optional membership offers coverage for hospital-differential charges for semi-private and private-ward care, ambulance services, drugs, appliances, home-nursing care, naturopathic services, clinical psychological services, and dental care needed because of accidental injury.

Payments to physicians are made at 100% of the fee-schedule of the provincial medical association. Doctors may elect to bill patients for fees beyond those paid by the plan. In such cases, doctors are required to notify patients beforehand, and must indicate to patients the total amount and also the amount that will be paid by the plan.

Ontario began participating on October 1, 1969. Enrolment is compulsory for employee groups of 15 or more persons and provision is made for the creation of compulsory groups in the case of five to 14 employees. The insured benefits cover all required services of medical practitioners and, in specified hospital settings, of oral surgeons, refractions by optometrists, a portion of out-of-hospital physiotherapy cost, ambulance cost, and, with limitations, certain paramedical services offered by chiropractors, osteopaths, and podiatrists.

Doctors may choose from two modes of receiving payment for insured services. Those billing directly to the medical plan are paid directly by the plan at 90% of the negotiated fee of the provincial medical association for the service rendered, and cannot bill the patient for the balance. Doctors electing to bill patients directly cannot be paid by the plan. Patients must pay the doctor the amount billed and can recover from the plan 90% of the fee for the service rendered.

The levy for the combined hospital-medical premium is $132 a year for single persons and $264 for couples and families. Premiums are waived for welfare recipients and for all residents 65 years of age or over. Premium-subsidy assistance was extended on April 1, 1972, to cover hospital insurance as well as medical insurance. Single persons and families with no taxable income in the current year are eligible for 100% assistance in premium payment and for 50% assistance if single with taxable income under $1,000, or if a couple or family with taxable income under $2,000.

Quebec entered the national program on November 1, 1970. Registration of all eligible residents is compulsory and, as with other plans, the benefits include all required medical services of physicians, refractions by optometrists, and a limited range of dental services. The medical services, provided mostly by doctors engaged in private fee practice, are paid for on the basis of claims submitted.

Doctors who participate receive their entire remuneration, directly or indirectly, from the provincial agency, the Quebec Health Insurance Board, in accordance with a negotiated schedule of benefit payments for each service provided, and they cannot extra-bill. They may choose to be paid directly by the Board, or indirectly by the patient, who is in turn reimbursed by the Board.

Doctors who choose not to participate must collect all fees (except for emergency care) from the patient, who cannot, unlike in other provinces, seek reimbursement from the provincial agency. He must pay the entire amount himself.

Part of the provincial share of costs is financed by a tax on wage and salary earnings. Each taxpayer whose net income in a year equals or exceeds $5,200 if married, or $2,600 if single, contributes 0.8% of such income, up to a maximum contribution of $125 for employees who get at least three quarters of their income from wages and salaries and $200 for others. Employers also contribute 0.8% of their entire payroll. Persons who have earnings below the income thresholds and all welfare recipients are covered without payment of the tax on earnings.

Prince Edward Island began participating on December 1, 1970. Benefits are comparable to those in other provinces. Registration is required but is not a condition of eligibility. The provincial share of costs is met from general revenue. A doctor who decides to collect directly from his patient can extra-bill, but only up to the amount listed for the service in the medical association fee-schedule and only after obtaining the patient's written consent and notifying the provincial agency of the amount. A doctor who bills the provincial agency directly is paid by the agency at 92% of the fee-schedule. He must accept this payment as payment in full unless he has obtained the patient's written consent.

New Brunswick began participating on January 1, 1971. Registration by the family head is required, although it is not an eligibility requirement. Doctors must indicate whether or not