (1).

(2.7) Despite subsection (2), the amount payable for the following services rendered on or after January 1, 2008 and before October 1, 2009 to an insured person who is at least 65 years of age, as those services are defined in the schedule of benefits, is increased by 15 per cent:

1. A general assessment (A003, A903, C003, W102, W109 or W903).
2. An intermediate assessment (A007). O. Reg. 318/06, s. 2 (3); O. Reg. 421/09, s. 2 (2).

(2.8) Despite subsection (2), the amount payable for a service rendered to an insured person by a physician and described by fee code H055, H065, H105, H112, H113, H121, H122, H123, H124, H131, H132, H133, H134, H151, H152, H153 or H154 of the schedule of benefits is increased by 5 per cent if the service was rendered on or after September 1, 2006 and before December 1, 2006. O. Reg. 98/07, s. 2.

(2.9) Despite anything in this Regulation, and despite anything in this Regulation as it existed at any time after September 19, 1999, but subject to subsection (2.10), the insured service described as gastric bypass or partition for morbid obesity (fee schedule code S120 in the schedule of benefits) does not include, and shall be deemed never to have included, the service described as adjustable gastric banding by laparoscopic or open surgical method. O. Reg. 8/08, s. 2.

(2.10) Subsection (2.9) does not affect the authority of the Appeal Board to direct the General Manager to make a payment for laparoscopic gastric banding in the same amount and subject to the same conditions as a payment could have been made for gastric bypass or partition for morbid obesity (fee schedule code S120) in response to a claim for payment for adjustable gastric banding by laparoscopic or open surgical method made in an appeal to the Appeal Board, if notice of the appeal was served on the General Manager before November 19, 2007. O. Reg. 8/08, s. 2.

(2.11) Despite subsection (2), the amount payable for a service rendered by a physician to an insured person on or after April 1, 2012 shall be determined as if page GP12 of the General Preamble to the schedule of benefits (Diagnostic Services Rendered by the Referring Physician), as it was deemed to read on April 1, 2012, did not exist. O. Reg. 8/13, s. 2.

(3) A laboratory service set out in the schedule of laboratory benefits and rendered by a physician is an insured service. O. Reg. 214/10, s. 2 (1).

(4) Revoked: O. Reg. 214/10, s. 2 (2).

(5) The basic fee payable for a laboratory service set out in the schedule of laboratory benefits and rendered by a physician is nil. O. Reg. 214/10, s. 2 (3).

(6) If, under this Regulation or under an agreement to which the Government of Ontario is a party, the fee payable for a laboratory service set out in the schedule of laboratory benefits and rendered by a physician is nil, the fee payable for an insured service rendered in relation to the laboratory service by a physician in a public hospital is nil. O. Reg. 404/10, s. 2.

(7) Despite subsection (6), if a physician who practises laboratory medicine in a public hospital renders a diagnostic consultation in relation to a laboratory service set out in the schedule of laboratory benefits at the request of another physician, the fee payable for the diagnostic consultation is the fee set out in the schedule of benefits. O. Reg. 404/10, s. 2.

(8) For the purposes of subsection (7), a diagnostic consultation occurs when a physician in a public hospital gives a written opinion with respect to tissue, slides or specimens,

- (a) that were prepared in a licensed laboratory that is not in the public hospital where the physician providing the diagnostic consultation practises;
- (b) that were prepared for the purpose of providing an insured service; and
- (c) that are referred to the physician providing the diagnostic consultation by the physician requesting the diagnostic consultation. O. Reg. 404/10, s. 2.

(9) In subsection (8),

“licensed laboratory” means a laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act*. O. Reg. 404/10, s. 2.

(10), (11) Revoked: O. Reg. 214/10, s. 2 (5).

37.1.1 (1) Despite subsection 37.1 (1), the following services rendered by an ophthalmologist in Ontario on or after April 1, 2002 and before June 15, 2002 are insured services if all of the conditions listed in subsection (2) are met:

1. Ocular photodynamic therapy, including establishment of intravenous access.
2. The provision of verteporfin.
3. The supervision of drug infusion and application of non-thermal diode laser for the activation of verteporfin. O. Reg. 169/02, s. 4.

(2) These are the conditions that must be met:

1. The service is provided for the treatment of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
2. The area of classic subfoveal choroidal neovascularization is equal to or greater than 50 per cent of the total lesion, as determined by fluorescein angiography.
3. The first treatment is commenced within 30 months after the initial diagnosis of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.
4. The patient’s visual acuity is 20/40 or worse. O. Reg. 169/02, s. 4.

(3) Despite subsection 37.1 (2), the basic fee payable by the Plan for an insured service described in subsection (1) is the lesser of,

- (a) the amount actually paid by the insured person for the service; and
- (b) the usual amount charged for the service in Ontario for similar treatment provided in similar circumstances. O. Reg. 169/02, s. 4.

37.2 Revoked: O. Reg. 370/00, s. 1.

37.3 (1) Subject to subsection (2), the basic fee payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be increased by 1.95 per cent if it is rendered on or after April 1, 2000. O. Reg. 369/00, s. 1.

(2) The increase in the basic fee payable under subsection (1) does not apply to an insured service referred to in Part 2 of Appendix E to the General Preamble to the schedule of benefits, other than a service referred to at the end of that Part of the Appendix under the heading "Other". O. Reg. 369/00, s. 1.

37.4 The basic fee payable for an insured service that is rendered in a hospital and set out in Part 2 of Appendix E to the General Preamble to the schedule of benefits shall be decreased by,

- (a) 6.7 per cent, if it is rendered before April 1, 1999;
- (b) 3 per cent, if it is rendered on or after April 1, 1999 but before October 1, 1999; and
- (c) 7 per cent, if it is rendered on or after October 1, 1999. O. Reg. 177/99, s. 1; O. Reg. 483/99, s. 1.

37.5 (1) This section, as it read immediately before April 1, 2002, continues to apply with respect to payments for services rendered before April 1, 2002. O. Reg. 267/05, s. 1.

(2) This section, as it read immediately before April 1, 2005, continues to apply with respect to payments for services rendered after March 31, 2002 and before April 1, 2005, except that, with respect to services rendered after March 31, 2004 and before April 1, 2005, the amount in the Table to this section as it existed at that time shall be read as if it said "\$466,375" instead of "\$455,000". O. Reg. 267/05, s. 1.

37.6 (1) The basic fee payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be increased by 2.5 per cent if,

- (a) the service is rendered on or after April 1, 2004; and
- (b) the service is listed in the publication of the Ministry of Health and Long-Term Care entitled "List of Family Practice Professional Fees described in s. 4.A.1(a) of the 2004 Memorandum of Agreement between the Ontario Medical Association and the Minister of Health and Long-Term Care". O. Reg. 267/05, s. 2.

(2) The basic fee payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be increased by 2 per cent if,

- (a) the service is rendered on or after April 1, 2004; and
- (b) the service is listed in the publication of the Ministry of Health and Long-Term Care entitled "List of Specialist Practice Professional Fees described in s. 4.A.1(b) of the 2004 Memorandum of Agreement between the Ontario Medical Association and the Minister of Health and Long-Term Care". O. Reg. 267/05, s. 2.

37.7 The basic fee payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be increased by 1 per cent if,

- (a) the service is rendered on or after April 1, 2005; and
- (b) the service is listed in the publication of the Ministry of Health and Long-Term Care entitled "List of Technical Fees described in s. 4.A.1(c) of the 2004 Memorandum of Agreement between the Ontario Medical Association and the Minister of Health and Long-Term Care". O. Reg. 267/05, s. 3.

37.8 Despite subsection 37.1 (2), the amount payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be reduced by 0.5 per cent if the service is rendered on or after April 1, 2013. O. Reg. 8/13, s. 3.

BILLING AND PAYMENT FOR INSURED SERVICES

38. (1) Revoked: O. Reg. 111/96, s. 3.

(2) A physician who does not submit his or her accounts directly to the Plan may commence to bill the Plan by giving written notice to the General Manager that he or she intends to bill the Plan directly and the notification becomes effective the first day of the third month following the month in which the General Manager receives such notification but may become effective on an earlier date as ordered by the General Manager. R.R.O. 1990, Reg. 552, s. 38 (2).

(3) A physician who does not submit his or her accounts directly to the Plan and who becomes a full-time member of a clinic that is registered with the Plan may give written notice to the General Manager that he or she intends to bill the Plan directly and the notification becomes effective the first day of the month following the month in which the General Manager receives such notification. R.R.O. 1990, Reg. 552, s. 38 (3).

(4) Subject to subsection (5), the following classes of accounts are exempt from the application of section 15 of the Act:

1. Accounts for the performance of insured services rendered to an insured person who is a recipient of a war veteran's allowance under the *War Veterans Allowance Act* (Canada).
2. Accounts for the performance of insured services rendered to an insured Indian who is a member of a band as defined in the *Indian Act* (Canada).
3. Accounts for the performance of insured services rendered to an insured person in an out-patient or any other clinical department of a public hospital.
4. Accounts for the performance of insured services rendered to an insured person in,
 - i. a long-term care home,
 - ii. Revoked: O. Reg. 100/10, s. 9 (1).
 - iii. a children's mental health centre under the *Children's Mental Health Services Act*, being chapter 69 of the Revised Statutes of Ontario, 1980,
 - iv. a hospital established or approved under the *Community Psychiatric Hospitals Act*,
 - v. a psychiatric facility under the *Mental Health Act*,
 - vi. an institution designated as an approved home under the *Mental Hospitals Act*,
 - vii. a designated facility to which the *Developmental Services Act* applies, or
 - viii. a home for special care, established, approved or licensed under the *Homes for Special Care Act*.

ix. Revoked: O. Reg. 100/10, s. 9 (2).

5. Accounts for the performance of insured services rendered to an insured person in a mobile vision or hearing van operated by a non-profit organization to provide eye or ear care in under-serviced areas in Ontario.
6. Accounts for the performance of an examination rendered to an insured person and for documentation prepared for the purpose of an investigation or confirmation of an alleged sexual assault. R.R.O. 1990, Reg. 552, s. 38 (4); O. Reg. 375/93, s. 9; O. Reg. 100/10, s. 9.

(5) Payment for the classes of accounts exempted by paragraphs 3 and 4 of subsection (4) may only be made where,

- (a) the physician performing the services is a member of an associate medical group that is registered with the Plan;
- (b) the accounts for such services are submitted by the association referred to in clause (a) directly to the Plan; and
- (c) the associate medical group referred to in clause (a) and physician accept the payment as constituting payment in full for the services. R.R.O. 1990, Reg. 552, s. 38 (5).

(6) Revoked: O. Reg. 86/93, s. 2.

(7) Revoked: O. Reg. 363/02, s. 2.

(8)-(10) Revoked: O. Reg. 86/93, s. 2.

(11) The Plan shall pay a designated hospital for insured services provided to an insured person on the day of the person's admission to the hospital but not on the day of the person's discharge from the hospital. R.R.O. 1990, Reg. 552, s. 38 (11).

(12) The Plan shall not make and a hospital shall not accept duplicate payments for any insured services provided by the hospital. R.R.O. 1990, Reg. 552, s. 38 (12).

38.0.0.1 (1) A physician or practitioner may give a direction under subsection 16.1 (1) of the Act (direction to make payments to prescribed person or entity) to the persons or entities and in the circumstances described in this section. O. Reg. 422/01, s. 1.

(2) A physician who ordinarily practises with one or more physicians at a department of a public hospital in Ontario (a "physician hospital group") may direct that payment for the insured services he or she renders at that department be made,

- (a) to the physician hospital group or to one or more members of that group;
- (b) to the public hospital; or
- (c) to a person or partnership with which the physician hospital group has an agreement concerning the provision of insured services at that department. O. Reg. 422/01, s. 1.

(3) A practitioner who ordinarily practises at a department of a public hospital in Ontario with one or more practitioners who are members of the same regulated health profession (a "practitioner hospital group") may direct that payment for the insured services he or she renders at that department be made,

- (a) to the practitioner hospital group or to one or more members of that group;
- (b) to the public hospital; or
- (c) to a person or partnership with which the practitioner hospital group has an agreement

concerning the provision of insured services at that department. O. Reg. 422/01, s. 1.

(4) Subject to subsection (6), a physician who ordinarily practises with one or more physicians (a “physician group”) at one or more sites in Ontario may direct that payment for the insured services he or she renders at the site or sites be made,

- (a) to the physician group or to one or more members of that group; or
- (b) to a person or partnership with which the physician group has an agreement concerning the provision of insured services at those sites. O. Reg. 422/01, s. 1.

(5) Subject to subsection (6), a practitioner who ordinarily practises at one or more sites in Ontario with one or more practitioners who are members of the same regulated health profession (a “practitioner group”) may direct that payment for the insured services he or she renders at the site or sites be made,

- (a) to the practitioner group or to one or more members of that group; or
- (b) to a person or partnership with which the practitioner group has an agreement concerning the provision of insured services at those sites. O. Reg. 422/01, s. 1.

(6) Revoked: O. Reg. 318/06, s. 3.

(7) A physician who renders insured services to insured persons pursuant to an alternative funding plan arrangement entered into with the Minister (an “AFP physician”) may direct that payment for the insured services he or she renders be made to one of the following or to both of the following as provided for in the direction:

1. The group of AFP physicians that ordinarily renders insured services to insured persons under the same alternative funding plan arrangement as the physician making the direction, or to one or more members of that group.
2. The governance organization responsible for ensuring provision of insured services by AFP physicians under the alternative funding plan arrangement entered into with the Minister. O. Reg. 441/03, s. 1.

38.0.1 (1) The following circumstances are prescribed for the purposes of paragraph 7 of subsection 18 (2) of the Act:

1. The General Manager is of the opinion that the account for the insured service has not been submitted in accordance with the Act and the regulations.
2. The General Manager is of the opinion that the fee code used by a physician or the amount claimed by a practitioner in the account submitted for payment is incorrect in the circumstances.
3. The General Manager is of the opinion that the insured service for which an account has been submitted was provided in circumstances in which no payment or a reduced payment is to be made, according to the Act, the regulations or the schedule of benefits.
4. The General Manager is of the opinion that the account submitted by a physician for payment includes two or more fee codes that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
5. The General Manager is of the opinion that the account submitted by a practitioner for payment includes two or more claims that reflect, in whole or in part, the provision of

a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.

6. The General Manager is of the opinion,

- i. that an account submitted for payment by a physician includes a fee code for a service (the “billed service”) that is described in the schedule of benefits as an element of an insured service (the “insured service”), and
- ii. that the insured service was rendered by another physician to the same person as the billed service was rendered and with respect to the same medical circumstances. O. Reg. 344/01, s. 1.

(2) The following circumstances are prescribed for the purposes of paragraph 5 of subsection 39.1 (6) of the Act:

1. The applicable committee is of the opinion that the account for the insured service has not been submitted in accordance with the Act and the regulations.
2. The applicable committee is of the opinion that the fee code used by a physician or the amount claimed by a practitioner in the account submitted for payment is incorrect in the circumstances.
3. The applicable committee is of the opinion that the insured service for which an account has been submitted was provided in circumstances in which no payment is to be made, according to the Act, the regulations or the schedule of benefits.
4. The applicable committee is of the opinion that the account submitted by a physician for payment includes two or more fee codes that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
5. The applicable committee is of the opinion that the account submitted by a practitioner for payment includes two or more claims that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.

