CHAPTER 197
Health Insurance Act

1. In this Act,

(a) "Appeal Board" means the Health Services Appeal Board under this Act;

(b) "dependant" means a dependant of an insured person, as defined in the regulations;

(c) "Deputy Minister" means the Deputy Minister of Health;

(d) "future cost of insured services" means the estimated total cost of the future insured services made necessary as the result of an injury that will probably be required by a patient after the date of settlement or, where there is no settlement, the first day of trial;

(e) "General Manager" means the General Manager appointed under section 4;

(f) "health facility" means extended care units in a nursing home, ambulance services, medical laboratories and such other health facilities as are prescribed by the regulations;

(g) "insured person" means a person who is entitled to insured services under this Act and the regulations;

(h) "insured services" means such services of hospitals and health facilities as are prescribed by the regulations, all services rendered by physicians that are medically necessary and such other health care services as are rendered by such practitioners and under such conditions and limitations as are prescribed by the regulations, but not including the services that a person is entitled to under the Workmen's Compensation Act, the Homes for Special Care Act or under any Act of the Parliament of Canada except the Hospital Insurance and Diagnostic Services Act (Canada) and the Medical Care Act (Canada);

(i) "Minister" means the Minister of Health;
(j) "past cost of insured services" means the total cost of the insured services made necessary as the result of an injury and provided to a patient up to and including the date of settlement or, where there is no settlement, the first day of trial;

(k) "physician" means a legally qualified medical practitioner lawfully entitled to practise medicine in the place where medical services are rendered by him;

(l) "Plan" means the Ontario Health Insurance Plan referred to in section 10;

(m) "practitioner" means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered;

(n) "regulations" means the regulations made under this Act;

(o) "resident" means a person who is legally entitled to remain in Canada and who makes his home and is ordinarily present in Ontario, but does not include a tourist, a transient or a visitor to Ontario, and the verb has a corresponding meaning. 1972, c. 91, s. 1; 1975, c. 52, s. 1.

ADMINISTRATION

2.—(1) The Minister is responsible in respect of the administration and operation of the Plan and is the provincial authority for Ontario for the purposes of the Medical Care Act (Canada).

Duties of Minister

(2) The Minister may,

(a) enter into arrangements for the payment of remuneration to physicians and practitioners rendering insured services to insured persons on a basis other than fee for service;

(b) enter into agreements with persons, organizations and government agencies outside Ontario for the provision of insured services to insured persons;

(c) limit the hospital and health care services outside Canada for which payment may be made under the Plan;

(d) establish one or more advisory committees to advise or assist in the operation of the Plan;
(e) authorize surveys and research programs and obtain statistics for purposes related to the Plan. 1972, c. 91, s. 2.

3.—(1) The Government of Ontario, represented by the Treasurer of Ontario, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to the provision of any insured services in or by hospitals and health facilities in accordance with such terms and conditions as the agreement provides.

(2) The Government of Ontario, represented by the Minister, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to insured services other than insured services provided in or by a hospital or health facility, in accordance with such terms and conditions as the agreement provides. 1972, c. 91, s. 3.

4.—(1) A General Manager for the Plan shall be appointed by the Lieutenant Governor in Council.

(2) Subject to this Act and the regulations, it is the function of the General Manager and he has the power,

(a) to administer the Plan as the chief executive officer of the Plan;

(b) to carry out enrolments in the Plan including the determination of eligibility and collection of premiums;

(c) to make payments by the Plan for insured services, including the determination of eligibility and amounts;

(d) to establish and maintain branch offices for the administration of the Plan;

(e) to conduct actions and negotiate settlements on behalf of the Plan under the subrogation of the Plan under this Act to the rights of insured persons;

(f) to require any information required or permitted to be provided to him under this Act or the regulations to be provided in such form as he specifies;

(g) to perform such other function and discharge such other duties as are assigned to him by this Act and the regulations or by the Minister. 1972, c. 91, s. 4.
5.—(1) The Medical Review Committee is continued as a committee of the College of Physicians and Surgeons consisting of,

(a) not more than six members appointed by the Minister from among the persons nominated for such purpose by the College of Physicians and Surgeons; and

(b) two members who are not physicians or practitioners, appointed by the Minister.

(2) Three members of the Medical Review Committee, one of whom shall be a member who is not a physician or practitioner, constitute a quorum of the Committee. 1974, c. 60, s. 1 (1).

(3) The members of the Medical Review Committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines. 1972, c. 91, s. 5 (2).

(4) The Medical Review Committee shall be paid such amounts for the administration expenses of the Committee and the engaging of assistance for the Committee as may be approved by the Minister. 1974, c. 60, s. 1 (2).

(5) No member of the Medical Review Committee shall be employed in the service of Ontario or any agency of the Crown.

(6) The Medical Review Committee shall make recommendations to the General Manager on any matter referred to it under section 24 and shall make reports and recommendations respecting any matter referred to it by this Act or the regulations or by the Minister, the Appeal Board or the College of Physicians and Surgeons and shall perform such other duties as are assigned to it by this Act or the regulations. 1972, c. 91, s. 5 (3, 4).

PRACTITIONER REVIEW COMMITTEES

6.—(1) The Minister shall appoint the following practitioner review committees:

1. A Chiropody Review Committee composed of two members who are not physicians or practitioners and three members from among the persons nomi-
nated by the Board of Regents appointed under the *Chiroprody Act*.  

