

HEALTH CARE INSURANCE ACT

(“Official Gazette of the Republic of Serbia” Nos. [107/05](#), [109/05](#) - corrected, [57/11](#), [110/12](#) - CC, [119/12](#))

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- Notwithstanding Article: [96](#) – effective as of 1st January 2014

I BASIC PROVISIONS

Article 1

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

Article 2

Health Care Insurance in the Republic of Serbia (hereinafter referred to as: the Republic) is compulsory and voluntary health care insurance.

Article 3

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

Article 4

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

Article 5

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

- (2) In carrying out compulsory health care insurance, the principles of health care are applied and patients' rights are exercised, as established by the act governing health care.

Article 6

- (1) Compulsory health care insurance is provided by and exercised through the Republican Health Care Insurance Fund (hereinafter referred to as: the Republican Fund) and the Republican Fund organizational units (hereinafter referred to as: branches).
- (2) Certain compulsory health care insurance issues are exercised through the Provincial Health Care Insurance Fund as well (hereinafter referred to as: the Provincial Fund) in accordance with law.
- (3) Voluntary health care insurance is exercised through legal entities engaged in insurance activities in accordance with law, including the Republican Fund.

Article 7

- (1) Entitlements deriving from compulsory and voluntary health care insurance are neither transferable to other persons nor may be inherited.
- (2) Mature pecuniary benefits that remain unpaid due to the death of the persons covered by compulsory, i.e. voluntary health care insurance may not be inherited.

Article 8

- (1) Funds for exercising entitlements deriving from compulsory health care insurance are provided through health care insurance contributions (hereinafter referred to as: contributions) and other sources as well, in accordance with law.
- (2) Funds for exercising entitlements deriving from voluntary health care insurance are provided in accordance with law.

II COMPULSORY HEALTH CARE INSURANCE

Article 9

Compulsory health care insurance includes:

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

1) COMPULSORY HEALTH CARE INSURANCE PRINCIPLES

Principle of Being Compulsory

Article 10

- (1) The principle of being compulsory is exercised by organizing and carrying out a comprehensive compulsory health care insurance of the employed and other citizens in the Republic (hereinafter referred to as: the insured) in accordance with this Act, by which the insured provide for themselves and members of their families (hereinafter referred to as: insured persons) entitlements to health care and pecuniary benefits for disease, in accordance with this Act and other regulations passed to implement this Act.
- (2) The principle of being compulsory is provided through obligation of paying compulsory health care insurance contributions imposed on 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.
- (3) The principle of being compulsory is carried out through complete organization of compulsory health care insurance which provides and guarantees for the employed and other persons covered by such insurance to obtain any entitlements deriving from compulsory health care insurance prescribed by this Act and other regulations passed to implement this Act.

Solidarity and Reciprocity Principle

Article 11

- (1) 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 care insurance.
- (2) Solidarity and reciprocity principle is exercised by establishing such compulsory health care insurance system where the compulsory health care 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 care insurance are used by the persons in whom a disease or other insurance risk occurred.

Transparency Principle

Article 12

Transparency principle is exercised by the entitlement of insured persons to all kinds of information regarding entitlements deriving from compulsory health care insurance and by transparent work of the Republican Fund's organs and offices in meeting the needs of insured persons, organs and organizations having an interest in the Republican Fund's activity.

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

Article 13 H

- (1) 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's interests to be the basis of the compulsory health care insurance and any insured person to easily protect and exercise his/her entitlements deriving from compulsory health care insurance, taking care that such rights exercise is not to other insured persons' rights and legal interests disadvantage or contrary to the public interest established by law.
- (2) Principle of protection of insured persons' rights and protection of the public interest is also exercised by the Republican Fund's obligation to draw attention of any insured persons to the existing grounds for the entitlements deriving from compulsory health care insurance to be exercised and to insured person obligations related to exercising the entitlements deriving from compulsory health care insurance.
- (3) Principle of protection of insured persons' rights and protection of the public interest is also exercised by taking measures and activities for financing the entitlements deriving from compulsory health care insurance in the way which enables the funds provided from compulsory health care insurance contributions to cover the insured according to the place where his/her insurance status is determined i.e. his/her rights exercised.