6. The applicable committee is of the opinion,

- i. that an account submitted for payment by a physician includes a fee code for a service (the “billed service”) that is described in the schedule of benefits as an element of an insured service (the “insured service”), and
- ii. that the insured service was rendered by another physician to the same person as the billed service was rendered and with respect to the same medical circumstances. O. Reg. 344/01, s. 1.

(3) In this section,

“fee code” means fee schedule code as listed in the schedule of benefits. O. Reg. 344/01, s. 1.

38.1 (1) For the purposes of clause 18.1 (2) (a) of the Act, a physician may request that a decision of the General Manager under subsection 18 (2) or (5) of the Act be reviewed by a single member of the Medical Review Committee if the amount in dispute is less than \$100,000. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 1 (1).

(2) For the purposes of clause 18.1 (4) (a) of the Act, a practitioner may request that a decision of the General Manager under subsection 18 (2) or (5) of the Act be reviewed by a

single member of the applicable practitioner review committee if the amount in dispute is less than \$100,000. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 1 (2).

38.2 (1) For the purposes of subsection 18.1 (5) of the Act, the amount that must accompany a request for review shall be equal to 5 per cent of the amount in dispute but in no case shall be more than \$2,500 or less than \$350. O. Reg. 256/03, s. 1.

(2) For the purposes of subsection 18.1 (8) of the Act, the amount that must accompany a request for reconsideration shall be \$350. O. Reg. 256/03, s. 1.

38.2.1 (1) For the purposes of subsection 18.1 (14) of the Act, interest on an amount payable by or to a physician or practitioner, that is payable as a result of a direction under subsection 18.1 (10), 18.2 (2) or 39.1 (5), shall be paid at the rate set by the Ministry of Finance under section 10 of the *Financial Administration Act*. O. Reg. 575/98, s. 1; O. Reg. 149/00, s. 1; O. Reg. 150/00, s. 3 (1).

(2) For the purposes of subsection 18.1 (14) of the Act, interest on an amount payable by or to a physician or practitioner shall be paid from the date determined in accordance with the following rules:

1. If the review committee directs an amount to be paid after reviewing a decision of the General Manager to refuse to pay for a service or to pay a reduced amount under subsection 18 (2) of the Act, interest is payable from the payment day that is or that follows the day the physician or practitioner receives notice of the General Manager's decision.
2. If the review committee directs the General Manager to return to a physician or practitioner all or part of a reimbursement that he or she paid after being required to reimburse the Plan under subsection 18 (5) of the Act, interest is payable from the day that the physician or practitioner made the reimbursement.
3. If the review committee confirms the General Manager's decision to require a physician or practitioner to reimburse the Plan under subsection 18 (5), interest is payable from the day the physician or practitioner receives notice of the General Manager's decision to require the reimbursement.
4. If a review committee directs an amount to be paid under subsection 18.2 (2) or 39.1 (5), interest is payable from the payment day that follows the end of the review period. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 3 (2).

(3) In subsection (2),

“payment day” means the day the Plan makes payments to physicians and practitioners and is the 15th day of each month;

“review period” means, with respect to a review by the Medical Review Committee or a practitioner review committee of the amount payable for services rendered by a physician or practitioner, the period of time during which those services were rendered. O. Reg. 575/98, s. 1.

38.2.2 (1) For the purposes of subsection 18.1 (15) of the Act, if, as a result of a review or a reconsideration of a review under section 18.1 of the Act, a physician or practitioner is required to reimburse money to the Plan or a direction is made directing the General Manager to pay an amount to a physician or practitioner that is less than the amount of the account submitted, the additional amount for the cost of the review or for the cost of the reconsideration of the review shall be calculated using the following formula:

$$\frac{A}{B} \times C \times D$$

where,

A is,

- (a) where the physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, or
- (b) where the General Manager is required to pay less than the amount of the account submitted, the portion of the amount the physician or practitioner claimed, in the review or reconsideration, should be paid to him or her that has been refused by the review committee;

B is,

- (a) where the physician or practitioner is required to reimburse money to the Plan, the amount that the physician or practitioner claimed he or she should not be required to reimburse in the review or reconsideration, or
- (b) where the General Manager is required to pay less than the amount of the account submitted, the amount that the physician or practitioner claimed should be paid to him or her in the review or reconsideration;

C is \$1000, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500, in the case of a review or reconsideration conducted by a practitioner review committee;

D is the number of review days in the review or reconsideration, as determined under subsection (5).

O. Reg. 149/00, s. 2.

(2) Despite subsection (1), the additional amount determined under that subsection shall not exceed the lesser of,

(a) the amount that is,

- (i) where the physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, multiplied by 0.35, or
- (ii) where the General Manager is required to pay less than the amount of the account submitted, the portion of the amount the physician or practitioner claimed, in the review or reconsideration, should be paid to him or her that has been refused by the review committee, multiplied by 0.35; and

(b) \$1000 for each review day, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500 for each review day, in the case of a review or a reconsideration conducted by a practitioner review committee. O. Reg. 149/00, s. 2.

(3) For the purposes of subsection 18.1 (15) of the Act, if, as a result of a review or a reconsideration of a review under section 18.1 of the Act, a direction is made confirming the decision of the General Manager to refuse to pay an account for services or if, as a result of a review or a reconsideration of a review under section 18.2 or 39.1 of the Act, a physician or practitioner is required to reimburse money to the Plan, the additional amount for the cost of the review or for the cost of the reconsideration of the review shall be calculated using the

following formula:

$$C \times D$$

where,

C is \$1000, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500, in the case of a review or reconsideration conducted by a practitioner review committee;

D is the number of review days in the review or reconsideration, as determined under subsection (5).

O. Reg. 149/00, s. 2; O. Reg. 150/00, s. 4 (1).

(4) Despite subsection (3), the additional amount determined under that subsection shall not exceed,

(a) where a direction is made confirming the decision of the General Manager to refuse to pay an account for services, the amount that the physician or practitioner claimed should be paid to him or her in the review or reconsideration, multiplied by 0.35; or

(b) where a physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, multiplied by 0.35. O. Reg. 149/00, s. 2.

(5) For the purposes of subsections (1), (2) and (3), if the direction of the committee is made on or after April 1, 2003 and if the circumstances set out in subsection (5.2) do not apply, the number of review days in a review or reconsideration is the lesser of 15 and the number determined as follows:

1. For each member of the committee, determine the number of days, including any partial days rounded to the first decimal, the member spent working on the review or reconsideration and on related matters after commencing to hear from the physician or practitioner.
2. If the parties agreed to a settlement of the review or reconsideration, determine, for each member, the number of days, including any partial days rounded to the first decimal, the member spent considering and agreeing to the offer to settle after commencing to hear from the physician or practitioner.
3. For each member of the committee, determine the days that are spent by the committee in hearing from the physician or practitioner, including any partial days rounded to the first decimal, to a maximum of two days.
4. For each member, subtract the number of days determined for the member under paragraphs 2 and 3 from the number of days determined for the member under paragraph 1.
5. Add the numbers determined under paragraph 4 for each member to calculate the total number of days all the members of the committee spent working on the review or reconsideration and on related matters.
6. For the purposes of the calculations in paragraphs 1, 2 and 3, the committee is "hearing from the physician or practitioner" when the physician or practitioner or his or her counsel or agent is in the presence of the committee for the purpose of making representations. O. Reg. 5/04, s. 1.

(5.1) For the purposes of subsections (1), (2) and (3), if the direction of the committee

was made before April 1, 2003 or if the circumstances set out in subsection (5.2) apply, the number of review days in a review or reconsideration shall be determined as follows:

1. For each member of the committee, determine the number of days, including any partial days rounded to the first decimal, the member spent working on the review or reconsideration and on related matters.
2. If the parties agreed to a settlement of the review or reconsideration, determine, for each member, the number of days, including any partial days rounded to the first decimal, the member spent considering and agreeing to the offer to settle.
3. For each member, subtract the number of days determined for the member under paragraph 2 from the number of days determined for the member under paragraph 1.
4. Add the numbers determined under paragraph 3 for each member to calculate the total number of days all the members of the committee spent working on the review or reconsideration and on related matters. O. Reg. 5/04, s. 1.

(5.2) The following are set out as circumstances for the purposes of subsections (5) and (5.1):

1. In the case of a practitioner, if a direction under subsection 18.1 (10) of the Act has previously been made requiring the practitioner to reimburse money to the Plan or directing the General Manager to pay an amount to the practitioner that is less than the amount of the account submitted.
2. In the case of a physician,
 - i. if a direction under subsection 18.1 (10) of the Act has previously been made requiring the physician to reimburse money to the Plan or directing the General Manager to pay an amount to the physician that is less than the amount of the account submitted, and
 - ii. the direction related, in whole or in part, to a claim or claims submitted with regard to one or more of the same schedule of benefits fee codes or classes of fee code as the claim or claims giving rise to the current review or reconsideration. O. Reg. 5/04, s. 1.

(5.3) The following are classes of fee code for the purposes of paragraph 2 of subsection (5.2):

1. Class 1 — all codes which are in respect of diagnostic tests or services, or the interpretation of a diagnostic test or service.
2. Class 2 — all codes in respect of surgical services.
3. Class 3 — all codes in respect of anesthesia services.
4. Class 4 — all codes other than those contained in any of classes 1 to 3. O. Reg. 5/04, s. 1.

(6) Despite subsections (1) and (3), the additional amount for the cost of a review or for the cost of a reconsideration of a review shall be a nil amount if the physician or practitioner who is a party to the review or reconsideration made an offer to settle the matter and the offer was refused and,

- (a) where the issue in the review or reconsideration related to whether the Plan owed money to the physician or practitioner, the settlement offer provided that the

physician or practitioner accept payment of an amount that was equal to or less than the amount that the committee or single member directed that the Plan pay; or

- (b) where the issue in the review or reconsideration related to whether the physician or practitioner owed money to the Plan, the settlement offer provided that the physician or practitioner reimburse an amount that was equal to or greater than the amount that the committee or single member directed the member to reimburse. O. Reg. 149/00, s. 2.

(6.1) Despite subsections (1) to (3), in the case of a review or a reconsideration of a review that, as of March 3, 2000, is before a review committee and in respect of which no direction has been issued, the additional amount for the cost of the review or reconsideration shall be a nil amount if the physician or practitioner made an offer to settle the matter on or before that date, or makes such an offer within 45 days after that date, and the offer is accepted at any time after it is made. O. Reg. 150/00, s. 4 (2).

(7) Upon the recommendation of the review committee, the General Manager may reduce the additional amount payable for the cost of a review or reconsideration of a review, as determined under subsections (1) to (5), by such amount as is reasonable in the circumstances. O. Reg. 149/00, s. 2.

(8) The review committee may recommend a reduction of the additional amount payable for the cost of a review or reconsideration of a review if, in the course of the review or reconsideration, either of the following circumstances are found to exist:

1. The review or reconsideration relates to accounts that were submitted to the Plan by a physician or practitioner in accordance with advice received from the General Manager.
2. The General Manager or review committee failed to provide the physician or practitioner with information that was likely to affect either his or her decision to proceed with the review or reconsideration or his or her decision to make an offer to settle the matter. O. Reg. 149/00, s. 2.

38.2.3 Sections 38.2.1 and 38.2.2 apply to any review or reconsideration of a review under section 18.1 or 39.1 of the Act that is commenced on or after November 5, 1998 or that was commenced before November 5, 1998 but in respect of which a direction had not been issued before that date. O. Reg. 149/00, s. 2.

38.3 (1) In this section,

“electronic data transfer” means a method approved by the Ministry of Health and Long-Term Care for electronically transferring information. O. Reg. 362/02, s. 1.

(2) It is a condition of payment that the following claims be submitted by electronic data transfer:

1. A claim for the cost of an insured service rendered by a physician, practitioner or health facility, if the physician, practitioner or health facility was first assigned an Ontario Health Insurance Plan identification number on or after January 1, 2003.
2. A claim for the cost of a laboratory service that is an insured service under section 22, if the medical director of the laboratory was first assigned an Ontario Health Insurance Plan identification number on or after January 1, 2003. O. Reg. 362/02, s. 1.

(3) It is a condition of payment that the following claims be submitted in a machine readable form acceptable to the Ministry of Health and Long-Term Care:

1. A claim for the cost of an insured service rendered by a physician, practitioner or health facility, if the physician, practitioner or health facility was assigned an Ontario Health Insurance Plan identification number on or after January 1, 1993 and before January 1, 2003.
2. A claim for the cost of a laboratory service that is an insured service under section 22, if the medical director of the laboratory was assigned an Ontario Health Insurance Plan identification number on or after January 1, 1993 and before January 1, 2003. O. Reg. 362/02, s. 1.

(4) Subsections (2) and (3) do not apply to a claim for the cost of an insured service rendered by a dental surgeon. O. Reg. 362/02, s. 1.

(5) A processing fee of \$1.87 is payable for every claim for the cost of insured services, unless the claim is submitted by electronic data transfer or in a machine readable form acceptable to the Ministry of Health and Long-Term Care. O. Reg. 254/07, s. 1.

(5.1) The fee is payable by the physician, practitioner, health facility or laboratory that rendered the insured services. O. Reg. 254/07, s. 1.

(6) This section does not apply to a claim for a service rendered to an insured person outside of Ontario. O. Reg. 362/02, s. 1.

38.4 (1) It is a condition of payment of a claim for an insured service rendered to an insured person in Ontario that the claim include the following information:

1. The Ontario Health Insurance Plan identification number for,
 - i. the physician or practitioner who rendered the service, or
 - ii. the medical director of the laboratory in which the service was rendered.
 - iii. Revoked: O. Reg. 138/13, s. 4 (1).
2. If the service was rendered by a physician, practitioner or laboratory,
 - i. the four characters assigned by the Plan that indicate whether the physician or practitioner practices alone or with one or more other physicians or practitioners or whether the service was provided in a laboratory, and
 - ii. the two characters assigned by the Plan that indicate the specialty of the physician, if any, or the specialty or profession of the practitioner or laboratory director, if any.
3. The most recently issued 10 digit health number for the insured person to whom the service was provided and any version code that may appear on the person's health card bearing that number.
4. The date of birth of the insured person to whom the service was rendered.
5. The payment program code "HCP".
6. Any characters assigned by the Ministry of Health and Long-Term Care that identify the payee as a provider or recipient of the insured service.
7. If the service is a diagnostic radiology procedure in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring

physician or registered nurse in the extended class.

