

HEALTH INSURANCE ACT

I. BASIC PROVISIONS

Article 1

This Act governs entitlements deriving from compulsory health insurance of insured persons and other citizens, being covered by compulsory health insurance, the compulsory health insurance organization and financing, voluntary health insurance and other issues relevant for the health insurance system.

Article 2

Health insurance in the Republic of Serbia is compulsory and voluntary health insurance.

Article 3

Compulsory health insurance is the health insurance by which a right to health care and right to pecuniary compensations in the cases established by this Act are provided for insured persons and other citizens, being covered by compulsory health insurance.

Article 4

Voluntary health insurance is the health insurance for citizens not insured under compulsory health insurance to have possibility to be insured, i.e. an insurance to major insurance range and standard as well as other kind of entitlements deriving from health insurance i.e. for insurance against participation in health care expenses in accordance with this Act.

Article 5

Compulsory health insurance is organized according to principle of reciprocity and solidarity, and other principles, established by this Act.

In implementing compulsory health insurance, the principles of health care are applied and patients' rights are executed, as established by the Health Care Act.

Article 6

Compulsory health insurance is provided by and exercised through the Republic Health Insurance Institute (hereinafter referred to as the Republic Institute) and the Republic Institute organizational units (hereinafter referred to as branches).

Certain compulsory health insurance issues are exercised through the Provincial Institute of Health Insurance as well (hereinafter referred to as Provincial Institute) in accordance with law.

Voluntary health insurance is exercised through the Republic Institute and other legal entities, in accordance with law.

Article 7

Entitlements deriving from compulsory and voluntary health insurance are not transferable to other persons nor may be inherited.

Article 8

Funds for exercising entitlements deriving from compulsory health insurance are provided through health insurance contributions and other sources as well, in accordance with law.

Funds for exercising entitlements deriving from voluntary health insurance are provided on the basis of the established insurance contributions, in accordance with law.

II. COMPULSORY HEALTH INSURANCE

Article 9

Compulsory health insurance includes:

1. insurance covering diseases and injuries not related to work;
2. insurance covering work-related injuries or diseases.

1. COMPULSORY HEALTH INSURANCE PRINCIPLES

Principle of Being Compulsory

Article 10

The principle of being compulsory is exercised by organizing and carrying out a comprehensive compulsory health insurance of the employed and other citizens in the Republic in accordance with this Act, by which such persons provide for themselves and members of their families (hereinafter referred to as insured persons) the rights to health care and pecuniary benefits for disease, in accordance with this Act and other regulations passed in regard to enforcement of this Act.

The principle of being compulsory is provided through obligation of paying compulsory health insurance contributions imposed to the employed and employer as well as all other contribution payers in accordance with this Act-, as a precondition for entitlements deriving from compulsory insurance to be obtained.

The principle of being compulsory is carried out through complete organization of compulsory health insurance which provides and guarantees for the employed and other persons covered by such insurance to obtain any entitlements deriving from compulsory health insurance prescribed by this Act and other regulations passed in regard to enforcement of this Act.

Solidarity and Reciprocity Principle

Article 11

Solidarity and reciprocity principle is exercised by establishing intergenerational solidarity and reciprocity, solidarity and reciprocity between genders, between the healthy and the sick, between the poor and the rich, in providing and using the entitlements deriving from compulsory health insurance.

Solidarity and reciprocity principle is exercised by establishing such compulsory health insurance system where the compulsory health insurance expenses are borne by the insured and other contribution payers, in proportion to one's financial ability, whereas the entitlements deriving from compulsory health insurance are used by the persons with insurance risk.

Transparency Principle

Article 12

Transparency principle is exercised by the right of the insured to all kind of information re entitlements deriving from compulsory health insurance and by transparent

work of the Institute organs and offices in meeting the needs of the insured, organs and organizations interested in the Institute activity.

***Principle of Protection of Insured Persons' Rights and
Protection of the Public Interest***

Article 13

Principle of protection of insured persons' rights and protection of the public interest is exercised by taking measures and activities which enable an insured person interests to be the basis of the compulsory health insurance and any insured person to easily protect and exercise his/her entitlements deriving from compulsory health insurance, taking care that such rights execution is not to other insured persons' rights and legal interests disadvantage or contrary to the public interest established by law.

Principle of protection of insured persons' rights and protection of the public interest is exercised as well by the Republic Institute obligation to draw attention of any insured persons to the existing grounds for the entitlements deriving from compulsory health insurance to be exercised and to insured person obligations related to exercising the entitlements deriving from compulsory health insurance.

Principle of protection of insured persons' rights and protection of the public interest is exercised as well by taking measures and activities for financing the entitlements deriving from compulsory health insurance in the way which enables the funds provided from compulsory health insurance contributions to cover the insured person according to the place where his/her insurance status is determined i.e. his/her rights exercised.

***Principle of Compulsory Health Insurance
Continuous Quality Improvement***

Article 14

Principle of health insurance continuous quality improvement is exercised by carrying out measures and activities which in accordance with the health insurance latest achievements enhance the possibilities for each insured person to execute the entitlements deriving from compulsory health insurance in more favourable way.

*Principle of Compulsory Health Insurance Efficiency
and Cost-Effectiveness*

Article 15

Principle of compulsory health insurance efficiency and cost-effectiveness is exercised by constant endeavor, in organizing and carrying out the compulsory health insurance, to enable the entitlements deriving from compulsory health insurance to be exercised by using as less funds as possible and with as less burden as possible for insured persons and other contribution payers.

Principle of compulsory health insurance efficiency and cost-effectiveness is exercised by achieving the best possible results with respect to available funds i.e. by achieving the highest level of entitlements deriving from compulsory health insurance with the lowest expenditure of such funds.

**2. INSURED PERSONS, PERSONS CONSIDERED TO BE INSURED
AND OTHER PERSONS INSURED
WITH REGARD TO PARTICULAR CIRCUMSTANCES**

Article 16

Insured persons having rights and obligations deriving out of compulsory health insurance, in terms of this Act, are considered to be the insured and members of the insured person family.

Entitlements deriving from compulsory health insurance are provided for persons considered to be insured as well as for other persons insured with regard to particular situations, in accordance with this Act.

1. The Insured

Article 17

The insured are physical persons covered by compulsory insurance in accordance with this Act, i.e.:

1. employees, i.e. persons employed by any company, other legal entity, government body, local self-government body and any other person (hereinafter referred to as the employed);
2. civilians employed in the Army or military units and military institutions;
3. elected, appointed or delegated persons, if receive any salaries or allowances in consideration of their work;
4. persons performing certain works, in accordance with the Labour Act, outside the employer's premises;
5. persons performing, in accordance with the Labour Act, domestic services;
6. citizens of the Republic employed in the territory of the Republic by foreign or international organizations and institutions, foreign consular or diplomatic offices or by foreign legal entities or private persons, unless otherwise provided by international agreement;
7. employees, i.e. the employed sent to work abroad, i.e. the employed of any company or other legal entity performing its economic activities or services abroad, if such employees are not covered by compulsory health insurance under the regulations of such country or unless otherwise provided by international agreement;
8. an employed parent not working on parental leave until the child is 3, in accordance with the regulations on labour, unless no other ground exist for the insured person status to be acquired;
9. citizens of the Republic employed abroad by foreign employer without having health insurance of any foreign health insurance carrier or without being covered by compulsory insurance under foreign regulations i.e. if the entitlements deriving from health insurance under such country regulations, for themselves or members of their family, may not be exercised or used out of the territory of such country;
10. foreign citizens and persons without citizenship employed, in the territory of the Republic, by foreign legal entities or private persons, unless otherwise provided by international agreement, as well as by international organizations and institutions and foreign consular and diplomatic offices, if such insurance is provided by international agreement;

11. citizen of the Republic of Serbia employed to work in household of any citizen of the Republic of Serbia employed abroad by an organization whose registered office is in the territory of the Republic;
12. persons whose employment is no longer needed, as well as persons whose employment ceased due to bankruptcy, liquidation i.e. in any other case of the ceased activity of the employer as well as persons who ceased to perform activities as self-employed, during the period when they are entitled to pecuniary benefit under the labour and employment regulations;
13. persons working on temporary and occasional basis in accordance with the Labour Act (the unemployed, the employed working part-time up to the full time and the old-age pension beneficiaries);
14. persons working on temporary and occasional basis, in accordance with law, through any youth or student employment agency, and being over 26 i.e. regardless of age if not at schooling
15. persons who exercise under this Act the right to benefit upon the termination of their employment;
16. persons working under agreement for services, spare-time employment agreement, author agreement, agreement on family accommodation under welfare regulations, agency and mediation agreement as well under other agreements in return for payment (hereinafter referred to as agreed compensation);
17. persons founders i.e. members i.e. shareholders of business companies, in accordance with the Business Companies Act (general partnership, limited partnership, limited liability company, joint stock company and other legal forms of business companies i.e. enterprises) who are not employed by such companies but carry out certain works (hereinafter referred to as founders of business companies);
18. entrepreneurs registered to perform any legal activity as profession for the purpose of carrying out self-employment activities i.e. free-lance activities, as well as free-lance artists, in accordance with law (hereinafter referred to as entrepreneurs);
19. athletes performing, in accordance with the Sport Act, any sports activity as self-employment activity;

20. priests and church officials, monks and nuns, who perform such activities as self-employment activity;
21. farmers over 18 who perform agricultural activity as the only or principal occupation, in accordance with law provided that they are not the insured as employees, self-employees under point 14 of this paragraph, pension beneficiaries, persons at schooling;
22. beneficiaries to pension and the right to pecuniary benefits who exercised such rights under the pension and disability insurance regulations;
23. citizens of the Republic of Serbia receiving pension or disability benefits exclusively from foreign insurance carrier while staying in the territory of the Republic of Serbia, i.e. receiving pension from the country no bilateral agreement on social insurance is signed with or if the entitlements deriving from health insurance under such country regulations, for themselves or members of their family, may not be exercised or used out of the territory of such country;
24. foreign citizen employed in the territory of the Republic by local organizations, i.e. private employers on the basis of special agreements on exchanging experts or agreement on international technical cooperation;
25. foreign citizens during the schooling or professional training in the territory of the Republic.

The insured status referred to in paragraph 1 of this Article may be obtained on the grounds of one insurance type only.

As an exception to paragraph 1 point 16 of this Article, persons obtaining an agreed compensation on the basis of a contract relating to renting their farmland provided that they are not the insured as employees, self-employees, the insured referred to in paragraph 1 point 14 of this Article, pension beneficiaries or persons at schooling, shall become the insured in accordance with paragraph 1 point 24 of this Article.

Article 18

The term 'carry out certain work' referred to in Article 17 para 1 point 17 of this Act means representation of and acting for a business company by its founders, partners, members i.e. shareholders and other persons in accordance with law, on the basis of

registration with competent authority as well as exercising business authorizations and company management in accordance with the Business Company Act.

Article 19

The insured status of an entrepreneur referred to in Article 17 paragraph 1 point 18 of this Act shall cease for the period of the economic activity temporary termination, if throughout such period he/she doesn't pay compulsory health insurance contributions, except for the period of temporary incapacity to work emerged before such termination, in accordance with this Act.

Article 20

The insured status of a person referred to in Article 17 para 1 point 21 of this Act, who is over 65, shall cease provided that:

1. such person is incapable of independent working and earning.
2. such person didn't exercised the right to pension in accordance with law;
3. such person's income is under the level prescribed by regulation referred to in Article 22 para 2 of this Act;

In the cases referred to in paragraph 1 of this Article, related to termination of the insured status, on request of the insured it shall be established a new basis for compulsory health insurance, in accordance with Article 22 of this Act.

Article 21

If the insured referred to in Article 17 of this Act fulfills all conditions to obtain the status of the insured on different insurance grounds, the prioritized insurance ground, excluding all others, is determined according the following priorities:

1. employment insurance (Article 17 paragraph 1 points 1 to 12 of this Act);
2. insurance on the grounds of business companies foundation, entrepreneurship and self-employment (Article 17 paragraph 1 points 17 to 20 of this Act);
3. insurance on the grounds of agricultural activities (Article 17 paragraph 1 point 21 of this Act);

4. insurance on the grounds of other prescribed insurance grounds (Article 17 para 1. points 13 to 16, 24 and 25 of this Act).

The prioritized insurance ground for a pension beneficiary – insured referred to in Article 17 paragraph 1 points 22 and 23 of this Act, in terms of this Article, is insurance on the grounds of the exercised right to pension.

The insured persons referred to in paragraph 1 of this Article exercise the entitlements deriving from compulsory health insurance according to determined prioritized insurance ground.

Article 22

The insured, in terms of this Act and under conditions prescribed by this Act, are considered to be as well any persons belonging to population groups at higher risk of illness, persons whose health care is needed with respect to prevention, curbing, early-stage diagnosis and treatment of diseases of higher social and medical importance; as well as persons belong to socially vulnerable population categories, if not covered by compulsory insurance in accordance with Article 17 of this Act or if such persons do not exercise entitlements deriving from compulsory health insurance as an insured person family members, that is:

1. children up to 15 years of age, school children and students until the end of prescribed schooling but not after 26 years of age, in accordance with law;
2. women with respect to family planning, as well as during the pregnancy, delivery and maternity up to 12 months after delivery;
3. the elderly over 65 years of age;
4. physically and mentally challenged persons;
5. HIV-positive persons and those suffering from other communicable diseases as provided by a separate Act governing the protection of population against malignant diseases, haemophilia, diabetes, psychosis, epilepsy, multiple sclerosis, persons in terminal phase of chronic renal insufficiency, cystic fibrosis, system autoimmune disease, rheumatic fever, dependency diseases, the sick and injured in need of emergency

- medical aid and as well as persons encompassed by health care in relation to donating and receiving tissues and organs;
6. monks and nuns;
 7. persons receiving income support in accordance with the regulations governing social welfare i.e. welfare for soldiers, war veteran invalids and civil invalids;
 8. beneficiaries of continuous pecuniary benefits, as well as beneficiaries of benefits for being accommodated in social welfare institutions or in other families, under the regulations governing social welfare;
 9. unemployed persons and persons who belong to other socially vulnerable categories whose income is under the income level established by this Act;
 10. beneficiaries of social welfare – family members whose breadwinner is currently serving under conscription;
 11. persons of Roma nationality without a permanent residence i.e. domicil in the Republic due to traditional way of life - travellers;

The income monthly amount enabling a citizen to obtain the insured status referred to in paragraph 1 point 9 of this Article is prescribed by mutual agreement by the Minister of Health (hereinafter referred to as the Minister) and the Minister of Social Affairs.

Household, in terms of this Act, is considered to be a domestic unit consisting of the members of a family who live together, earn and spend incomes earned by its members' work regardless of kinship.

The insured in terms of this Article is considered to be a person to whom a competent government authority has established a status of refugee i.e. expellee from the former Yugoslav republics, if satisfies conditions referred to in paragraph 2 of this Article and resides in the territory of the Republic.

Budget of the Republic provides funds for compulsory health insurance contributions to be paid for persons referred to in paragraphs 1 and 4 of this Article under insurance-benefit base and compulsory health insurance contributions rate prescribed by this Act.

Persons referred to in paragraphs 1 and 4 of this Article exercise the entitlements deriving from compulsory health insurance with regard to type, range, manner

and procedure thereof in accordance with this Act and other regulations passed in regard to enforcement of this Act.

2. Persons who are to be included into Compulsory Health Insurance

Article 23

Persons who are not insured under the compulsory health insurance may be included in such insurance in order to provide for themselves and members of their nuclear family the entitlements deriving from compulsory health insurance, under conditions, in the manner and range prescribed by this Act.

Persons referred to in paragraph 1 of this Article have status of the insured i.e. the insured persons.

Status of the insured is obtained i.e. terminates by the date a request has been filed, in accordance with this Act.

Persons referred to in paragraph 1 of this Article having the status of the insured pay contributions by themselves, out of their income, in accordance with the Act governing contributions for compulsory social insurance.

3. Members of the Family of Primary Insured Person

Article 24

Entitlements deriving from compulsory health insurance, established under this Act, are provided to members of the family of persons referred to in Article 17 paragraph 1 of this Act except points 24 and 25 of that Article.

Entitlements deriving from the compulsory health insurance, established under this Act, are provided to members of the family of persons referred to in Article 22. paragraph 1 point 7 to 9 and 11 of this Act, as well as in Article 23, paragraph 1 of this Act.

Members of family, in terms of this Act, are considered to be:

- 1) members of nuclear family (spouses or common-law spouses and children born in or out of wedlock, adopted and stepchildren, foster children);
- 2) members of wider family (parents, stepfather, stepmother, adopting parent, grandfather, grandmother, grandchildren, brothers and sisters, maintained by the

insured person, in terms of the regulations governing social insurance and citizens social security guarantee).

A common-law spouse with whom the primary insured person lives in common-law marriage at least two years before the application for insurance has been filed, is considered to be a member of nuclear family, in terms of this Act, as well.

Article 25

The insured person's spouse or common-law spouse has the right to entitlements deriving from basic social insurance as long as he/she is married to the insured or they live in common-law marriage in accordance with the regulations governing family issues.

Divorced spouse who obtained by final court order the right to alimony, has the right to entitlements deriving from health insurance if at the time of divorce was over 45 (woman) i.e. 55 (man) or regardless of age if at the time of divorce it was determined his/her full inability to work in terms of the regulations governing pension and disability insurance issues.

Article 26

The insured person's child has the right to entitlements deriving from compulsory health insurance until 18 years of age i.e. until the end of prescribed schooling but not later than 26 years of age.

A child referred to in paragraph 1 of this Article, who came to recess in schooling due to illness, has the right to entitlements deriving from compulsory health insurance throughout the period of illness, and in the case of continuing the schooling he/she has the right to entitlements deriving from basic health insurance even after the age limit referred to in paragraph 1 of this Article but only for the schooling recess period of time due to illness. Whether such recess in schooling due to illness is justifiable is assessed by a medical board to be formed in accordance with this Act.

If a child referred to in paragraph 1 of this Article becomes incapable to live and work autonomously, in terms of the regulations governing pension and disability insurance, before the schooling period limits expire, he/she has the right to entitlements deriving from basic health insurance during the period of time such incapability lasts.

A child referred to in paragraph 1 of this Article who becomes incapable to live and work autonomously, in terms of the regulations governing pension and disability

insurance, after the age limit referred to in paragraph 1 of this Article, he/she has the right to entitlements deriving from compulsory health insurance throughout the period of such inability if maintained by the insured persons for he/she has no personal earnings for living.

Article 27

Parents, stepfather and stepmother, adopting parent maintained, in terms of the regulations on family issues, by the insured due to their lack of financial means have the right to entitlements deriving from compulsory health insurance if over 65 or if younger but incapable to work, whereas such inability corresponds to full inability to work in terms of the regulations governing disability insurance.

Grandfather and grandmother have the right to entitlements deriving from compulsory health insurance under conditions referred to in paragraph 1 of this Article.

4. Persons provided with Entitlements deriving from Compulsory Health Insurance in Particular Circumstances

Article 28

Entitlements deriving from compulsory health insurance established under this Act, in the case of work-related injuries and diseases only, are provided to:

1. school children and university students who are attending, in accordance with law, any professional practice and training;
2. persons who are not receiving, in accordance with law, any income i.e. any allowances for the job performed (under voluntary service agreement);
3. persons working on temporary and occasional basis, in accordance with law, through any youth or student employment agency, and being under 26 years of age, if at schooling;
4. persons undergoing any professional training, additional schooling or retraining on request of a competent employment organization;
5. persons involved in organization of public works of the common good;
6. persons involved in rescue operations or in protection and rescue operations during any act of God and other accidents;

7. persons engaged in fire departments on firefighting and persons undergoing firefighting training;
8. persons undergoing any training and qualifying activities with regard to defence, or any other training necessary for the country defence;
9. persons engaged in securing the public rallies, cultural and sports events and other public gatherings of citizens;
10. persons detained in prison while working in any facility of such penitentiary institution (workshop, work site, etc.) and in any other working place.

**5. Foreign citizens with whose Countries
an International Agreement on Social Insurance has been undersigned**

Article 29

Foreign citizens with whose countries an international agreement on social insurance has been undersigned, exercise the right deriving out of compulsory health insurance under provisions of this Act, unless otherwise provided by the agreement thereof.

Health care expenses relating to foreign citizens referred to in paragraph 1 of this Article, if the international agreement provides reciprocal payments, are paid in accordance with law i.e. international agreement.

Health care expenses relating to foreign citizens with whose countries an international agreement on social insurance has been undersigned, if such agreement determines a compensation of actual expenses, are borne entirely by the Republic Institution which shall reimburse such expenses from the foreign health insurance carrier.

**3. ENTITLEMENTS DERIVING FROM COMPULSORY
HEALTH INSURANCE**

Article 30

Entitlements deriving from compulsory health insurance are as follows:

1. right to health care;
2. right to salary benefit for the period of temporary inability to work (hereinafter referred to as salary benefit);

3. right to transportation benefit relating to the use of health care services (hereinafter referred to as transportation benefit);

Entitlements deriving from health insurance referred to in paragraph 1 of this Article are exercised only if due health insurance contributions have been paid, unless otherwise provided by this Act.

Article 31

The insured persons referred to in Article 17 paragraph 1 of this Act are provided with the entitlements deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1) to 3) of this Act, unless otherwise provided by this Act.

The insured persons referred to in Article 17 paragraph 1 point 24 and 25 are provided with the entitlements deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1) to 3) of this Act.

The insured persons referred to in Article 22 paragraph 1 and 4 of this Act are provided with the entitlements deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1) to 3) of this Act.

The persons who are to be included into compulsory health insurance referred to in Article 23 paragraph 1 of this Act, are provided with the entitlement deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1) to 3) of this Act.