2. A Chiropractic Review Committee composed of two members who are not physicians or practitioners and three members from among the persons nominated by the Board of Directors of Chiropractic appointed under the *Drugless Practitioners Act*.  

3. A Dentistry Review Committee composed of two members who are not physicians or practitioners and three members from among the persons nominated by The Royal College of Dental Surgeons of Ontario.  

4. An Optometry Review Committee composed of two members who are not physicians or practitioners and three members from among the persons nominated by the College of Optometrists of Ontario.  

5. An Osteopathy Review Committee composed of two members who are not physicians or practitioners and three members from among the persons nominated by the Board of Directors of Osteopathy appointed under the *Drugless Practitioners Act*. 1974, c. 60, s. 2, *part.*  

(2) Every practitioner review committee is a committee of the board or college that nominates persons appointed as members of the committee. 1975, c. 52, s. 2 (1).  

(3) Three members of a practitioner review committee, one of whom shall be a member who is not a physician or practitioner, constitute a quorum of the committee.  

(4) The members of a practitioner review committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines.  

(5) Every practitioner review committee shall be paid such amounts for the expenses of the committee and the engaging of assistance for the committee as may be approved by the Minister.  

(6) No member of a practitioner review committee shall be employed in the public service of Ontario or by any agency of the Crown. 1974, c. 60, s. 2, *part.*  

(7) Every practitioner review committee shall make recommendations to the General Manager on any matter referred to it under section 24 and shall make reports and recommendations respecting any matter referred to it by this Act or the regulations or by the Minister, the Appeal Board
or the board or college of which it is a committee, and shall perform such other duties as are assigned to it by this Act or the regulations. 1974, c. 60, s. 2, part; 1975, c. 52, s. 2 (2).

MEDICAL ELIGIBILITY COMMITTEE

7.—(1) The Minister may appoint in writing such number of physicians as he considers appropriate, from time to time, not to exceed fifteen, to form the Medical Eligibility Committee.

(2) The Minister shall specify the term of office for each physician in his written appointment.

(3) Any three members constitute a quorum and are sufficient for the exercise of all functions of the Committee.

(4) The Medical Eligibility Committee may sit in several divisions simultaneously providing a quorum of the Committee is present in each division.

(5) The decision of the majority of the members of the Medical Eligibility Committee present and constituting a quorum is the decision of the Committee.

(6) No member of the Medical Eligibility Committee shall be employed in the service of Ontario or any agency of the Crown.

(7) The Minister shall, from time to time, designate one of the physicians to be the chairman of the Committee who shall assign the members to sit on the various divisions of the Committee and prescribe the duties to be performed by each division.

(8) The members of the Medical Eligibility Committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines.

(9) The Medical Eligibility Committee shall look into and report with its recommendations to the General Manager on any matter referred to it under section 25 and shall perform such other duties as are assigned to it by this Act or the regulations or by the Minister. 1972, c. 91, s. 6.

HEALTH SERVICES APPEAL BOARD

8.—(1) The Health Services Appeal Board is continued and shall be composed of not fewer than five and not more than nine members, of whom not more than three shall be physicians, who shall be appointed by the Lieutenant Governor in Council.
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(2) One member of the Appeal Board shall be designated as Appeal Board chairman and another member of the Board shall be designated as vice-chairman by the Lieutenant Governor in Council.

(3) Three members of the Appeal Board constitute a quorum and are sufficient for the exercise of all the jurisdiction and powers of the Appeal Board.

(4) The decision of the majority of the members of the Appeal Board present and constituting a quorum is the decision of the Board, but, if there is no majority, the decision of the Appeal Board chairman or vice-chairman governs.

(5) No member of the Appeal Board shall be employed in the service of Ontario or any agency of the Crown.

(6) The members of the Appeal Board shall be paid such remuneration for their services as the Lieutenant Governor in Council determines.

(7) The functions of the Appeal Board are,

(a) to hear and determine appeals from decisions made by the General Manager under section 26; and

(b) to perform any other duties assigned by this Act or the regulations or by the Minister,

subject to and in accordance with this Act and the regulations. 1972, c. 91, s. 7, revised.

9. The Minister shall make a report annually to the Lieutenant Governor in Council upon the affairs of the Plan and the Minister shall lay the report before the Assembly if it is in session or, if not, at the next ensuing session. 1972, c. 91, s. 8.

ONTARIO HEALTH INSURANCE PLAN

10. The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto. 1972, c. 91, s. 9, revised.
11.—(1) Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations.

(2) Every dependant of an insured person is an insured person. 1972, c. 91, s. 10 (1, 2).

12. Every insured person is entitled to payment to himself or on his behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed during the period in respect of which his premium is paid or dispensed with under this Act. 1972, c. 91, s. 11.

13. The premium for insured services shall be such amount as is prescribed by the regulations, payable three months in advance of the period in respect of which the premium is paid and remitted to the General Manager payable to the Treasurer of Ontario. 1972, c. 91, s. 12.

14.—(1) Any person who is sixty-five years of age or over and who applies and is eligible therefor, and his spouse and dependants, are entitled to be insured persons without payment of a premium.

(2) Subsection (1) does not apply to a person unless he has been ordinarily resident in Ontario for the previous twelve months. 1972, c. 91, s. 13.

15.—(1) Subject to section 26, the General Manager may grant relief from or assistance in the payment of premiums for such residents and in such amounts based upon the taxable income or estimated taxable income of the resident and his spouse, if any, or upon such other circumstances as are determined in accordance with the regulations. 1972, c. 91, s. 14 (1).