8. If the service is a laboratory or other diagnostic procedure listed under “Nuclear Medicine”, “Pulmonary Function Studies” or “Diagnostic Ultrasound” in the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician, midwife, registered nurse in the extended class or laboratory.
- 8.1 If the service is a diagnostic procedure listed under the “Magnetic Resonance Imaging” or “Diagnostic and Therapeutic Procedures” in the schedule of benefits, that is listed with both a professional and technical component, the Ontario Health Insurance Plan identification number of the referring physician.
9. If the service is a consultation in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.
10. If the service is an assessment requested by a midwife in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the midwife.
11. If the service was rendered in a mobile independent health facility licensed under the *Independent Health Facilities Act* or if the service consists of the interpretation of the results of a diagnostic procedure performed in that type of facility, the four character service site indicator assigned by the Plan to identify the location at which the service was rendered.
12. If the service was provided to a person who was an in-patient in a hospital, the date of the person’s admission to the hospital.
- 12.1 If it is required by the Ontario Health Insurance Plan, the master number specified by the Plan for the location at the hospital site at which the service was rendered.
13. If it is required by the Ontario Health Insurance Plan for a service rendered by a physician in a hospital on or after April 1, 2006, the service location indicator code assigned by the Plan that indicates whether the service was an in-patient, out-patient, day surgery or emergency department service.
14. The fee code that, in the circumstances in which the service was rendered, correctly describes the service as specified,
 - i. in the schedule of benefits, if the service was rendered by a physician,
 - ii. in Schedule 13, 14 or 15 to this Regulation, if the service was rendered by a member of the Royal College of Dental Surgeons of Ontario,
 - iii. in Schedule 23 to this Regulation, if the service was rendered by a member of the College of Optometrists of Ontario, and
 - iv. by the Plan, if the service was rendered by a podiatrist who is a member of the College of Chiropodists of Ontario or by an osteopath.
15. In the case of a service other than a laboratory service described in section 22, the amount of the fee being claimed.
16. If it is relevant under the schedule of benefits, the number of times the service was rendered or the number of units claimed for the service.
17. The date the service was rendered.
18. If it is required by the Plan, the diagnostic code specified by the Plan for the service

that relates to the insured person's condition.

19. If the service was an X-ray or laboratory or other diagnostic procedure that was provided in a hospital upon the requisition of an oral and maxillofacial surgeon, the Ontario Health Insurance Plan identification number of the referring oral and maxillofacial surgeon. O. Reg. 362/02, s. 1; O. Reg. 352/04, s. 6; O. Reg. 129/05, s. 5; O. Reg. 376/06, s. 2; O. Reg. 76/12, s. 11; O. Reg. 138/13, s. 4.

(2) It is a condition of payment of a claim for an insured service rendered in Ontario to a person who is insured by a health insurance scheme provided by another province or territory of Canada applies that the following information be included:

1. The payment program code "RMB", the health number or other identification number issued to the person by the health insurance scheme in the other province or territory, the person's first and last names, the person's sex and the code for the province or territory in which the person is insured, as specified by the Plan.
2. The Ontario Health Insurance Plan identification number for,
 - i. the physician who rendered the service, or
 - ii. the medical director of the laboratory in which the service was rendered.
3. If the service was rendered by a physician or laboratory,
 - i. the four characters assigned by the Plan that indicate whether the physician practices alone or with one or more other physicians or whether the service was provided in a laboratory, and
 - ii. the two characters assigned by the Plan that indicate the specialty of the physician, if any, or the specialty of the laboratory director, if any.
4. Any characters assigned by the Ministry of Health and Long-Term Care that identify the payee as a provider or recipient of the insured service.
5. If the service is a diagnostic radiology procedure in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.
6. If the service is a laboratory or other diagnostic procedure listed under "Nuclear Medicine", "Pulmonary Function Studies" or "Diagnostic Ultrasound" in the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician or registered nurse in the extended class.
7. If the service is a consultation in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.
8. If the service was rendered in a mobile independent health facility licensed under the *Independent Health Facilities Act* or the service consists of the interpretation of the result of a diagnostic procedure performed in that type of facility, the four character service site indicator assigned by the Plan to identify the location at which the service was rendered.
9. If the service was provided to a person who was an in-patient in a hospital, the date of the person's admission to the hospital.
10. If the service was rendered by a physician, the fee code that, in the circumstances in which the service was rendered, correctly describes the service as specified in the

schedule of benefits.

11. In the case of a service other than a laboratory service described in section 22, the amount of the fee being claimed.
12. If it is relevant under the schedule of benefits, the number of times the service was rendered or the number of units claimed for the service.
13. The date the service was rendered.
14. If it is required by the Plan, the diagnostic code specified by the Plan for the services that relates to the insured person's condition. O. Reg. 362/02, s. 1; O. Reg. 217/11, s. 6.

(3) In the case of a claim submitted in machine readable form, it is a condition of payment that the claim include the following additional information with respect to each service for which payment is claimed:

1. The transaction identifier code "HE".
2. The appropriate identification code for the record.
3. The identifier code for the technical specification release.
4. The code for the Ministry of Health and Long-Term Care district office where the service provider is registered for the purpose of claims payments.
5. In the case of a claim that is included in a batch of claims, the date on which the batch of claims was created and the sequence number of the batch.
6. The operator number assigned by the Ministry of Health and Long-Term Care to the person authorized to submit the claim by magnetic cartridge or tape.
7. On the last record in each batch of claims, the total number of each of the record identification codes H, R, and T. O. Reg. 362/02, s. 1.

38.5 In sections 38.3 and 38.4,

"Ontario Health Insurance Plan identification number" means the number issued by the Plan to a physician, practitioner, registered nurse in the extended class, midwife, medical director of a laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act*, hospital or health facility for the purposes of monitoring, processing and paying claims for payment of insured services and of monitoring and controlling the delivery of insured services. O. Reg. 362/02, s. 1.

38.6 (1) For the purposes of subsection 27.2 (3) of the Act, the General Manager may require a physician or practitioner to submit accounts directly to the Plan if the physician or practitioner owes money to the Plan, has received the notice referred to in subsection (2) and has not paid the amount specified in the notice within 30 days after the day the notice is given. O. Reg. 14/01, s. 2.

- (2) The General Manager shall give a physician or practitioner 30 days written notice of,
 - (a) the amount owing to the Plan;
 - (b) the matter in respect of which the amount is owing; and
 - (c) the intention of the General Manager to require the physician or practitioner to submit accounts directly to the Plan. O. Reg. 14/01, s. 2.

SUBROGATION (PROCEDURAL)

39. (1) In this section,

“notice” means notice in writing by personal delivery or mailed by registered mail addressed to the latest post office address of the person to whom the notice is sent as shown on the records of the Plan or, where no address is shown for the person on the records of the Plan, addressed to the person at the person’s post office address as shown on the records of the hospital or other provider of the insured services. R.R.O. 1990, Reg. 552, s. 39 (1).

(2) Where an insured person commences an action referred to in section 31 of the Act, his or her solicitor shall so inform the General Manager forthwith after issuing the writ and shall act as solicitor for the Plan for the purpose of this section unless notified by the General Manager in writing that he or she is no longer acting for the Plan and in such case the General Manager may appoint another solicitor to represent the Plan. R.R.O. 1990, Reg. 552, s. 39 (2).

(3) Where the insured person and the General Manager cannot agree as to any offer of settlement or where the solicitor receives conflicting instructions from the General Manager and the insured person, the solicitor may so inform the General Manager in writing and thereupon shall cease to act for the Plan and the General Manager may appoint another solicitor for the purpose of this section. R.R.O. 1990, Reg. 552, s. 39 (3).

(4) Where the General Manager appoints a solicitor under subsection (2) or (3), the solicitor may participate in the action as fully as if acting for a plaintiff and shall be at liberty to appear at the trial of the action and take part therein in such manner and to such extent as the trial judge may direct but, if, upon the application of the defendant or the insured, it appears that such participation may embarrass or delay the trial of the action, the court may order separate trials, or make such other order as may be expedient. R.R.O. 1990, Reg. 552, s. 39 (4).

(5) Where the insured person and the General Manager cannot agree as to any offer of settlement in the action the insured person may make a settlement of his or her claims and thereafter the General Manager shall have the conduct of the action. R.R.O. 1990, Reg. 552, s. 39 (5).

(6) Subject to subsection (8), where an insured person obtains a final judgment in an action in which he or she includes a claim on behalf of the Plan, the Plan shall bear the same proportion of the taxable costs otherwise payable by the insured person, whether on a party and party basis or on a solicitor and client basis, as the recovery made on behalf of the Plan bears to the total recovery of the insured person in the action or, where no recovery is made, as the assessed claim of the Plan bears to the total damages of the insured person assessed by the court. R.R.O. 1990, Reg. 552, s. 39 (6).

(7) Where a claim is settled, the Plan shall bear the same proportion of the taxable costs otherwise payable by the insured person as is set out in subsection (6) in respect of a recovery made. R.R.O. 1990, Reg. 552, s. 39 (7).

(8) The costs for which the Plan may be liable to bear a portion under subsection (6) are the costs of bringing the action to the conclusion of the trial only and do not include the costs of any other proceeding without the written consent of the General Manager. R.R.O. 1990, Reg. 552, s. 39 (8).

(9) If no action has been commenced by an insured person for the recovery of damages arising out of injury or disability within eleven months of the last act or omission that caused or contributed to the injury or disability, or thirty days before the expiration of the limitation period for the action, whichever occurs first, the General Manager,

- (a) after notice thereof to the insured person, may commence an action in the name of the Plan or in the name of the insured for damages in the amount of the costs of insured services; and
- (b) may effect settlement of the claim without prejudice to the right of the insured person to commence an action to recover for his or her injuries or other damages. R.R.O. 1990, Reg. 552, s. 39 (9).

(10) The insured person, at any time prior to the trial of an action commenced under clause (9) (a), may, subject to the rules of court, join in such action any additional claims arising out of the same occurrence and thereafter the insured person shall have the conduct of the action as if he or she had commenced it under section 31 of the Act. R.R.O. 1990, Reg. 552, s. 39 (10).

(11) Where the insured person is a minor or under other disability or has died, the General Manager may commence an action in the name of the Plan for the recovery of the cost of insured services rendered to the person and, in that event, shall forthwith give notice of the institution of such action to the parent or guardian of the minor, or to a lawfully authorized substitute decision maker, or to the personal representative, if any, of the deceased person, and subsections (9) and (10) apply with necessary modifications to such action. R.R.O. 1990, Reg. 552, s. 39 (11); O. Reg. 13/95, s. 1.

(12) This section does not apply to any action arising out of negligence or other wrongful act or omission in the use or operation of a motor vehicle, where,

- (a) the accident resulting in the injuries occurred after the 30th day of November, 1978;
- (b) at the time of the accident, the owner of the motor vehicle was insured against liability under a motor vehicle liability policy issued by an insurer set out in Schedule 12; and
- (c) at the time of the accident, the motor vehicle was the subject of a permit issued under subsection 7 (7) of the *Highway Traffic Act*. R.R.O. 1990, Reg. 552, s. 39 (12).

TABLE 1 Revoked: O. Reg. 375/93, s. 10.

TABLE 2

Item	Column 1 Effective Period	Column 2 Person Receiving Chronic Care Services	Column 3 Monthly Co-Payment	Column 4 Daily Co-Payment
1.	On or after the 1st day of November, 1990, but before the 1st day of February, 1991.	Person with no dependants — maximum estimated income \$840.02	Estimated income less \$100.00	Estimated income less \$100.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$4,700.00	Aggregate estimated incomes less \$2,480.00, divided by 3	Aggregate estimated incomes less \$2,480.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,055.00	Aggregate estimated incomes less \$2,835.00, divided by 3	Aggregate estimated incomes less \$2,835.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,377.00	Aggregate estimated incomes less \$3,157.00, divided by 3	Aggregate estimated incomes less \$3,157.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$5,666.00	Aggregate estimated incomes less \$3,446.00, divided by 3	Aggregate estimated incomes less \$3,446.00, divided by 91.2
		Person not referred to elsewhere in this item	\$740.02	\$24.33
2.	On or after the 1st day of February, 1991, but before the 1st day of May, 1991.	Person with no dependants — maximum estimated income \$847.71	Estimated income less \$100.00	Estimated income less \$100.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated	Aggregate estimated incomes less \$2,480.00, divided by 3	Aggregate estimated incomes less \$2,480.00, divided by 91.2

		incomes \$4,723.00		
		Person with two dependants — maximum aggregate estimated incomes \$5,078.00	Aggregate estimated incomes less \$2,835.00, divided by 3	Aggregate estimated incomes less \$2,835.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,400.00	Aggregate estimated incomes less \$3,157.00, divided by 3	Aggregate estimated incomes less \$3,157.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$5,689.00	Aggregate estimated incomes less \$3,446.00, divided by 3	Aggregate estimated incomes less \$3,446.00, divided by 91.2
		Person not referred to elsewhere in this item	\$747.71	\$24.58
3.	On or after the 1st day of May, 1991, but before the 1st day of August, 1991.	Person with no dependants — maximum estimated income \$864.02	Estimated income less \$100.00	Estimated income less \$100.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$4,772.00	Aggregate estimated incomes less \$2,480.00, divided by 3	Aggregate estimated incomes less \$2,480.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,127.00	Aggregate estimated incomes less \$2,835.00, divided by 3	Aggregate estimated incomes less \$2,835.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,449.00	Aggregate estimated incomes less \$3,157.00, divided by 3	Aggregate estimated incomes less \$3,157.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$5,738.00	Aggregate estimated incomes less \$3,446.00, divided by 3	Aggregate estimated incomes less \$3,446.00, divided by 91.2
		Person not referred to elsewhere in this item	\$764.02	\$25.12
4.	On or after the 1st day of August, 1991, but before the 1st day of November, 1991.	Person with no dependants — maximum estimated income \$891.88	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$4,976.00	Aggregate estimated incomes less \$2,636.00, divided by 3	Aggregate estimated incomes less \$2,636.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,354.00	Aggregate estimated incomes less \$3,014.00, divided by 3	Aggregate estimated incomes less \$3,014.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,696.00	Aggregate estimated incomes less \$3,356.00, divided by 3	Aggregate estimated incomes less \$3,356.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,003.00	Aggregate estimated incomes less \$3,663.00, divided by 3	Aggregate estimated incomes less \$3,663.00, divided by 91.2
		Person not referred to elsewhere in this item	\$779.88	\$25.64
5.	On or after the 1st day of November, 1991, but before the 1st day of February, 1992.	Person with no dependants — maximum estimated income \$899.97	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,000.00	Aggregate estimated incomes less \$2,636.00, divided by 3	Aggregate estimated incomes less \$2,636.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,378.00	Aggregate estimated incomes less \$3,014.00, divided by 3	Aggregate estimated incomes less \$3,014.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,720.00	Aggregate estimated incomes less \$3,356.00, divided by 3	Aggregate estimated incomes less \$3,356.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,027.00	Aggregate estimated incomes less \$3,663.00, divided by 3	Aggregate estimated incomes less \$3,663.00, divided by 91.2
		Person not referred to elsewhere in this item	\$787.97	\$25.91
6.	On or after the 1st day of February, 1992, but before the 1st day of May, 1992.	Person with no dependants — maximum estimated income \$901.61	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,005.00	Aggregate estimated incomes less \$2,636.00, divided by 3	Aggregate estimated incomes less \$2,636.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated	Aggregate estimated incomes less \$3,014.00, divided by 3	Aggregate estimated incomes less \$3,014.00, divided by 91.2