The insured referred to in Article 17 paragraph 1 of this Act are entitled to salary benefit under the conditions prescribed by this Act, if during the temporary inability to work they lose their salary or a part of salary gained in accordance with the regulations related to labor issues.

Family members referred to in Articles 24 to 27 of this Act are provided with entitlements deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1) and 3) of this Act.

Persons referred to in Article 28 of this Act are provided with entitlements deriving from compulsory health insurance referred to in Article 30 paragraph 1 point 1 and 3 of this Act.

Foreign citizens with whose countries an international agreement on social insurance has been undersigned referred to in Article 29 of this Act, are provided with entitlements deriving from compulsory health insurance in accordance with such agreement.

1. Time Period of Already Existing Health Insurance Coverage

Article 32

In order to exercise the entitlements referred to in Article 30 of this Act, prior to using the entitlements deriving from compulsory health insurance, the insured persons must have, in accordance with this Act, at least three-month qualifying compulsory health insurance coverage in continuity or within discontinuing period of six months during the last eighteen months before starting to exercise a certain entitlement deriving from health insurance (hereinafter referred to as already existing insurance).

The already existing insurance is calculated as the period starting from the date the insured has obtained such status in accordance with this Act, for which contributions were paid.

As an exception to paragraph 1 of this Article, the insured exercises the entitlements deriving from the compulsory health insurance even in the case the already existing insurance requirements are not met, that is:

1. in the case of work-related injury of disease of the insured referred to in Article 17 of this Act;
2. in the case of emergency medical aid and exercising of pecuniary benefits referred to in Article 30 of this Act, the insured is entitled to;
3. in order to exercise the right to due pecuniary benefits in the amount of minimum salary in accordance with the regulations of work for the month the compensation of salary is paid.

Members of family of the insured person exercise the entitlements deriving from compulsory health insurance provided that the insured person under whose insurance they exercise such rights meets the requirements with regard to already existing insurance.

2. Right to Health Care

Article 33

Right to health care in the case of injuries and diseases not related to work covers health care with regard to prevention, early-stage diagnosis, family planning,

pregnancy, birth and postnatal period up to 12 months after delivery as well as other health care services with regard to diseases and injuries not related to work at primary, secondary and tertiary level, in accordance with this Act and other regulations passed in regard to enforcement of this Act.

Right to health care in the case of work-related injuries or diseases covers the health care in the case of work-related diseases and injuries provided at primary, secondary and tertiary level.

The health care referred to in paragraphs 1 and 2 of this Article is provided in the manner to preserve, restore or improve health condition of the insured person and his/her ability to work and to satisfy his/her personal needs, in accordance with this Act and other regulations passed in regard to enforcement of this Act.

The work-related injuries referred to in paragraph 2 of this Article is determined on the basis of a report on the injury occurred at work which is under the employer's direct or indirect control, in accordance with the regulations governing health protection and safety at work.

The work-related injuries or diseases are determined in accordance with regulations governing the pension and disability insurance.

In the procedure of exercising entitlements deriving from compulsory health insurance, the Republic Institute, i.e. the respective branch, shall apprise the report on work-related injury referred to in paragraph 3 of this Article, i.e. whether such injury is determined in accordance with regulations governing the pension and disability insurance.

Range of the Right to Health Care

Article 34

Right to health care provided by virtue of compulsory health insurance referred to in Article 33 of this Act includes:

1. preventive health care and early-stage diagnosis measures;
2. medical examinations and treatment of women relating to family planning, pregnancy, delivery and postnatal period up to 12 months after delivery;
3. medical examinations and treatment of the sick and injured;
4. prevention and treatment of dental diseases;

5. medical rehabilitation of the sick and injured;
6. medicines and medical supplies;
7. prosthetic, orthotic and other devices for moving, standing and sitting, sight, hearing and speech devices, dentures and other auxiliary and sanitary devices (hereinafter referred to as medical-technical devices).

For certain types of diagnostic and therapeutic procedures in particular, inpatient facility treatments or home care, i.e. for using health care referred to in paragraph 1 of this Article, the Republic Institute may prescribe a prior consent of the first-instance medical commission.

Preventive Health Care Measures

Article 35

For the purpose of health preservation and improvement, prevention, curbing and early-stage diagnosis of diseases and other health disturbances, the insured persons are provided with the following preventive measures:

1. health education consisting of special lectures or advisory sessions given by health professionals with regard to protection, preservation and improvement of health, discovering and curbing risk factors and gaining healthy lifestyle knowledge and habits;
2. general and other medical examinations of children, school children, university students at schooling up to 26 years of age, women with regard to pregnancy and adults in accordance with national programme relating to prevention and early-diagnosis of diseases of major social and medical importance and other established standards;
3. preventive dental examinations and prophylactic measures for dental diseases prevention for pregnant women, children under the age of 18 and the elderly with profound physical and mental disability;
4. health care education with regard to family planning, pregnancy prevention, birth control and surgical sterilization, pregnancy testing, testing and treatments of sexually transmitted diseases and HIV infections;

5. inoculation, immunoprophylaxis and chemoprophylaxis which is compulsory under the national programme on immunization of the population against certain contagious diseases;
6. hygienic, epidemiological and other measures and activities prescribed by law with regard to curbing, discovering and treatment of HIV infection and other contagious diseases in order to be prevented from spreading.

The Government shall develop the national programme relating to prevention and early-diagnosis of diseases of major social and medical importance, national programme relating to dental health protection of children up to 18 years of age and pregnant women, as well as the national programme relating to immunization of the population against certain contagious diseases as well as the medical measures and activities standards arising out of such programmes.

*Medical Examinations and Treatments with regard to Pregnancy, Delivery
and Postnatal Period*

Article 36

With regard to family planning, pregnancy, delivery and the 12-month postnatal period, women are provided with the following:

1. medical examinations and treatments by gynecologist and midwives relating to pregnancy (including the prenatal period, delivery and the postnatal period) and conditions which may cause pregnancy complications as well as pregnancy termination for medical reasons;
2. hospital treatment when considered medically necessary, and delivery in inpatient facilities;
3. home visits, assistance to mother and the newborn care to be delivered by health visitors;
4. infertility diagnostic and treatment.

Medical examination in terms of paragraph 1 point 1 of this Article is considered to be prenatal and genetic testing and other preventive measures, in accordance with medical standards.

Medical Examinations and Treatment of the Injured and Sick

Article 37

The sick i.e. injured insured persons, subject to medical indications and professional methodological and doctrinal opinions, are provided with the following:

1. emergency medical aid at the place of medical emergency or in inpatient medical facilities i.e. other type of health activity (hereinafter referred to as private practice);
2. emergency medical transportation services for diseases or injuries threatening the insured person's life;
3. non-emergency medical transportation services when medically indicated and necessary;
4. medical examinations and treatments at primary health care level and at the insured person's home by a chosen physician;
5. ambulatory medical examinations and treatments provided by a specialist under the referral of a chosen physician;
6. laboratory, x-ray and other diagnostic suggested by chosen physician or physician specialist, being medically justifiable and necessary for such disease or injury to be diagnostically identified and treated;
7. treatment in inpatient health care facilities, when medically justified and necessary, which encompasses diagnostic and treatment by physical specialist, medical care, accommodation in a group or intensive care room and nourishment i.e. particular diet in inpatient health facilities;
8. right to an escorting person for the insured under the age of 15 as well as for older person with severe physical or mental disability for the period of hospital treatment and medical rehabilitation, when medically necessary;
9. home treatment, when justified and medically necessary.

Article 38

Emergency medical transportation referred to in Article 37 point 1) of this Act includes ambulance transportation due to disease or injury threatening the insured

person's life, to the nearest health care facility qualified to provide further treatment of the sick or injured.

Non-emergency medical transportation referred to in Article 37 point 3) of this Act includes transportation to a health care facility qualified to provide justified and medically necessary health care, as well as transportation from such health care facility to the insured person's home.

Non-emergency medical transportation is justifiable and medically necessary in the case any other type of transportation may endanger the insured persons's life and health.

Article 39

Inpatient care treatment referred to in Article 37 point 5) of this Act is justified and medically necessary if needed health care (diagnostic, treatment or rehabilitation) or a part of this may be delivered only in an inpatient care facilities i.e. if it may not be deliver in outpatient care facilities or at home.

As an exception to paragraph 1 of this Article, the terminally ill and disabled insured persons, i.e. persons able to move only with other people help, in need of palliative care more than four hours a day, have the right to short-duration hospital treatment for the purpose of applying symptomatic therapy and health care, under the conditions prescribed by the Republic Institute general by-law.

Article 40

Home treatment referred to in Article 37 paragraph 1 point 9) of this Act is justifiable and medically necessary in the case parenteral medicines administration or medical and rehabilitation procedures which may be delivered to disabled or assisted persons at home, by health professional, are indicated by a chosen physician or physician specialist.

Home treatment is provided as post-hospital treatment as well.

Examination and Treatment of Dental Diseases

Article 41

The insured persons are provided with examination and treatment of dental diseases in outpatient, clinical and hospital inpatient facilities, i.e. at least:

1. examinations and treatment of mouth and dental diseases in children under the age of 18, the elderly with severe mental and physical disability, as well as persons with inborn and acquired serious facial and mandible malformation;
2. examinations and treatment of mouth and dental diseases, excluding prosthetic care, in pregnant women and 12 months after delivery;
3. emergency dental aid for adults;
4. examinations of mouth and teeth, excluding prosthetic care, before kidneys transplantation i.e. heart surgery;
5. examinations and treatment of mouth and dental diseases within pre- and post- operative treatment of malignant disease of maxillofacial area;
6. emergency dental and surgical examination and treatment of teeth and facial bones injuries, including primary reconstruction by osteosynthetic material;
7. total and partial acrylate prosthesis for persons over the age of 65;
8. necessary dental treatment including fixed orthodontic appliances within pre- and post-surgery treatment for persons with inborn and acquired serious facial and mandible malformation;
9. facial and mandible prosthetic implants (post-resection intraoral prosthesis and facial prosthesis) within a post-tumorous rehabilitation and reconstruction including fixed on implants.

Medical Rehabilitation in the Case of Disease and Injury

Article 42

The insured are provided with medical rehabilitation for the purpose of improving or restoring to a preexisting state a body function lost or impaired due to an acute disease or injury, worsening of chronic disease or medical intervention, congenital anomaly or developmental disorder.

Medical rehabilitation implies establishment, application and evaluation of rehabilitation procedure which encompasses kinesitherapy and all kind of physical therapy, occupational therapy, oral and speech therapy, including certain types of medical-technical devices, advising, testing, fixing and training for the use of such medical-technical devices.

Occupational therapy provides the insured with medical rehabilitation procedures after a disease and injury, which are aimed to enable the insured to be autonomous, i.e. to improve functioning in other activities of everyday life.

Oral and speech rehabilitation provides the insured with medical procedures and use of appropriate appliances necessary for diagnoses and treatment of diseases and injuries or congenital anomaly resulting in impairment of voice, speech and language which caused impossibility of communication to the insured, i.e impairment of deglutination following an illness or injury.

Physical therapy implies establishment, application and evaluation of all physical agents including natural salubrious factor in treatment of the insured person injured or ill.

The insured person is provided with medical rehabilitation in outpatient, clinical and hospital inpatient facilities, when justified and necessary for treatment of the insured.

Inpatient health facilities rehabilitation (early rehabilitation) provides the insured with intensive rehabilitation programme, within basic medical treatment, which requires multidisciplinary team work, within a basic medical treatment, in order to improve health status and remove functional disorders.

Inpatient health facilities specialized in rehabilitation provide the insured with rehabilitation (extended rehabilitation) as continuous extension of treatment and rehabilitation, within an indicated area, when functional disorder cannot be extenuated or removed with equal efficiency in outpatient or clinical health facilities and within hospital treatment of the basic illness.

Through its by-law, the Republic Institute determines the types of indications for medical rehabilitation to be used, duration of such rehabilitation, the way and procedure of exercising such rehabilitation and rehabilitation referral procedure referred to in paragraph 1 of this Article.

The general by-law referred to in paragraph 1 of this Article shall be published in the "Official Gazette of the Republic of Serbia".

Medicines and Medical Supplies

Article 43

Right to medicines and medical supplies includes:

1. right to medicines from the List of medicines which are issued against medical prescription or order and whose expenses are borne by the compulsory health insurance funds (hereinafter referred to as the List of medicines);
2. right to medical supplies which are provided from the compulsory health insurance funds i.e. which are prescribed by order or implanted in the insured person's body.

As an exception to paragraph 1 of this Article, the insured person is provided with medicine which is not on the List of medicines, but is medically necessary for treatment, under the conditions established by the Republic Institute general by-law.

The Republic Institute adopts a general by-law establishing the List of medicines containing a list of minimum medicines needs - essential medicines for treatment of diseases and injuries, regardless of cause, which represent entitlement deriving from compulsory health insurance, in accordance World Health Organization Model List for essential medicines.

The Republic Institute adopts a general by-law establishing the criteria, manner and procedure for putting medicines in the List i.e. taking them off.

The Republic Institute adopts a general by-law establishing type and standard of medical supplies for implantation in the insured person's body (hereinafter referred to as implants), as well as other types of necessary medical supplies.

The Government of the Republic of Serbia gives consent on the Republic Institute general by-law referred to in paragraph 3 of this Article.

The Republic Institute's general by-laws referred to in paragraphs 3, 4 and 5 of this Article shall be published in the "Official Gazette of the Republic of Serbia".

Medical-Technical Devices

Article 44

The insured persons are provided with medical-technical devices for functional and cosmetic replacement of lost body parts, i.e. for providing support, preventing malformations and correcting the existing deformities, as well as making easier the basic life functions performance.

The insured persons are provided with medical-technical devices necessary for treatment and rehabilitation which enable improvement of basic life functions, support of autonomous life, barrier overcoming in the environment and prevention of substantial worsening of health status or death of the insured.

The Republic Institute determines a type of medical-technical devices and indications for their use, standards for materials such appliances are made, duration, i.e. purchase, maintenance and renewal as well as the manner and procedure of exercising the right to medical-technical devices.

The Republic Institute's general by-law referred to in paragraphs 3 of this Article shall be published in the "Official Gazette of the Republic of Serbia".

Article 45

The insured persons, while exercising the right to health care deriving from compulsory health insurance referred to in Article 34 to 44 of this Act, are provided with the following benefits:

1. 100% coverage – payment of services out of the compulsory health insurance funds for:
 - health care preventive measures;
 - medical examinations and treatments with regard to family planning, pregnancy, delivery and postnatal period including pregnancy termination for medical reasons,
 - medical examinations, treatment and medical rehabilitation in the case of illness or injury of children, school children and university students until the end of prescribed schooling period but not later than 26 years of age, i.e. the elderly persons with profound physical and mental disability ;
 - medical examinations and treatment of mouth and teeth diseases of children under the age of 18 as well as the elderly persons with profound physical and mental disabilities, woman with regard to pregnancy and 12 months after delivery, and persons with inborn or acquired facial and mandible malformation;
 - medical examinations and treatment with regard to HIV infection and other communicable diseases in the case of which the law

provides measures to be taken in order to be prevented from spreading;

- medical examinations and treatment of malignant disease, haemophilia, diabetes, psychosis, epilepsy, multiple sclerosis, progressive neuromuscular diseases, cerebral paralysis, paraplegia, tetraplegia, permanent chronic renal insufficiency with indicated dialysis or kidney transplantation, cystic fibrosis, system autoimmune disease, rheumatic fever and related complications;
- medical examinations and treatment with regard to donating, receiving and exchanging tissues and organs from the insured and other persons for the purpose of health care to be provided for the insured persons;
- medical examinations, treatment and rehabilitation following work-related injuries and diseases;
- providing emergency medical and dental aid, as well as emergency medical transportation services;
- medical-technical devices, implants and medical appliances with regard to treatment of diseases and injuries referred to in this point.

2. At least 95% of the price of health care service out of the compulsory health insurance funds for:

- intensive care in an inpatient health care facility,
- surgical operations performed in a surgical room including implantation material for the most complex and expensive health care services;
- the most complex laboratory, x-ray and other diagnostic and therapeutic procedures (magnetic resonance, scanner, nuclear medicine, etc.);
- treatment of the insured referred for treatment abroad;

3. At least 80% from the price of health care service out of the compulsory health insurance funds for:

- medical examinations and treatment by a chosen physician and physician specialist;
- laboratory, x-ray and other diagnostic and therapeutic procedures not encompassed by point 2 of this Article;
- home treatment;
- dental examinations and treatment with regard to teeth and facial bones injury, as well as dental examinations and teeth treatment before heart surgery and kidney transplantation;
- treatment of complications due to caries in children and youth, and tooth extraction following caries, as well as execution of mobile orthodontic devices;
- inpatient care treatment, as well as inpatient health care facility rehabilitation;
- medical examinations and treatment in day hospital including surgery operations out of a surgical room;
- medical rehabilitation in outpatient and clinical facilities;
- medical-technical devices, implants and medical appliances not encompassed by point 1 of this Article;

4. At least 65% of the price of services out of the compulsory health insurance funds for:

- diagnostic and treatment of infertility;
- total and partial acrylate prosthesis for persons over the age of 65;
- ocular and auricular appliances for adults;
- non-emergency medical transportation.

Article 46

In the List of medicines referred to in Article 43 paragraph 3 of this Act, the Republic Institute shall establish the amount of funds to be provided for medicines from the List out of the compulsory health insurance, i.e. the amount to be provided by the insured.

Article 47

Scope, range and standards of the right to health care deriving from compulsory health insurance referred to in Article 34 to 44 and Article 45 point 1 to 4 of this

Act, for certain types of health care services and certain types of diseases, percentages to be paid out of the compulsory health insurance funds up to the total amount of health care service price, percentage to be paid by the insured and annual financial plan of the Republic Institute are determined by the Republic Institute in the adopted general by-law for each calendar year.

By the by-law referred to in paragraph 1 of this Article, the Republic Institute may determine to pay to the insured out of compulsory health insurance funds, for certain types of health care services and certain types of disease, a higher percentage of the health care service price in order to cover the total amount of price referred to in Article 45 paragraph 1 points 2) to 4) of this Act, in accordance with available funds of the Republic Institute.

In the general by-law referred to in paragraph 2 of this Article, the Republic Institute establishes the highest annual amount i.e. the highest amount per certain health care service, which the insured pays out of his/her own funds, taking care not to discourage by such amount the insured person from using health care i.e. prevent successful carrying out of the insured person's health care.

The Institute shall adopt a general by-law referred to in paragraph 1 of this Article by 31. december of the current year for the next one, at the latest.

The Government gives consent to the by-law referred to in paragraph 1 of this Article.

The by-law referred to in paragraph 1 of this Article is published in the "Official Gazette of the Republic of Serbia".

Participation

Article 48

The amount covering the remaining amount up to the total price of health care service referred to in Article 45 point 2 to 4 of this Act as well as the amount in money referred to in Article 46 of this Act (hereinafter referred to as participation), shall be paid by the insured person using such health care services, unless otherwise provided by this Act, i.e. shall be paid by the legal entity which issued to the insured a voluntary health insurance policy.

The Republic Institute may establish, through a general by-law referred to in Article 47 paragraph 1 of this Act, for the participation which is born by the insured to be

paid in fixed amount, whereas such fixed amount cannot be higher than the percentage amount prescribed in accordance with this Act.

By the general by-law referred to in Article 47 paragraph 1 of this Act, the Republic Institute establishes the manner and procedure of the payment of participation, termination of such payment in the course of the calendar year, as well as reimbursement of the money paid over the highest annual amount i.e. the highest amount of participation for certain type of health care service.

It is forbidden for health care facilities, i.e private practice or any other legal entity entered into an agreement with the respective branch i.e. Republic Insitute regarding health care delivery (hereinafter referred to as health care service provider), to charge for delivered health care services which are covered by compulsory health the participation amounts which differ from the amounts prescribed in Articles 45 to 47 of this Act as well as to charge participation to the insured who paid the highest annual amount of participation or the highest amount of participation for certain type of health care service.

It is forbidden for the health care service provider to charge the participation amount to the insured having voluntary health insurance.

Article 49

Health care service provider is bound to issue to the insured a receipt regarding the the health care service provided with the data on the amount to be provided by the Republic Institute fund on the grounds of the entitlements deriving from compulsory health insurance and the amount of participation to be paid by the insured.

A model of receipt referred to in paragraph 1 of this Article is prescribed by the Republic Institute.

The receipt model referred to in paragraph 2 of this Article is published in the “Official Gazette of the Republic of Serbia”.

The insured is bound to keep all receipts for participation paid during one calendar year, which shall serve as evidence in the procedure of establishing the right non to pay participation in the corse of such calednar year, under conditions prescribed by the general by-law of the Republic Institute referred to in Article 47 paragraph 3 of this Act.

*The insured Persons to which the Coverage
of the Total Amount of the Health Care Cost is Provided*

Article 50

The insured persons are provided with coverage of the total amount of the health care cost from the compulsory health insurance funds, without being bound to pay any participation, that is:

1. war military invalids and war civil invalids;
2. the blind and permanently disabled persons as well as persons receiving pecuniary benefits for assistance and care by other person, in accordance with law;
3. voluntary blood donors who gave blood ten or more times, except for medicines from the List of medicines as well as for medical-technical devices and implants;
4. voluntary blood donors who gave blood less than ten times, within 12 months after each blood donation, except for medicines from the List of medicines, as well as for medical-technical devices and implants.

Article 51

The insured referred to in Article 22 paragraph 1 and 4 of this Act, are provided with health care which expenses are borne in whole by the compulsory health insurance funds without the insured being bound to pay any participation.