(2) A resident who is unable to make payment of his premiums due to unemployment, illness, disability or financial hardship may apply to the General Manager for assistance in establishing or continuing his entitlement to insured services and, subject to section 26, the General Manager may direct that the applicant be relieved of the payment of the whole or any part of his premium during his unemployment, illness, disability or financial hardship. 1974, c. 60, s. 3.
(3) Any person who was entitled to insured services without the payment of a premium or to premium assistance immediately before the 1st day of April, 1972 continues to be so entitled under this Act, subject to the provisions thereof. 1972, c. 91, s. 14 (3).

16.—(1) In this section, “employees” includes the employer of the employees if the employer is an individual or a member of a partnership.

(2) Where the number of employees of an employer totals fifteen or more, the employees who are residents of Ontario are a mandatory group.

(3) Where the number of employees of an employer totals more than five but fewer than fifteen, the General Manager may, upon application therefor, designate the employees who are residents of Ontario as a mandatory group. 1974, c. 60, s. 4.

(4) Every person who is a member of a mandatory group shall be an insured person in accordance with this Act and the regulations.

(5) The employer shall deduct from the remuneration of each employee in his mandatory group the premiums required under this Act or such part as is agreed upon by the employer and his employee, but each member of the group is primarily liable to pay the premium.

(6) The deduction by an employer from the remuneration of an employee in his mandatory group of the premium required under this Act shall discharge the primary liability of that employee to pay the premium so deducted.

(7) No person shall make any charge for acting in his capacity as the employer of a mandatory group. 1972, c. 91, s. 15 (3-6).

17.—(1) Upon the application of an organization having fifteen or more members who are residents of Ontario and wish to apply for health insurance, the General Manager may designate the organization a collector’s group and shall designate the person who shall be the collector.

(2) Each member of the group is primarily liable to pay the premium.

(3) No person shall make any charge for acting in his capacity as a collector.
(4) The General Manager may, at the request of the Government of Canada, designate as a collector's group any group for whom and on whose behalf the Government of Canada undertakes to remit the premiums and information in the prescribed form. 1972, c. 91, s. 16.

18. Every person who receives, retains or withholds any amount for the purpose of paying a premium on behalf of an insured person shall be deemed to have received and to be holding the amount in trust for the Treasurer of Ontario and all accounts of such premium amounts shall be kept separate and apart from his own money. 1972, c. 91, s. 17.

19. This Act shall not be administered or construed to affect the right of an insured person to choose his own physician or practitioner, and does not impose any obligation upon any physician or practitioner to treat an insured person. 1972, c. 91, s. 18.

20.—(1) Every contract of insurance, other than insurance provided under section 232 of the Insurance Act, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,

(a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;

(b) compensation for loss of time from usual or normal activities because of disability requiring insured services,

performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract.

(2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection (1) whereby he or his dependants may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service.

(3) Subsections (1) and (2) do not apply to a contract of insurance entered into by a resident whose principal employment is in the United States of America and who is entitled to enter into the contract by virtue of his employment.

(4) Where payment is made to or on behalf of an insured person under a contract or agreement referred to in sub-
section (3) and such payment is less than would have been made under this Act and the regulations for the same insured services, the General Manager may pay to or on behalf of the insured person the difference between the amount paid under the contract or agreement and the amount established by the regulations for the insured services for which payment was made under the contract or agreement.

(5) Subsections (1) and (2) do not apply for the first three months after a person takes up residence in Ontario. 1972, c. 91, s. 19.

21.—(1) Subject to subsection (6), a physician may submit his accounts for the performance of insured services directly to the Plan for payment thereof directly to him by notifying the General Manager of his intention to do so in the manner and subject to the requirements prescribed by the regulations.

(2) Where a physician submits his accounts directly to the Plan under this section, he shall thereafter submit all his accounts for the performance of insured services directly to the Plan in accordance with and subject to the requirements of this Act and the regulations.

(3) Where a physician submits his accounts directly to the Plan under this section,

(a) payment thereof shall be made directly to him;

(b) he shall not submit any account for any amount to the patient in respect of insured services; and

(c) the payment by the Plan for the insured services performed constitutes payment in full of the account therefor.

(4) A physician may at any time notify the General Manager in writing that he intends to cease submitting his accounts directly to the Plan and subsection (3) ceases to apply to him on and after the first day of the third month next following the month in which the General Manager receives such notification.

(5) The General Manager shall not make any payment in respect of the performance of insured services directly to any physician who does not submit his accounts therefor directly to the Plan under this section.

(6) Every physician who was submitting his accounts directly to the Plan immediately prior to the 1st day of April, 1972 shall be considered to be one who is submitting his accounts directly to the Plan under this Act. 1972, c. 91, s. 20.
22.—(1) A practitioner engaged in the practice of a discipline designated by the regulations may submit his accounts for the performance of insured services directly to the Plan for payment thereof directly to him by notifying the General Manager of his intention to do so in the manner and subject to the requirements prescribed by the regulations.

(2) Where a practitioner submits his accounts directly to the Plan under this section, he shall thereafter submit all his accounts for the performance of insured services directly to the Plan in accordance with and subject to the requirements of this Act and the regulations.

(3) Where a practitioner submits his accounts directly to the Plan under this section,

(a) payment thereof shall be made directly to him;

(b) he shall not submit any account for any amount to the patient in respect of insured services; and

(c) the payment by the Plan for the insured services performed constitutes payment in full of the account therefor.