		incomes \$5,383.00		
		Person with three dependants — maximum aggregate estimated incomes \$5,725.00	Aggregate estimated incomes less \$3,356.00, divided by 3	Aggregate estimated incomes less \$3,356.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,032.00	Aggregate estimated incomes less \$3,663.00, divided by 3	Aggregate estimated incomes less \$3,663.00, divided by 91.2
		Person not referred to elsewhere in this item	\$789.61	\$25.96
7.	On or after the 1st day of May, 1992, but before the 1st day of August, 1992.	Person with no dependants — maximum estimated income \$902.42	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,007.00	Aggregate estimated incomes less \$2,636.00, divided by 3	Aggregate estimated incomes less \$2,636.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,385.00	Aggregate estimated incomes less \$3,014.00, divided by 3	Aggregate estimated incomes less \$3,014.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,727.00	Aggregate estimated incomes less \$3,356.00, divided by 3	Aggregate estimated incomes less \$3,356.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,034.00	Aggregate estimated incomes less \$3,663.00, divided by 3	Aggregate estimated incomes less \$3,663.00, divided by 91.2
		Person not referred to elsewhere in this item	\$790.42	\$25.99
8.	On or after the 1st day of August, 1992, but before the 1st day of November, 1992.	Person with no dependants — maximum estimated income \$906.51	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,064.00	Aggregate estimated incomes less \$2,680.00, divided by 3	Aggregate estimated incomes less \$2,680.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,448.00	Aggregate estimated incomes less \$3,064.00, divided by 3	Aggregate estimated incomes less \$3,064.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,796.00	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,108.00	Aggregate estimated incomes less \$3,724.00, divided by 3	Aggregate estimated incomes less \$3,724.00, divided by 91.2
		Person not referred to elsewhere in this item	\$794.51	\$26.12
9.	On or after the 1st day of November, 1992, but before the 1st day of February, 1993.	Person with no dependants — maximum estimated income \$910.63	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,076.00	Aggregate estimated incomes less \$2,680.00, divided by 3	Aggregate estimated incomes less \$2,680.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,460.00	Aggregate estimated incomes less \$3,064.00, divided by 3	Aggregate estimated incomes less \$3,064.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,808.00	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,120.00	Aggregate estimated incomes less \$3,724.00, divided by 3	Aggregate estimated incomes less \$3,724.00, divided by 91.2
		Person not referred to elsewhere in this item.	\$798.63	\$26.26
10.	On or after the 1st day of February, 1993, but before the 1st day of May, 1993	Person with no dependants — maximum estimated income \$912.29	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,081.00	Aggregate estimated incomes less \$2,680.00, divided by 3	Aggregate estimated incomes less \$2,680.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,465.00	Aggregate estimated incomes less \$3,064.00, divided by 3	Aggregate estimated incomes less \$3,064.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2

		incomes \$5,813.00		
		Person with four or more dependants — maximum aggregate estimated incomes \$6,125.00	Aggregate estimated incomes less \$3,724.00, divided by 3	Aggregate estimated incomes less \$3,724.00, divided by 91.2
		Person not referred to elsewhere in this item	\$800.29	\$26.31
11.	On or after May 1, 1993, but before August 1, 1993	Person with no dependants — maximum estimated income \$918.09	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,098.00	Aggregate estimated incomes less \$2,680.00, divided by 3	Aggregate estimated incomes less \$2,680.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,482.00	Aggregate estimated incomes less \$3,064.00, divided by 3	Aggregate estimated incomes less \$3,064.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,830.00	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,142.00	Aggregate estimated incomes less \$3,724.00, divided by 3	Aggregate estimated incomes less \$3,724.00, divided by 91.2
		Person not referred to elsewhere in this item	\$806.09	\$26.50
12.	On or after August 1, 1993, but before November 1, 1993	Person with no dependants — maximum estimated income \$922.27	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,159.00	Aggregate estimated incomes less \$2,728.00, divided by 3	Aggregate estimated incomes less \$2,728.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,550.00	Aggregate estimated incomes less \$3,119.00, divided by 3	Aggregate estimated incomes less \$3,119.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,904.00	Aggregate estimated incomes less \$3,474.00, divided by 3	Aggregate estimated incomes less \$3,474.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,222.00	Aggregate estimated incomes less \$3,791.00, divided by 3	Aggregate estimated incomes less \$3,791.00, divided by 91.2
		Person not referred to elsewhere in this item	\$810.27	\$26.64
13.	On or after November 1, 1993 but before February 1, 1994	Person with no dependants — maximum estimated income \$924.79	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,167.00	Aggregate estimated incomes less \$2,728.00, divided by 3	Aggregate estimated incomes less \$2,728.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,558.00	Aggregate estimated incomes less \$3,119.00, divided by 3	Aggregate estimated incomes less \$3,119.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,913.00	Aggregate estimated incomes less \$3,474.00, divided by 3	Aggregate estimated incomes less \$3,474.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,230.00	Aggregate estimated incomes less \$3,791.00, divided by 3	Aggregate estimated incomes less \$3,791.00, divided by 91.2
		Person not referred to elsewhere in this item	\$812.79	\$26.72
14.	On or after February 1, 1994, but before May 1, 1994	Person with no dependants — maximum estimated income \$927.31	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,174.00	Aggregate estimated incomes less \$2,728.00, divided by 3	Aggregate estimated incomes less \$2,728.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,565.00	Aggregate estimated incomes less \$3,119.00, divided by 3	Aggregate estimated incomes less \$3,119.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,920.00	Aggregate estimated incomes less \$3,474.00, divided by 3	Aggregate estimated incomes less \$3,474.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,237.00	Aggregate estimated incomes less \$3,791.00, divided by 3	Aggregate estimated incomes less \$3,791.00, divided by 91.2

		Person not referred to elsewhere in this item	\$815.31	\$26.80
15.	On or after May 1, 1994 but before August 1, 1994	Person with no dependants — maximum estimated income \$931.53	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,187.00	Aggregate estimated incomes less \$2,728.00, divided by 3	Aggregate estimated incomes less \$2,728.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,578.00	Aggregate estimated incomes less \$3,119.00, divided by 3	Aggregate estimated incomes less \$3,119.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,933.00	Aggregate estimated incomes less \$3,474.00, divided by 3	Aggregate estimated incomes less \$3,474.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,250.00	Aggregate estimated incomes less \$3,791.00, divided by 3	Aggregate estimated incomes less \$3,791.00, divided by 91.2
		Person not referred to elsewhere in this item	\$819.53	\$26.94
16.	On or after August 1, 1994 but before January 1, 1997	Person with no dependants — maximum estimated income \$931.53	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$5,193.00	Aggregate estimated incomes less \$2,734.00, divided by 3	Aggregate estimated incomes less \$2,734.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$5,585.00	Aggregate estimated incomes less \$3,126.00, divided by 3	Aggregate estimated incomes less \$3,126.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$5,941.00	Aggregate estimated incomes less \$3,482.00, divided by 3	Aggregate estimated incomes less \$3,482.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$6,259.00	Aggregate estimated incomes less \$3,800.00, divided by 3	Aggregate estimated incomes less \$3,800.00, divided by 91.2
		Person not referred to elsewhere in this item	\$819.53	\$26.94
17.	On or after January 1, 1997 but before July 1, 1997	Person with no dependants — maximum estimated income \$1,337.62	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$6,518.00	Aggregate estimated incomes less \$2,841.00, divided by 3	Aggregate estimated incomes less \$2,841.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$6,925.00	Aggregate estimated incomes less \$3,248.00, divided by 3	Aggregate estimated incomes less \$3,248.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$7,295.00	Aggregate estimated incomes less \$3,618.00, divided by 3	Aggregate estimated incomes less \$3,618.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$7,626.00	Aggregate estimated incomes less \$3,949.00, divided by 3	Aggregate estimated incomes less \$3,949.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,225.62	\$40.29
18.	On or after July 1, 1997 but before July 1, 1998	Person with no dependants — maximum estimated income \$1,364.04	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$6,659.00	Aggregate estimated incomes less \$2,902.00, divided by 3	Aggregate estimated incomes less \$2,902.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$7,075.00	Aggregate estimated incomes less \$3,318.00, divided by 3	Aggregate estimated incomes less \$3,318.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$7,453.00	Aggregate estimated incomes less \$3,696.00, divided by 3	Aggregate estimated incomes less \$3,696.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$7,791.00	Aggregate estimated incomes less \$4,034.00, divided by 3	Aggregate estimated incomes less \$4,034.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,252.04	\$41.16
19.	On or after July 1, 1998 but before August 1, 1999	Person with no dependants — maximum estimated income \$1,376.01	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4

		Person with one dependant — maximum aggregate estimated incomes \$6,722.00	Aggregate estimated incomes less \$2,929.00, divided by 3	Aggregate estimated incomes less \$2,929.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$7,142.00	Aggregate estimated incomes less \$3,349.00, divided by 3	Aggregate estimated incomes less \$3,349.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$7,524.00	Aggregate estimated incomes less \$3,731.00, divided by 3	Aggregate estimated incomes less \$3,731.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$7,865.00	Aggregate estimated incomes less \$4,072.00, divided by 3	Aggregate estimated incomes less \$4,072.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,264.01	\$41.56
20.	On or after August 1, 1999 but before July 1, 2000	Person with no dependants — maximum estimated income \$1,389.95	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$6,741.00	Aggregate estimated incomes less \$2,948.00, divided by 3	Aggregate estimated incomes less \$2,948.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$7,164.00	Aggregate estimated incomes less \$3,371.00, divided by 3	Aggregate estimated incomes less \$3,371.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$7,548.00	Aggregate estimated incomes less \$3,755.00, divided by 3	Aggregate estimated incomes less \$3,755.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$7,891.00	Aggregate estimated incomes less \$4,098.00, divided by 3	Aggregate estimated incomes less \$4,098.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,277.95	\$42.01
21.	On or after July 1, 2000 but before July 1, 2001	Person with no dependants — maximum estimated income \$1,420.89	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$6,943.00	Aggregate estimated incomes less \$3,016.00, divided by 3	Aggregate estimated incomes less \$3,016.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$7,375.00	Aggregate estimated incomes less \$3,448.00, divided by 3	Aggregate estimated incomes less \$3,448.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$7,768.00	Aggregate estimated incomes less \$3,841.00, divided by 3	Aggregate estimated incomes less \$3,841.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$8,119.00	Aggregate estimated incomes less \$4,192.00, divided by 3	Aggregate estimated incomes less \$4,192.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,308.89	\$43.03
22.	On or after July 1, 2001 but before September 1, 2002	Person with no dependants — maximum estimated income \$1,465.73	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4
		Person with one dependant — maximum aggregate estimated incomes \$7,173.00	Aggregate estimated incomes less \$3,111.00, divided by 3	Aggregate estimated incomes less \$3,111.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$7,618.00	Aggregate estimated incomes less \$3,556.00, divided by 3	Aggregate estimated incomes less \$3,556.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,024.00	Aggregate estimated incomes less \$3,962.00, divided by 3	Aggregate estimated incomes less \$3,962.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$8,386.00	Aggregate estimated incomes less \$4,324.00, divided by 3	Aggregate estimated incomes less \$4,324.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,353.73	\$44.51
23.	On or after September 1, 2002 but before July 1, 2003	Person with no dependants — maximum estimated income \$1,496.74	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$7,492.00	Aggregate estimated incomes less \$3,155.00, divided by 3	Aggregate estimated incomes less \$3,155.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated	Aggregate estimated incomes less \$3,607.00, divided by 3	Aggregate estimated incomes less \$3,607.00, divided by 91.2

		incomes \$7,944.00		
		Person with three dependants — maximum aggregate estimated incomes \$8,355.00	Aggregate estimated incomes less \$4,018.00, divided by 3	Aggregate estimated incomes less \$4,018.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$8,723.00	Aggregate estimated incomes less \$4,386.00, divided by 3	Aggregate estimated incomes less \$4,386.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,445.71	\$47.53
24.	On or after July 1, 2003 but before July 1, 2004	Person with no dependants — maximum estimated income \$1,532.15	Estimated income less \$112.00	Estimated income less \$112.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$7,717.00	Aggregate estimated incomes less \$3,273.00, divided by 3	Aggregate estimated incomes less \$3,273.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,186.00	Aggregate estimated incomes less \$3,742.00, divided by 3	Aggregate estimated incomes less \$3,742.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,612.00	Aggregate estimated incomes less \$4,168.00, divided by 3	Aggregate estimated incomes less \$4,168.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$8,994.00	Aggregate estimated incomes less \$4,550.00, divided by 3	Aggregate estimated incomes less \$4,550.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,480.99	\$48.69
25.	On or after July 1, 2004 but before August 1, 2006	Person with no dependants — maximum estimated income \$1,536.15	Estimated income less \$116.00	Estimated income less \$116.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$7,717.00	Aggregate estimated incomes less \$3,273.00, divided by 3	Aggregate estimated incomes less \$3,273.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,186.00	Aggregate estimated incomes less \$3,742.00, divided by 3	Aggregate estimated incomes less \$3,742.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,612.00	Aggregate estimated incomes less \$4,168.00, divided by 3	Aggregate estimated incomes less \$4,168.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$8,994.00	Aggregate estimated incomes less \$4,550.00, divided by 3	Aggregate estimated incomes less \$4,550.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,480.99	\$48.69
26.	On or after August 1, 2006 but before November 1, 2006	Person with no dependants — maximum estimated income \$1,629.53	Estimated income less \$116.00	Estimated income less \$116.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$7,887.00	Aggregate estimated incomes less \$3,345.00, divided by 3	Aggregate estimated incomes less \$3,345.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,366.00	Aggregate estimated incomes less \$3,824.00, divided by 3	Aggregate estimated incomes less \$3,824.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,802.00	Aggregate estimated incomes less \$4,260.00, divided by 3	Aggregate estimated incomes less \$4,260.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,192.00	Aggregate estimated incomes less \$4,650.00, divided by 3	Aggregate estimated incomes less \$4,650.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,513.53	\$49.76
27.	On or after November 1, 2006 but before July 1, 2007	Person with no dependants — maximum estimated income \$1,632.53	Estimated income less \$119.00	Estimated income less \$119.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$7,887.00	Aggregate estimated incomes less \$3,345.00, divided by 3	Aggregate estimated incomes less \$3,345.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,366.00	Aggregate estimated incomes less \$3,824.00, divided by 3	Aggregate estimated incomes less \$3,824.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,802.00	Aggregate estimated incomes less \$4,260.00, divided by 3	Aggregate estimated incomes less \$4,260.00, divided by 91.2