Members of nuclear family of the insured referred to in Article 22 paragraph 1 points 7 to 9 and 11 of this Act, as well as members of nuclear family of the insured referred to in paragraph 4 of that Article, are provided with health care which expenses are borne in whole by the compulsory health insurance funds without the insured being bound to pay any participation, for treatment of the diseases prescribed by such point.

Health Care Scope, Range and Standards

Article 52

Health care scope, in terms of this Act, implies procedures and methods of diagnostic, treatment and rehabilitation for the purpose of prevention, curbing, early-stage diagnosis and treatment of diseases, injuries and other health disturbances which are covered by the compulsory health insurance.

Health care range, in terms of this Act, implies the number and duration of procedures and methods of diagnostic, treatment and rehabilitation as well as other references by which the range of certain contents of health care may be expressed (systematic health care delivery in a certain period of time, etc.), and which are encompassed by the entitlements deriving from the compulsory health insurance.

Health care standards, in terms of this Act, imply conditions for using procedures and methods which are encompassed by the entitlements deriving from the compulsory health insurance, including limitations for using and the manner of providing such health care services.

Emergency Medical Aid and Necessary Health Care

Article 53

Emergency medical aid is, in terms of this Act, immediate-instant medical aid provided in order to prevent the life of the insured to be endangered, i.e. the serious and irreparable impairments of health or death of the insured.

Emergency medical aid, in terms of this Act, is considered to be medical aid provided within 12 hours from the moment of the admittance of the insured in order to prevent an emergency situation.

Necessary health care, in terms of this Act, encompasses an appropriate health care i.e. necessary for diagnostic, i.e. treatment of diseases or injuries of the insured, and which complies with good medical practice standards in the country and which is not delivered at request of the insured person or health care professional for the purpose of gaining better position with respect to other insured persons i.e. acquiring special benefits for health care facility, private practice or health professional.

In the procedure of exercising rights of the insured persons deriving from the compulsory health insurance, the emergency and necessary health care is determined by professional medical entities in the course of such procedure.

Health Care Programme relating to Health Care deriving from Compulsory Health Insurance

Article 54

The entitlements of the insured to health care referred to in Articles 34 to 45 of this Act are determined on the grounds of the health care programme relating to health care deriving from compulsory health insurance which is developed on the basis of the following:

- 1) health needs of the insured;
- 2) financial funds provided for carrying out the compulsory health insurance;
- 3) priorities determined for carrying out the health care at primary, secondary and tertiary level,
- 4) the health care service available potentials.

The programme referred to in paragraph 1 of this Article is developed by the Republic Institute for each calendar year, by 31. december of previous year, at the latest.

The Minister gives consent for the programme referred to in paragraph 1 of this Article.

The programme referred to in paragraph 1 of this Article is published in the “Official Gazette of the Republic of Serbia”.

Nomenclature and Health Care Services Price

Article 55

Health care services nomenclature referred to in Article 45 paragraph 1 point 1 to 4 of this Act is established by the Ministry.

Prices of health care services referred to in Article 45 paragraph 1 point 1 to 5 of this Act are established by a by-law which is adopted by the Republic Institute.

The Minister gives consent for the by-law referred to in paragraph 2 of this Article.

Prices of health care services referred to in paragraph 2 of this Article are created on the basis of the following:

1. health care services nomenclature and work normative for providing such services;
2. expenses for the work invested by the employed for health care services;
3. material expenses;
4. amortizations prescribed by law;

5. other obligations prescribed by law.

The by-law relating to prices of health care services referred to in paragraph 2 of this Article are published in the “Official Gazette of the Republic of Serbia”.

Waiting list

Article 56

For certain types of health care services which are provided out of the compulsory health insurance funds and are not urgent, an order of use may be established depending on medical indications and health status of the insured, as well as on the data such insured person present him/herself in the health care facility, whereas the waiting time cannot be such to endanger health or life of the insured (hereinafter referred to as waiting list).

The Republic Institute adopts a general by-law establishing types of health care services the waiting lists are to be made for, as well as criteria, standardized measures for the patient’s health status evaluation and for putting patients on waiting list, the longest waiting time for health care services to be delivered, necessary data and methodology for creating such waiting lists.

The by-law referred to in paragraph 2 of this Article is adopted by the Republic Institute on the basis of the professional-methodological instruction given by the Minister.

The by-law referred to in paragraph 2 of this Article, prescribes the way of informing patient, physician who referred a patient and the Republic Institute about important data from waiting list, modifications, amendments as well as cancellation of the insured persons from waiting list, control over waiting list as well as the way of using health care regardless of waiting list.

Health care services provider which entered into an agreement with the respective branch i.e. Republic Insititute regarding health care delivery at the expense of compulsory health insurance funds, is bound to make a waiting list pursuant to paragraphs 1 to 4 of this Article, and to deliver health care service to the insured person in accordance with such waiting list.

Prior notification of the insured

Article 57

If any health care services provider which entered into an agreement with the Republic Institute i.e. the respective branch, establishes that a health care service is not medically necessary i.e. justified for health condition of the insured, such provider is bound to issue a written notification to the insured (hereinafter referred to as prior notification) before providing the health care.

Prior notification is to be given by a health care services provider to the insured which is put on waiting list as well, in accordance with Article 56 of this Act.

Prior notification contains a written information given by a health care services provider about the reasons such health care service is non medically necessary i.e. justified for health condition of the insured as well as the reasons why the insured is to be put on waiting list, as well as about the established order of such waiting list.

If the insured is provided with certain health care service on personal request of the insured regardless of the prior notification referred to in paragraph 1 of this Article,, all expenses relating to the health care service delivered therein shall be borne by the insured.

Right of the Republic Institute to Refuse to Pay certain Health Care Services

Article 58

The Republic Institute is entitled to refuse to pay expenses to health care service providers for delivered health care services, medical-technical appliances, medicines, medical supplies, implants, as well as other types of health care services which are not established as entitlements deriving from the compulsory health insurance, i.e. which are not in accordance with the scope, range and standards of health care covered by compulsory health insurance.

Exercising the Rights Deriving from Compulsory Health Insurance in Special Circumstances

Article 59

If the scope and range of the rights to health care covered by the compulsory health insurance, established in accordance with this Act and regulations passed in regard to enforcement of this Act, may not be exercised due to insufficient income realized by the Republic Institute, i.e due to any other special circumstances, the Government of the Republic of Serbia may deliver an enactment by which the priority shall be established in providing and executing health care.

State Guarantee for Execution of the Republic Institute's Obligations

Article 60

The Republic is guarantor for the obligation of the Republic Institute in exercising the rights deriving from compulsory health insurance (state guarantee), for emergency medical aid and health care provided to the insured in inpatient health facilities, which is established as priority in accordance with Article 59 of this Act.

*Health Care not provided under the
Compulsory Health Insurance*

Article 61

The insured persons exercising their rights under the compulsory health insurance, are not provided with health care which includes the following:

1. medical examinations in order to determine the health status, body impairment and disability during the proceedings before any competent body, except the examinations upon the referral given by a professional medical body during the procedures of exercising any right deriving from health insurance, i.e. in order to exercise certain rights regarding other bodies and organizations.
2. medical examinations necessary for enrolment in high school, college, university and courses, for obtaining health certificates to start to work i.e. other certificates with regard to work, recreation and sport;
3. determining health status of the insured upon the request of other bodies i.e. not upon request of professional medical bodies during the procedures in accordance with this Act (before insurance companies, courts, criminal

- proceeding and criminal investigations, issuance of driver's certificates, medical examinations upon request of employer, measures related to protection at work, etc.), unless otherwise provided by this Act;
4. the employer's obligations to provide specified health care for employees as health related social care at the level of employer in accordance with the Health Care Act;
 5. exercising health care contrary to the way and procedure prescribed by this Act and regulations passed in regard to enforcement of this Act;
 6. personal comfort and special accomodation and personal care in hospital inpatient facilities, i.e. single or double room accomodation with separate bathroom, TV set, telephone and other special accomodation conditions, medically unnecessary or provided on personal request;
 7. services related to treatment of acute alcohol intoxication;
 8. cosmetic procedures aiming to improve appearance without restoring body functions as well as cosmetic corrections of organs and body parts except for: correction of inborn body deformities producing functional disorders, cosmetic correction of brests following mastectomy and cosmetic correction following serious injuries in order to restore vital functions of organs and body parts;
 9. pregnancy termination for non-medical reasons;
 10. non-compulsory immunizations and immunizations related to travelling abroad or to performing certain job;
 11. dental services not established as entitlements deriving from the compulsory health insurance in accordance with this Act and other regulations passed in regard to enforcement of this Act;
 12. diagnostic and treatment of sexual dysfunction or sexual inadequacy, including impotency, health care services, medicines and medical-technical devices relating to sex change and reversion of previously voluntary surgical sterilization;
 13. surgical or invasive treatment (including gastric baloon) related to weight reduction, except if medically needed, dietary counseling and weight loss programmes used by persons under the age fo 15, except dietetic nurishment to be prescribed for newly discovered diabetes patients and patients with terminally renal insufficiency;

14. methods and procedures of alternative, complementary or traditional medicine;
15. medicines which are not on the List of medicines (except for medicines referred to in Article 43 paragraph 2 of this Act), i.e. medicines issued without any prescription, prophylactic medicines and medicines aimed to change athletic capabilities, medicines given for cosmetic reasons, for stopping smoking, weight loss, as well as food supplements for special diets except those for treatment of inherited metabolic diseases and diseases followed by malabsorption;
16. diagnostic and treatment in research i.e. experimental phase i.e. treatment with application of medicines and medical supplies which are in the phase of clinical trials, diagnostic, treatment and rehabilitation, medicines and medical-technical devices not provided in accordance with accepted standards of medical, dental and pharmaceutical practice;
17. medical examinations and treatments of professional and amateur athletes, which are not covered by the right deriving from the compulsory health insurance, i.e. sport medicine programmes aiming to improve athletic capabilities;
18. radial keratotomy or any other surgical procedure for sight improvement, in the case when the sight may be adequately improved by use of glasses or contact lenses;
19. medical transportation services when the insured person may be safely transported in other adequate way, and emergency air transport when the insured person may be safely transported by road or other transport;
20. hydrotherapy, hypnosis therapy, electrohypnosis, electrosleep therapy, electronarcosis and narcosynthesis;
21. psychological counseling related to behaviour disturbances, treatment of bad family and work relationships, and memory and learning incapability;
22. long-term care and home care, as well as care provided in health care facility and social care facility, primarily delivered in order to provide ordinary personal care and recover, i.e to care and assist the insured person in daily life activities, such as walking, putting in and getting out of bed, bathing, dressing, food preparation, medicine administration

- control, and not aiming at diagnostic, therapy or rehabilitation due to disease or injury;
23. medical-technical devices and implants, as well as medical supplies for implantation in the human body, which exceed functional standards medically necessary for treatment of disease or injury ;
 24. treatment of complications following health care services not covered from the compulsory health insurance funds, in accordance with this Act;
 25. other kind of health care services not established as entitlements deriving from the compulsory health insurance, in accordance with the Republic Institute's general by-law.

Health care services referred to in paragraph 1 of this Article are provided at the expense of the insured, at prices to be determined by the health care service provider.

Health Care of the Insured Persons Abroad

Article 62

The insured person referred to in Article 17 of this Act, sent by employer to work, professional training or schooling in any country having an international agreement signed with this country relating to social insurance, is entitled to health care at the expense of compulsory health insurance funds, in accordance with international agreement on social insurance undersigned.

The insured person referred to in paragraph 1 of this Article shall use health care abroad in the way and through procedure prescribed by this Act and regulations passed in regard to enforcement of this Act, as well as by international agreement on social insurance undersigned between countries in question.

Member of nuclear family of the insured person referred to in paragraph 1 of this Article, who resides with the insured person abroad, shall use health care under the same conditions as the insured person referred to in paragraph 1 of this Article.

Article 63

The insured person sent abroad by employer with registered office on the territory of the Republic of Serbia in a country which hasn't an international agreement on

social insurance signed with the Republic, is entitled to use health care at the expense of compulsory social insurance funds if:

1. sent to work as an employee in a local company or mixed company, institutions, other organizations or with an entrepreneur (detached employees);
2. sent to work as an employee in households of our citizens working in such country, with international and foreign organizations, i.e. employers;
3. if sent to schooling, professional training and specialization
4. on business trip.

For the period of their sojourn abroad, the persons referred to in paragraph 1 of this Article are entitled to use health care only in the case of emergency medical aid directed to remove immediate life and health risk threatening the insured person.

Members of nuclear family residing with the insured person abroad, except in the case of business trip of the insured, are entitled to use health care in foreign country under the same conditions as the insured referred to in paragraph 1 of this Article.

Article 64

For the period of a private sojourn abroad (tourist travels, etc.), the insured person is entitled to use health care only in the case of emergency medical aid directed to remove immediate life and health risk threatening the insured person.

Article 65

The insured persons are entitled to use health care abroad at the expense of compulsory social insurance funds if it was established prior to their departure for a foreign country that they don't suffer from any acute disease, chronic disease in acute phase or other disturbances of health status for which a treatment or continuous medical control is necessary.

Health status referred to in paragraph 1 of this Article is determined by first-instance medical commission of the respective branch which issues a certificate of health status of the insured person for the purpose of using health care abroad (hereinafter referred to as the certificate on using health care abroad).

Certificate on using health care abroad is issued on the basis of findings and opinions given by a chosen physician stating that the insured person doesn't suffer from any acute or chronic diseases which require longer or continuous treatment, i.e. that the insured person is not in such health status which would require, soon after the arrival in foreign country, a longer treatment or accommodation in inpatient health facility (pregnancy, or alike).

In order to issue the certificate on using health care abroad, a first-instance medical commission may ask from the insured to make certain medical examinations by which a health status of the insured shall be established.

Findings and opinions of a chosen physician referred to in paragraph 3 of this Article are provided to the insured from the compulsory social insurance funds.

Certificate on using health care abroad is issued on the basis of a direct medical examination of the insured by chosen physician, as well as on the basis of medical documentation, that is: health care record, extracts from such record, findings and opinion of the chosen physician that such insured person hasn't suffered from acute or chronic diseases for the period of the last 12 months, laboratory blood test and urin analysis, as well as a certificate of the chosen physician-dentist with regard to teeth condition.

The respective branch issues a certificate on using health care abroad on a prescribed module of the Republic Institute with printed explanation about the way, procedure and conditions of using health care abroad.

Article 66

Certificate on using health care is valid until the expiry date of this, but not longer than 12 months i.e. for the shorter period of time the insured person shall spend abroad, and cannot be issued to the insured if a first-instance medical commission has discovered that health status of the insured is upset.

As an exception to paragraph 1 of this Article, a certificate on using health care service during a private sojourn abroad referred to in Article 64 of this Act is issued for the 90 days period at the most from the date such certificate is issued.

Article 67

The insured person resided in foreign country without prior health status examination by the first-instance medical commission i.e. without an issued certificate on using health care abroad, has no right to reimbursement of expenses incurred by using emergency medical aid during the sojourn abroad.

Article 68

If the insured uses emergency medical aid in inpatient hospital facility during the sojourn in foreign country, he/she may use such treatment only for the period of time necessary to recover in order to come back in the home country safely.

Whether the hospital treatment referred to in paragraph 1 of this Article is justified shall be assessed by the first-instance medical commission of the respective branch.

Article 69

During the sojourn in foreign country, the insured may use health care covered by the compulsory health insurance only in health facilities being a part of public health system of such foreign country.

Article 70

Whether the temporary inability to work, occurred during the temporary sojourn abroad, in a country with no international agreement undersigned on social insurance, is justifiable shall be assessed by the medical commission of the respective branch on the basis of proposal made by a chosen physician on request of the insured and the enclosed medical documentation from the first day of such inability.

Article 71

The insured persons exercise abroad the right to purchase medical-technical devices as well as medical supplies and implants, which are necessary in the case of emergency medical aid, in the same way as the insured in the country, upon prior approval of the medical commission of the respective branch.

The right referred to in paragraph 1 of this Article is exercised on the basis of the medical documentation and cost estimate and specification to be enclosed on request of the medical commission of the branch.

Total expenses to be reimbursed from the compulsory health insurance funds for using the right referred to in paragraphs 1 and 2 of this Article, shall not be higher than such expenses relating to the use of the same rights in the country, under conditions prescribed by this Act.

Referral for Treatment Abroad

Article 72

Referral for treatment abroad may be exceptionally approved to the insured person, at the expense of compulsory health insurance funds, for treatment of diseases, conditions or injuries which cannot be successfully treated in the Republic while in the country he/she is referred exists the possibility for such disease, condition or injury to be successfully treated.

The Republic Institute adopts a general by-law governing details relating to conditions, the way and procedure as well as type of diseases, conditions or injuries for which a treatment abroad may be approved.

General by-law referred to in paragraph 2 of this Act is published in the “Official Gazette of the Republic of Serbia”.

3. Right to Salary Benefit during Temporary Inability to Work

Cases and Conditions for the Right to Salary Benefit to Be Acquired

Article 73

The following insured persons are entitled to the salary benefit at the expense of compulsory health insurance funds:

1. the employed referred to in Article 17 point 1 to 7 of this Act;
2. entrepreneurs referred to in Article 17 point 18 of this Act;
3. priests and church officials referred to in Article 17 point 20 of this Act.

Article 74

The insured persons referred to in Article 73 of this Act are entitled to salary benefit for the period of temporary inability to work if the health status of the insured i.e. of a member of his/her nuclear family is such to disable him/her to work for reasons prescribed by this Act, regardless of the benefit payer, i.e. in the following situations:

1. temporary inability to work due to disease or injury not related to work;
2. temporary inability to work due to work-related disease or injury;
3. temporary inability to work due to sickness or complication relating to pregnancy maintenance;
4. temporary inability to work due to measures prescribed for compulsory isolation as germ carriers or due to contagious diseases in his/her environment;
5. temporary inability to work due to care for a nuclear family member under conditions prescribed by this Act;
6. temporary inability to work due to voluntary organs and tissue donation, excluding voluntary blood donation;
7. temporary inability to work because appointed as an escorting person to a sick insured person referred for treatment or medical examination in other location, i.e. while staying as an escorting person in hospital health care facility, in accordance with the Republic Institute general by-law;

Duration of temporary inability to work is assessed by the professional medical body of the Republic Institute i.e. of the respective branch, on the basis of medical-doctrinal standards for establishing temporary inability to work.

Medical-doctrinal standards referred to in paragraph 2 of this Article establishes the Republic Institute on the basis of a proposal of the republic expert commission for certain type of disease.

It is forbidden for a chosen physician or a member of the expert-medical body of the Republic Institute, i.e. of the respective branch, to established temporary inability in any insured person if the requirements referred to in paragraph 1 point 1 to 7 of this Article are not met.

Article 75

The insured person who hasn't the already existing insurance referred to in Article 32 of this Act at the time a temporary inability to work occurs, is entitled to the right to salary benefit from the compulsory health insurance funds in the amount of minimum salary determined in accordance with regulations governing labour issues for the month such benefit is being paid.

By the day the insured has met the conditions in regard to the already existing insurance, and has exercised the salary which constitutes a base for salary benefit calculation, in accordance with this Act, the insured is entitled to salary benefit which is calculated and paid under the conditions prescribed by this Act.

Consecutive Temporary Inability to Work

Article 76

In the case the insured is temporarily unable to work by reason of one cause referred to in Article 74 paragraph 1 of this Act, and then without interruption (the next day) he/she becomes temporarily unable to work by reason of a different cause referred to in Article 74 paragraph 1 of this Act, days of temporary inability to work of the insured are not adjoined in regard to the base, amount and payer of the salary benefit.

In the case the insured is temporarily unable to work by reason of one disease or injury, and the other day (without interruption), i.e. within six days from the last day of previous temporary inability at the most, becomes temporarily unable to work by reason of the same or a different disease or injury, days of temporary inability to work are adjoined in regard to the base, amount and payer of the salary benefit.

In the case the insured is temporarily unable to work by reason of the same or two different diseases i.e. injuries, with interruption between temporary inability to work which is longer than six days from the last day of previous temporary inability, days of temporary inability to work are not adjoined in regard to the base, amount and payer of the salary benefit.

In the case referred to in paragraph 2 of this Article, the chosen physician is bound to refer the insured to a first-instance medical commission upon the expiry of the thirtieth day of the total period of temporary inability to work.

In the case referred to in paragraph 3 of this Article, the chosen physician is bound to refer the insured to a first-instance medical commission if the insured was temporarily unable to work for a total of 30 days during the 45-day period from the day of the first inability to work.

Usage Duration of the Right to Benefit during Temporary Inability to Work

Article 77

Temporary inability to work starts on the day when a chosen physician establishes that the insured is unable to work due to disease or injury, i.e. on the day when he/she establishes a need for a member of nuclear family of the insured to be cared for or when establishes any other prescribed cause for temporary inability to work of the insured.

As an exception to paragraph 1 of this Article, a chosen physician may evaluate temporary inability to work of the insured for the period before the insured appeared for medical examination for the first time i.e. before his/her appearance before a chosen physician, but for three days retroactively at the most from the day the insured has appeared before a chosen physician.

If the insured was at hospital inpatient treatment or if temporary inability to work occurred during his/her sojourn abroad, as well as in other justifiable cases when the insured couldn't come to a chosen physician, i.e. couldn't notify such physician about the reasons for his/her being unable to work, to the proposal of the chosen physician a medical commission may evaluate such inability of the insured for the period longer than three days before his/her appearance before a chosen physician.

Article 78

A chosen physician i.e. medical commission establishes temporary inability to work of the insured by the date such temporary inability to work starts and by the date such temporary inability to work ends.