(4) A practitioner may at any time notify the General Manager in writing that he intends to cease submitting his accounts directly to the Plan and subsection (3) ceases to apply to him on and after the first day of the third month next following the month in which the General Manager receives such notification.

(5) The General Manager shall not make any payment in respect of the performance of insured services directly to any practitioner engaged in the practice of a discipline designated by the regulations who does not submit his accounts therefor directly to the Plan under this section.

(6) Every practitioner engaged in the practice of a discipline designated by the regulations who was submitting his accounts directly to the Plan immediately before the discipline is designated by the regulations for the purpose of this section shall be considered to be one who is submitting his accounts directly to the Plan under this Act. 1975, c. 52, s. 3.

23.—(1) Every physician and practitioner shall submit his accounts for insured services performed by him in such form as the General Manager shall prescribe, whether such accounts are submitted directly to the Plan or are submitted to the patient.
(2) An account for insured services performed by a physician or a practitioner shall be submitted to the General Manager by the physician or the practitioner, or by the patient where the patient is billed directly, as the case may be, not later than six months after the insured services are performed but the General Manager may pay the account after that time where there are extenuating circumstances. 1972, c. 91, s. 21.

24.—(1) Subject to section 26, the General Manager shall approve and assess claims for insured services, determine the amounts to be paid therefor and authorize the payment thereof in accordance with this Act and the regulations. 1972, c. 91, s. 22 (1).

(2) Notwithstanding any action taken by the General Manager under subsection (1), where, in respect of insured services rendered by a physician, it appears to the General Manager on reasonable grounds that,

(a) all or part of the insured services were not in fact rendered;

(b) all or part of such services were not medically necessary;

(c) all or part of such services were not provided in accordance with accepted professional standards and practice; or

(d) the nature of the services is misrepresented,

the General Manager shall refer the matter to the Medical Review Committee and the Medical Review Committee may recommend to the General Manager that he pay, or refuse or reduce payment of, or require and recover reimbursement from the physician of any overpayment of, the amount otherwise payable and, subject to sections 26 to 30 and subsections 31 (3) to (9), the General Manager shall carry out the recommendations of the Committee. 1974, c. 60, s. 5 (1); 1975, c. 52, s. 4 (1).

(3) Notwithstanding any action taken by the General Manager under subsection (1), where, in respect of insured services rendered by a practitioner who is engaged in the practice of a health discipline in respect of which a practitioner review committee has been appointed under this Act, it appears to the General Manager on reasonable grounds that,

(a) all or part of the insured services were not in fact rendered;

(b) all or part of such services were not therapeutically necessary;
(c) all or part of such services were not provided in accordance with accepted professional standards and practice; or

(d) the nature of the services is misrepresented,

the General Manager shall refer the matter to the practitioner review committee appointed in respect of the health discipline in which the practitioner is engaged in practice and the practitioner review committee may recommend to the General Manager that he pay, or refuse or reduce payment of, or require and recover reimbursement from the practitioner of any overpayment of, the amount otherwise payable and, subject to sections 26 to 30 and subsections 31 (3) to (9), the General Manager shall carry out the recommendations of the committee. 1974, c. 60, s. 5 (2); 1975, c. 52, s. 4 (2).

(4) The General Manager may deduct from the amount payable by the Plan to a physician or practitioner an amount that shall be retained by the Plan equal to the amount of any overpayment by the Plan to the physician or practitioner. 1974, c. 60, s. 5 (3).

(5) Where a hearing is required or an appeal is taken pursuant to sections 26 to 30, the General Manager shall carry out the recommendations of the Medical Review Committee or of a practitioner review committee made pursuant to subsection (2) or (3) pending the decision or order of the Appeal Board or the Supreme Court. 1974, c. 86, s. 1.

25.—(1) Where there is a dispute regarding a decision by the General Manager that an insured person is not entitled to an insured service in a hospital or health facility because such service is not medically necessary, the General Manager, upon receiving notice of such dispute, shall refer the matter to the Medical Eligibility Committee.

(2) The Medical Eligibility Committee shall consider the facts relevant to the disputed decision, including any medical records and reports about the insured person and, when considered necessary by the Committee, interviewing the insured person and discussing the matter with him and his physician.

(3) After giving consideration to the matter, the Medical Eligibility Committee shall recommend to the General Manager either that he pay or that he refuse to pay, according to the findings of the Committee, the sum or sums claimed by the insured person to be payable to him or on his behalf, as the case may be, and that the General Manager approve or refuse to approve, in accordance with the
recommendations of the Committee, the provision of the insured service or services that are in dispute and, subject to sections 26 to 30, the General Manager shall carry out the recommendations of the Committee. 1972, c. 91, s. 23.

26.—(1) Where the General Manager,

(a) refuses an application to become or continue to be an insured person;

(b) refuses an application for relief from or assistance in the payment of the premium;

(c) refuses a claim for payment for insured services or reduces the amount so claimed to an amount less than the amount payable by the Plan;

(d) carries out a recommendation of the Medical Review Committee or a practitioner review committee that he require and recover reimbursement of any overpayment by the Plan,

the General Manager shall serve notice on the applicant, claimant, physician or practitioner, as the case may be, of his decision, together with written reasons therefor. 1972, c. 91, s. 24 (1); 1974, c. 60, s. 6; 1975, c. 52, s. 5.