		Person with four or more dependants — maximum aggregate estimated incomes \$9,192.00	Aggregate estimated incomes less \$4,650.00, divided by 3	Aggregate estimated incomes less \$4,650.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,513.53	\$49.76
28.	On or after July 1, 2007 but before November 1, 2007	Person with no dependants — maximum estimated income \$1,662.95	Estimated income less \$119.00	Estimated income less \$119.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,045.00	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,533.00	Aggregate estimated incomes less \$3,900.00, divided by 3	Aggregate estimated incomes less \$3,900.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,978.00	Aggregate estimated incomes less \$4,345.00, divided by 3	Aggregate estimated incomes less \$4,345.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,376.00	Aggregate estimated incomes less \$4,743.00, divided by 3	Aggregate estimated incomes less \$4,743.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,543.95	\$50.76
29.	On or after November 1, 2007 but before July 1, 2008	Person with no dependants — maximum estimated income \$1,665.95	Estimated income less \$122.00	Estimated income less \$122.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,045.00	Aggregate estimated incomes less \$3,412.00, divided by 3	Aggregate estimated incomes less \$3,412.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,533.00	Aggregate estimated incomes less \$3,900.00, divided by 3	Aggregate estimated incomes less \$3,900.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$8,978.00	Aggregate estimated incomes less \$4,345.00, divided by 3	Aggregate estimated incomes less \$4,345.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,376.00	Aggregate estimated incomes less \$4,743.00, divided by 3	Aggregate estimated incomes less \$4,743.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,543.95	\$50.76
30.	On or after July 1, 2008 but before November 1, 2008	Person with no dependants — maximum estimated income \$1,700.02	Estimated income less \$122.00	Estimated income less \$122.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,222.00	Aggregate estimated incomes less \$3,487.00, divided by 3	Aggregate estimated incomes less \$3,487.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,721.00	Aggregate estimated incomes less \$3,986.00, divided by 3	Aggregate estimated incomes less \$3,986.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,176.00	Aggregate estimated incomes less \$4,441.00, divided by 3	Aggregate estimated incomes less \$4,441.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,582.00	Aggregate estimated incomes less \$4,847.00, divided by 3	Aggregate estimated incomes less \$4,847.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,578.02	\$51.88
31.	On or after November 1, 2008 but before July 1, 2009	Person with no dependants — maximum estimated income \$1,703.02	Estimated income less \$125.00	Estimated income less \$125.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,222.00	Aggregate estimated incomes less \$3,487.00, divided by 3	Aggregate estimated incomes less \$3,487.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,721.00	Aggregate estimated incomes less \$3,986.00, divided by 3	Aggregate estimated incomes less \$3,986.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,176.00	Aggregate estimated incomes less \$4,441.00, divided by 3	Aggregate estimated incomes less \$4,441.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,582.00	Aggregate estimated incomes less \$4,847.00, divided by 3	Aggregate estimated incomes less \$4,847.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,578.02	\$51.88

		this item		
32.	On or after July 1, 2009 but before November 1, 2009	Person with no dependants — maximum estimated income \$1,739.21	Estimated income less \$125.00	Estimated income less \$125.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,411.00	Aggregate estimated incomes less \$3,567.00, divided by 3	Aggregate estimated incomes less \$3,567.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,921.00	Aggregate estimated incomes less \$4,078.00, divided by 3	Aggregate estimated incomes less \$4,078.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,387.00	Aggregate estimated incomes less \$4,543.00, divided by 3	Aggregate estimated incomes less \$4,543.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,802.00	Aggregate estimated incomes less \$4,958.00, divided by 3	Aggregate estimated incomes less \$4,958.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,614.21	\$53.07
33.	On or after November 1, 2009 but before July 1, 2010	Person with no dependants — maximum estimated income \$1,742.21	Estimated income less \$128.00	Estimated income less \$128.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,411.00	Aggregate estimated incomes less \$3,567.00, divided by 3	Aggregate estimated incomes less \$3,567.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,921.00	Aggregate estimated incomes less \$4,078.00, divided by 3	Aggregate estimated incomes less \$4,078.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,387.00	Aggregate estimated incomes less \$4,543.00, divided by 3	Aggregate estimated incomes less \$4,543.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,802.00	Aggregate estimated incomes less \$4,958.00, divided by 3	Aggregate estimated incomes less \$4,958.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,614.21	\$53.07
34.	On or after July 1, 2010 but before November 1, 2010	Person with no dependants — maximum estimated income \$1,747.08	Estimated income less \$128.00	Estimated income less \$128.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,436.00	Aggregate estimated incomes less \$3,578.00, divided by 3	Aggregate estimated incomes less \$3,578.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,948.00	Aggregate estimated incomes less \$4,090.00, divided by 3	Aggregate estimated incomes less \$4,090.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,415.00	Aggregate estimated incomes less \$4,557.00, divided by 3	Aggregate estimated incomes less \$4,557.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,831.00	Aggregate estimated incomes less \$4,973.00, divided by 3	Aggregate estimated incomes less \$4,973.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,619.08	\$53.23
35.	On or after November 1, 2010 but before November 1, 2011	Person with no dependants — maximum estimated income \$1,749.08	Estimated income less \$130.00	Estimated income less \$130.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,436.00	Aggregate estimated incomes less \$3,578.00, divided by 3	Aggregate estimated incomes less \$3,578.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,948.00	Aggregate estimated incomes less \$4,090.00, divided by 3	Aggregate estimated incomes less \$4,090.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,415.00	Aggregate estimated incomes less \$4,557.00, divided by 3	Aggregate estimated incomes less \$4,557.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,831.00	Aggregate estimated incomes less \$4,973.00, divided by 3	Aggregate estimated incomes less \$4,973.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,619.08	\$53.23
36.	On or after November 1, 2011 but before July 1, 2012	Person with no dependants — maximum estimated income \$1,751.08	Estimated income less \$132.00	Estimated income less \$132.00, divided by 30.4167

		Person with one dependant — maximum aggregate estimated incomes \$8,436.00	Aggregate estimated incomes less \$3,578.00, divided by 3	Aggregate estimated incomes less \$3,578.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$8,948.00	Aggregate estimated incomes less \$4,090.00, divided by 3	Aggregate estimated incomes less \$4,090.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,415.00	Aggregate estimated incomes less \$4,557.00, divided by 3	Aggregate estimated incomes less \$4,557.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$9,831.00	Aggregate estimated incomes less \$4,973.00, divided by 3	Aggregate estimated incomes less \$4,973.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,619.08	\$53.23
37.	On or after July 1, 2012 but before November 1, 2012	Person with no dependants — maximum estimated income \$1,806.14	Estimated income less \$132.00	Estimated income less \$132.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,722.00	Aggregate estimated incomes less \$3,701.00, divided by 3	Aggregate estimated incomes less \$3,701.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$9,251.00	Aggregate estimated incomes less \$4,230.00, divided by 3	Aggregate estimated incomes less \$4,230.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,734.00	Aggregate estimated incomes less \$4,713.00, divided by 3	Aggregate estimated incomes less \$4,713.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$10,164.00	Aggregate estimated incomes less \$5,143.00, divided by 3	Aggregate estimated incomes less \$5,143.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,674.14	\$55.04
38.	On or after November 1, 2012 but before July 1, 2013	Person with no dependants — maximum estimated income \$1,808.14	Estimated income less \$134.00	Estimated income less \$134.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,722.00	Aggregate estimated incomes less \$3,701.00, divided by 3	Aggregate estimated incomes less \$3,701.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$9,251.00	Aggregate estimated incomes less \$4,230.00, divided by 3	Aggregate estimated incomes less \$4,230.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,734.00	Aggregate estimated incomes less \$4,713.00, divided by 3	Aggregate estimated incomes less \$4,713.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$10,164.00	Aggregate estimated incomes less \$5,143.00, divided by 3	Aggregate estimated incomes less \$5,143.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,674.14	\$55.04
39.	On or after July 1, 2013 but before September 1, 2013	Person with no dependants — maximum estimated income \$1,841.59	Estimated income less \$134.00	Estimated income less \$134.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,899.00	Aggregate estimated incomes less \$3,775.00, divided by 3	Aggregate estimated incomes less \$3,775.00, divided by 91.2
		Person with two dependants — maximum aggregate estimated incomes \$9,439.00	Aggregate estimated incomes less \$4,315.00, divided by 3	Aggregate estimated incomes less \$4,315.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,931.00	Aggregate estimated incomes less \$4,807.00, divided by 3	Aggregate estimated incomes less \$4,807.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$10,370.00	Aggregate estimated incomes less \$5,246.00, divided by 3	Aggregate estimated incomes less \$5,246.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,707.59	\$56.14
40.	On or after September 1, 2013	Person with no dependants — maximum estimated income \$1,843.59	Estimated income less \$136.00	Estimated income less \$136.00, divided by 30.4167
		Person with one dependant — maximum aggregate estimated incomes \$8,899.00	Aggregate estimated incomes less \$3,775.00, divided by 3	Aggregate estimated incomes less \$3,775.00, divided by 91.2
		Person with two dependants —	Aggregate estimated incomes	Aggregate estimated incomes

		maximum aggregate estimated incomes \$9,439.00	less \$4,315.00, divided by 3	less \$4,315.00, divided by 91.2
		Person with three dependants — maximum aggregate estimated incomes \$9,931.00	Aggregate estimated incomes less \$4,807.00, divided by 3	Aggregate estimated incomes less \$4,807.00, divided by 91.2
		Person with four or more dependants — maximum aggregate estimated incomes \$10,370.00	Aggregate estimated incomes less \$5,246.00, divided by 3	Aggregate estimated incomes less \$5,246.00, divided by 91.2
		Person not referred to elsewhere in this item	\$1,707.59	\$56.14

R.R.O. 1990, Reg. 552, Table 2; O. Reg. 9/91, s. 2; O. Reg. 161/91, s. 2; O. Reg. 435/91, s. 3; O. Reg. 656/91, s. 2; O. Reg. 36/92, s. 2; O. Reg. 215/92, s. 2; O. Reg. 408/92, s. 3; O. Reg. 655/92, s. 2; O. Reg. 33/93, s. 2; O. Reg. 203/93, s. 2; O. Reg. 430/93, s. 1; O. Reg. 736/93, s. 1; O. Reg. 19/94, s. 1; O. Reg. 302/94, s. 1; O. Reg. 502/94, s. 2; O. Reg. 496/96, s. 4; O. Reg. 197/97, ss. 2, 3; O. Reg. 236/98, s. 1; O. Reg. 368/99, s. 1; O. Reg. 300/00, s. 1; O. Reg. 183/01, s. 1; O. Reg. 234/02, s. 1; O. Reg. 221/03, s. 4; O. Reg. 311/04, s. 1; O. Reg. 314/06, s. 2; O. Reg. 209/07, s. 2; O. Reg. 156/08, s. 1; O. Reg. 192/09, s. 2; O. Reg. 174/10, ss. 1, 2; O. Reg. 307/11, s. 1; O. Reg. 107/12, s. 1; O. Reg. 219/12, s. 1; O. Reg. 163/13, s. 1; O. Reg. 262/13, s. 1.

TABLE 3 Revoked: O. Reg. 375/93, s. 10.

TABLE 4

Item	Column 1	Column 2	Column 3	Column 4
1.	On or after April 1, 1991	On or after April 1, 1991	51.7	38.7

O. Reg. 2/98, s. 3.

TABLE 5

Item	Column 1	Column 2	Column 3	Column 4	Column 5
1.	On or after April 1, 1991	On or after April 1, 1991	51.7	38.7	25.8

O. Reg. 2/98, s. 4.

TABLE 6

Column 1	Column 2
From and including April 1, 1991 to and including March 31, 1992	From and including April 1, 1992

O. Reg. 322/93, s. 4.

SCHEDULE 1

PART I

<i>Active Treatment Hospitals</i>		
Item	Location	Name of Hospital
1.	Don Mills	One Medical Place
2.	Scarborough	Bellwood Health Services Inc.
3.	Thornhill	Shouldice Hospital Limited
4.	Toronto	Institute of Traumatic, Plastic and Restorative Surgery

PART II

<i>Chronic Care Hospitals</i>		
Item	Location	Name of Hospital
1.	Lakefield	Lakefield Private Hospital
2.	London	Grace Villa Hospital
3.	Penetanguishene	Beechwood Private Hospital

4.	Perth	Wiseman's Private Hospital
5.	Willowdale	St. Joseph's Infirmary
6.	Woodstock	Woodstock Private Hospital

O. Reg. 306/01, s. 1.

SCHEDULE 2 FEDERAL HOSPITALS

PART I

<i>Active Treatment Hospitals:</i>		
Item	Location	Name of Hospital
1.	Attawapiskat	Nursing Station
2.	Big Trout Lake	Nursing Station
3.	Fort Albany (on the Island of St. Clair)	Nursing Station
4.	Fort Hope	Nursing Station
5.	Kashechewan	Nursing Station
6.	Lac Seul	Nursing Station
7.	Lansdowne House	Nursing Station
8.	Manitowaning	Manitowaning Hospital
9.	Moose Factory	Moose Factory General Hospital
10.	Moosonee	R.C.A.F. Hospital
11.	Ohsweken	Lady Willingdon Hospital
12.	Osnaburgh	Nursing Station
13.	Ottawa	National Defence Medical Centre
14.	Pikangikum	Nursing Station
15.	Round Lake	Nursing Station
16.	Sandy Lake	Nursing Station
17.	Sioux Lookout	Sioux Lookout Indian Hospital
18.	Winisk	Nursing Station

PART II

<i>Chronic Care Hospitals:</i>		
Item	Location	Name of Hospital
1.	Ottawa	National Defence Medical Centre (Chronic Unit)

R.R.O. 1990, Reg. 552, Sched. 2.

SCHEDULE 3 Revoked: O. Reg. 375/93, s. 11.

SCHEDULE 4 HOSPITALS FOR PSYCHIATRIC ILLNESSES AND FOR ALCOHOLISM AND DRUG ADDICTION

PART I

<i>Public Hospitals for Psychiatric Illnesses:</i>		
Item	Location	Name of Hospital
1.	Toronto	Addiction and Mental Health Services Corporation-Clarke Institute Site
2.	Toronto	Addiction and Mental Health Services Corporation-Queen Street Mental Health Centre Site

PART II

<i>Public Hospitals for Alcoholism and Drug Addiction:</i>		
Item	Location	Name of Hospital
1.	Toronto	Addiction and Mental Health Services

		Corporation-Donwood Site
2.	Toronto	Addiction and Mental Health Services Corporation-Addiction Research Foundation Site

O. Reg. 111/98, s. 2.

SCHEDULE 5 Revoked: O. Reg. 129/05, s. 6.