The right of the insured to a benefit for the period of temporary inability to work may last only until causes of such inability to work are removed, depending on the type and cause of disease i.e. injury, in accordance of this Act and other regulations passed for enacting this Act.

The right to salary benefit is exercised from the first day of such inability to work and throughout its duration, but only for the period of employment the insured person would receive the salary for, in accordance with the regulations governing labour issues, i.e. for the period of time he/she would perform the activity as entrepreneur if temporary inability to work hadn't occur.

As an exclusion to paragraph 3 of this Article, if temporary inability to work occurs as a consequence of work-related injury or professional disease, the insured is entitled to salary benefit from the first day of such inability and throughout its duration, as well as after the employment of the insured terminates, until causes of such temporary

inability to work are ceased under the evaluation of a chosen physician, i.e. medical commission.

Article 79

The insured referred to in Article 73 of this Act is entitled to salary benefit due to care for a sick nuclear family member under the age of 7 or an elderly nuclear family member with profound physical and mental disability, up to 15 calendar days at the most in each single case of illness, whereas if such sick i.e. injured nuclear family member is over the age of 7, up to 7 calendar days at the most.

As an exception to paragraph 1 of this Article, when there are justifiable reasons relating to health status of a nuclear family member, the first-instance medical commission may extend duration of temporary inability to work due to care for a nuclear family member up to 30 days as the most, in the case of a child under 7 years of age or an elderly nuclear family member with profound physical and mental disability to be cared for, i.e. up to 14 days in the case of a nuclear family member over the age of 7 to be cared for.

In the case of profound health impairment of a child under the age of 18 due to profound impairment of brain structures, malignant disease or any other profound worsening of the child health status, the second-instance medical commission, to the proposal of health care institution at tertiary level responsible for treatment of such child and the referral of the chosen physician, may extend the right to salary benefit due to care for a nuclear family member up to 4 months.

Article 80

Salary benefit relating to care for a child may be enjoyed if both parents are employed, i.e. if both parents carry out any activity as entrepreneur under which they are insured, or if such child has only one parent, i.e. if one parent is unemployed, i.e. doesn't carry out any activity as entrepreneur, but is not capable of taking care for the sick child.

Compulsory Referral of the Insured to Ability-to-Work Assessment before the Competent Pension and Disability Body

Article 81

Regardless of duration and causes of temporary inability to work to the insured, a chosen physician i.e. medical commission is bound to forthwith refer the insured

person to a competent body for ability to work i.e. disability assesment in accordance with the regulations governing pension and disability insurance issues (hereinafter referred to as disability commission), even before the expiry of the term referred to in paragraph 1 of this Article, if such chosen physician i.e. medical commission evaluates that health status of the insured indicates ability-to-work loss, i.e. that improvement of health care of the insured, which would enable him/her to restore ability to work, is not expected.

In the case that inability to work due to disease or injury lasts longer, but not later than the expiry of 6 months of continuous inability to work i.e. if for the period of the last 18 months the insured person has presented inability to work for 12 months with temporary discontinuances, a chosen physician i.e. medical commission is bound to refer the insured person with necessary medical documentation to disability commission for ability-to-work loss assessment.

Article 82

When during the temporary inability to work, the insured is referred to disability commission referred to in Article 81 of this Act, he/she is entitled to salary benefit from the compulsory health insurance funds for 60 days at the most, from the date of application for the procedure to be initiated before the competent compulsory pension and disability insurance organization.

The competent compulsory pension and disability insurance organization is bound to assess, within the term referred to in paragraph 1 of this Article, in accordance with regulations governing pension and disability insurance, whether there is or there is not total ability-to-work loss for the insured referred to such assessment in accordance with Article 81 of this Act.

If the competent compulsory pension and disability insurance organization fails to provide a decision on disability referred to in paragraph 2 of this Article within 60 days from the date of application for the procedure to be initiated in accordance with Article 81 of this Act, as of the sixty-first day the insured is entitled to salary benefit which is to be provided by the competent compulsory pension and disability organization out of its own funds.

As an exception to paragraph 1 of this Article, if disability commission establishes a total ability-to-work loss, before the expiry of the 60 days term from the date of application, the compulsory health insurance funds shall bear the expenses of salary benefit until the date of establishing a total ability-to-work loss while upon such date the salary

benefit shall be provided by the competent compulsory pension and disability insurance organization.

The claim for the paid salary benefit from the competent pension and disability insurance organization is due on the date when such salary benefit is paid whereas the reimbursement of the salary benefit is made in accordance with the provisions of the Act governing contractual relationship issues.

Article 83

During the whole period of temporary inability to work, every thirty days of such inability a medical commission, regardless of the payer of salary benefit, evaluates such temporary inability to work of the insured who is referred to disability commission in accordance with this Act, to the proposal of the chosen physician, in the manner and according to the procedure established by this Act and regulations passed in regard to enforcement of this Act, up to the day the decision referred to in Article 82 of this Act is received.

Article 84

The competent compulsory pension and disability insurance organization is bound to promptly deliver to the respective branch i.e. to the Republic Institute a decision on the insured person's total ability-to-work loss, i.e. that there is no such total ability-to-work loss, but not later than 15 days upon such decision has been made.

The right to salary benefit ceases when the legally effective decision referred to in paragraph 1 of this Article is delivered.

Relationships between the Institute and the competent pension and disability insurance organization with regard to referral of the insured person to ability-to-work assessment, salary benefit payments and other issues of mutual interest, are governed by a separate agreement.

Cases not entitled to the Right to Salary Benefit

Article 85

The insured with temporary inability to work in accordance with this Act is not entitled to the right to salary benefit, regardless of the payer, in the following cases:

1. inability to work deliberately caused;
2. inability to work caused by acute alcohol intoxication or by use of psychotropic substances;
3. deliberately prevented restoration of health i.e. restoration of ability to work;
4. if refuses treatment without justified reason, except under the circumstances that a consent provided by law is not needed;
5. if fails to present him/herself to a chosen physician for temporary inability-to-work assesment without justifiable reason, or doesn't respond to a summon from the medical commission, within 3 days from the date such temporary inability to work has occurred, i.e. from the date a summon to appear before the medical commission has been received i.e. from the date the circumstances which prevented him/her from it has ceased;
6. if carries out any economic or other activity for the period of such temporary inability to work, by which obtains income;
7. if leaves the place of residence, i.e. domicile, without permission of the professional medical body of the respective branch or the Republic Institute, or if a chosen physician i.e. a competent body for control of using the entitlements deriving from compulsory health insurance establishes that the insured doesn't comply with instructions for treatment;
8. if receives salary benefit under any other regulations;
9. if abuses of the right to use medical leave due to temporary inability to work in any other way;

The insured person is not entitled to salary benefit from the day the circumstances referred to in paragraph 1 of this Article are determined, and throughout the period such circumstances or their consequences remain.

Persons detained in prison and persons under security measures of inpatient compulsory psychiatric treatment and custody, and inpatient compulsory treatment of alcoholics and drug abusers are not entitled to salary benefit.

If the facts referred to in paragraph 1 of this Article are found after the use of the right to salary benefit has been initiated, i.e. when the right to salary benefit is already

approved, the payment of such salary benefit shall be suspended, i.e. the benefit payer is entitled to reimbursement of all payments.

Article 86

The insured referred to in Article 17 paragraph 1 point 18 of this Act is not entitled to salary benefit to be paid from the compulsory health insurance funds, if for the period such temporary inability to work he/she hasn't terminated performing economic activity on a temporary basis, regardless of the benefit payer.

In the case of paragraph 1 of this Article, the insured person who employs one or more employees is entitled to 50% of the salary benefit to which he/she would be entitled if he/she terminated economic activity.

Salary Benefit Base

Article 87

The base of the salary benefit for the employed insured persons referred to in Article 73 point 1 of this Act, which is paid by employer from its funds, is established in accordance with the regulations governing labour issues.

Article 88

The base for the salary benefit calculation (hereinafter referred to as salary benefit base), paid out of the compulsory health insurance funds for the insured referred to in Article 73 point 1 of this Act, consists of the base salary realized by the insured in three months preceding the month when temporary inability to work has occurred.

Salary in terms of paragraph 1 of this Article consists of the salary for work performed and time spent at work established in accordance with the regulations governing labour issues, that is:

- 1) base salary of the employee;
- 2) increased salary on the grounds of time spent at work for each full year of work realized in employment relationship.

For the period of salary benefit payments from the compulsory health insurance funds, for the insured with already existing insurance, the benefit base is established in accordance with paragraph 1 of this Article.

For the insured who does not meet the conditions relating to the already existing insurance at the time of beginning to use the right to salary benefit from the compulsory health insurance funds, the salary benefit base is established in accordance with paragraph 1 of this Article from the moment such conditions in regard to the already existing insurance have been met as well as in regard to exercising the salary referred to in paragraph 2 of this Article.

Article 89

The base for the salary benefit to be calculated for each single month included in average amount of salary referred to in Article 88 of this Act, may not exceed the highest monthly base on which the contributions for the month calculated in the average amount of salary are paid, in accordance with the Act governing the compulsory social insurance contributions.

The highest base for the salary benefit is the sum of the highest monthly bases on which the contributions have been paid for each of three months entering into the average salary.

If the insured who meets the condition in regard to already existing insurance hasn't realized the salary in three calendar months preceeding the month when temporary inability to work has occurred, the salary benefit base consists of the average salary referred to in Article 88 paragraph 2 of this Act for the period of time the insured person realized the salary in, with limitation of the highest benefit base referred to in paragraph 2 of this Article.

If the insured who meets the condition in regard to already existing insurance hasn't realized salary in any of three calendar months preceeding the month before temporary inability to work has occurred, the salary benefit base consists of the salary which the insured would have earned in accordance with Article 88 paragraph 2 of this Act, in the month for which salary benefit is paid, if it hadn't occurred such temporary inability to work.

Article 90

Salary benefit base for the insured referred to in Article 73 points 2 and 3 of this Act who meet the condition in regard to already existing insurance, consists of average monthly base on which the contributions for compulsory health insurance have been paid in accordance with law, established in the calendar trimester preceeding the trimester when situation occurred on the basis of which the right to salary benefit is obtained, whereas if

he/she has been insured on that grounds for shorter period in the previous trimester, the salary benefit base consists of the base on which the contributions for compulsory health insurance are paid, established according to the period of time he/she has been insured in the previous trimester.

If the insured person referred to in paragraph 1 of this Article, hasn't performed an economic activity as entrepreneur, i.e. any religious function, the salary benefit base consists of the base referred to in paragraph 1 of this Article established for current calendar trimester.

Article 91

For the insured who worked with two or more employers or who carried out an activity as entrepreneur and worked with an employer before temporary inability to work has occurred, i.e. during the period on the grounds of which the salary benefit base is established, such salary benefit base is established according to the total sum of the salary benefit bases referred to in Article 88 and 90 of this Act, where such sum cannot exceed the highest salary benefit base referred to in Article 89 paragraph 2 of this Act.

Harmonization of Salary Benefit Base

Article 92

When the insured referred to in Article 73 points 1 of this Act receives the salary benefit from the compulsory health insurance funds longer than two calendar months, he/she is entitled to harmonization of the salary benefit base.

Harmonization of the salary benefit base is made from the first day of the calendar month following the expiry of the second calendar month of continuous inability to work.

The salary benefit base referred to in paragraph 1 of this Article, is harmonized with fluctuation of salaries at the employer's company in the month preceding the month from which the insured is entitled to harmonization of the salary benefit base (first harmonization of the salary benefit base).

Each consecutive harmonization of the salary benefit base is carried out monthly according to fluctuation of salaries at the employer's company.

Article 93

When the insured referred to in Article 73 points 2 and 3 of this Act receives the salary benefit from the compulsory health insurance funds longer than two calendar months, he/she is entitled to harmonization of the salary benefit base.

Harmonization of the salary benefit base is made from the first day of the calendar month following the expiry of the second calendar month of continuous inability to work.

The salary benefit base referred to in paragraph 1 of this Article, is harmonized with fluctuation of average monthly salary per employee on the territory of the Republic of Serbia according to the last published information of the national statistics body, in the month preceding the month from which the insured is entitled to harmonization of the salary benefit base (first harmonization of the salary benefit base).

Each consecutive harmonization of the salary benefit base is carried out monthly according to fluctuation of average monthly salary per employee on the territory of the Republic according to the last published information of the national statistics body.

Article 94

The harmonized amount of the salary benefit base referred to in Articles 92 and 93 of this Act may not exceed the highest salary benefit base referred to in Article 89 paragraph 2 of this Act.

Salary Benefit Amount

Article 95

The amount of salary benefit sustained by employer from its own funds for the first 30 days of inability to work in the cases referred to in Article 74 paragraph 1 of this Act, is determined in accordance with the regulations governing labour issues, and this Act.

Article 96

The amount of salary benefit sustained from the compulsory health insurance funds, as well as by employer from its own funds, in the cases referred to in Article 74 paragraph 1, 3, 4, 5 and 7 of this Act, is equivalent to 65% of the salary benefit base.

The amount of salary benefit sustained from the compulsory health insurance funds, as well as by employer from its own funds, in the cases referred to in Article 74 paragraph 1 point 2 and 6 of this Act, is equivalent to 100% of the salary benefit base

Article 97

The amount of salary benefit sustained from the compulsory health insurance funds cannot be lower than minimum salary determined according to the regulations governing labour issues for the month for which the calculation of salary benefit is made, nor can exceed a 65% i.e. 100% of the highest salary benefit base established in accordance with this Act.

Article 98

The insured person is entitled to salary benefit sustained from the compulsory health insurance funds in the amount of minimum salary for the month in which payment is carried out, in accordance with the regulations governing labour issues, for the period when his/her employer doesn't pay any salary to its employees but calculates and pays contributions,, but not longer than three calendar months.

If the employer ulteriorly pays salary to employees, the insured referred to in paragraph 1 of this Article is entitled to re-calculation of salary benefit sustained from the compulsory health insurance funds, under conditions provided by this Act.

Salary Benefit in Special Cases

Article 99

When the expert-medical body of the respective branch i.e. of the Republic Institute establishes during the treatment of the insured receiving salary benefit, that his/her health status is improved and the work would help the insured person to better recover his/her full ability to work, it may decide for the insured to work shortened working hours i.e. minimum four hours a day.

Shortened working hours referred to in paragraph 1 of this Article may last at the most three month continuously or with discontinuances for the period of twelve months from the day such shortened working hours have initiated.

The employer is bound to provide for the employed a possibility to work shortened working hours in accordance with paragraph 1 and 2 of this Article.

Article 100

The insured who works shortened working hours during temporary inability to work, in accordance with Article 99 of this Act, is entitled to salary benefit which is proportionally equivalent to time spent at work according to full working hours.

Article 101

If during the use of the right to salary benefit, the insured is removed from work due to any criminal procedure moved against him/her, in the case of detention or due to any other cases in accordance with law, the salary benefit shall be paid in the amount of one fourth of the established salary benefit, and if he/she maintains the nuclear family members, in the amount of one third of such salary benefit.

If the procedure against the insured referred to in paragraph 1 of this Article is suspended i.e. if all charges against the insured are dropped, i.e. if no disciplinary measure has been passed against the insured in regard to violation of work obligation or working discipline, such insured person will be paid a part of the salary benefit up to the full amount established in accordance with this Act.

Providing the Salary Benefit Payment

Article 102

Salary benefit in the cases of temporary inability to work referred to in Article 74 of this Act for the first 30 days of such inability is sustained by the employer from its own funds, whereas from the 31st day such benefit is sustained by the Republic Institute i.e. the respective branch.

As an exception to paragraph 1 of this Article, the salary benefit sustained from the compulsory health insurance funds is provided from the first day of inability to work for the insured whose inability to work is due to voluntary tissue and organs donation, as well as for the insured mother, i.e. father, adopting parent or other insured person who cares for a child, during the period of temporary inability to work due to care for sick child under the age of 3.

As an exception to paragraph 1 of this Article, the salary benefit in the case of temporary inability to work due to work-related injury or professional disease is sustained for the insured referred to in Article 73 point 1 of this Act by the employer from its own

funds, during the employment relation of the insured, from the first day of temporary inability to work throughout the entire duration of such inability of the insured.

For the insured whose employment relation has ceased while exercising the right to salary benefit due to work-related injury or professional disease, the salary benefit payment is sustained by the respective branch or the Republic Institute, from the day such employment relation of the insured has ceased.

For the insured referred to in Article 73 point 2 and 3 of this Act, the salary benefit due to work-related injury or professional disease is sustained by the respective branch i.e. the Republic Institute from the thirty-first day of the continuous inability to work and throughout the entire duration of such inability of the insured.

Article 103

The employer pays to employees a salary benefit which is sustained from the compulsory health insurance funds, in accordance with this Act.

The employer makes an account of salary benefit referred to in paragraph 1 of this Article in accordance with this Act and submits it to the respective branch.

The respective branch establishes the right to salary benefit and amount of salary benefit and within 30 days from the date it receives the account referred to in paragraph 2 of this Article, transfers the appropriate funds into the employer's special account.

The funds referred to in paragraph 3 of this Article which are not paid to the insured within 30 days from the date such funds are received, the employers is bound to send it back to the respective branch including interests by which such funds are increased while being on the employer's special account.

The funds referred to in paragraph 3 of this Article may not be used otherwise than for the purpose referred to in paragraph 1 of this Article.

Salary benefit sustained from the respective branch funds for entrepreneurs and their employees, provided that entrepreneurs don't have special account, as well as for priests and church officials, are calculated and paid by such respective branch.

The employer may pay salary benefit from its own funds even when such benefit is sustained from the compulsory health insurance funds, whereas the respective branch is bound to reimburse such paid amounts to the employer within 30 days from the day a request is submitted to such respective branch.

4. Right to Transportation Benefit

Article 104

Transportation benefit relating to the use of health care is provided for the insured, as well as for an escorting person of the insured in the case of referring to a health care institution out of the respective branch territory, if such health care institution is distant at least 50 km from his/her place of residence, in accordance with provisions of this Act.

The insured person is entitled to transportation benefit when such insured has been referred or invited by the chosen physical, health care institution or competent medical commission to another place within the territory of the respective branch for health care delivery or temporary inability-to-work assessment.

As an exception to paragraph 1 of this Article, the insured referred to dialysis, a child under the age of 18 and the elderly with profoun physical and mental disability referred to everyday exercises and rehabilitation to health care insitution i.e. private practice out of his/her place of residence, to another place within the territory of the respective branch is entitled to transportation benefit on the basis of an opinion given by a medical commission.

Article 105

The insured persons are entitled to transportation benefit in comparison with the shortest distance in the amount equivalent to the price of bus or second class train fare.

As an exception to paragraph 1 of this Article, considering the nature of disease or injury, the insured person is entitled to transportation benefit for other means of transport if such such transportation is necessary.

In the case of necessary health care, the insured person may use an ambulance, upon an order of the medical commission, and if such ambulance cannot be provided regardless of the emergency, the insured is entitled to the actual transportation costs reimbursment but at the most up to 10 % of the price of one liter of petrol for each kilometer.

Article 106

The insured person which falls ill i.e. becomes injured while staying somewhere else (business trip, holiday, etc.) is not entitled to transportation benefit to return where he/she works or resides, unless special transportation is necessary because of the

health status of the insured, which shall be decided by the first-instance medical commission.

Article 107

If the insured person is, upon other regulations, entitled to transport free of charge, no allowance for the transport costs are to be allocated to his/her, and if he/she is entitled to transport with a discount, he/she is to be allocated an allowance up to the full transport costs.

Article 108

To the insured person an escort while travelling, or while travelling and staying in another place may, be designated, if necessary.

An escorting person is to be reimbursed for the transport costs under the same conditions as prescribed for the insured person.

An escorting person is to be reimbursed for the transport costs for both returning to his/her place of residence or going to another place in the escorting capacity for the insured person.

If a child is sent to a medical treatment or to see a physician at a place other than the place of residence, an escort is considered to be needed if the child is under 18, i.e. in the case of the elderly with profound physical or mental disability.

5. Due Entitlements and Time Period for Exercising thereof

Article 109

Salary payment is due when the last day expires for which the insured person is entitled to such payment if the temporary impediment to work lasts less than one month, and if it lasts one month and longer, then when the last day in a month expires for each month for which the insured person is entitled to such payment.

Transport expenses reimbursement is due on the day of termination of travel for purposes of medical treatment.

The branch carries out payment of pecuniary benefits referred to in paragraph 1 and 2 of this Act within 30 days from the day a request for such payment of benefits has been presented.

Article 110

A request for realizing benefits and allowances and other rights upon health insurance may be submitted within three years as of the date when such rights are due.

4. DEFINING THE STATUS OF THE INSURED PERSON AND EXERCISING RIGHTS UPON COMPULSORY HEALTH INSURANCE

1. Defining the Status of the Insured Person

Article 111

The status of the insured is defined by the respective branch on which territory the insured has residence i.e. on which territory a contribution payer has registered seat, and which is considered as such in terms of this Act, unless otherwise prescribed by this Act.

The status of the insured is defined upon one basis only.

The status of the insured ceases on the day the basis upon which such status is recognised has ceased.

Article 112

A person recognised the status of the insured is issued by the respective branch a prescribed document on health insurance (hereinafter referred to as insurance document).

A person provided with entitlements deriving from compulsory health insurance in particular circumstances, referred to in Article 28 of this Act, is issued a special document for using health care only in the case of work-related injuries and diseases.

The Republic Institute adopts a general by-law governing the content and form of the insurance document i.e. the special document for using health care referred to in paragraph 1 and 2 of this Article, its authentication and other relevant issues for the use of such documents.

Article 113

Legal and physical entities are bound to present the respective branch all information in regard to the application to, termination of and any changes in the

compulsory health insurance, in order to define the status of the insured person/entity, or to discontinue or enter changes to the status of such person.