(2) A notice under subsection (1) shall inform the applicant or claimant that he is entitled to a hearing by the Appeal Board if he mails or delivers to the General Manager and to the Appeal Board, within fifteen days after the notice is served on him, notice in writing requiring a hearing and he may so require such a hearing. 1972, c. 91, s. 24 (2).

27.—(1) Where a person requires a hearing by the Appeal Board, the Appeal Board shall appoint a time for and hold the hearing and may by order direct the General Manager to take such action as the Appeal Board considers the General Manager should take in accordance with this Act and the regulations, and for such purposes the Appeal Board may substitute its opinion for that of the General Manager.

(2) The Appeal Board may extend the time for the giving of notice by a person requiring a hearing under this section, either before or after expiration of such time, where it is satisfied that there are prima facie grounds for granting relief to the claimant pursuant to a hearing and that there are reasonable grounds for applying for the extension, and the Appeal Board may give such directions as it considers proper consequent upon the extension. 1972, c. 91, s. 25.
28. The General Manager and,

(a) in the case of a refusal under clause 26 (1) (a) or (b), the applicant;

(b) in the case of a refusal or reduction under clause 26 (1) (c), the insured person and his physician or practitioner; or

(c) in the case of the carrying out of a recommendation under clause 26 (1) (d), the insured person and his physician or practitioner and the Medical Review Committee or practitioner review committee, as the case may be, and such other persons as the Appeal Board may specify, are parties to proceedings before the Appeal Board. 1975, c. 52, s. 6.

29.—(1) A person who is a party to proceedings before the Appeal Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report, the contents of which will be given in evidence at the hearing.

(2) Members of the Appeal Board holding a hearing shall not have taken part, before the hearing, in any investigation or consideration of the subject-matter of the hearing and shall not communicate directly or indirectly in relation to the subject-matter of the hearing with any person or with any party or his representative except upon notice to and with opportunity for all parties to participate, but the Appeal Board may seek legal advice from an adviser independent from the parties and in such case the nature of the advice should be made known to the parties in order that they may make submissions as to the law.

(3) The oral evidence taken before the Appeal Board at a hearing shall be recorded and, if so required, copies or a transcript thereof shall be furnished upon the same terms as in the Supreme Court.

(4) The findings of fact of the Appeal Board pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under section 15 or 16 of the Statutory Powers Procedure Act.

(5) No member of the Appeal Board shall participate in a decision of the Appeal Board pursuant to a hearing unless he was present throughout the hearing and heard the evidence
and argument of the parties and, except with the consent of the parties, no decision of the Appeal Board shall be given unless all members so present participate in the decision.

(6) Documents and things put in evidence at the hearing shall, upon the request of the person who produced them, be released to him by the Appeal Board within a reasonable time after the matter in issue has been finally determined. 1972, c. 91, s. 27.

30.—(1) Any party to the proceedings before the Appeal Board may appeal from its decision or order to the Divisional Court in accordance with the rules of court.

(2) Where any party appeals from a decision or order of the Appeal Board, the Appeal Board shall forthwith file in the Supreme Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Appeal Board's record, shall constitute the record in the appeal.

(3) The Minister is entitled to be heard by counsel or otherwise upon the argument of an appeal under this section.

(4) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the decision of the Appeal Board and may exercise all powers of the Appeal Board to direct the General Manager to take any action which the Appeal Board may direct him to take and as the court considers proper and for such purposes the court may substitute its opinion for that of the General Manager or of the Appeal Board, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. 1972, c. 91, s. 28.

31.—(1) Where a decision of the General Manager to refuse or reduce a payment or to require and recover reimbursement of any overpayment of any amount paid by the Plan on any of the grounds referred to in clauses 24 (2) (a) to (d) or 24 (3) (a) to (d) has become final, the General Manager shall furnish the Minister and the governing body of the profession of which the physician or practitioner rendering the services is a member with a copy of the decision and the reasons therefor, and in all other cases the General Manager may furnish such governing body with a copy of the decision and the reasons therefor. 1975, c. 52, s. 7 (1).

(2) Where the claim for an account for insured services of a physician or practitioner who is not submitting his accounts
directly to the Plan is refused or reduced on any of the grounds referred to in clauses 24 (2) (a) to (d) or 24 (3) (a) to (d), the insured person is not liable to the physician or practitioner for the difference between the amount to which the General Manager reduces the account on such grounds and the amount that would otherwise be payable under the Plan. 1972, c. 91, s. 29 (2); 1974, c. 60, s. 7 (2).

(3) Where a decision of the General Manager to carry out a recommendation referred to in clause 26 (1) (d) has become final in respect of a physician or practitioner who is not submitting his accounts directly to the Plan, the General Manager may serve notice on the physician or practitioner of the amount of the overpayment to be recovered by the General Manager from the physician or practitioner.

(4) A notice under subsection (3) shall set out or be accompanied by a written statement that identifies each of the insured services and the amount paid by the Plan for each of the services, and the notice shall inform the physician or practitioner that he is entitled to a hearing by the Appeal Board in respect of the services for the purpose of ensuring that the amount to be recovered from the physician or practitioner in respect of each of the services does not exceed the amount received by the physician or practitioner for the service if the physician or practitioner mails or delivers to the General Manager and to the Appeal Board, within fifteen days after the notice is served on him, notice in writing requiring a hearing and he may so require such a hearing.

(5) On a hearing under this section, the Appeal Board shall determine the amount received by the physician or practitioner for each service identified in the statement mentioned in subsection (4), and the amount of the reimbursement to the Plan to be recovered from the physician or practitioner in respect of each of the services shall not exceed the amount that the Appeal Board determines was received by the physician or practitioner for the service.