SCHEDULE 6 REHABILITATION AND CRIPPLED CHILDREN'S CENTRES

PART I

<i>Centres providing Occupational Therapy:</i>		
Item	Location	Name of Centre
1.	Brantford	Lansdowne Children's Centre
2.	Hamilton	Hamilton District Society for Crippled Children
3.	Kitchener	Kitchener-Waterloo Rotary Children's Centre
4.	London	Thames Valley Children's Centre
5.	Mississauga	Credit Valley Treatment Centre for Children
6.	Oshawa	Simcoe Hall Children's Centre
7.	Ottawa	The Ottawa Crippled Children's Treatment Centre
8.	Peterborough	Five Counties Children's Centre
9.	St. Catharines	Niagara Peninsula Crippled Children's Treatment Centre
10.	St. Catharines	Niagara Peninsula Rehabilitation Centre
11.	Sarnia	Sarnia and District Children's Treatment Centre
12.	Sudbury	Laurentian Hospital Children's Treatment Centre
13.	Thunder Bay	George Jeffrey Children's Treatment Centre
14.	Toronto	Ontario Crippled Children's Centre
15.	Toronto	Toronto Rehabilitation Centre
16.	Windsor	The Children's Rehabilitation Centre of Essex County

PART II

<i>Centres providing Physiotherapy:</i>		
Item	Location	Name of Centre
1.	Brantford	Lansdowne Children's Centre
2.	Chatham	Kent County Children's Treatment Centre
3.	Hamilton	Hamilton District Society for Crippled Children
4.	Kitchener	Kitchener-Waterloo Rotary Children's Centre
5.	London	Thames Valley Children's Centre
6.	Mississauga	Credit Valley Treatment Centre for Children
7.	Oshawa	Simcoe Hall Children's Centre
8.	Ottawa	The Ottawa Crippled Children's Treatment Centre
9.	Peterborough	Five Counties Children's Centre
10.	St. Catharines	Niagara Peninsula Crippled Children's Treatment Centre
11.	St. Catharines	Niagara Peninsula Rehabilitation Centre
12.	Sarnia	Sarnia and District Children's Treatment Centre
13.	Sault Ste.	Sault Ste. Marie Children's

	Marie	Rehabilitation Centre
14.	Sudbury	Laurentian Hospital Children's Treatment Centre
15.	Thunder Bay	George Jeffrey Children's Treatment Centre
16.	Toronto	The Canadian Arthritis and Rheumatism Society
17.	Toronto	Ontario Crippled Children's Centre
18.	Toronto	Toronto Rehabilitation Centre
19.	Windsor	The Children's Rehabilitation Centre of Essex County

PART III

<i>Centres providing Speech Therapy:</i>		
Item	Location	Name of Centre
1.	Brantford	Lansdowne Children's Centre
2.	Chatham	Kent County Children's Treatment Centre
3.	Hamilton	Hamilton District Society for Crippled Children
4.	Kitchener	Kitchener-Waterloo Rotary Children's Centre
5.	London	Thames Valley Children's Centre
6.	Mississauga	Credit Valley Treatment Centre for Children
7.	Oshawa	Simcoe Hall Children's Centre
8.	Ottawa	The Ottawa Crippled Children's Treatment Centre
9.	Peterborough	Five Counties Children's Centre
10.	St. Catharines	Niagara Peninsula Crippled Children's Treatment Centre
11.	St. Catharines	Niagara Peninsula Rehabilitation Centre
12.	Sarnia	Sarnia and District Children's Treatment Centre
13.	Sault Ste. Marie	Sault Ste. Marie Children's Rehabilitation Centre
14.	Sudbury	Laurentian Hospital Children's Treatment Centre
15.	Thunder Bay	George Jeffrey Children's Treatment Centre
16.	Toronto	Ontario Crippled Children's Centre
17.	Toronto	Toronto Rehabilitation Centre
18.	Windsor	The Children's Rehabilitation Centre of Essex County
19.	Windsor	Remedial Speech Association of Essex

R.R.O. 1990, Reg. 552, Sched. 6.

SCHEDULE 7 AMBULANCE SERVICE OPERATORS

PART I

<i>Hospital Ambulance Services:</i>		
Item	Location	Name of Operator
1.	Ajax	Ajax and Pickering General Hospital
2.	Alexandria	Glengarry Memorial Hospital
3.	Alliston	The Stevenson Memorial Hospital
4.	Almonte	Almonte General Hospital
5.	Arnprior	Arnprior and District Memorial Hospital
6.	Atikokan	Atikokan General Hospital
7.	Barrie	Royal Victoria Hospital of Barrie
8.	Barry's Bay	St. Francis Memorial Hospital
9.	Blind River	St. Joseph's General Hospital

10.	Bowmanville	Memorial Hospital
11.	Brockville	Brockville General Hospital
12.	Burk's Falls	Red Cross Outpost Hospital
13.	Cambridge	Cambridge Memorial Hospital
14.	Campbellford	Campbellford Memorial Hospital
15.	Chapleau	Lady Minto Hospital
16.	Cochenour	Margaret Cochenour Hospital
17.	Cochrane	Lady Minto Hospital at Cochrane
18.	Dryden	Dryden District General Hospital
19.	Dunnville	Haldimand War Memorial Hospital
20.	Durham	Durham Memorial Hospital
21.	Elliot Lake	St. Joseph's General Hospital
22.	Englehart	Englehart and District Hospital
23.	Espanola	Espanola General Hospital
24.	Fergus	Groves Memorial Community Hospital
25.	Forest	Forest District Ambulance Service
26.	Fort Frances	La Verendrye Hospital
27.	Goderich	Alexandra Marine and General Hospital
28.	Hagersville	West Haldimand General Hospital
29.	Hanover	Hanover Memorial Hospital
30.	Hearst	Notre-Dame Hospital
31.	Hornepayne	Hornepayne Community Hospital
32.	Huntsville	Huntsville District Memorial Hospital
33.	Iroquois Falls	Anson General Hospital
34.	Kapuskasing	Sensenbrenner Hospital
35.	Kemptville	Kemptville District Hospital
36.	Kenora	Lake of the Woods District Hospital
37.	Kincardine	Kincardine General Hospital
38.	Kingston	Hotel Dieu Hospital
39.	Kirkland Lake	Kirkland and District Hospital
40.	Kitchener	Kitchener-Waterloo Hospital
41.	Listowel	The Listowel Memorial Hospital
42.	Little Current	Manitoulin Health Centre
43.	Manitouwadge	Manitouwadge General Hospital
44.	Marathon	Wilson Memorial General Hospital
45.	Markdale	Centre Grey General Hospital
46.	Matheson	Bingham Memorial Hospital
47.	Mattawa	Mattawa General Hospital
48.	Meaford	Meaford General Hospital
49.	Newmarket	York County Hospital
50.	Nipigon	Nipigon District Memorial Hospital
51.	North Bay	North Bay Civic Hospital
52.	Orangeville	Dufferin Area Hospital
53.	Owen Sound	The Owen Sound General and Marine Hospital
54.	Paris	The Willett Hospital
55.	Parry Sound	The Parry Sound General Hospital
56.	Pembroke	General Hospital
57.	Perth	The Great War Memorial Hospital of Perth District
58.	Peterborough	The Peterborough Civic Hospital
59.	Rainy River	Red Cross Outpost Hospital
60.	Richard's Landing	Red Cross Outpost Hospital
61.	St. Catharines	Hotel Dieu Hospital
62.	St. Marys	St. Marys Memorial Hospital
63.	St. Thomas	St. Thomas-Elgin General Hospital
64.	Sarnia	Sarnia General Hospital
65.	Sault Ste. Marie	Plummer Memorial Public Hospital
66.	Shelburne	Shelburne District Hospital
67.	Sioux Lookout	Sioux Lookout General Hospital
68.	Smooth Rock	Smooth Rock Falls Hospital

	Falls	
69.	Stratford	Stratford General Hospital
70.	Sturgeon Falls	St. Jean de Brébeuf Hospital
71.	Sudbury	Sudbury General Hospital
72.	Thessalon	Red Cross Outpost Hospital
73.	Thunder Bay	McKellar General Hospital
74.	Thunder Bay	St. Joseph's General Hospital
75.	Tillsonburg	Tillsonburg District Memorial Hospital
76.	Uxbridge	The Cottage Hospital (Uxbridge)
77.	Walkerton	County of Bruce General Hospital
78.	Wawa	The Lady Dunn General Hospital
79.	Wiarton	Bruce Peninsula and District Memorial Hospital
80.	Wingham	Wingham and District Hospital

PART II

<i>Municipal Ambulance Services:</i>		
Item	Location	Name of Operator
1.	Ancaster	Township of Ancaster Volunteer Ambulance Service
2.	Beardmore	Improvement District of Beardmore
3.	Brantford	City of Brantford Fire Department
4.	Ear Falls	Ear Falls Ambulance Service
5.	Haliburton	Municipality of Dysart et al
6.	Ignace	Township of Ignace
7.	Lindsay	Lindsay Fire Department and Ambulance Service
8.	Minden	Minden Ambulance Service
9.	Noelville	Noelville Ambulance Service
10.	Sioux Narrows	Sioux Narrows Ambulance Service
11.	Temagami	Improvement District of Temagami
12.	Timmins	Timmins Dispatch Centre
13.	Toronto	Municipality of Metropolitan Toronto, Department of Emergency Services
14.	Virginiatown	Township of McGarry Ambulance Service
15.	Wasaga Beach	Wasaga Beach Ambulance Service
16.	White River	Improvement District of White River

PART III

<i>Private Ambulance Operators:</i>		
Item	Location	Name of Operator
1.	Agincourt	Ogden Ambulance Service
2.	Alfred	Lamarre & Son Ambulance Service
3.	Bancroft	Hattin's Ambulance Service
4.	Beaverton	Beaverton Ambulance Service
5.	Belleville	City Ambulance (of Quinte) Ltd.
6.	Belleville	LaSalle Ambulance Service
7.	Bobcaygeon	Bobcaygeon Ambulance Service
8.	Bracebridge	Muskoka Ambulance Service
9.	Bradford	Lewis Ambulance Service
10.	Brigden	Steadman's Ambulance Service
11.	Burlington	District of Halton and Mississauga Ambulance Service
12.	Carleton Place	Allan R. Barker Ambulance Service
13.	Casselman	Casselman Ambulance Service
14.	Chatham	Arbour's Chatham Ambulance Service Limited
15.	Cobourg	Cobourg Ambulance Service
16.	Colborne	Rutherford's Ambulance Service
17.	Collingwood	McKechnie Ambulance Service
18.	Dashwood	Hoffman's Ambulance Service

19.	Delhi	D.L. Murphy Ambulance Service
20.	Drayton	N. Wellington Ambulance Service
21.	Fenelon Falls	Fenelon Ambulance Service
22.	Finch	Brownlee Ambulance Service
23.	Fisherville	Yeates Ambulance Service
24.	Gananoque	Gananoque Ambulance Service
25.	Geraldton	Fawcett Ambulance Service
26.	Glencoe	J.B. Gough & Son Ambulance Service
27.	Grimsby	West Lincoln Ambulance Service
28.	Guelph	Royal City Ambulance Service
29.	Haileybury	Buffam Ambulance Service
30.	Hamilton	Fleetview Services Limited
31.	Hamilton	Superior Ambulance Limited
32.	Harrow	Gerald A. Smith & Sons Ambulance Service
33.	Hawkesbury	Noel Ambulance Service Limited
34.	Hawkesbury	Quenneville Ambulance Service
35.	Langton	Verhoeve Ambulance Service
36.	Leamington	Sunparlour Ambulance Service
37.	London	Thames Valley Ambulance Limited
38.	Lucan	Lucan Ambulance Service
39.	MacTier	Jordan's Ambulance Service
40.	Madoc	City Ambulance Service (of Quinte) Limited
41.	Midland	Midland District Ambulance Service
42.	Mississauga	Fleuty Ambulance Service
43.	Morrisburg	Seaway Valley Ambulance Service Limited
44.	Mount Forest	Hiller Ambulance Service
45.	Napanee	City Ambulance Service of Quinte Limited
46.	Palmerston	Henderson Ambulance Service
47.	Parham	Parham District Ambulance Service
48.	Parkhill	Parkhill Ambulance Service
49.	Petawawa	Upper Ottawa Valley Ambulance
50.	Petrolia	Jay's Ambulance Service
51.	Picton	Bond's Ambulance Service
52.	Port Colborne	Port Colborne Ambulance Service
53.	Port Elgin	Saugeen District Ambulance Service
54.	Port Perry	Brignall's Ambulance Service
55.	Port Rowan	Port Rowan Ambulance Service
56.	Rodney	Padfield Ambulance Service
57.	Schreiber	King's Ambulance Service
58.	Seaforth	R.S. Box Ambulance Service
59.	Simcoe	Green's Ambulance Service
60.	Smithville	Book's Ambulance Service
61.	Stratford	Stratford Ambulance Service
62.	Strathroy	Denning Brothers Ambulance Service
63.	Streetsville	Lee Ambulance Service
64.	Sutton	Taylor's Ambulance Service
65.	Tecumseh	Suburban Ambulance Service
66.	Thedford	Gilpin Ambulance Service
67.	Tilbury	Tilbury District Ambulance Service
68.	Timmins	Porcupine Area Ambulance Service
69.	Toronto	Hallowell Ambulance Service
70.	Toronto	Kane Ambulance Service
71.	Toronto	Metro Ambulance Service
72.	Toronto	Watson Ambulance Service
73.	Trenton	Rushnell's Ambulance Service
74.	Wallaceburg	Arbour's Chatham Ambulance Service Limited
75.	Waterdown	Patton Ambulance Service

76.	Welland	Greater Welland Ambulance Service
77.	Whitby	W.C. Town Ambulance Service
78.	Woodstock	Woodstock Ambulance Limited
79.	Zurich	Westlake Ambulance Service

PART IV

<i>Volunteer Ambulance Operators:</i>		
Item	Location	Name of Operator
1.	Amherstburg	Amherstburg, Anderdon & Malden District First Aid Squad
2.	Bolton	Bolton & District Ambulance Association (Volunteer)
3.	Dubreuilville	Dubreuilville Volunteer Ambulance Service
4.	Georgetown	Georgetown Volunteer Ambulance Service
5.	Gore Bay	Gore Bay Volunteer Ambulance Group
6.	Hastings	Hastings Ambulance Service
7.	Nestor Falls	Nestor Falls Volunteer Ambulance Service
8.	Niagara-on-the-Lake	Niagara Volunteer Ambulance Service
9.	Nobleton	Nobleton Firefighters & Ambulance Association
10.	Powassan	Powassan & District Ambulance Service
11.	Rockland	Rockland Ambulance Service
12.	Seeley's Bay	Seeley's Bay Emergency Ambulance

R.R.O. 1990, Reg. 552, Sched. 7.

SCHEDULE 8

PUBLIC HEALTH LABORATORIES APPROVED AS RELATED HEALTH FACILITIES

Item	Location	Ontario Agency for Health Protection and Promotion Public Health Laboratories
1.	Hamilton	Hamilton Psychiatric Hospital Fennell Avenue West Mailing Address: P.O. Box 2100 L8N 3R5
2.	Kingston	Government Building 181 Barrie Street Mailing Address: Box 240 K7L 4V8
3.	London	Fifth Floor London Psychiatric Hospital Off Highbury Avenue Mailing Address: Box 5704, Postal Terminal 'A' N6A 4L6
4.	Orillia	Highway 11B Mailing Address: Box 600 L3V 6K5
5.	Ottawa	346 Moodie Drive R.R. 2 Bells Corners Mailing Address: Box 6301 K2A 1S8
6.	Revoked: O. Reg. 448/08, s. 1 (2).	
7.	Peterborough	1341 Dobbin Avenue Mailing Address: P.O. Box 265 K9J 6Y8
8.	Sault Ste. Marie	Albert and Brock Streets

		Mailing Address: P.O. Box 220
		P6A 5L6
9.	Sudbury	1300 Paris Crescent
		Mailing Address: 1300 Paris Crescent
		P3E 3A3
10.	Thunder Bay	336 South Syndicate Avenue
		Mailing Address: P.O. Box 1100,
		Station 'F', P7C 4X9
11.	Timmins	67 Wilson Avenue
		Mailing Address: 67 Wilson Avenue
		P4N 2S5
		Toronto
12.	Toronto	Central Public Health Laboratory
		Resources Road
		Islington and Highway 401
		Etobicoke
		Mailing Address: Box 9000,
		Terminal 'A', M5W 1R5
13.	Windsor	3400 Huron Church Rd.
		Mailing Address: P.O. Box 1616
		N9A 6S2

R.R.O. 1990, Reg. 552, Sched. 8; O. Reg. 448/08, s. 1.