Based on the information referred to in paragraph 1 of this Article, the respective branch establishes facts for acquiring the status of the insured on a compulsory basis.

The term for submitting the insurance application, termination thereof or any changes therein is eight days as of the date when such said changes occurred.

Article 114

If the respective branch does not recognise the status of insurance for the person for whom the application for compulsory health insurance has been submitted, or recognises the status upon some other basis, the respective branch is bound to issue a decision upon the matter and to deliver it to the requester.

The respective branch is bound to issue a decision on the set definition on the insured status based on a compulsory insurance, or its termination, or any changes in the status of such person, all on request of the insured, or some other competent body.

If any legal or physical entity didn't file an application for compulsory health insurance within the term prescribed by this Act, the respective branch, following its official duties, shall define the status of the insured person, upon which it makes a decision.

In the decision referred to in paragraph 3 of this Article, the respective branch defines the date of acquiring the status of the insured and due obligations upon payment of contributions on the date such decision has been made.

2. Central Record on the Insured and Exercise of the Rights deriving from Compulsory Health Insurance

Article 115

The status of the insured on the basis of compulsory health insurance is determined on the basis of data kept in the central record in regard to the insured persons and exercising the rights deriving from the compulsory health insurance (hereinafter referred to as the central record) which is integrally governed and organized by the Republic Institute for the entire territory of the Republic.

The respective branch carries out certain activities of the central record, in accordance with this Act and other regulations passed for enforcing this Act.

Article 116

The Central Record keeps data on the insured, i.e. persons who are insured, contribution payers and use of the rights deriving from compulsory health insurance.

The Central Record is kept according to the prescribed unified methodological standards.

Information are entered into the Central Record according to the prescribed unified code system.

Information are entered in the Central Record on the basis of applications submitted on the prescribed forms which may be submitted via means of electronic data transfer.

In the cases when the insurance applications, or insurance termination, or insurance changes are submitted via means of electronic data transfer, the person submitting any kind of such applications is bound, upon a request of the Republic Institute i.e. of the respective branch, to do so on a form prescribed for such purpose.

The unified methodological standards for keeping the Central Record, unified code system and insurance application forms in regard to insurance request, termination or changes, and other issues relevant for the Central Record to be kept – is governed by the Government.

Article 117

The Central Record is made by entering information on the insured and other contribution payer, on the basis of the data from the health insurance application, as well as of other data in accordance with this Act.

Article 118

The following data are entered into the Central Record:

1. data about the insured,
2. data about family members of the insured,
3. data about contribution payers for compulsory health insurance,
4. data about using the entitlements deriving from compulsory health insurance,

Data referred to in paragraph 1 point 4 of this Article, represent official secrets and are kept separately from other data, and such data may be entered, i.e. used, by a specially authorized official of the respective branch i.e. the Republic Institute

Article 119

The following information about the insured and about persons who are considered to be insured under this Act are entered in the Central Record:

1. family name and first name;
2. personal ID number and TIN (Tax Identification Number);
3. gender;
4. day, month and year of birth;
5. occupation;
6. education degree;
7. insurance basis;
8. date of acquiring i.e. terminating of the insured status, as well as any changes during such status;
9. period of health insurance;
10. contributions payer;
11. amount of the contribution to be paid;
12. salary, benefits and allowances and other earnings and allowances serving as insurance benefit base on which contributions are calculated and paid;
13. amount of the contribution paid;
14. place of residence, address;
15. name of the employer, register number of the employer, classification of economic activity and the employer's registered office;
16. municipality the real estate is situated in;
17. citizenship.

Except for data about the insured referred to in paragraph 1 of this Article, the following data are entered for family members of the insured:

1. family name and first name;
2. personal ID number;

3. gender;
4. day, month and year of birth;
5. kinship to the insured;
6. place of residence and address;
7. occupation;
8. citizenship.

Data about work-related injuries i.e. diseases of the insured are entered in the Central Record as well.

Article 120

Data related to the insured, prescribed by the Act governing record keeping in the health care activities, are entered in the Central Record as well.

In the Central Record the data in regard to use of the right deriving from the compulsory health insurance are entered, and in particular:

1. type of entitlements deriving from health insurance to be provided to the insured;
2. health care services delivered to the insured;
3. pecuniary benefits;
4. medical-technical devices;
5. medicines issued on prescription;
6. annual amount of the participations paid;
7. chosen physician of the insured;
8. use of the rights before medical commissions;
9. use of the rights concerning work-related injuries and diseases of the insured;
10. referral to a disability commission in accordance with this Act.

The Republic Institute may prescribe by general by-law other data to be entered in the Central Record and relating to use of the right deriving from compulsory health insurance, as well as special forms for records to be kept regarding the use of rights deriving from compulsory health insurance (receipts and other specific financial documentation) which are not prescribed by the Act governing records to be kept in the field of health).

In the Central Record are entered as well data about health care services provider entered into an agreement with the branch i.e. the Republic Institute regarding health care delivery to the insured from compulsory health insurance funds.

The general by-law referred to in paragraph 3 of this Article is published in the “Official Gazette of the Republic of Serbia”.

Article 121

The Republic Institute i.e. the respective branch is entitled to obtain upon official duty all data referred to in Articles 119 and 120 of this Act kept with other competent government authorities and organizations relating to the insured persons.

Article 122

The Republic Institute designates a register number to contributions payers.

Register number referred to in paragraph 1 of this Article, consists of the mark of the Republic Institute i.e. the branch, municipality, current register number and control number.

Article 123

The following are persons who file to the respective branch i.e. the Republic Institute the forms with data to be entered into the Central Record:

1. employer,
 - (1) form with data about the contribution payer, which include the date of commence of the activity, changes occurred in the course of the activity and cessation of the activity;
 - (2) health insurance application, notification on changes in insurance and termination of insurance for the insured referred to in Article 17, paragraph 1, point 1) to 8), point 10 and points 13) and 14) of this Act;
 - (3) form with data for establishing time period of health insurance, data on salary, benefits and allowances and other earnings and allowances serving for establishing the base and the amount of the contribution paid,

- (4) notification on the contributions paid upon an agreed compensation according to a contract on additional work rendered or other type of contract, and the amount of such compensation;
2. competent revenue office – form with data for establishing time period of health insurance, insurance base and the amount of contribution paid – for the self-employed insured (entrepreneurs), insured farmers, priests and other church officials, monks and nuns, as well as a notification on changes in such data;
3. organisations, associations and societies – health insurance application or termination form, except for the self-employed insured (entrepreneurs), as well as the notification on any changes in such data;
4. the insured who are themselves contribution payers of the compulsory health insurance, except for the insured referred to in points 2) and 3) of this Article:
 - (1) form with data about the contribution payer;
 - (2) health insurance application form, changes in insurance and termination of insurance forms;
5. Employment Agency:
 - (1) health insurance application form and termination of insurance form for the insured for which the Agency is, in accordance with law, contributions payer for compulsory health insurance, as well as the notification of any changes of such data.
 - (2) form with data for establishing time period of health insurance, data on salary benefit and the amount of the contribution paid for the persons referred to in subpoint 1 of this point, as well as notification of any change in such data;
6. Pension and Disability Insurance Organization:
 - (1) health insurance application, changes in the insurance or termination of insurance for the insured for which, in accordance with law, such organization pays contributions for compulsory health insurance;
 - (2) form with data for establishing time period of health insurance and the amount of contributions paid for persons referred to in subpoint 1 of this point, as well as changes of such data;
7. The Republic Institute :

- (1) enters into the Central Record data about health insurance applications, changes and terminations, in accordance with this Act, about established time period of health insurance, salary, salary benefits and other earnings and allowances serving for calculation and payment of contributions as well as the amount of the contribution paid for the insured who are themselves contribution payers, unless otherwise provided by this Act,
- (2) keeps a special record on the contributions paid as referred to in point 1), sub-point (4) of this Article.

Article 124

For the insured referred to in Article 22 of this Act, the forms for application to, changes in and termination of insurance are submitted by such persons along with necessary evidence for establishing the insured status, except for the insured referred to in point 7 and 8 of that Article for whom such forms for application to, changes in and termination of insurance are submitted by the payer of social welfare i.e. permanent financial aid.

For a person to be included into compulsory health insurance referred to in Article 23 of this Act, the forms for application, changes and termination of compulsory health insurance are submitted by such person along with necessary evidence for establishing the status of the insured.

The Republic Institute keeps special record of the insured referred to in Article 22 and 23 of this Act.

By general by-law, the Republic Institute governs the manner and procedure, as well as necessary evidence, for establishing the status of the insured of the person referred to in Article 22 of this Act.

By general by-law, the Republic Institute governs the manner and procedure, as well as necessary evidence, for the person referred to in Article 23 of this Act to be included into compulsory health insurance.

The general by-laws referred to in paragraph 4 and 5 of this Article are published in the "Official Gazette of the Republic of Serbia"

Article 125

The forms with data to be entered into the Central Record are to contain only data based on public documents and records prescribed by law and the regulations passed in regard to enforcement of this Act.

Article 126

The submitter is held accountable for the data provided in the application form to be true and correct.

The respective branch is bound to verify for the data entered in the application to be true and correct, to require evidence and verify such data in records and documentations upon which such data have been provided in the application for, as well as to obtain, when needed, all necessary data.

The submitter of application forms is bound to provide the insured i.e. the user of entitlements deriving from compulsory health insurance, accurate data i.e. data relevant to acquiring and using the rights deriving from compulsory health insurance, as well as to provide the respective branch all evidence and to enable an insight into records and documentation.

Article 127

Status of the insured for persons for whom the application has been submitted is defined by entering their data in the Central Record and by confirming the receipt on the insurance application form.

At receiving the insurance application form, the data provided in the form are checked and evidence required upon which the data provided are based.

Provisions referred to in paragraphs 1 and 2 of this Article are implemented at receiving the insurance termination and changes in the insurance forms, as well.

The submitter is bound to provide the person for whom the form for insurance application or termination or changes in the insurance has been submitted, a certified photocopy of the receipt of such forms, within 8 days as of the date of issuing the receipt.

If it has been established on the basis of the submitted form for insurance application that the conditions for recognising the insured status are not met, the submitter is to be provided with a written decision thereof.

For the self-employed users (entrepreneurs), farmers and other persons on whom a competent revenue office keeps a record, the respective branch i.e. the Republic Institute is bound to provide such revenue office with a copy of receipt of such forms for insurance application or termination by the 5th date of each month for the previous one.

Data submission referred to in paragraph 6 of this Article may be carried out in electronic form as well, whereas there is obligation for submitting a copy of confirmation of the application i.e. termination form receipt within 8 days.

Article 128

Person for whom no forms for insurance application has been submitted to the Republic Institute i.e. the respective branch by the contribution payer, may apply themselves for the insured status to be defined.

The application referred to in paragraph 1 of this Article may be submitted to the contribution payer, as well.

The respective branch shall set in motion proceedings for defining the insured status when it has been established through a control or in any other way that no form for insurance application has been submitted for persons having rights deriving from the compulsory health insurance.

In the cases referred to in paragraphs 1 to 3 of this Article the respective branch issues a decision on defining the insured status.

On the basis of the decision defining the insured status referred to in paragraph 4 of this Article, any persons under obligation to submit any forms for insurance application are bound to do so.

Provisions referred to in paragraphs 1 to 5 of this Article are also applicable in the case when a person under obligation to submit a form for termination of insurance i.e. for changes in insurance, has not submitted such forms..

Article 129

Forms with data to be entered into the Central Record is submitted to the respective branch, as follows:

1. for the insured employed referred to in Article 17, paragraph 1, point 1) to 8), point 10 and 11), 13) to 16) and 24) of this Act – according to the employer's registered seat or his organisation unit (branch, division, local or regional office, representative

- office, agency or other operating unit) whereas for the insured referred to in point 17) – according to the company’s registered seat ;
2. for the insured employed referred to in Article 17, point 9) of this Act – according to the residence of the insured in the Republic;
 3. for the self-employed insured (entrepreneurs) referred to in Article 17, point 12) of this Act – according to the residence of the insured or the place where her/his last job was;
 4. for the self-employed insured (entrepreneurs) referred to in Article 17, paragraph 1, point 18 of this Act, except for the insured who do not have a regular monthly income – according to the place the insured registered the business on which grounds she/he is insured;
 5. for the insured referred to in Article 17, paragraph 1, point 19) to 20) of this Act, and for the insured who do not have a regular monthly income – according to their residence, or a temporary residence in the Republic;
 6. for the insured referred to in Article 17, paragraph 1, point 22) of this Act – according to their temporary residence,;
 7. for the insured referred to in Article 17, paragraph 1, point 23 of this Act – according to the permanent or temporary residence;
 8. for the insured referred to in Article 17, point 25) of this Act – according to the residence or the registered seat of the university or school;
 9. for the insured farmers, referred to in Article 17, paragraph 1, point 21 of this Act – according to the registered seat of the competent body which determines taxes on the cadastre income from agricultural activities.

For family members of the primary insured, forms with data to be entered into the Central Record are to be submitted to the respective branch i.e. the branch, in the manner as described in paragraph 1 of this Article.

Article 130

Forms with data for the Central Record regarding the insured referred to in Article 22 paragraph 1 of this Act are submitted to the respective branch according to the permanent residence, whereas regarding the insured referred to in point 11 of that Article, according to permanent i.e. temporary residence.

Forms with data to be entered into the Central Record for persons who are to be included in the compulsory health insurance under the Article 23 of this Act are to be done according to the person's residence.

For family members of the insured referred to in pars. 1 and 2 of this Article, forms with data to be entered into the Central Record is to be done at the respective branch which established the status of the insured and for the primary insured under paragraphs 1 and 2 of this Article.

Article 131

Status of the insured, income amount, benefits and other earnings which serve as insurance benefit base on the grounds of which contributions are calculated and paid, are to be determined by the respective branch based upon the submission of the forms with data referred to in Article 119 of this Act.

Article 132

If the respective branch, while checking the data referred to in Article 110 of this Act, finds that the data supplied about the time period of the insurance, income, salary benefits, basic amounts for insurance, or agreed benefits and allowances and the amounts of paid contributions have not been stated correctly or in accordance with the regulations on the compulsory health insurance, it shall order the applicant to correct them within a time period not longer than 30 days.

Article 133

The respective branch is obliged, on personal request of the insured, to issue a certificate on the data entered into the Central Record.

The certificate referred to in paragraph. 1 of this Article is considered to be a public document.

Article 134

Data supplied for the Central Record, in the manner set hereby, may be altered in the following cases:

1. if a competent body subsequently, in the course of a prescribed procedure, finds that there has been a change in the information;

2. if the data on the insured, time period of the insurance, income, benefits and allowances, agreed allowances, basic amount and rate for insurance and the paid contribution amounts, as well as other data kept in the Central Record were entered in the Central Record upon presented false documents;
3. if subsequently, while checking the data or in any other way, it is found that incorrect or incomplete data have been entered in the Central Record.

Alteration of data entered in the Central Record is carried out upon an appropriate request for the alteration of information, through a procedure prescribed by this Act.

Article 135

Data to be entered in the Central Record, according hereto, are to be supplied within 8 days as of the date of commencement of business activities, or employment, or of closing a contract or performing any other economic activity which constitutes basis for acquiring the status of the insured.

Data on establishing the time period of health insurance, income, benefits and allowances, insurance benefit base or the agreed allowances serving for paying the contribution – are to be supplied upon the payment.

Data on alterations are to be supplied within 8 days as of the date alteration has been established, or as of the date of receipt of a valid decision on such alterations.

The respective branch is obligated to enter the aforesaid data in the Central Record within 60 day as of their receipt, or by the end of the current year at the latest for the previous one.

Article 136

Data to be entered in the Central Record is to be kept for at least 10 years as of the date of their enter in the Central Record.

Instead of originally supplied information, they may stored on a microfilm, or any means for electronic data processing.

Article 137

Destruction of the original forms upon which the data for the Central Record have been supplied is to be done by a commission appointed by the Republic Institute.

Article 138

The data contained in the Central Record are used solely for purposes of compulsory health insurance, unless otherwise provided by this Act.

The data in the Central Record related to an individual insured person and to the rights exercised according to the compulsory health insurance are personal data considered to be confidential and cannot be disclosed or publicised.

The data contained in the Central Record may also be used for statistical purposes in accordance with law.

Protection of data contained in the Central Record is to be provided in the manner prescribed in accordance with law.

3. Providing and Exercising Entitlements Deriving from Compulsory Health Insurance

Article 139

The insured is provided with entitlements deriving from compulsory health insurance at the respective branch, unless otherwise prescribed hereby.

Financial means for providing the entitlements deriving from the compulsory health insurance for the insured on the territory of the respective branch, the Republic Institute transfers to the branch in accordance with law and regulations passed in regard to enforcement of this Act.

Members of the family of the insured are provided with the entitlements sustained in the compulsory health insurance at the respective branch where such entitlements are provided for the primary insured from whom the members draw their secondary health insurance.

The insured referred to in Article 22 of this Act, as well as persons who are to be included in the compulsory health insurance subject to the Article 23 of this Act, as well as the persons referred to in Article 28 of this Act, the rights deriving from the compulsory health insurance are exercised at the branch on which territory such persons have permanent or temporary residence.

Article 140

Entitlements deriving from health insurance are provided to:

1. persons referred to in Article 17, paragraph 1, point. 1) to 8), point. 10) and 11), point. 13) to 16) and point. 24) of this Act– in the branch on which territory is the seat of their employer, and for those employed out of the seat of the employer – in the branch of the employer’s division;
2. persons referred to in Article 17, paragraph 1, point. 17) of this Act– in the branch on which territory is the seat of the company or a shop, or according to the place of the economic activity;
3. persons referred to in Article 17, paragraph 1, point. 25) of this Act – in the branch according to the place of the school or university;
4. other insured – in the branch according to the place of residence.

Exceptional to paragraph 1 of this Article, the insured referred to in Article 17, paragraph 1, point 21 of this Act, exercise their rights to health insurance at the branch on which territory the greater part of their farming land is located where agricultural activities are carried out.

The insured without the residence on the territory of the respective branch where his/her right to health insurance is exercised, may exercise such rights, according to the Republic Institute general by-law, at the branch of his/her residence.

The insured – pupils and students – exercise their right to health care deriving from the compulsory health insurance, according to the Republic Institute general by-law, at the branch on which the school or university is located.

Business unit, in terms of paragraph 1, point 1) of this Article, is a plant, shop, warehouse, representative office and alike.

Business unit organised for performing economic activities up to six months is not considered a unit in terms of paragraph 1 point 1 of this Article.

Article 141

The insured exercises his/her health care at a health care facility or other provider of health services, having registered seat on the territory of the respective branch, with which a contract on providing health care services to the insured has been executed.

The insured exercises his/her health care also at a health care facility i.e. at another provider of health care services, outside the territory of the respective branch under

terms and conditions prescribed hereby and under regulations passed for enforcing the herein Act.

At providing health care to the insured, also a free choice of a health care facility and a free choice of a physician (hereinafter referred to as “chosen physician”) is provided, with whom the Republic Institute has executed a contract on providing health care to the insured.

In a general by-law, the Institute regulates in detail the manner and procedure of exercising rights deriving from the compulsory health insurance.

The general by-law referred to in paragraph 4 of this Article is published in the “Official Gazette of the Republic of Serbia”.

Article 142

Entitlement deriving from health insurance are exercised subject to a certified document on insurance i.e. special document on exercising health care.

Certification of the document is provided by the respective branch based upon the available information, which are the evidence of payment of the due contribution, in accordance with law.

If the insurance document is not certified because the due contribution amount has not been paid, a subsequent certification shall be done when the due amount has been covered.

In the case that the due contribution for the compulsory health insurance has not been paid, or has not been paid in full, the right to health care may be exercised in the case of emergency medical aid only.

Article 143

Costs accrued at a health care facility upon the use of health care by the insured who has not paid the health insurance contribution or has not paid it in full, the insured using the services pays to the health care facility, except in the case of emergency medical aid.

If the employer, or any other persons, is the one who is responsible to pay the health insurance contribution in accordance with law, but has not made the due payment, the insured is entitled to compensation of the costs accrued for the received health care services, referred to in paragraph 1 of this Article, by the employer, or any other person responsible for making the health insurance contribution payments.

The employer, or other person responsible for paying the health insurance contributions, from whom the insured claims compensation for the costs accrued while receiving health care services and which falls in the compulsory health insurance, is bound to make the payment of the accrued costs to the account of the insured, or in any other properly determined manner within 30 days as of the date of submitting the request by the insured.

The insured is also entitled to receive a legally set interest on the amount referred to in paragraph 3 of this Article, not paid in due time.

Article 144

The insured exercises his/her entitlement to health care in the manner and the procedure under terms and conditions in accordance with this Act and the regulations passed in regard to enforcement of this Act..

Health care costs which are not accrued in the manner and procedure set in accordance with paragraph 1 of this Article, are to be borne by the insured.

While exercising the right to health care, the insured is provided with the use of health care, in accordance with law, with application of all the safety and medical measures and procedures, medicaments and medical materials, implants and medical-technical appliances.

The exercising of the right to health care as well as other rights deriving from the compulsory health insurance for the insured residing in the Republic of Montenegro shall be governed by an agreement between the Republic of Serbia and the Republic of Montenegro.

4. Participation of Professional Medical Bodies in the Proceedings

Article 145

In determining the type, range and standards, the manner and proceedings of exercising right to health care and assessing the temporary inability to work of the insured, and in exercising right to transportation benefit, as expert-medical bodies of the respective branch i.e. Republic Institute, in the proceedings the following are included:

- 1) chosen physician,
- 2) first-instance medical commission,

3) second-instance medical commission

A physician who has performed a medical examination, i.e. a physician who is treating the insured, cannot be a member of the first-instance or second-instance medical commission which gives the assessment on the insured.