(6) The General Manager, the physician or practitioner and such other persons as the Appeal Board may specify are parties to the proceedings before the Appeal Board under this section.

(7) Subsection 27 (2) and sections 29 and 30 apply to proceedings before the Appeal Board under this section.
(8) Where notice is served pursuant to subsection (3) and no hearing is required or no appeal is taken or the decision referred to in subsection (3) is confirmed or varied upon a hearing or an appeal, the General Manager may file a copy of the decision or of the decision as confirmed or varied, including the amount to be recovered from the physician or practitioner by the General Manager for reimbursement to the Plan and excluding the reasons for the decision or for the decision as confirmed or varied, in the office of the Registrar of the Supreme Court and the decision shall be entered and is enforceable in the same way as a judgment of the Supreme Court.

(9) Where the Appeal Board or the Divisional Court extends the time for a hearing or an appeal and a decision has been filed in the office of the Registrar of the Supreme Court, the Appeal Board or the Divisional Court, as the case may be, may stay the enforcement of the decision pending the hearing or appeal. 1975, c. 52, s. 7 (2).

32. Except where otherwise provided, any notice required by this Act to be served may be served personally or by registered mail addressed to the person to whom the notice is being given at his latest known address and, where notice is served by registered mail, the service shall be considered to have been made on the seventh day after the day of mailing unless the person to whom notice is given establishes that he did not, acting in good faith, through absence, accident, illness or other cause beyond his control receive the notice until a later date. 1972, c. 91, s. 30; 1975, c. 52, s. 8.

33. At least six months before any proposed revision of the schedule of fees of the Ontario Medical Association, the Ontario Medical Association shall notify the Minister of the proposed revision and the Minister shall arrange and implement discussions with representatives of the said Association respecting the details and extent of any proposed changes in the schedule of fees. 1972, c. 91, s. 31.

34. Any amounts payable to or on behalf of an insured person under the Plan in respect of insured services provided by or in a hospital or health facility may be paid in the form of the payment by the Province of all or any part of the annual expenditures of such hospital or health facility, where such payment by the Province is authorized under any Act. 1972, c. 91, s. 32.
35.—(1) Every physician and practitioner who performs an insured service for an insured person, shall provide the insured person, or the General Manager, with the particulars of his services and account that are required by this Act and the regulations or the General Manager for the purpose of payment of the claim.

(2) Every insured person shall be deemed to have authorized his physician or practitioner who performed insured services to provide the General Manager with such information respecting the insured services performed as the General Manager requires for the purposes of the Plan.

36.—(1) Where, as the result of the negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he receives insured services under this Act, the Plan is subrogated to any right of the insured person to recover the cost incurred for past insured services and the cost that will probably be incurred for future insured services, and the General Manager may bring action in the name of the Plan or in the name of that person for the recovery of such costs.

(2) For the purposes of subsection (1), the payment by the Plan for insured services shall not be construed to affect the right of the insured person to recover the amounts so paid in the same manner as if such amounts are paid or to be paid by the insured person.

(3) For the purposes of this section, the cost of insured services rendered to an insured person in or by a hospital or health facility shall be at the rate charged by the hospital or health facility to a person who is not an insured person. 1972, c. 91, s. 35.

37.—(1) Any person who commences an action to recover for loss or damages arising out of the negligence or other wrongful act of a third party, to which the injury or disability in respect of which insured services have been provided is

Information authorized

Immunity for disclosure

Payment by Plan recoverable by insured

Cost of hospital services

Subrogated claim included in action
related shall, unless otherwise advised in writing by the General Manager, include a claim on behalf of the Plan for the cost of the insured services.

(2) Where a person recovers a sum in respect of the cost of insured services, he shall forthwith pay the sum recovered to the Treasurer of Ontario. 1972, c. 91, s. 36.

38. The Plan is not an insurer within the meaning of the Insurance Act, as referred to in section 20 of the Motor Vehicle Accident Claims Act, and may be awarded payment from the Motor Vehicle Accident Claims Fund. 1972, c. 91, s. 37.

39. The judge at trial shall, if the evidence permits, apportion the elements of the injured person's loss and damages so as to clearly designate the amount of the Plan's recovery for the past cost of insured services and separate it from the amount of the Plan's recovery of future cost of insured services, if any. 1972, c. 91, s. 38.

40. No release or settlement of a claim for damages for personal injuries in a case where the injured person has received insured services under this Act shall be binding on the Plan unless the General Manager has approved the release or settlement. 1972, c. 91, s. 39.

41. A liability insurer shall notify the General Manager of negotiations for settlement of any claim for damages including insured services and may pay to the Treasurer of Ontario any amount referable to a claim for recovery of the cost of insured services and such payment discharges the obligation of the liability insurer to pay that amount to the insured person. 1972, c. 91, s. 40.

42. Where a judgment or settlement includes future cost of insured services, the Plan shall provide the future insured services included in the judgment or settlement. 1972, c. 91, s. 41.

GENERAL

43.—(1) The Minister, from among persons nominated for such purpose by The College of Physicians and Surgeons of Ontario, may appoint in writing medical and financial inspectors with the duty and power to inspect, examine and audit books, accounts, reports and medical records maintained
in hospitals and health facilities, offices of physicians and other health care facilities respecting patients who are receiving or who have received insured services, and such medical and financial inspectors shall act only at the direction of the Medical Review Committee. 1972, c. 91, s. 43 (1); 1974, c. 60, s. 8 (1).