SCHEDULES 9, 10 Revoked: O. Reg. 253/00, s. 6.

SCHEDULE 11 Revoked: O. Reg. 201/99, s. 6.

SCHEDULE 12

1. Abstainers Insurance Company
2. Advocate General Insurance Company of Canada
3. Aetna Casualty Company of Canada
4. The Aetna Casualty and Surety Company
5. Aetna Insurance Company
6. Algoma Mutual Fire Insurance Company
7. Allianz Insurance Company
8. Allstate Insurance Company of Canada
9. Alpina Insurance Company Limited
10. The American Insurance Company
11. American Mutual Liability Insurance Company
12. Anglo Canada General Insurance Company
13. The Ayr Farmers' Mutual Fire Insurance Company
14. Baltica-Skandinavia Insurance Company of Canada
15. The Bay City General Insurance Company
16. Bay of Quinte Agricultural Mutual Fire Insurance Company
17. Bertie and Clinton Mutual Fire Insurance Company
18. Blanchard Mutual Fire Insurance Company
19. Brant Mutual Fire Insurance Company
20. The Canada Accident and Fire Assurance Company
21. The Canadian Commerce Insurance Company
22. Canadian General Insurance Company
23. Canadian Home Assurance Company
24. The Canadian Indemnity Company
25. The Canadian Provincial Insurance Company
26. The Canadian Surety Company
27. Canadian Universal Insurance Company Limited
28. The Casualty Company of Canada
29. Cayuga Mutual Fire Insurance Company
30. Centennial Insurance Company
31. The Century Insurance Company of Canada
32. Chateau Insurance Company
33. The Citadel General Assurance Company

34. Coachman Insurance Company
35. Commercial Union Assurance Company of Canada
36. Constitution Insurance Company of Canada
37. The Continental Insurance Company
38. The Continental Insurance Company of Canada
39. The Contingency Insurance Company Limited
40. Co-Operative Fire and Casualty Company
41. Co-Operators Insurance Association
42. Cornhill Insurance Company Limited
43. Coronation Insurance Company Limited
44. Culross Mutual Fire Insurance Company
45. Cumis General Insurance Company
46. Cumis Insurance Society, Inc.
47. Dominion Insurance Corporation
48. The Dominion of Canada General Insurance Company
49. Dufferin Mutual Fire Insurance Company
50. Dumfries Mutual Fire Insurance Company
51. Dunwich Farmers' Mutual Fire Insurance Company
52. East Williams Mutual Fire Insurance Company
53. Eaton Bay Insurance Company
54. Economical Mutual Insurance Company
55. Elma Mutual Fire Insurance Company
56. Employers Insurance of Wasau a Mutual Company
57. Erie Mutual Fire Insurance Company
58. Farmers' Mutual Fire Insurance Company (Lindsay)
59. Federal Insurance Company
60. Federated Mutual Insurance Company
61. Federation Insurance Company of Canada
62. Fidelity Insurance Company of Canada
63. Fireman's Fund Insurance Company
64. Fireman's Fund Insurance Company of Canada
65. First National Insurance Company of America
66. Formosa Mutual Fire Insurance Company
67. The General Accident Assurance Company of Canada
68. General Insurance Company of America
69. General Security Insurance Company of Canada
70. Gerling Global General Insurance Company
71. Germania Farmers' Mutual Fire Insurance Company
72. Gibraltar General Insurance Company
73. Gold Circle Insurance Company
74. Gore Mutual Insurance Company
75. The Grenville Patron Mutual Fire Insurance Company
76. Grey & Bruce Mutual Fire Insurance Company
77. Guarantee Company of North America
78. Guardian Insurance Company of Canada
79. The Halifax Insurance Company
80. Halwell Mutual Fire Insurance Company
81. The Hartford Fire Insurance Company
82. Hay Township Farmers' Mutual Fire Insurance Company
83. Herald Insurance Company
84. Highlands Insurance Company
85. The Home Insurance Company
86. Howard Mutual Fire Insurance Company
87. Howick Farmers' Mutual Fire Insurance Company
88. INA Insurance Company of Canada
89. Insurance Company of North America
90. The Insurance Corporation of Ireland Limited
91. Jevco Insurance Company
92. Lambton Mutual Fire Insurance Company
93. The Lanark County Farmers' Mutual Fire Insurance Company
94. La Paix General Insurance Company of Canada
95. La Paix Compagnie D'Assurances Generales Du Canada
96. Liberty Mutual Fire Insurance Company

97. The London Assurance
98. London-Canada Insurance Company
99. London Township Mutual Fire Insurance Company
100. Lumbermen's Mutual Casualty Company
101. Maplex General Insurance Company
102. Markel Insurance Company of Canada
103. McGillivray Mutual Fire Insurance Company
104. McKillop Mutual Fire Insurance Company
105. The Mississquoi and Rouville Insurance Company
106. National Employers Mutual General Insurance Association Limited
107. Niagara Fire Insurance Company
108. Non-Marine Underwriters, Members of (Lloyd's) London, England
109. Norfolk Mutual Fire Insurance Company
110. North Blenheim Farmers' Mutual Fire Insurance Company
111. North Kent Mutual Fire Insurance Company
112. Northern Frontier General Insurance Company
113. The Nova Scotia General Insurance Company
114. The Omaha Indemnity Company
115. Ontario Motorist Insurance Company
116. Ontario Mutual General Insurance Company
117. Otter Dorchester Mutual Insurance Company
118. Oxford Mutual Fire Insurance Company
119. Pafco Insurance Company, Limited
120. The Peel and Maryborough Mutual Fire Insurance Company
121. The Personal Insurance Company of Canada
122. Perth Insurance Company
123. Phoenix Assurance Company of Canada
124. Pilot Insurance Company
125. Pitts Insurance Company
126. The Portage la Prairie Mutual Insurance Company
127. Premier Insurance Company
128. Prescott Mutual Fire Insurance
129. La Prevoyance Compagnie D'Assurances
130. The Provident Assurance Company
131. The Prudential Assurance Company Limited (of England)
132. Quebec Assurance Company
133. Reliance Insurance Company
134. Royal General Insurance Company of Canada
135. Royal Insurance Company of Canada
136. Safeco Insurance Company of America
137. Scottish & York Insurance Company Limited
138. St. Paul Fire and Marine Insurance Company
139. Security Casualty Company
140. Security Mutual Casualty Company
141. Sentry Insurance A Mutual Company
142. Simcoe & Erie General Insurance Company
143. South Easthope Farmers' Mutual Fire Insurance Company
144. The Sovereign General Insurance Company
145. The Stanstead & Sherbrooke Insurance Company
146. State Farm Mutual Automobile Insurance Company
147. Sun Alliance Insurance Company
148. The Tokio Marine and Fire Insurance Company Limited
149. Toronto General Insurance Company
150. Townsend Farmers' Mutual Fire Insurance Company
151. Traders General Insurance Company
152. Trafalgar Insurance Company Limited
153. Transit Insurance Company
154. Transport Insurance Company
155. Travelers Indemnity Company
156. Travelers Indemnity Company of Canada

157. The United Provinces Insurance Company
158. United States Fidelity and Guaranty Company
159. United States Fire Insurance Company
160. The Unity Fire and General Insurance Company
161. Victoria Insurance Company of Canada
162. Wabisa Mutual Fire Insurance Company
163. Waterloo Mutual Insurance Company
164. The Wawanesa Mutual Insurance Company
165. West Elgin Mutual Fire Insurance Company
166. West Wawanosh Mutual Fire Insurance Company
167. The Western Assurance Company
168. Westminster Mutual Fire Insurance Company
169. The Yarmouth Mutual Fire Insurance Company
170. York Fire & Casualty Insurance Company
171. Zurich Insurance Company

R.R.O. 1990, Reg. 552, Sched. 12.

SCHEDULES 13-15 Revoked: O. Reg. 86/03, s. 3.

SCHEDULE 16

SCHEDULE OF BENEFITS FOR OUT OF PROVINCE SERVICES NUCLEAR MEDICINE — IN VIVO

NUCLEAR MEDICINE — IN VIVO

Code	Cardiovascular System	
J802/J602	Venography — peripheral and superior vena cava	91.70
J804/J604	First transit without blood pool images	15.30
J867/J667	First transit with blood pool images	54.60
J806/J606	Cardioangiography — first pass for shunt detection, cardiac output and transit studies	90.60
J807/J607	Myocardial perfusion scintigraphy — immediate post stress, resting	207.30
J808/J608	— delayed	76.40
J810/J610	Myocardial scintigraphy — acute infarction, injury	84.00
J811/J611	Myocardial wall motion studies	90.60
J812/J612	— repeat same day (maximum of three repeats)	45.80
J813/J613	Myocardial wall motion studies with ejection fraction	128.80
J814/J614	— repeat same day (maximum of three repeats)	45.80
J815/J615	Detection of venous thrombosis using radioiodinated fibrinogen up to ten days	125.50
Endocrine System		
J816/J616	Adrenal scintigraphy with idiocholesterol	367.75
J868/J668	— with idiocholesterol and dexamethasone suppression	431.05
J869/J669	— with MIBG	529.05
J817/J617	Thyroid uptake	27.30
J870/J670	— repeat	14.20
J818/J618	Thyroid scintigraphy with Tc99m or I-131	61.10
J871/J671	— with I-123	98.20
J820/J620	Parathyroid scintigraphy — dual isotope technique with Tl201 and Tc99m Iodine	224.80
J872/J672	Metastatic survey with I-131	229.10

Gastrointestinal System

J821/J621	Schilling test — single isotope	42.60
J823/J623	— dual isotope	45.80
J824/J624	Malabsorption test with C14 substrate	54.60
J873/J673	— with whole body counting	131.00
J825/J625	Gastrointestinal protein loss	78.50
J874/J674	Gastrointestinal blood loss — Cr51	58.90
J826/J626	Calcium absorption — Ca45	58.90
J875/J675	Calcium47 absorption/excretion	241.15
J827/J627	Esophageal motility studies — one or more	114.60
J829/J629	Gastrointestinal transit	98.20
J876/J676	Gastrointestinal reflux	54.60
J877/J677	Gastroesophageal aspiration	38.20
J830/J630	Abdominal scintigraphy for gastrointestinal bleed — Tc99m sulphur colloid or Tc04	82.90
J878/J678	— labeled RBCs	136.40
J879/J679	— Le Veen shunt patency	63.25
J831/J631	Biliary scintigraphy	109.10
J832/J632	Liver/spleen scintigraphy	76.30
J833/J633	Salivary gland scintigraphy	91.65

Genitourinary System

J834/J634	Dynamic renal imaging	91.65
J835/J635	Computer assessed renal function (includes first transit)	125.50
J880/J680	— repeat after pharmacological intervention	43.00
J836/J636	Static renal scintigraphy	30.50
J837/J637	ERPF by blood sample method	38.20
J838/J638	GFR by blood sample method	38.20
J839/J639	Cystography for vesicoureteric reflux	114.80
J840/J640	Testicular and scrotal scintigraphy (includes first transit)	78.50

Hematopoietic System

J841/J641	Plasma volume	41.45
J843/J643	Red cell volume	45.80
J847/J647	Ferrokinetics — clearance, turnover, and utilization	381.90
J848/J648	Red cell, white cell or platelet survival	98.20
J849/J649	Red cell, survival with serial surface counts	141.90
J881/J681	Bone marrow scintigraphy — whole body	109.10
J882/J682	— single site	80.80
J883/J683	In-111 leukocyte scintigraphy — whole body	347.00
J884/J684	— single site	305.60

Musculoskeletal System

J850/J650	Bone scintigraphy — general survey	98.80
J851/J651	— single site	80.80
J852/J652	Gallium scintigraphy — general survey	169.20
J853/J653	— single site	117.85
J854/J654	Bone mineral density by single photon method	29.50
J855/J655	Total body calcium — neutron activation	185.50
J888/J688	Bone mineral content by dual photon absorptiometry — single site	111.90
J856/J656	— two or more sites	146.40

Nervous System

J857/J657	CSF circulation — with Tc99m or I-131 HSA	114.60
J885/J685	— with In-111	294.60
J886/J686	— via shunt puncture	85.05
J858/J658	Brain scintigraphy	86.20

Respiratory System

J859/J659	Perfusion long scintigraphy	81.80
J887/J687	Ventilation lung scintigraphy	102.60
J860/J660	Perfusion and ventilation scintigraphy — same day	163.70

Miscellaneous

J861/J661	Radionuclide lymphangiogram	106.90
J862/J662	Ocular tumour localization	72.00
J864/J664	Tear duct scintigraphy	92.80
J865/J665	Total body counting	179.00
J866/J666	Tomography (SPECT)	41.45

DIAGNOSTIC RADIOLOGY**Head and Neck**

X001	Skull — four views	30.65
X009	— five or more views	38.20
X003	Sella turcica (when skull not examined)	15.30
X004	Facial bones — minimum of three views	22.20
X005	Nose — minimum of two views	15.30
X006	Mandible — minimum of three views (uni or bilateral)	22.20
X012	— four or more views	30.65
X007	Temporomandibular joints — minimum of four views including open and closed mouth views	22.20
X008	Sinuses — minimum of three views	22.20
X010	Mastoids — bilateral — minimum of six views	29.40
X011	Internal auditory meati (when skull not examined)	22.20
X016	Eye, for foreign body	15.20
X017	Eye, for localization, additional	15.60
X018	Optic foramina	17.20
X019	Salivary gland region	14.10
X020	Neck for soft tissues — minimum of two views	14.10

Spine and Pelvis

X025	Cervical spine — two or three views	26.50
X202	— four or five views	34.20
X203	— six or more views	41.40
X027	Thoracic spine — two views	24.30
X204	— three or more	31.90
X028	Lumbar or lumbrosacral spine — two or three views	26.50
X205	— four or five views	34.20
X206	— six or more views	41.50
X032	Entire spine — (scoliosis series) minimum of four views	54.95
X033	— Orthoroentgenogram (3 foot film) — single view	22.20
X031	— two or more views	30.60
X034	Sacrum and/or coccyx — two views	25.60
X207	— three or more views	31.90
X035	Sacro-iliac joints — two or three views	22.20
X208	— four or more views	29.70
X036	Pelvis and/or hip(s) — one view	15.30

X037	— two views (e.g. A.P. and frog view, both hips; or A.P. both hips plus lateral one hip)	28.50
X038	— three or more views (e.g. pelvis and sacro-iliac joints, or A.P. both hips plus lateral each hip)	32.70