By a general by-law, the Republic Institute sets the manner of work, composition, organisation, territorial distribution, first-instance or second-instance medical commission assessment control, as well as work fees for the members of the commission to be paid out of the compulsory health insurance funds.

The general by-law referred to in paragraph 3 of this Article, is to be published in the *Official Gazette* of the republic of Serbia.

Chosen Physician

Article 146

A chosen physician is:

1. an MD or an MD specialist of general or occupational medicine;
2. an MD specialist in paediatrics;
3. an MD specialist in gynaecology;
4. a dentist.

Exceptional to paragraph 1 of this Article, the chosen physician may an MD of any other specialisation, under conditions prescribed by the Minister on the basis of the Health Care Act.

An insured person may have only one chosen physician of the fields referred to above, par. 1 and 2 of this Article.

By the general by-law referred to in Article 141 paragraph 4 of this Act, the Republic Institute specify in detail the manner and procedure of exercising health care entitlements and other entitlements deriving from compulsory health insurance at the chosen physician, as well as the manner and procedure of a free choice of the physician, and standard number of the insured per one chosen physician.

The Minister is the one to give approval for the standard number of the insured per one chosen physician referred to in paragraph 4 of this Article.

Article 147

A contract entered into between the respective branch and a health care provider (hereinafter referred to as “carriers of healthcare activities”) establishes who of the individual physicians are authorised to be chosen physicians.

The health care provider referred to in paragraph 1 of this Article, is obliged to post on a prominent place a list of physicians whom the insured may choose for her/his chosen physician.

A chosen physician enters into a special contract with the respective branch on the activities of the chosen physician for the needs of the compulsory insured persons.

Article 148

A physician who meets the conditions of a chosen physician prescribed hereby, is obliged to receive every insured persons who chooses such physician, unless the chosen physician already has the standard number of the insured registered.

Article 149

At the first visit to the chosen physician, the insured signs a document on having chosen the said physician.

The insured chooses or changes the physician, referred to in paragraph. 1 of this Article, to a period of at least one calendar year.

The manner and procedure of choosing or changing the physician the Republic Institute defines in a bylaw referred to in Article 141, paragraph 4 of this Act.

Article 150

A document on choosing the physician, referred to in Article 149 hereof, contains a declaration by which the insured allows the competent authorised health care worker – a person monitoring the compulsory health insurance, may have access to personal data of the insured, which are related to exercising entitlements deriving from compulsory health insurance.

If the insured does not sign a declaration referred to in paragraph 1 of this Article, the respective branch is not obliged to bear the costs of health protection which cannot be verified by an authorised person monitoring the compulsory health insurance.

An authorised person monitoring the compulsory health insurance, as well as other competent officers of the Republic Institute or a branch, are obliged to keep confidential all personal data of the insured, referred to in paragraph 1 of this Article.

Article 151

The chosen physician:

1. organises and carries out measures for maintaining and improving health of the insured, does work on discovering and preventing risk factors of illnesses, performs preventive examinations, applies measures and procedures, including health care education, which are as a right included in the compulsory health insurance;
2. performs diagnostics and effective treatment of the insured;
3. determines the manner and type of treatment, monitors the course of treatment and synchronises opinions and suggestions for further treatment of the insured;
4. renders medical assistance;
5. refers the insured to out-patient or specialist examinations, or other appropriate health care facility, or other carriers of healthcare activities with whom there is a closed contract on rendering health care services, according to medical indications, monitors the course of treatment and synchronises opinions and suggestions for further treatment of the insured, or refers the insured to a secondary or tertiary level of health care;
6. determines the type and period of the treatment at home and monitors its progress;
7. prescribes medicaments, medical means and certain types of medical aid;
8. practices health care in the field of mental health;
9. keeps an accurate medical documentation on the treatment and health condition of the insured, in accordance with the law;
10. gives assessment of health conditions of the insured and refers the insured to be assessed on working abilities or disabilities, in accordance with the law;
11. determines the length of a temporary inability to work of the insured due to disease and injury up to 30 days and suggests to the first-instance medical commission an extension of such temporary inability to work , unless otherwise prescribed by this Act;
12. suggests to a first-instance medical commission to determine the need of the insured for shortened working hours for the period of treatment, in accordance with this Act;

13. determines a need for the insured to have an escort while travelling away;
14. determines a need for the insured to be absent from work in order to take care of a nuclear family member, in accordance with Article 79, paragraph 1 of this Act;
15. gives an opinion on whether an inability to work has been intentionally caused, or health improvement intentionally hindered;
16. gives an opinion on health condition of the insured on which grounds a certificate on health condition of the insured is issued for purposes of having health care abroad;
17. determines the use and type of a transport means of a patient, according to his/her health condition;
18. performs other activities in regard to exercising entitlements deriving from health insurance, in accordance with an contract between the Republic Institute i.e. the branche and the health care service provider.

Besides the activities referred to in paragraph 1 of this Article, the chosen physician, as part of the compulsory health insurance, determines the advancement of pregnancy in order to determine the period of the pregnancy and delivery leave, gives opinion on the condition of the child for purposes of exercising entitlements to a leave from work due to a necessary special child care, in accordance with law, and establishes a temporary inability to work of the insured according to regulations on employment and insurance in the case of unemployment.

Chosen physician gives assessment on a temporary inability to work based on a direct examination of the insured and on the existing medical documentation.

Article 152

The competencies referred to in Article 151 of this Act, which are related to diagnostics and treatment, including prescribing of prescription drugs (for TB and HIV), as well as referral to hospital treatment, the chosen physician may transfer to a competent physician specialist if the such is necessary due to a health condition of the insured and due to practical purposes in rendering health care services, in accordance with a general by-law of the Republic Institute referred to in Article 141, paragraph 4 of this Act.

Article 153

In a case the chosen physician abuses his/her professional position in the proceedings of exercising entitlements of the insured, the branch shall terminate the contract

with the chosen physician and sets a motion at a competent medical association for revoking the licence for practicing of such chosen physician.

First-Instance Medical Commission

Article 154

The first-instance medical commission consists of three physicians and a corresponding number of substitutes, who are appointed by the Republic Institute.

The commission referred to in paragraph 1 of this Act, has at least one member who is permanently employed at the respective branch.

Article 155

A first-instance medical commission:

1. gives assessment on working abilities of the insured who is temporarily unable for work, at a recommendation from the chosen physician, for the period of more than 30 days of temporary inability to work, or in the cases of the necessary care for a member of the nuclear family for the period of more than 15 days, or more than 7 days, in accordance herewith;
2. gives assessment upon an complaint of the insured or employer to an assessment of the chosen physician on the temporary disability to work due to an illness or injury up to 30 days, or temporary disability to work due to a necessary care for a member of the nuclear family, in accordance herewith;
3. gives assessment on a need for providing escort to patient for the period of his/her stay at an in-patient healthcare facility, under conditions set by the general by-law of the Republic Institute;
4. assesses whether a request for issuing or making of new prosthetic or medical aid appliances is justifiable prior to the expiry date of the old ones;
5. gives opinion on requests for treatment and travel benefit;
6. assesses medical justification of certain manners of health care outside those established by this Act and the regulations passed in regard to enforcement of this Act;

7. gives opinion on referring the insured to treatment to healthcare facilities specialised in rehabilitation, or on referring the insured to treatment out of the local respective branch territory;
8. suggests referrals for the insured in the cases when the insured is hindered from work for a longer period of time, in accordance with this Act, to a body competent for assessing the working ability, or disability, according to regulations on pension and disability insurance;
9. evaluates the chosen physician opinion;
10. determines health status of the insured in order to issue a certificate for exercising health care abroad, in accordance with this Act;
11. determines the necessity of the insured for shortened working time during the treatment, in accordance with this Act;
12. performs other activities related to exercising entitlements deriving from health insurance.

Besides the activities referred to in paragraph 1 of this Article, the first-instance medical commission performs other activities related to Article 151, paragraph 2 of this Act.

The first-instance medical commission evaluates temporary inability to work based on a direct examination of the insured and upon medical documentation.

Second-Instance Medical Commission

Article 156

The second-instance medical commission assess the regularity of the first-instance medical commission.

The second-instance medical commission consists of three physicians and a corresponding number of substitutes, who are appointed by the Republic Institute.

The medical commission referred to in paragraph 2 of this Article has at least one member who is permanently employed at the respective branch.

Article 157

A second-instance medical commission:

1. makes assessment upon a complaint by the insured or employer filed in regard to an assessment, i.e. the state of facts established by the first-instance medical commission;
2. upon request of the insured, or the territorial branch, or the employer assesses the regularity of the assessment of the first-instance medical commission, and gives its opinion.
3. makes assessment of extension of the right to salary benefit in accordance with Article 79 paragraph 3 of this Act.

The second-instance medical commission may effect a revision of all the rights i.e. expert-assessments relating to all the rights deriving from the compulsory health insurance which were decided upon by the chosen physician i.e. the first-instance medical commission, upon request of the insured, employer, the respective branch i.e. the Republic Institute.

5. Complaints in the Course of Exercising Right to Health Insurance

Article 158

If the insured is not content with the assessment given by a chosen physician, he/she may place a complaint to the first-instance medical commission.

The complaint is placed both orally or in writing within 48 hours as of receiving the original assessment, to the chosen physician - physician against whose assessment the complaint is placed, or directly to the medical commission.

The chosen physician to whom the complaint has been placed orally, and if he/she does not alter the given assessment, is obligated to make a record of the complaint, which is also signed by the insured.

The chosen physician to whom the complaint has been placed is obliged to forward the case immediately to the competent medical commission.

Article 159

The first-instance medical commission is obligated to immediately take the complaint for consideration in order to make an assessment decision.

If the complaint is placed against an assessment on temporary inability to work of the insured, the medical commission is obliged to immediately summon the insured for an examination. In other cases the medical commission immediately summons the

insured to an examination if it considers it necessary for making the assessment. If the medical commission deems necessary an additional medical examination, it will, without delay, specify necessary medical examinations the chosen physician is bound to carry out.

Evaluation of health condition and temporary inability to work of the insured must be complete, with a rationale and in accordance with the documentation that makes a basis of the assessment.

Assessment of the first-instance medical commission upon a placed complaint by the insured against a chosen physician's opinion referred to in paragraph 1 of this Article, is final.

The insured, chosen physician, respective branch and employer are to be notified in writing about the medical commission assessment results.

Article 160

A complaint to the second-instance medical commission may be placed by the insured unsatisfied with the first-instance medical commission assessment if it has been passed without the prior chosen physician's assessment, within three days as of the date of declaring the first-instance medical commission assessment.

The complaint is placed either orally in the minutes, or in writing to the first-instance medical commission against whose assessment the complaint is placed. The commission is obligated to forward both the complaint and the whole case documentation to the second-instance medical commission. The complaint may also be placed in writing directly to the second-instance medical commission.

Article 161

The second-instance medical commission is obliged to take the case in consideration immediately.

If the complaint has been placed against an assessment on temporary inability to work, the second-instance medical commission is obliged to summon the insured immediately to examination. In other cases, the commission makes its assessment based on the medical documentation, and may, if it finds necessary, summon the insured to examination. If the commission deems it necessary to add to the medical proceedings, it will, without delay, specify necessary medical examinations.

Assessment of the second-instance medical commission upon a placed complaint against first-instance medical commission opinion, is final.

The insured, first-instance medical commission against whose assessment the complaint was placed, respective branch and employer are to be notified in writing about the second-instance medical commission evaluation results.

If the insured is not content with the second-instance medical commission assessment results, he/she may require from the branch to issue a decision on the matter.

Article 162

Duly placed complaint to the Primary Care Physician's opinion, or of the first-instance medical commission, delays execution of evaluation.

6. Renewal of Evaluation Results on Temporary Inability to Work

Article 163

The Republic Institute, or respective branch, or employer may require that the insured, whose temporary inability to work was evaluated by the chosen physician, or the first-instance medical commission, be subjected to an examination by the first-instance medical commission, or the second-instance medical commission in order to renew the evaluation results of his/her ability to work. Renewal may not be required if the insured is undergoing an inpatient treatment.

The chosen physician, i.e. the second-instance medical commission may also initiate a requirement for the insured to be subjected to a repeated examination, referred to in paragraph 1 of this Article.

The repeated examination may be required within 30 days as of the date of the completed evaluation of the expert-medical body.

The insured is obligated to report to the first-instance medical commission, or the second-instance medical commission, for the examination to be performed, in a time period prescribed by either body. If the insured does not report to be examined due to any justifiable reason, his/her salary benefits shall be stopped, and no benefits are to be appropriated until he/she reports to the examination.

7. Expert Assessment in the Proceedings of Exercising Rights to Compulsory Health Insurance

Article 164

The Republic Institute i.e. the respective branch, following its official duties or on request of an employer, may place a request for an expert assessment in relation to exercising all rights deriving from the compulsory health insurance, including expert assessment of health status of the insured.

In that case, new assessment is performed by: first-instance medical commission – if the original assessment came from chosen physician, second-instance medical commission – if the assessment came from the first-instance medical commission, or three specialists from an appropriate health care facility – if the assessment came from the second-instance medical commission.

Renewal of the assessment may be required within one year as of the date of the performed assessment of an appropriate professional medical body involved in the proceedings.

Article 165

The Republic Institute may require an expert assessment in regard to the exercised rights deriving from compulsory health insurance of the insured, to be conducted by independent experts from appropriate health care facilities, or expert commissions from particular branch of medicine.

Article 166

Upon a conducted expert assessment proceeding in regard to exercising certain entitlements deriving from compulsory health insurance, the Republic Institute may negate exercise of such entitlements by requiring compensation of damages from the insured, or other responsible person, in accordance with the indemnity proceeding as prescribed by this Act.

8. Exercising Rights to Pecuniary Benefits

Article 167

The respective branch i.e. employer decides on the right to pecuniary benefit. Benefits are paid upon submitted evidence.

On request of the insured, the entity paying the benefits is obligated to issue a decision thereupon.

Article 168

The right to salary benefit is decided upon by the employer if such salary benefit is to be borne by the employer, or the respective branch if the salary benefits is to be borne by the branch.

Salary benefit is paid upon submitted evidence, without any special application thereto.

Article 169

Salary benefit set in accordance with this Act may be paid and provided only against claims in regard to livelihood established by a court decision or court settlement.

Article 170

Salary benefit is paid upon a report on temporary inability to work (medical leave pay voucher) issued by an expert-medical body.

Assessment of a temporary inability to work is done by an expert-medical body at the place of residence of the respective branch of the insured.

If the assessment of a temporary inability to work has not been given by the body referred to in paragraph. 2 of this Article, the branch, i.e. employer shall decide on salary benefit for the given period, on the basis of a subsequent assessment of the body referred to in paragraph 2 of this Article.

Article 171

Chosen physician independently performs assessment of the temporary inability to work up to 30 days of such inability, except in the cases of necessary care for a member of the nuclear family, in accordance herewith.

Assessment on temporary inability to work after the 30th day is performed by the first-instance medical commission.

Assessment on temporary inability to work of the insured on an inpatient treatment is performed by a chosen physician.

Article 172

Chosen physician independently assesses temporary inability to work due to rendering necessary care to a nuclear family member under 7 years of age or an elderly member with profound physical and mental disability, up to 15 days of inability, and for a nuclear family member over 7 years of age, up to 7 days of inability, in accordance with Article 79, paragraph 1 of this Act.

Assessment on temporary inability to work after the 15th, or 7th day is performed by the first-instance medical commission.

9. Protection of the Rights of the Insured

Article 173

The respective branch decides on the entitlements deriving from compulsory health insurance in the basis of the submitted evidence, without making any official decision, unless otherwise established by this Act i.e. by a general by-law of the Republic Institute, or if such decision is requested by the insured i.e. an employer.

In the proceedings of exercising entitlements established by this Act, provisions of the General Administrative Procedure Act are to be applied, unless otherwise provided by this Act.

Article 174

The insured person who deems that a decision on her/his rights deriving from compulsory health insurance have been made contrary to this Act and contrary to the regulations passed in regard to enforcement of this Act, is entitled to move a motion for protection of the rights before a competent body.

An employer too may seek protection of rights, in accordance with this Act.

In the first instance, the rights set by this Act are decided upon by the respective branch and in the second instance by the Republic Institute, or Provincial Institute for the territory of the autonomous province, unless otherwise provided by this Act..

The right to health care services abroad and to referrals to treatments abroad, in the first instance, are decided upon by the Republic Institute Commission, appointed by the Institute Managing Board, and in the second instance by the Director of the Republic Institute.

Article 175

Administrative proceedings may be set in motion against the final Republic Institute's document which sets decision on rights deriving from compulsory health insurance.

Notwithstanding paragraph 1 of this Article, no administrative proceedings may be set in motion against the final Republic Institute's document on exercising rights to health insurance referred to in Articles 34 to 46 of this Act.

Against the decision referred to in paragraph 2 of this Article, protection of an entitlement may be sought in a litigation procedure before a competent court within 30 days as of the date of decision receipt. A proceeding before the court is summary.

Article 176

The respective branch i.e. the Republic Institute, as well as the Provincial Institute is obliged to provide the insured with professional and legal help in the cases when the insured deems that the health service provider unjustifiably prevented her/him from exercising entitlements deriving from compulsory health insurance, or that her/his entitlements were provided contrary to this Act and contrary to regulations passed in regard to enforcement of this Act.

In the case referred to in paragraph 1 of this Article, the respective branch or the Republic Institute i.e. the Provincial Institute is obliged to provide the insured with advice and directions on exercising the entitlements deriving from compulsory health insurance, or to undertake measures against health care service provider which does not perform in accordance with this Act and the regulations passed in regard to enforcement of this Act.

The respective branch, or the Republic Institute, i.e the Provincial Institute is obliged to take in consideration all the complaints filed by the insured in regard to the cases referred to in paragraph 1 of this Article.

5. HEALTH CARE SERVICES CONTRACTING

1. Entering into a Contract

Article 177

The Contract, normally entered into for a period of one calendar year, governs relationships between the respective branch i.e. the Republic Institute and health care services providers in order to enable the insured person to exercise the rights to health care.

The contract referred to in paragraph 1 of this Article is entered into on the basis of an offer by a health services provider regarding the provision of health care programme and services covered by the compulsory health insurance, presented in a form of a working plan of such health care services provider.

Term of the contract referred to in paragraph 1 of this Article may be extended to a period specified in the contract, and if by the end of a calendar year no contract is entered into for the following year, until such is expired the contract previously entered into is to be valid and standing, if this is not contrary to the general by-law of the Republic Institute referred to in Article 179 paragraph 1 of this Act.

The contract referred to in paragraph 1 of this Article governs relationships between the respective branch i.e the Republic Institute and providers of health care services covered by the compulsory health insurance and in particular: type, scope and quantity of health care services provided, measures necessary to provide good quality health care to the insured, cadres on the basis of the cadres norms and working standards necessary to exercise health care of the insured, benefits i.e. prices paid by the respective branch i.e. the Republic Institute for health care services provided, the calculation and payment, control and liability for obligations to be carried out, due term for such obligations to be carried out, resolution of issues under dispute, termination of contract, as well as other mutual rights and obligations as parties to the contract.

Article 178

Healthcare facilities having obtained in the course of accreditation procedure a certificate on quality in accordance with the Health Care Act, have a priority in entering into a contract with the respective branch, i.e the Republic Institute.

Before entering into a contract with a health care services provider in regard to health care provision, the Republic Institute, i.e. the respective branch, may conduct a control of enforcement and execution of the contracts previously entered into with such provider of health care services.

A health care services provider, with whom the respective branch i.e. the Republic Institute entered into a contract on providing health care services, is obliged to provide the insured with the necessary medicaments, medical appliances, implants and medical-technical devices established as the right deriving from compulsory health insurance.

Article 179

The Republic Institute passes a general by-law which specifies terms and conditions, criteria and standards for entering into contract with health care services providers and for establishing fees for their work for each calendar year, . .

The Republic Institute passes the general by-law referred to in paragraph 1 of this Article in co-operation with the association of healthcare facilities founded in accordance with the Health Care Act, as well as with the representatives of health professionals chambers, founded in accordance with law

The Ministry gives an approval for the general by-law referred to in par. 1 of this Article.

The general by-law referred to in par. 1 of this Article is published in the Official Gazette of the Republic of Serbia.

Article 180

The contract referred to in Article 177 of this Act is entered into on the basis of the following issues:

1. annual plan relating to health care deriving from the compulsory health insurance;
2. established cadres norms, working standards and health care capacities necessary for exercising rights to health insurance of the insured;
3. general by-law of the Republic Institute referred to in Article 179 paragraph 1 of this Act;
4. a by-law on health care services price list;
5. financial plan of the Republic Institute.

The contract entered into between the respective branch, i.e. the Institute, and a health care services provider may establish lower prices of health care services than those set in accordance with Article 55 of this Act for health care services provided out of the compulsory health insurance funds.

Article 181

The contract referred to in Article 177 of this Act may define the following manners of payments for the health care services:

1. payment per every single insured person (hereinafter referred to as: capitation);
2. payment per particular case, or episode of illness or injury;
3. payment per price of single health care service;
4. payment covering the working plan of the health care provider;
5. any other manner established by the contract.

Article 182

The respective branch enters into a contract with a health care services provider on providing health care established as the right deriving from the compulsory health insurance for the insured on the territory of the respective branch, in accordance with the regulations passed in regard to enforcement of this Act.