(2) The Minister, from among persons nominated for such purpose by a body referred to in section 6 that nominates persons for appointment to a practitioner review committee in respect of a health discipline, may appoint in writing practitioner and financial inspectors with the duty and power to inspect, examine and audit books, accounts, reports and records maintained in hospitals and health facilities, offices of practitioners and other health care facilities respecting patients who are receiving or who have received insured services provided by or at the direction of one or more practitioners engaged in the practice of the health discipline in respect of which the practitioner review committee has been appointed, and such practitioner and financial inspectors shall act only at the direction of such practitioner review committee. 1974, c. 60, s. 8 (2).

(3) No person shall obstruct a medical or practitioner or financial inspector in the performance of his duties under this Act and the regulations. 1972, c. 91, s. 43 (2); 1974, c. 60, s. 8 (3).

44.—(1) Each member of the Medical Review Committee, every practitioner review committee, the Medical Eligibility Committee and the Appeal Board and each employee thereof, the General Manager and each person engaged in the administration of this Act and the regulations shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties pertaining to insured persons and any insured services rendered and the payments made therefor, and shall not communicate any such matters to any other person except as otherwise provided in this Act. 1972, c. 91, s. 44 (1); 1974, c. 60, s. 9.

(2) A person referred to in subsection (1) may furnish information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable, but such information shall be furnished only,
(a) in connection with the administration of this Act, the Health Disciplines Act, the Public Hospitals Act, the Private Hospitals Act or the Ambulance Act or the Hospital Insurance and Diagnostic Services Act (Canada), the Medical Care Act (Canada) or the Criminal Code (Canada), or regulations made thereunder;

(b) in proceedings under this Act or the regulations;

(c) to the person who provided the service, his solicitor or personal representative, the executor, administrator or committee of his estate, his trustee in bankruptcy or other legal representative;

(d) to the person who received the services, his solicitor, personal representative or guardian, the committee or guardian of his estate or other legal representative of that person; or

(e) pursuant to a subpoena by a court of competent jurisdiction. 1972, c. 91, s. 44 (2); 1974, c. 86, s. 2.

(3) The information referred to in subsection (1) may be published by the Ministry of Health in statistical form if the individual names and identities of persons who received insured services are not thereby revealed.

(4) The General Manager may communicate information of the kind referred to in subsection (2) and any other information pertaining to the nature of the insured services provided and any diagnosis given by the person who provided the services to the statutory body governing the profession or to a professional association of which he is a member. 1972, c. 91, s. 44 (3, 4).

45. Members of the Medical Review Committee, practitioner review committees, the Medical Eligibility Committee, or the Appeal Board and employees thereof, the General Manager and persons engaged in the administration of this Act are not liable for anything done or made bona fide by them in the performance of their duties under this Act and the regulations. 1972, c. 91, s. 45; 1974, c. 60, s. 10.

46.—(1) Any person designated in writing by the General Manager may at any time enter the premises of an employer of a mandatory group or a collector under this Act and inspect
the books of account, payroll records and other records for the purpose of obtaining information relating to the membership of the group.

Access for inspection

(2) Every person, when requested to do so by a person designated under subsection (1), shall produce and permit inspection of the accounts and records and supply extracts therefrom.

Obstruction of inspector

(3) No person shall hinder or obstruct a person designated under subsection (1) in the performance of his duties or refuse to permit him to carry out his duties or refuse to furnish him with information or furnish him with false information. 1972, c. 91, s. 46.

Offence, failure to remit premiums 47.—(1) Subject to subsection (2), an employer or collector who fails to remit the premiums required to be remitted under this Act is guilty of an offence and on conviction is liable to a fine of not less than $2,000.

Order to pay premiums

(2) Where an employer or collector is convicted of an offence under subsection (1), the provincial offences court shall determine the amount of the premiums the employer failed to remit and shall make an order requiring the person convicted to remit the amount so determined to the General Manager.

Liability of officers and directors

(3) Every director or officer of a corporation who knowingly concurs in a failure to remit the premiums required to be remitted by the corporation under this Act is liable, jointly and severally with every other such officer and director, to make a payment ordered to be made under subsection (2). 1972, c. 91, s. 47.

Liability of directors on winding up

48. Where an employer or collector that is a corporation fails to remit the premiums required to be remitted under this Act, and,

(a) goes into liquidation;

(b) is ordered to be wound up;

(c) makes an authorized assignment under the Bankruptcy Act (Canada);

(d) has a receiving order under the Bankruptcy Act (Canada) made against it; or

(e) ceases to carry on its undertaking,
the directors thereof are jointly and severally liable for the payment of the amount of the premiums in default. 1972, c. 91, s. 48; 1974, c. 60, s. 11.

49. —(1) No person shall knowingly obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that he is not entitled to obtain or receive under this Act and the regulations.

(2) No person shall knowingly aid or abet another person to obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that such other person is not entitled to obtain or receive under this Act and the regulations. 1972, c. 91, s. 49.

(3) No person shall knowingly give false information in an application, return or statement made to the Plan or to the General Manager in respect of any matter under this Act or the regulations. 1974, c. 86, s. 3.

50. Every person who contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and on conviction is liable to a fine of not more than $2,000. 1972, c. 91, s. 50.