Upper Extremities

X045	Clavicle — two views	15.30
X209	— three or more views	23.50
X046	Acromioclavicular joints (bilateral) with or without weighted distraction — two views	22.20
X210	— three or more views	30.40
X047	Sternoclavicular joints — (bilateral) — two or three views	18.30
X211	— four or more views	26.40
X048	Shoulder — two views	18.30
X212	— three or more views	26.40
X049	Scapula — two views	18.30
X213	— three or more views	26.40
X050	Humerus — including one joint — two views	15.30
X214	— three or more views	23.50
X051	Elbow — two views	15.30
X215	— three or four views	23.50
X216	— five or more views	31.60
X052	Forearm — including one joint — two views	15.30
X217	— three or more views	23.50
X053	Wrist — two or three views	15.30
X218	— four or more views	23.50
X054	Hand — two or three views	15.30
X219	— four or more views	23.50
X055	Wrist and hand — two or three views	22.20
X220	— four or more views	28.35
X056	Finger or thumb — two views	11.80
X221	— three or more views	15.30

Lower Extremities

X060	Hip — (unilateral) — two or more views	24.30
X063	Femur, including one joint — two views	15.30
X223	— three or more views	23.50
X065	Knee (including patella) — two views	15.30
X224	— three or four views	23.50
X225	— five or more views	31.60
X066	Tibia and fibula (including one joint) — two views	15.30
X226	— three or more views	23.50
X067	Ankle — two or three views	15.30
X227	— four or more views	23.50
X068	Calcaneus — two views	15.30
X228	— three or more views	23.50
X069	Foot — two or three views	15.30
X229	— four or more views	23.50
X072	Toe — two views	11.80
X230	— three or more views	15.30
X064	Leg length studies (orthoroentgenogram)	22.20

Skeletal Surveys

X057	Skeletal survey for bone age — single film	15.30
X058	— two or more films or views	22.40
X080	Other survey studies — e.g., rheumatoid, metabolic or metastatic —	7.60

	basic	
X081	— plus per film or view	7.60

Chest

X090	Single film	15.30
X091	Two views	22.50
X092	Three or more views	28.90
X039	Ribs — two or more views	18.30
X040	Sternum — two or more views	18.30
X096	Thoracic inlet — two or more views	15.30

Abdomen

X100	Single view	15.30
X101	Two or more views	23.40

G.I. Tract

X105	Palatopharyngeal analysis (cine or videotape)	30.20
X106	Pharynx and oesophagus (cine or videotape)	30.20
X107	Oesophagus — when X103, X104, X108 or X109 not billed	27.40
X108	Oesophagus, stomach and duodenum — including survey film if taken	47.50
X104	Oesophagus, stomach and duodenum — double contrast, including survey film if taken	49.40
X103	Oesophagus, stomach and duodenum — double contrast, including survey film if taken, and small bowel	62.50
X109	Oesophagus, stomach and small bowel	60.55
X110	Hypotonic duodenogram	40.40
X111	Small bowel only — when only examination performed during patient's visit	27.40
X112	Colon — barium enema (including survey film, if taken)	49.50
X113	Colon — air contrast, primary or secondary, including survey films, if taken	62.60
X114	Gallbladder (one or multiple day examinations)	30.65
X120	Gallbladder (one or multiple day examinations with preliminary plain film)	40.80
X116	T-tube cholangiogram	22.20
X117	Operative cholangiogram	22.20
X118	Intravenous cholangiogram	50.70
X123	Operative pancreatogram or E.R.C.P.	22.20

G.U. Tract

X129	Retrograde pyelogram, unilateral or bilateral	22.20
X130	Intravenous pyelogram including preliminary film	50.80
X137	Cystogram (catheter)	24.40
X135	Cystourethrogram, stress or voiding (catheter)	28.30
X131	Cystourethrogram (non-catheter)	5.95
X191	Intestinal conduit examination or nephrostogram	22.20
X138	Percutaneous antegrade pyelogram	22.20
X139	Percutaneous nephrostogram	22.20
X134	Urethrogram (retrograde)	18.30
X136	Vasogram	18.30

Obstetrics and Gynaecology

X143	Survey film	15.30
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X144	Pelvimetry	22.20
X147	Hysterosalpingogram	30.60
X148	Intra-uterine foetal transfusion — radiological control	40.40
Fluoroscopy — by physician with or without spot films		
X195	Chest	9.50
X196	Skeleton	9.50
X197	Abdomen	9.50
X189	Fluoroscopic control of clinical procedures done by another physician per 1/4 hour	7.50
Special Examinations		
X155	Abdominal or pelvic pneumogram Angiography — by catheterization — abdominal, thoracic, cervical, or cranial — using single films	41.00
X179	non-selective	30.60
X180	selective (per vessel to max. of 4) — using film changer, cine or multiformat camera	40.40
X181	non-selective	61.15
X182	selective (per vessel to a max. of 4)	81.40
X140	selective (5 or more vessels)	325.60
X160	Carotid angiogram — direct puncture — unilateral	50.15
X161	— bilateral	80.60
X174	Peripheral angiogram — unilateral	30.60
X175	— bilateral	40.40
X198	Splenoportogram	60.60
X199	Translumbar aortogram	60.60
X132	Vertebral angiogram — direct puncture or retrograde brachial injection — unilateral	50.15
X133	— bilateral	82.00
X156	Arthrogram, tenogram, or bursogram	26.90
X200	— with fluoroscopy and complete positioning throughout by physician	37.70
X157	Bone density (mineral content) measurement	34.30
X158	Bronchogram — unilateral	30.10
X159	— bilateral	39.90
X162	Cerebral stereotaxis	61.15
X122	Cholangiogram, percutaneous transhepatic	30.30
Miscellaneous Examinations		
X151	Cordotomy, percutaneous	50.15
X163	Dacrocystogram	30.60
X164	Discogram(s) — one or more levels	30.10
X167	Fistula or sinus	22.20
X169	Laminogram, planigram, tomogram	41.00
X170	Laryngogram	30.10
X171	Lymphangiogram	50.70
X192	Mammary ductography	22.20
X184	Mammogram — dedicated equipment — unilateral	25.40
X185	— bilateral	37.80
X186	— using xeroradiography — unilateral	31.45
X187	— bilateral	48.30
X150	Mechanical evaluation of knee	26.20
X193	Microradioscopy of the hands	15.05

X173	Myelogram (spine and/or posterior fossa)	35.90
X190	Pantomography	18.30
X154	Penis	16.40
X176	Sialogram	30.60
X177	Skin thickness measurement	16.10
X183	Ventriculogram	50.15
X166	Examination using portable machine, add to first examination only	64.80
	Note: X166 may only be claimed one per day regardless of the number of people x-rayed in the same residence	

DIAGNOSTIC ULTRASOUND

Head and Neck

J122	Brain — complete, B-mode	46.10
	Echography — ophthalmic (excluding vascular study)	
J102	Quantitative, A-mode	21.80
J103	B-scan immersion	42.90
J107	B-scan contact	21.70
J108	Biometry (Axial length — A-mode)	22.20
J105	Face and/or neck (excluding vascular study)	46.20
J106	Paranasal sinuses, A-mode	6.35

Heart — echocardiography (see listings in Diagnostic and Therapeutic Procedures)**Thorax**

J125	Chest masses, pleural effusion — A & B-mode	47.60
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Abdomen and Retroperitoneum

J135	Abdominal scan, complete	47.60
J128	Abdominal scan, limited study (e.g. gallbladder only, aorta only or follow-up study)	31.40

Pelvis

J159	Pregnancy, complete	47.60
J162	Pelvic, complete	47.60
J163	Pelvis or pregnancy, limited study (e.g. foetal age determination, placental localization, I.U.C.D. localization)	31.40
J138	Intracavity ultrasound (e.g. transrectal, transvaginal)	47.60

Vascular System

J190	Extra-cranial vessel assessment (bilateral carotid and/or subclavian and/or vertebral arteries) — Doppler scan or B scan	41.70
J191	— frequency analysis	41.70
J192	— frequency analysis with Doppler scan	52.40
J201	— Duplex scan i.e. simultaneous real time, B mode imaging and spectral analysis	64.60
J193	Peripheral artery and/or vein evaluation — Doppler scan or B scan, unilateral	21.60
J194	— frequency analysis, unilateral	14.40
J195	— frequency analysis with Doppler scan, unilateral	27.10
J202	— Duplex scan i.e. simultaneous real time, B-mode imaging and spectral	32.40

	analysis, unilateral	
J198	Venous assessment (bilateral — includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manoeuvres and permanent record)	7.20
J205	Doppler evaluation of organ transplantation — arterial and/or venous	21.60

Vascular laboratory fees

J200	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	19.90
J196	Ankle pressure measurements with exercise and/or quantitative measurements added to the above	7.80
J197	Penile pressure recordings — two or more pressures	6.75
J203	Transcutaneous tissue oxygen tension measurements	23.50
J204	— when done in addition to Doppler studies	12.90

Miscellaneous

J180	Echography for placement of radiation therapy fields, scan B-mode	34.30
J182	Extremities — per limb (excluding vascular study)	23.10
J127	Breast — scan B-mode (per breast)	23.10
J183	Scrotal — scan	46.20
J149	Ultrasonic guidance of biopsy, aspiration, amniocentesis or drainage procedures (one physician only)	46.20

PULMONARY FUNCTION STUDIES

J311	Functional residual capacity by gas dilution method	16.00
J307	Functional residual capacity by body plethysmography	17.30
J305	Lung compliance (pressure volume curve of the lung from TLC to FRC)	51.30
J306	Airways resistance by plethysmography or estimated using esophageal catheter	15.90
J340	Maximum inspiratory and expiratory pressures	2.70
J309	Carbon monoxide diffusing capacity by steady state at rest	10.60
J310	Carbon monoxide diffusing capacity by single breath method	21.20
J308	Carbon dioxide ventilatory response	19.70
J328	Oxygen ventilatory response (physician must be present)	19.70
J315	Stage I: Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload)	61.70
E450	J315 plus J301 or J304 before and/or after exercise, add	13.10
E451	J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise, add	17.90
J316	Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO ₂ , VCO ₂ , BP, ECG, end tidal and mixed venous CO ₂ at rest, 3 levels of exercise and recovery	88.95

J317	Stage III: J316 plus arterial blood gases, pH and bicarbonate or lactate	171.50
J330	Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301 or J304 before exercise and 5-10 minutes post exercise)	32.90
J319	Blood gas analysis: pH, PO ₂ , PCO ₂ , bicarbonate and base excess	11.10
J318	Arterialized venous blood sample collection (e.g. ear lobe)	3.70
J320	A-a oxygen gradient requiring measurement of RQ by sampling mixed expired gas and using alveolar air equation	27.20
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen	27.20
J313	Mixed venous PCO ₂ , by the rebreathing method	11.10
J323	O ₂ saturation by oximetry at rest, with or without O ₂	4.20
J332	Oxygen saturation by oximetry at rest and exercise, or during sleep with or without O ₂	17.40
J334	J332 with at least two levels of supplemental O ₂	30.25
J322	Standard O ₂ consumption and CO ₂ production	5.20
J333	Non-specific bronchial provocative test (histamine, methylcholine, thermal challenge)	47.65
J335	Antigen challenge test	51.20
J341	Trans diaphragmatic pressure measurement	51.30

R.R.O. 1990, Reg. 552, Sched. 16.

SCHEDULE 17

MEDICATIONS FOR THE TREATMENT OF CYSTIC FIBROSIS

- I. Oral Anti-infectives
 - amoxicillin
 - amoxicillin/clavulanic acid
 - cefaclor
 - cefuroxime axetil
 - cephalexin
 - chloramphenicol
 - ciprofloxacin
 - clindamycin
 - cloxacillin capsules
 - erythromycin
 - erythromycin/sulfisoxazole
 - flucloxacillin oral liquid
 - itraconazole
 - metronidazole
 - nystatin suspension
 - ofloxacin
 - pivampicillin
 - tetracycline
 - trimethoprim/sulfamethoxazole
 - vancomycin
- II. Inhaled/Intravenous Anti-infectives
 - amikacin
 - ceftazidime
 - chloramphenicol

- clindamycin
 - cloxacillin
 - colistimethate
 - gentamicin
 - imipenem
 - netilmycin
 - piperacillin
 - polymyxin b sulphate
 - ticarcillin
 - tobramycin
- III. Other Anti-infectives
- nystatin topical
 - nystatin vaginal
- IV. Chest Therapy
- amiloride
 - beclomethasone
 - budesonide
 - cromoglycate sodium
 - fenoterol
 - ipratropium
 - n-acetylcysteine
 - prednisone
 - salbutamol
 - terbutaline
 - theophylline
- V. Pancreatic Enzymes
- VI. Gastrointestinal Therapy
- cimetidine
 - cisapride
 - domperidone
 - gastric lavage solution
 - lactulose
 - mineral oil
 - omeprazole
 - ranitidine
 - sucralfate
 - ursodiol
- VII. Vitamins
- vitamin A
 - vitamin D
 - vitamin E
 - vitamin K
 - vitamin B12 injection
 - fluoride
- VIII. Nutrition Products
- Alimentum
 - Biocare
 - Boost
 - Caloreen
 - Compleat Modified
 - Ensure
 - Ensure Plus
 - Isocal
 - Isosource
 - Magnacal

MCT Oil
 Meritene
 Mighty Shakes
 Mineral Mix
 Nutren
 Pediasure
 Peptamen
 Polycose
 Pregestimil
 Pulmocare
 Resource
 Resource Plus
 Scandishakes
 Sustacal
 Vital HN

IX. Others
 beclomethasone nasal spray/aqueous nasal spray
 budesonide aqueous nasal spray
 ibuprofen tablets
 naproxen oral suspension
 insulin
 chlorpropamide
 glyburide
 metformin
 tolbutamide
 digoxin
 furosemide
 hydrochlorothiazide/spironolactone
 sodium chloride 0.9% ampoules
 sterile water ampoules

O. Reg. 175/95, s. 2.

SCHEDULE 18 MEDICATIONS FOR THE TREATMENT OF THALASSEMIA

amoxicillin
 ascorbic acid (vitamin C)
 deferoxamine
 folic acid
 hydrocortisone injection
 penicillin
 sterile water for injection
 trimethoprim/sulfamethoxazole

O. Reg. 175/95, s. 2.

SCHEDULES 19-21 Revoked: O. Reg. 370/00, s. 4.

SCHEDULE 22 Revoked: O. Reg. 217/11, s. 7.

SCHEDULE 23 OPTOMETRY SERVICES

Item	Fee Code	Insured Service	Fee Payable
1.	V402	Oculo-visual minor assessment	\$19.25
2.	V404	Periodic oculo-visual assessment of a person 19 years of age or younger	39.15
3.	V405	Periodic oculo-visual assessment of a person older than 19 years of age and younger than 65	39.15

4.	V406	Periodic oculo-visual assessment of a person 65 years of age or older	39.15
5.	V407	Additional periodic oculo-visual assessment of a person older than 19 years of age and younger than 65	39.15

O. Reg. 145/98, s. 2.

FORM 1 Revoked: O. Reg. 375/93, s. 12.

FORM 2 Revoked: O. Reg. 44/98, s. 8.

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