The Institute enters into contracts with health care providers for certain types of health care services to be provided to all the insured in the Republic, i.e. for implementation of particular health care programmes which are delivered in accordance with law, as well as with health care facilities which conduct doctrinaire, expert-methodological and other activities of significance for implementing health insurance, i.e. with other legal entities – for certain rights deriving from the compulsory health insurance to be exercised.

Article 183

To those health care facilities i.e. private practice with which a contract on health care services hasn't been entered into, may be paid out of the compulsory health insurance funds only the health care services provided to the insured in the case of an emergency medical aid, at prices established by the by-law referred to in Article 55 of this Act.

If the insured has paid for the emergency medical aid to the health care facility, i.e. private practice referred to in paragraph 1 of this Article, he/she is entitled to reimbursement of such expenses out of the compulsory health insurance funds up to the price of the health care service provided, established by the by-law referred to in Article 55 of this Act.

2. Arbitration

Article 184

In order to resolve any disputes arisen between the branches i.e. the Republic Institute and health care providers, in regard to entering into, modifying and implementation of the contract on providing health care, an arbitration may be constituted.

A health care facility i.e. private practice with whom the contract is not entered into on providing health care to the insured whose costs are to be at the expense of the compulsory health insurance funds, and which has rendered an emergency medical aid to the insured, may require an agreement to be made on setting the arbitration, in accordance with this Act

Each party involved in a dispute referred to in paragraphs. 1 and 2 of this Article, may require an agreement to be made on arbitration within 8 days as of the date of arising a dispute, i.e. as of the date of delivering the contract referred to in Article 175 of this Act, to a health care services provider.

Arbitration shall consist of 5 members: a representative of the branch, i.e. the Republic Institute and a health care provider, as parties involved in a dispute, a representative of the associations of health care facilities, a representative of the health professionals' chambers, founded in accordance with law and a representative from the Ministry.

In dispute resolutions between the branch and the health care providers from the territory of the autonomous province, one member of the arbitration is to be a representative of the Provincial Institute.

The President of the arbitration is chosen among the arbitration members by mutual agreement of the disputing parties, and if they cannot reach such an agreement, the President shall be appointed by the Minister.

Article 185

Proceeding before the arbitration is summary, and the award on the issue in dispute is to be made within 30 days as of the date of making an agreement on settling the arbitration, by the majority of votes among the members of the arbitration.

For the duration of arbitration, terms for bringing the case before the court are of no effect.

If the parties involved reach a settlement upon the issue in dispute, the arbitration shall on their request make an award on the basis of such settlement, unless the settlement reached by the parties is contrary to the public policy.

An award made on the basis of the settlement is effective as any other arbitration award, except that it needs not have a rationale.

The arbitration is governed by the provisions of the Act governing the chosen court, i.e. arbitration, unless otherwise provided by this Act.

3. Contract Enforcement Control

Article 186

The Republic Institute is obliged to arrange for and carry out control over enforcement of the contracts entered into with the health care services providers.

The Republic Institute controls how the contracts between branches and providers of health care services are being enforced.

The control of such contracts is made by the branches and the Provincial Institute as well, in accordance with this Act..

Article 187

An officer of the Republic Institute, the branch, i.e. the Provincial Institute (hereinafter referred to as the “Insurance Supervisor”) controls the regularity of enforcement of the contracts entered into with providers of health care services, as well as the legal and purposeful use of the compulsory health insurance funds, which have been designated to providers of health care services for purposes of exercising the rights of the insured prescribed by law.

Control of personal data related to health status of the insured, which are kept in the medical record of the insured, in accordance with law, is made by an insurance supervisor i.e. an authorised MD, dentist or pharmacist.

The Republic Institute delivers a general by-law specifying in detail the manner and procedure of performing activities referred to in paragraphs 1 and 2 of this Article.

The general by-law, referred to in paragraph 3 of this Article is published in the *Official Gazette* of the Republic of Serbia.

Article 188

While carrying out the control referred to in Article 161 of this Act, an Insurance Supervisor is to have and produce an official ID document.

The official ID document is issued by the Director of the Republic Institute.

The form, appearance and contents of the ID document is prescribed by the Director of the Institute.

Article 189

While performing his/her job, an Insurance Supervisor is authorised to have a direct insight in the required information, official and financial documentation of the provider of health care services, as well as an insight in certain medical documentation relevant for exercising rights of the insured covered out of the compulsory health insurance funds.

Upon the established state of facts in the control procedure, the Insurance Supervisor makes an official record and delivers it to the provider of health care services.

The Insurance Supervisor shall grant the provider of health care services 15 days as of the date of presenting the official record for rectifying any established irregularities in providing health services or in carrying out the contract entered into with the Republic Institute i.e. the respective branch.

If the health care services provider fails to rectify within due term referred in paragraph 3 of this Article any established irregularities in providing health services or in carrying out the contract entered into, the Insurance Supervisor may suggest for the measures referred to in Article 190 of this Act to be applied.

Article 190

The Insurance Supervisor may do the following:

1. order for the established irregularities and faults, or activities which are contrary to law and the contract entered into with the provider of health care services, to be rectified in a certain time period;
2. suggest a temporary suspension of funds transfer until the provider of health care services rectifies the established irregularities in carrying out the contract;
3. suggest a termination of contract with a chosen physician;

4. suggest for the funds allocated for a provider of health care services to be decreased for the part of the obligations undertaken under the contract which the provider has not carried out;
5. suggest a termination of a part of the contract or the whole contract entered into with the provider of health care services; and
6. undertake other measures in accordance with law and the contract entered into.

A decision on the suggested measures referred to in paragraph 1 of this Article is made by the Director of the Republic Institute, i.e. Director of the respective branch who shall notify the Director of the Republic Institute thereof.

6. COMPENSATION FOR DAMAGES IN HEALTH INSURANCE IMPLEMENTATION

Article 191

The insured to whom a payment has been made out of the compulsory health insurance funds is obligated to return such payments to the Republic Institute i.e. the respective branch under the following conditions:

1. if the payment has been made based on incorrect data about which he/she knew or should have known to be incorrect, or if he/she has exercised the right to a compensation not entitled to, or has received an amount larger than entitled to;
2. if he/she has received any sum on the grounds of not reporting significant changes relevant to the loss or range of any rights, whereas he/she knew or should have known about such changes;
3. if he/she has received money payments in the amount larger than the one designated by an appropriate decision.

Time limitations for placing claims referred to in paragraphs 1 to 3 of this Article, start as of the date when the decision – on whether the money paid does not belong to the insured or belongs but in a lesser amount – in administrative proceedings has become final, i.e. as of the date the last unwarranted payment has been made.

Article 192

The respective branch or the Republic Institute has the right to claim indemnity for damages incurred to be compensated by a person who deliberately caused an illness, injury or death of the insured.

For damages sustained by the respective branch or the Republic Institute, in the case referred to in paragraph 1 of this Article, caused by an employee at work, or in situations pertaining to work, the employer with whom such employee is employed shall be held accountable.

The respective branch or the Republic Institute has the right, in the cases referred to in par. 2 of this Article, to claim indemnities for damages also directly from the employee if he/she has intentionally caused illness, injury or death of the insured.

Article 193

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the employer if an illness, injury or death of the insured have occurred because no safety measures at work have been implemented in accordance with the regulations pertaining to safety and health at work, or if other measures for protection of citizens have not been implemented.

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the employer if the damages have been incurred because an employee started to work without the prescribed medical examination performed previously, and it is established subsequently, by a medical examination, that the said employee was not medically capable of performing the work he/she has been posted on.

Article 194

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the employer in the following cases:

1. if the damages have been incurred because no data or incorrect data have been provided, upon which entitlements or acquiring thereof depend;
2. if the payment have been made upon false data provided in the insurance application, or because no application on changes of circumstances or on insurance termination have been submitted, or if the submitted application forms have been submitted later than the prescribed time period;

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the insured who is bound to submit by him/herself the insurance application form about the information, changes or termination, or to report certain data about health insurance, if the damages have been incurred because the said application forms have not been submitted, or data have not been reported, or have been reported falsely.

Article 195

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the chosen physician who establishes inability to work of the insured in an illegal manner, or prescribes medicaments, medical appliances, or medical aid and devices, or other entitlements deriving from compulsory health insurance, for which no grounds in the health insurance of the insured exist.

If the damages, referred to in paragraph 1 of this Article, have been incurred due to illicit performance of the medical commission, members of the commission are accountable for such damages.

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages from the physician or the health care services provider if the damages have been incurred due to malpractice i.e. improper or negligent treatment of the insured by a physician i.e. health care services provider.

Article 196

At establishing the right to indemnities for damages caused to the respective branch i.e. the Republic Institute, the Act governing contractual relationship issues.

The amount of indemnities is established according to the treatment costs and other expenses related to treatment, benefits paid to the insured in accordance with provisions of this Act and other expenses sustained by the respective branch i.e. the Republic Institute.

Article 197

The respective branch i.e. the Republic Institute has the right to claim indemnities for damages directly from the insurance company which performs its economic activities in accordance with the Act governing the insurance issues, and which has signed,

in accordance with a special Act, a compulsory motorcar liability insurance policy with the person who has caused the damages to health, or caused death of the insured. .

If the damages occurred by use of an unknown motorcar, the respective branch i.e. the Republic Institute, have the right to claim compensation directly from a reinsurance company.

The respective branch i.e the Republic Institute, has the right to claim the compensation directly from the reinsurance company if damages are caused by a motorcar of foreign registration plates which is not included in the compulsory motorcar liability insurance on the territory of the Republic of Serbia.

The respective branch i.e. the Republic Institute, also has the right to claim the compensation for damages when such damages are caused by a motor vehicle abroad, in accordance with the Act that governs insurance in regard to international traffic.

Article 198

In accordance with this Act, indemnities may be claimed by the insured who has suffered the damages within the implementation of the compulsory health insurance, as well as the employer who has suffered the damages within the implementation of the compulsory health insurance in regard to its personnel.

Article 199

When the respective branch i.e. the Republic Institute establishes that it suffered the damages in the course of implementation of health insurance, it shall order the party which has caused the damages to indemnify it within 30 days as of the date the damages indemnity has been established.

If the damages are not indemnified in due term, the respective branch or the Republic Institute may bring a lawsuit before a competent court .

Article 200

Employers, health care services providers with whom the respective branch, i.e. the Republic Institute has entered into a contract on providing health care out of the compulsory health insurance funds, then the competent government bodies, as well as other legal entities which collect data in accordance with the Act on performing such regular economic activities, or which keep records of evidence relevant to damages compensation in

accordance with this Act, in the cases of caused illness, injury or death of the insured, are bound to submit such data to the respective branch i.e. the Republic Institute.

The obligation stated above also applies to companies which, in accordance with a special act, perform insurance activities in the cases of injury or death of the insured in a traffic accident if the insured has closed a contract on compulsory traffic liability insurance with the insurance company.

7. COMPULSORY HEALTH INSURANCE FUNDING

1. Funding the Rights deriving from the Compulsory Health Insurance

Article 201

Funding the rights deriving from the compulsory health insurance is provided by payments of contributions for the compulsory health insurance, and from other sources, in accordance with this Act and the Act which governs the compulsory social insurance contribution payments.

Means referred to in paragraph 1 of this Article are an income of the branch or the Institute.

Article 202

Decision on the amount of funds to be transferred to the branch is made by the Republic Institute for each budget year.

The government grants an approval for the by-law referred to in paragraph 1 of this Article.

The funds referred to in paragraph 1 of this Article have to be in accordance with activities under the competence of the branch i.e. activities under the competence of the Institute in providing and implementing entitlements deriving the compulsory health insurance, which are prescribed by this Act and by the regulations passed in regard to enforcement of this Act.

Decision on the funds referred to in paragraph 1 of this Article is based upon the following:

1. the Republic Institute financial plan;

2. health care programme in regard to health care deriving from compulsory health insurance;
3. the number and age structure of the insured persons whose status has been established by the respective branch;
4. the data on the insured who suffer from diseases of greater social and medical significance for the territory of the respective branch;
5. the contribution amount paid within the territory of the respective branch, pursuant to the record of the amounts paid;
6. activities under the competence of the respective branch in implementing compulsory health insurance;
7. activities under the competence of the Republic Institute in implementing compulsory health insurance;
8. indicators of shortage of funds that are paid within the territory of the respective branch for the rights deriving from compulsory health insurance to be provided for;
9. the funds that should be provided for regular implementation of the rights deriving from in the compulsory health insurance (hereinafter referred to as the “solidarity funds”) referred to in Article 232 of this Act;
10. other indicators;

Decision referred to in paragraph 1 of this Article, shall be passed by the Republic Institute by the 31st of January at the latest for the current year.

Decision referred to in paragraph 3 of this Article is published in the *Official Gazette* of the Republic of Serbia.

Article 203

The funds provided out of contributions are destined for the rights deriving from the compulsory health insurance to be exercised, in the case of disease and injury suffered out of the work place, as well as in the case of work-related injury or professional disease.

2. Contributions for the Insured referred to in Article 22 of this Act

Article 204

Funds for contribution payments for the insured referred to in Article 22 of this Act are provided within the budget of the Republic of Serbia.

The base for the contribution payments referred to in paragraph 1 of this Article, is the lowest monthly base established in accordance with the Act which governs the compulsory social insurance contributions.

The rate for the contributions to be calculated and paid, referred to in paragraph 1 of this Article, is 12.3%.

The funds obtained from the contribution payments, referred to in paragraph 1 of this Article, constitute the income of the Republic Institute.

3. Contributions for the Insured Who Get Included in the Compulsory Health Insurance

Article 205

Contributions for the insured referred to in Article 23 of this Act, who get included in the compulsory health insurance, are calculated and paid on the base for contribution payments and upon a rate prescribed in accordance with the Act which governs the compulsory social insurance contributions.

4. Contribution Calculation, Define and Payment and Control thereof

Article 206

Calculation, defining, payment and control of contributions referred to in Article 206 of this Act, are prescribed by mutual agreement by the Minister and the Minister of Finance.

Article 207

When the branch, in its official capacity, makes a decision on establishing a status of the insured, an obligation is also established in regard to calculation and payment of the contributions valid on the date such decision is made.

III. ORGANISATION OF HEALTH INSURANCE

1. General Provisions

Article 208

The compulsory health insurance is provided and implemented by the Republic Institute of Health Insurance, with its official seat in Belgrade.

The Republic Institute performs public authorizations in providing and implementing health insurance, as well as in resolving issues relating to rights and obligations deriving from the compulsory health insurance, in accordance with this Act.

The Institute also performs activities relating to the voluntary health insurance, in accordance with law.

Article 209

The Republic Institute is legal entity with a status of an organization for compulsory social insurance where the rights sustained in the compulsory health insurance are exercised and funds for the compulsory health insurance are provided in accordance with the law.

Rights, obligations and responsibilities of the Republic Institute are specified by law and the statute of the Republic Institute.

The Republic Institute is managed by the insured who are equally represented in the Managing Board of the Republic Institute in proportion to the type and number of the insured established by this Act.

Article 210

In order to provide and implement health insurance on the territory of the Republic of Serbia, the branches and the Provincial Institute are founded.

The branches are established for the territory of a region, with a seat in that region i.e. for the territory of the City of Belgrade, with the seat in Belgrade, whereas municipalities of Ražanj and Sokobanja pertain to the branch with the seat in Niš.

The branch consists of organisational units (hereinafter referred to as: branch divisions), which are organised in such a manner so as to make the services available to the insured on the territory of the Republic.

Competences and responsibilities of the branch, territorial organisation of the branch divisions, and the Provincial Institute, as well as other issues significant for the branches i.e. Provincial Institute work are regulated in accordance with law and the Statute of the Republic Institute.

2. The Republic Institute Funds

Article 211

The Republic Institute has a separate account for

1. the compulsory health insurance;
2. voluntary health insurance;

3. The Republic Institute Activities

Article 212

The Republic Institute:

1. formulates the Statute;
2. formulates general bylaws on the basis of the competencies in accordance with this Act, which regulates in detail the enforcement of the compulsory health insurance;
3. plans and provides funds for carrying out compulsory health insurance;
4. within available funds, makes plans and provides conditions for carrying out health insurance on an even basis on the territory of the Republic of Serbia and provides the solidarity funds for equaling the conditions for in the rights deriving from the compulsory health insurance to be exercised on the territory of the branches;
5. provides financial and other conditions for the rights to health care abroad to be exercised i.e. for referring the insured to treatment abroad;
6. formulates a working plan for providing the rights deriving from compulsory health insurance in accordance with work plans of the branches;
7. formulates a financial plan, in accordance with law;
8. enters into contracts with the health care services providers in accordance with this Act, and provides funds for carrying out health care on the basis of the said contracts;
9. transfers the funds for the compulsory health insurance to the branches in accordance with Article 202 of this Act;
10. provides legal, purposeful and economical use of funds, takes care of the funds to be increased on economic bases;
11. provides direct, efficient, rational and legal exercise of rights deriving from health insurance and organises the activities to be carried out for the purposes of exercising the insurance;

12. organises activities for carrying out health insurance, which is directly exercised in the Republic Institute;
13. co-ordinates work in the branches;
14. organises and controls work in the branches and legal and purposeful use of funds, which are paid to the branch for exercising the rights deriving from the compulsory health insurance;
15. controls the carrying out of the contracts entered into between the branches and the health care services providers i.e. controls the exercising of the rights deriving from the compulsory health insurance;
16. establishes, organises and controls activities of the Central Record;
17. organises, controls and harmonises work of the first and second-instance medical commissions;
18. provides execution of international contracts on the compulsory health insurance;
19. keeps record and monitors contribution payments, along with the competent bodies, exchanges data with such bodies on health insurance contribution payers, as well as other data relating to contributions;
20. performs other activities established by law and the Statute of the Republic Institute.

4. The Branch

Article 213

The branch:

1. carries out the compulsory health insurance on its territory;
2. plans the needs of the insured on its territory and formulates working plans in accordance with the available funds i.e. with the financial plan of the Republic Institute;
3. disposes of the transferred funds for carrying out the compulsory health insurance for the insured on its territory, in accordance with this Act;
4. provides for the rights deriving from the health insurance to be exercised for the insured on its territory, in accordance with this Act;
5. enters into contracts with the health care services providers;

6. organises and controls execution of contractual obligations of the health care services providers with whom the contract is entered into, for the purposes of protection of the insured persons' entitlements;
7. provides legal, purposeful and economical use of the funds of the compulsory health insurance transferred on its territory;
8. keeps the Central Record on the insured with the data necessary for carrying out the compulsory health insurance and for providing and controlling the exercise of the rights deriving from health insurance;
9. controls applications to insurance and all the data of significance for acquiring, exercising and termination of such rights;
10. keeps records and monitors contribution payments, along with the competent bodies, exchanges data on contribution payers with the competent bodies, as well as other data relating to contributions;
11. provides the necessary professional help to the insured in regard to exercising the rights deriving from health insurance, and protection of their interests related to the insurance;
12. performs certain activities for executing international contracts on health insurance;
13. provides conditions for the first and second-instance medical commissions to work on its territory, in accordance with by-laws of the Republic Institute;
14. performs activities relating to the indemnity of damages in exercising the compulsory health insurance;
15. performs other activities in accordance with law and the Statute of the Republic Institute.

The branch performs certain activities relating to the voluntary health insurance which are organised and carried out by the Republic Institute.

The activities referred to in paragraphs 1 and 2 of this Article are carried out by the branch on behalf of the Republic Institute.

Article 214

The branch submits a six months' report on the work performed to the Managing Board of the Republic Institute.

Article 215

The branch is managed by its Director.

The branch director is accountable for the legality of the branch activities, as well as for purposeful use of funds transferred for carrying out health insurance.

The branch director puts into practice decisions of the Republic Institute bodies.

Upon a public contest, the branch director is appointed by the Institute Director for a period of four years.

The branch director has to meet the conditions referred to in Article 219, paragraphs 3 to 5 of this Act.

While at the office, the branch director performs a public function.

Such office of the branch Director is governed by the provisions of the Act governing prevention of conflict of interest at public functions as well as by the provisions of this Act governing prevention of conflict of public and private interest.

Article 216

The branch establishes its Council.

The branch council is a counselling body of the branch director and consists of representatives of the insured and employers from the branch territory.

The branch council consists of 9 members at the most, of which 6 are representatives of the insured and 3 representatives of employers, whereas municipalities covered by the branch should be evenly represented.

One representative of the insured in the branch council comes from an association of persons with disabilities on the territory of the branch.

Council members have to meet the conditions referred to in Article 224, paragraphs 3 to 5 of this Act.

The branch council:

1. proposes measures for carrying out and improvement of health insurance on the branch territory;
2. gives opinion on the working plan of the branch;
3. gives opinion on decisions made by the branch in regard to upon effecting the rights deriving from the health insurance and to contracts entered into with the health care services providers;
4. submits proposals for rational disposal and spending of health insurance funds;

5. gives opinion on the Report the branch submits to the Managing Board of the Republic Institute;
6. performs other activities set by the Statute of the Republic Institute.

5. The Provincial Institute

Article 217

The Provincial Institute is an organisational unit of the Republic Institute, which performs the following activities:

1. co-ordinates work of branches organized on the territory of the autonomous province, in co-operation with the Republic Institute, in accordance with law;
2. controls work of branches and purposeful use of funds provided for the branches which are transferred by the Republic Institute to the branches for exercising the rights deriving from the compulsory health insurance on the Autonomous Province territory;
3. control execution of the contracts entered into between the branches and the health care services providers on the territory of the Province;
4. decides in a second-instance on the entitlements sustained in the compulsory health insurance, in accordance with this Act;
5. provided the necessary professional help to the insured in regard to exercising the rights deriving from health insurance, and protection of their interests related to the insurance
6. provide conditions for medical commissions formed on the territory of the autonomous province to work, in accordance with law;
7. provides an information sub-system as part of a unified information system of the Republic in the field of health insurance, in accordance with law;
8. conducts statistical and other research in the field of health insurance;
9. co-operates with the competent provincial bodies;
10. performs other activities set by the Statute of the Republic Institute;
11. submits the six- and twelve-month reports concerning the work to the Managing and Supervisory Board of the Republic Institute.