51.—(1) The Lieutenant Governor in Council may make regulations,

(a) providing for the enrolment of persons as insured persons and prescribing waiting periods therefor;

(b) prescribing who are dependants of insured persons for the purposes of this Act;

(c) prescribing the persons who shall be deemed employees for the purposes of section 16 and the employees who shall be members of a mandatory group;

(d) governing the collection, accounting for and remission of premiums by employers of mandatory groups and by collectors and requiring employers and collectors to furnish such information and returns as are prescribed;

(e) providing for the conditions under which a mandatory group shall continue notwithstanding its reduction

Offence
benefits by fraud
Idem
False
information
General penalty
Regulations
in numbers and for the termination of mandatory and collectors' groups;

(f) providing for the continuation and termination of insurance coverage in respect of insured persons who cease to be eligible;

(g) prescribing the qualifications for assistance in the payment of premiums and for determining the amount thereof;

(h) prescribing the premiums that shall be paid by or on behalf of insured persons and specifying the time and manner of making such payments;

(i) designating disciplines for the purpose of section 22;

(j) prescribing the services rendered in or by hospitals and health facilities and by practitioners that are insured services;

(k) prescribing the amounts payable by the Plan for insured services rendered in or outside of Ontario in or by hospitals and health facilities and by physicians and practitioners and the conditions for their performance and for payment, but no schedule of payments shall be prescribed under this clause that disqualifies the Plan for contribution by the Government of Canada under the Medical Care Act (Canada);

(l) prescribing services that shall be deemed not to be insured services for the purposes of this Act and the conditions under which the costs of any class of insured services are payable and limiting the payment commensurate with the circumstances of the performance of the services;

(m) prescribing services that, notwithstanding any provision of this Act, shall be deemed,

(i) not to be insured services in respect of prescribed age groups of insured persons, or

(ii) to be insured services only in respect of prescribed age groups of insured persons,

but no service or age group shall be prescribed under this clause that disqualifies the Plan as a medical care insurance plan under the Medical Care Act (Canada);
(n) providing for the making of claims for payment of the cost of insured services and prescribing the information that shall be furnished in connection therewith;

(o) prescribing the co-payments that shall be made by or on behalf of an insured person, in addition to the payment of the premiums, to qualify him to receive those insured services specified in the regulations as requiring co-payments;

(p) providing for the times when and manner in which physicians may submit accounts directly to the Plan under section 21;

(q) providing for the times when and manner in which practitioners may submit accounts directly to the Plan under section 22;

(r) exempting any class of accounts from the application of section 21 or any provision thereof;

(s) exempting any class of accounts from the application of section 22 or any provision thereof;

(t) requiring as a condition to payment for insured services or any class thereof that they be provided in or by designated hospitals or health facilities or any class thereof;

(u) prescribing facilities that are health facilities for the purposes of this Act in addition to those referred to in clause 1 (f);

(v) prescribing procedures for the enforcement of and recovery under rights to which the Plan is subrogated and without restricting the generality of the foregoing,

(i) requiring the insured person and his solicitor to act on behalf of the Plan in any action,

(ii) requiring such notices as are prescribed,

(iii) providing for the terms and conditions under which an action to enforce such rights may be begun, conducted and settled,

(iv) prescribing the portion of the costs of an insured person incurred in an action for the recovery of such rights that shall be borne by the Plan;
(w) assigning additional duties to the General Manager, the Medical Review Committee, practitioner review committees, the Medical Eligibility Committee and the Appeal Board;

(x) prescribing forms for the purposes of this Act and providing for their use. 1972, c. 91, s. 51; 1974, c. 60, s. 12; 1975, c. 52, s. 9 (1, 2).

Adoption of schedules of fees

(2) A regulation may adopt by reference in whole or in part, with such changes as the Lieutenant Governor in Council considers necessary, the fees in any schedule of fees as prescribed amounts payable in whole or in part, by the Plan. 1974, c. 86, s. 4.

When regulation may be effective

(3) A regulation is, if it so provides, effective with reference to a period before it is filed. 1975, c. 52, s. 9 (3).

Mental Illness

52.-(1) In this section, "hospital" means a sanitarium licensed under the Private Sanitaria Act that is approved by the Minister for the purposes of this section, a children's mental health centre or an approved children's mental health centre under the Children's Mental Health Services Act, a hospital established or approved under the Community Psychiatric Hospitals Act, a psychiatric facility under the Mental Health Act, or an institution designated an approved home or residential unit under the Mental Hospitals Act.

(2) An insured person who is entitled to insured services under this Act and the regulations and who is admitted to a hospital under this section is entitled to such services as are required for his maintenance, care, diagnosis and treatment in accordance with this Act and the regulations without being required to pay or have paid on his behalf any additional premium or other charge beyond that necessary to entitle him to insured services under the Plan.

Exceptions

(3) Notwithstanding subsection (2), an insured person in respect of whom, but for this Act, the Government of Canada would have assumed the cost of the maintenance, care, diagnosis and treatment provided under this section is not entitled to receive insured services in a hospital as an insured person.

Accounts

(4) The General Manager shall keep the accounts, if any, of insured persons who receive hospital services under this section separate from the accounts of patients who receive insured services under the Plan.
(5) Where, as the result of negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he receives services under this section, the Plan is subrogated to any right of the insured person to recover the cost incurred for such services, past or future, and the provisions of this Act and the regulations applying to subrogation of the Plan for the cost of insured services apply, with necessary modifications, to subrogation of the Plan for the cost of services under this section. 1972, c. 91, s. 52.