6. The Republic Institute Administration

Article 218

The Republic Institute is managed by the representatives of the insured in accordance with this Act.

7. The Republic Institute Bodies

Article 219

The Republic Institute bodies are: the Managing Board, Supervisory Board and the Director.

The Republic Institute also has a Deputy Director who is appointed and recalled under conditions, in the manner and in accordance with a procedure prescribed therefor.

Members of the Managing Board, members of the Supervisory Board, Director, or his deputy director may not directly or through any third party, physical or legal entity, participate as shareholders, stockholders, employees, or persons under a jobbing contract in any legal or physical entity being health care services providers with whom contracts are entered into for providing rights deriving from compulsory health insurance, or in any insurance companies operating in the voluntary health insurance, all for the purposes of preventing a conflict of public or private interest.

A person referred to in paragraph 3 of this Article may not be a person elected, appointed or designated to any office in any government body, or in a government body of a territorial autonomy, or local government, or any body of an authorised initiator referred to in Articles 222 and 225 of this Act.

A person referred to in paragraph 3 of this Article shall sign an affidavit declaring that there is no conflict of public and private interest referred to in paragraph 3 of this Article.

A person referred to in paragraph 3 of this Article performs a public office.

A performance of public office by persons referred to in paragraph 3 of this Article is governed by the provisions of the Act which regulates prevention of conflict of public and private interest in performing public offices, as well as the provisions of this Act.

Persons referred to in paragraph 3 of this Article may be appointed to the public office in the Republic Institute bodies twice at the most.

Article 220

In the Republic Institute bodies referred to in Article 219 of this Act, the insured persons must be equally represented in terms of gender, age, professional education, and the branches must be equally represented as well.

Managing Board

Article 221

Managing Board:

1. formulates the Statute and other general by-laws of the Republic Institute;
2. decides on the Republic Institute operating, as well as on other issues significant for its operating;
3. formulates a financial plan and the annual balance sheet of the Republic Institute;
4. deliberate on and adopts an operating report;
5. organises public competition for the appointment of a Director of the Republic Institute;
6. performs other activities in accordance with law and the Statute;

The Republic Institute Statute governs in detail the activities of the Republic Institute, internal organisation, administration, business, conditions for the appointment of the Director and Deputy Director, as well as other issues significant for the Republic Institute operating.

The Republic Institute activities, which are governed by the Statute referred to in paragraph 2 of this Article include: effectuating the compulsory health insurance, as well as voluntary health insurance organised and exercised by the Institute, entering into contracts with health care services providers, executing international contracts on social insurance, financial operations, performance of other professional, supervisory and administration activities, as well as rendering legal and other professional help to the insured.

The Government of the Republic of Serbia gives an approval on the Statute of the Republic Institute.

The Managing Board submits the operating report to the Government of the Republic of Serbia not later than 31st March of the current year for the previous one.

Article 222

The Managing Board of the Republic Institute consists of 21 members, 14 of which are representatives of employers, 2 representatives from each rank i.e rank of pensioners, rank of farmers and rank of self-employed, and 1 representative of the association of persons with disabilities who has the status of the insured in terms of this Act.

Members of the Managing Board represent the interests of the insured in the provision and effectuation of entitlements deriving from the compulsory health insurance, in accordance with this Act.

Members of the Managing Board of the Republic Institute are appointed and revoked by the Government upon a proposal of: the representative trade unions on the level of the Republic, in accordance with the Labour Act – for the representatives of the employed insured; of the Pensioners' Associations, organised on the level of the Republic, having more than 50,000 registered members – for the representatives of the insured pensioners; of the Farmers' Associations, having more than 50,000 registered members – for the insured farmers; of the Chamber of Commerce of Serbia – for the self-employed insured (entrepreneurs) and of the Association of persons with disabilities, having the greatest number of registered members – for the representative of the Association of persons with disabilities.

The number of members of the Associations referred to in paragraph 3 of this Article, is established on the basis of evidence of the number of registered members.

Article 223

The Government of the Republic of Serbia appoints and revokes the president and the deputy president of the Managing Board among the members of the Managing Board.

Members of the Managing Board, the president and the deputy president of the Managing Board are appointed to four-year term.

The performance of activities, powers and responsibilities of the Managing Board members, as well as other issues significant to the Managing Board work are governed by the Statute of the Republic Institute.

Supervisory Board

Article 224

The Supervisory Board:

1. supervises financial operating of the Republic Institute;
2. supervises financial operating of the branches;
3. controls effectuation of legal obligations of the Republic Institute and the Provincial Institute;
4. controls implementation of the Managing Board decisions;
5. performs other activities in accordance with law and the Statute of the Republic Institute.

At least once a year, the Supervisory Board submits a report on supervision to the Managing Board and the Government.

Article 225

The Supervisory Board consists of 7 members, 3 of which are representatives of the employed insured, 1 representative from each rank i.e. rank the insured pensioners, rank of the insured farmers and rank of the insured self-employed, and one representative employed in the Republic Institute, i.e. branch or in the Provincial Institute.

Members of the Supervisory Board are appointed and revoked by the Government upon a proposal of: the representative trade unions on the level of the Republic, in accordance with the Labour Act – for the representatives of the employed insured; of the Pensioners' Associations, organised on the level of the Republic, having more than 50,000 registered members – for the representatives of the insured pensioners; of the Farmers' Associations, having more than 50,000 registered members – for the insured farmers; of the Chamber of Commerce of Serbia – for the self-employed insured (entrepreneurs) and of the Association of persons with disabilities, having the greatest number of registered members – for the representative of the Association of persons with disabilities.

The Government of the Republic of Serbia appoints and revokes the president of the Supervisory Board among the members of the Supervisory Board

The number of members of the Associations referred to in paragraph 2 of this Article, is established on the basis of evidence of the number of registered members.

Article 226

Members of the Supervisory Board, the president and the deputy president of the Supervisory Board are appointed to four-year term.

The performance of activities, powers and responsibilities of the Managing Board members, as well as other issues significant to the Supervisory Board work are governed by the Statute of the Republic Institute.

Director of the Republic Institute

Article 227

Director of the Republic Institute:

1. organises work and operating of the Republic Institute;
2. represents and acts for the Republic Institute;
3. ensures the legality of the Republic Institute operating and is accountable for the legality thereof;
4. executes the Managing Board decisions;
5. formulates a bylaw on work organisation and job classification in the Republic Institute;
6. prescribes a form of an official ID card for the Insurance Supervisor, as well as its appearance and content;
7. manages the work of the Institute employees;
8. appoints branch directors, upon a public competition for the appointment of the branch director, except for the branches within the territory of the autonomous province;
9. performs other activities in accordance with law and the Statute.

A mandate of the director of the Republic Instituted lasts 4 years.

Director of the Provincial Institute

Article 228

Director of the Provincial Institute is appointed by the Managing Board upon a proposal of a competent body of the autonomous province.

Director of the Provincial Institute participates in the Managing Board work, without the decision making right.

Director of the Provincial Institute appoints branch directors on the territory of the autonomous province, under conditions and in the manner prescribed by this Act for appointing branch directors outside the autonomous province territory.

The Provincial Institute Director is subject to the provisions referred to in Article 219, paragraphs 3 to 7 of this Act.

6. The Republic Institute Expert Service

Article 229

Expert, administrative and financial activities related to operating and work of the Republic Institute and carrying out of the health insurance are performed by the employees of the Republic Institute.

Issues in regard to rights, obligations and responsibilities of the employees of the Republic Institute, are governed by the Labour Act.

7. The Republic Institute Funds

Article 230

Funds of the Republic Institute consist of the following means :

1. contributions for the compulsory health insurance;
2. premiums for the voluntary health insurance organised and carried out by the Republic Institute;
3. obtained from assets the Republic Institute disposes of;
4. domestic and foreign credits and loans;
5. other means, in accordance with law.

Article 231

The Republic Institute funds may be used only for the purposes prescribed by law, that is:

1. for exercising rights of the insured;

2. for the health insurance system improvement;
3. for exercising rights of the insured on the voluntary health insurance basis, organised and carried out by the Republic Institute;
4. for covering the costs of carrying out health insurance;
5. for other expenditures in accordance with law.

Article 232

In the Republic Institute, on the basis of the Managing Board decision referred to in Article 202 of this Act, the solidarity funds are allocated within the available financial means for carrying out compulsory health insurance on an even basis on the territory of the Republic and for equalling the conditions for providing the rights deriving from the compulsory health insurance on the territory of the branches.

Article 233

The Republic Institute deposits its own means at a bank, in securities and other means for the purposes of obtaining profit, or issues specified-purpose loans to health care facilities in accordance with law.

IV. SUPERVISION OF THE REPUBLIC INSTITUTE OPERATING

Article 234

In supervising the work of the Republic Institute, the Ministry is empowered to:

1. require reports and data on operating;
2. establish the effectiveness of operating, warn about the irregularities and establish measures for their correction;
3. issue instructions;
4. order for the activities to be undertaken if finds it necessary;
5. set in motion proceedings for establishing responsibility;
6. directly perform certain activities if it finds there is no other way for the law or any general by-law to be enforced;
7. propose to the Government to undertake measures within its competencies.

The operating report contains a layout of carrying out the work, the measures undertaken and their effect, as well as other information.

Article 235

As the holder of public powers in carrying out the state administration tasks, the Republic Institute is bound to obtain from the Ministry, before publishing the regulations which it is empowered by this Act to pass, an opinion on such regulations constitutionality and legality, while the Ministry is bound to deliver to the Republic Institut an argued proposal of how to harmonise the regulation with the Constitution, law, other regulations or general by-law of the Parliament and the Government.

If the Republic Institut does not proceed as proposed by the Ministry, it is bound to propose to the Government to make a decision on suspension of enforcement of the regulation and all singl by-laws based on it and to start the procedure for assessment of constitutionality and legality of the regulations, in accordance with the Act governing the state administration.

V. VOLUNTARY HEALTH INSURANCE

Article 236

Voluntary health insurance may be organised and carried out by the Republic Institute and other legal entities dealing in insurance activities in accordance with the Act governing insurance (hereinafter referred to as: the insurer).

Article 237

Voluntary health insurance may be organised and carried out by investment funds for the voluntary health insurance, in accordance with the special Act.

Article 238

Upon a proposal of the the Minister, the Government regulates the types of the voluntary health insurance, conditions, the manner and procedure of organising and implementing the voluntary health insurance.

If the voluntary health insurance is regulated differently by another Act, the provision of this Act and the regulations passed in regard to enforcement of this Act shall be applied.

VI. LAW ENFORCEMENT SUPERVISION

Article 239

Supervision of enforcement of this Act is conducted by the Ministry.

VII. PENALTY CLAUSES

Offences

Article 240

A fine of 300,000 to 1,000,000 dinars shall be imposed for an offence made by a health care facility, or any other legal entity, with whom the Republic Institute i.e. a branch, has entered into a contract on providing health care services deriving from the compulsory health insurance fund in the following cases:

1. If does not provide the insured person with the health care services that are covered by the compulsory health insurance, or if such services are not rendered in full scope and content, or if such services have been rendered to a person who is not entitled to them (Arts. 33 – 47);
2. if collects the payment from the insured in the amount other than the set amount of the participation prescribed by this Act and under regulations passed in regard to enforcement of this Act (Art. 48, pars. 4 and 5);
3. if does not issue an insured person a receipt on collected participation on a prescribed form (Art. 49, par. 1);
4. if it collects participation money from an insured person whose health protection is covered in full against the compulsory health insurance funds (Arts. 50 – 51);

5. if does not establish a waiting list for certain types of health care services, which are provided for against the compulsory health insurance funds, or if it makes the waiting lists contrary to this Act or to the regulations passed in regard to enforcement of this Act, or if it does not render health care services to an insured person in accordance with the waiting list (Art. 56, par. 5);
6. if the health care services which are not provided against the compulsory health insurance fund are rendered against the compulsory health insurance fund (Art. 61);
7. if it does not provide the necessary medicaments, medical material, implants and medical devices for the insured, which are under entitlements included in the compulsory health insurance (Art. 178, par. 3);

A fine of 400,000 to 500,000 dinars shall be imposed for offences referred to in par. 1 points 1 to 7 of this Article, committed by an entrepreneur.

A fine of 40,000 to 50,000 dinars shall be imposed for offences referred to in par. 1 of this Article, committed by a responsible person within a legal entity.

If an offence mentioned in paragraph 1 of this Article yields material damage to an insured, or the respective branch, i.e the Republic Institute, i.e. another legal entity, health care facility or private practice (entrepreneur), a protective measure may be imposed – a ban on practicing, in accordance with law.

Article 241

A fine of 200,000 to 500,000 dinars shall be imposed to a health care facility, or other legal entity, with whom the Republic Institute i.e the branch has entered into a contract on rendering health care services against the compulsory health insurance fund in the following cases:

1. if does not initially give a notification in writing to an insured person on the reasons why a particular service, included in the compulsory health insurance, is not necessary, or justified for the state of health of the insured person, or if it does not initially notify the insured, who is put on the waiting list, on the reasons therefor (Art. 57, par. 1 to 3);
2. if it does not post on a prominent place a list of physicians whom the insured may choose for her/his chosen physician (Art. 147, par. 2);

3. if it does not grant an authorise Insurance Supervisor insight in the documentation significant for exercising entitlements covered by the compulsory health insurance fund (Art. 189, par. 1);
4. if it does not submit to the branch i.e. the Republic Institute the data it collects i.e. keeps in the cases of a caused illness, injury or death of an insured person, for purposes of indemnities for damages (Art. 200, par. 1);

A fine of 300,000 to 500,000 dinars shall be imposed for offences referred to in par. 1 of this Article, committed by an entrepreneur.

A fine of 30,000 to 50,000 dinars shall be imposed for offences referred to in par. 1 of this Article, committed by a responsible person within a legal entity.

Article 242

A fine of 300,000 to 1,000,000 dinars shall be imposed to an employer, having a status of a legal entity, in the following cases:

1. if does not calculate the salary benefit which is provided for the insured from the compulsory health insurance funds, or if he does not make the payment of the salary benefit to the insured, which is provided from the compulsory health insurance funds, or if he does not pay the insured the salary benefit from the compulsory health insurance funds, which is transferred to a special account of the employers, within 30 days as of the date of the money receipt (Art. 103, pars. 1, 2 and 4);
2. if does not present to the respective branch all data in regard to the application to, termination of and any changes in the compulsory health insurance for its employees, in order to define the status of the insured person/entity, or to discontinue or enter changes to the status of such person, or if such data are presented within eight days as of the date when such said changes occurred (Art. 113, pars. 1 and 3);
3. if enters false data on the application form meant for the Central Record (Art. 119);
4. if he does not submit an application of data to be entered the Central Record, and if he submits such application later than the prescribed time period referred to in Article 135 of this Act (Arts. 123 and 135);
5. if does not provide the insured, user of entitlements deriving form compulsory health insurance, accurate data i.e. data relevant to acquiring and using the rights deriving from compulsory health insurance, as well as to provide the respective branch with

- all evidence and to enable an insight in records and documentation (Art. 126, par. 3));
6. if he does not make the payment of the accrued costs to the account of the insured, or in any other properly determined manner within 30 days as of the date of submitting the request by the insured, for the costs accrued while receiving health care services, because contributions for the health insurance have not been paid either entirely or partially (Art. 143, pars. 3 and 4);
 7. if he does not present to the branch i.e. the Republic Institute the data he collects i.e. keeps in the cases of caused illness, injury or death of the insured, for the purposes of indemnities of damages (Art 200, par. 1);

A fine of 40,000 to 50,000 dinars shall be imposed for offences referred to in par. 1 of this Article, committed by a responsible person within a legal entity.

Article 243

A fine of 300,000 to 1,000,000 dinars shall be imposed to the Republic Institute, in the following cases:

1. If the data kept in the Central Record, pertaining to exercising entitlements deriving from health insurance for the insured, are not kept separately from other data contained in the Central Record, or if such data are entered and handled by a person not authorised for such activities (Art. 118, par. 2);
2. if the Republic Institute does not provide a copy of receipt of forms for insurance application or termination for the insured who are self-employed (entrepreneurs), or farmers, or other persons on whom the competent revenue office keeps the record, by the 5th day of each month for the previous one (Art. 127, par. 6);
3. If does not, upon request of the insured, issue a certificate on the data supplied for the Central Record (Art. 133, par. 1);
4. If it discloses or publicises data kept in the Central Record, which are related to the exercise of entitlements deriving from compulsory health insurance for a single insured person and which constitute personal data on such insured person (Art. 138, par. 2);
5. If it certifies a health insurance document without any evidence that the contributions for the compulsory health insurance have been paid (Art. 142, par. 2);

6. if it does not accept a request for arbitration, from a health care services provider, with whom it has entered into a contract on rendering health care services against the compulsory health insurance funds (Art 184, pars. 1 and 3);
7. if the control of personal data related to health condition of the insured, while exercising entitlements deriving from compulsory health insurance, which are kept in the medical file of the insured, is carried out by an Insurance Supervisor who is not an authorised MD, dentist or a pharmacist (Art. 187, par. 2).

A fine of 40,000 to 50,000 dinars shall be imposed for offences referred to in par. 1 of this Article, committed by a responsible person within the Republic Institute.

Article 244

A fine of 30,000 to 50,000 dinars shall be imposed for offences committed by health care professional in the following cases:

1. if a chosen physician, or a member of the medical commission issues a finding and an opinion on the health condition of the insured suffering from acute or chronic diseases or any other health related disorders, stating thereby that she/he does not suffer from acute or chronic diseases or any other health related disorders, and thereby enable issuing a certificate on the health condition of the insured for purposes of exercising entitlements to health protection abroad (Art. 65, par. 3);
2. if she/he determines a temporary inability to work in the manner contrary to Art. 74 of this Act;
3. if she/he does not receive each and every insured person who has chosen her/him as the chosen physician, unless the chosen physician already has registered the greater number of the insured than prescribed by the standard (Art. 148);
4. if the chosen physician abuses her/his position of competence in a procedure of exercising entitlements of the insured (Art 153).

Article 245

A fine of 30,000 to 50,000 dinars shall be imposed for offences committed by an insured if she/he intentionally causes inability to work, or intentionally hinders the process of healing, or ability to work, if without any justifiable reason does not report to the chosen physician for an assessment of a temporary inability to work, or does not appear

before the medical commission, if while being temporarily unable to work, deals in economic or any other activities in order to gain income, if without a permission from an expert medical body of the Republic Institute, leaves the place of permanent or temporary residence, if abuses the right to a sick leave (Art. 85).

VIII. TRANSITIONAL AND FINAL PROVISIONS

Article 246

The regulations for enforcement of this Act shall be passed within 12 months as of the date this Act comes into force, unless otherwise provided by this Act.

Until other regulations referred to in the paragraph 1 of this Article, are passed, the regulations in force before this Act is passed shall be applied, if not contrary to this Act.

Article 247

On the date this Act comes into force, the Republic Institute of Health Insurance continues its operating with all its rights and obligations established by this Act.

The Republic Institute of Health Insurance is obliged to harmonise its organisation and work with the provisions of this Act within 12 months as of the date this Act comes into force.

Article 248

The Government shall appoint the Managing Board and the Supervisory Board of the Republic Institute within 90 days as of the date this Act comes into force.

The Managing Board shall appoint the Director of the Republic Institute within 60 days as of the date the Managing Board has been appointed.

Article 249

The Director of the Republic Institute shall appoint the branch directors within 60 days as of the date of her/his assuming the office.

The branch council shall be established within 30 days as of the date of the Director's assuming the office.

Article 250

The Managing Board shall formulate and adopt the Statute within 60 days as of the date of appointment of the Managing Board members.

Article 251

The Republic Institute shall formulate the general bylaw referred to in Article 124 paragraph 5 of this Act within 60 days as of the date this Act comes into force.

Article 252

The insured persons who exercise on the date this Act comes into force the rights deriving from compulsory health insurance acquired in accordance with the regulations in force up to the date of coming into force of this Act, they shall exercise such rights in accordance with the provisions of this Act from that date on.

Article 253

Complaints filed against decisions made prior to the date this Act comes into force, shall be considered in accordance with the regulations which were in force up to the date this Act came into force.

Article 254

The Republic Institute shall organise and establish activities of the Central Record by 30th June 2006.

The respective branch shall certify the insurance documents as of 1st July 2006.

Article 255

In 2006 and 2007 exceptionally, in the cases when income is established by the financial plan of the Republic Institute for a certain budget year, in the amount greater than expenditures planned to be spent for such budget year, by which income the funds for the compulsory health insurance of the insured referred to in Art. 22 paragraphs 1 and 4 of this Act, may be entirely provided, under the conditions prescribed by this Act, the funds in the budget of the Republic for such budget year shall not be planne as provided in Art. 22 paragraph 5 of this Act.

Article 256

On the date this Act comes into force, the Health Insurance Act ceases to have effect (Official Gazette of the Republic of Serbia, No. 18/92, 26/93, 53/93, 67/93, 48/94, 25/96, 46/98, 54/99, 29/01, 18/02, 80/02, 84/04 and 45/05).

Article 257

This Act shall take effect on the eighth day following the date it has been published in the Official Gazette of the Republic of Serbia, except for Articles 20 and 22, Article 45 in the section referring to percentage of payment of services from the compulsory health insurance funds, or the insured person's funds, Articles 202 and 204 of this Act, which are to take effect as of 1st January 2007.