Principle of Compulsory Health Care Insurance Continuous Quality Improvement

Article 14

Principle of health care insurance continuous quality improvement is exercised by keeping abreast of the latest developments in the field of compulsory health care insurance and by carrying out measures and activities which in accordance with the health care insurance

latest achievements enhance the possibilities for each insured person to exercise the entitlements deriving from compulsory health care insurance in a more favourable way.

Principle of Compulsory Health Care Insurance Efficiency and Cost-Effectiveness

Article 15

- (1) Principle of compulsory health care insurance efficiency and cost-effectiveness is exercised by constant endeavour, in organizing and carrying out the compulsory health care insurance, to enable the entitlements deriving from compulsory health care insurance to be exercised by using as less funds as possible and with as less burden as possible.
- (2) Principle of compulsory health care 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 care insurance with the lowest expenditure of such funds.

2) INSURED PERSONS AND OTHER PERSONS INSURED WITH REGARD TO PARTICULAR CIRCUMSTANCES

Article 16

- (1) Insured persons having rights and obligations deriving from compulsory health care insurance, in accordance with this Act and other regulations passed to implement this Act, are considered to be the insured and members of their families.
- (2) Entitlements deriving from compulsory health care insurance are also provided for other persons insured with regard to particular situations, in accordance with this Act.

1. The Insured

Article 17

- (1) The insured are natural 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 and autonomous province body and natural entities (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 they receive any salaries or benefits in consideration of their work;
- 4) persons performing certain works, in accordance with the act governing labour, outside the employer's premises;
- 5) persons performing domestic services, in accordance with the act governing labour,;
- 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 natural 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 care insurance under the regulations of such country or unless otherwise provided by an international agreement;
- 8) an employed parent, adoptive parent, foster parent or guardian on parental leave until the child is 3, his rights and duties in respect of employment suspended, in accordance with the regulations on labour;
- 9) citizens of the Republic employed abroad by foreign employer without having health care insurance of any foreign health care insurance carrier or without being covered by compulsory insurance under foreign regulations, i.e. if the entitlements deriving from health care insurance under such country regulations, for themselves or members of their family, may not be exercised or used outside 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 natural persons, unless otherwise provided by an international agreement, as well as by international organizations and institutions and foreign consular and diplomatic offices, if such insurance is provided by an international agreement;

- 11) citizens of the Republic employed to work in the household of any citizen of the Republic employed abroad by an organization whose registered office is in the territory of the Republic;
- 12) persons entitled to unemployment benefits, under employment legislation;
- 13) persons working on temporary and occasional basis in accordance with the act governing labour (the unemployed, the employed working part-time up to the full time and the old-age pension beneficiaries); ^[3]
- 14) persons working on temporary and occasional basis, in accordance with the law, through any youth or student employment agency, and being over 26, i.e. regardless of age if not at schooling; ^[3]
- 15) persons who exercise under this Act the right to benefits upon the termination of their employment due to work-related injuries or diseases;
- 16) persons working under agreement for services, author agreement, agreement on family accommodation under welfare regulations, as well under other agreements in return for payment (hereinafter referred to as: agreed compensation);
- 17) persons founders, members i.e. shareholders of companies (general partnership, limited partnership, limited liability company, joint stock company and other legal forms of 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 Sports Act, any sports activity as self-employment activity;
- 20) priests and church officials 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, the insured as self-employees, the insured under item 17 above, pension beneficiaries, persons at schooling;
- 22) beneficiaries to pension and the right to pecuniary benefits who have exercised such rights under the pension and disability insurance regulations;
- 23) **persons receiving pension or disability benefits exclusively from foreign insurance carrier who are domiciled or resident, i.e. having a place of domicile or residence, in the territory of the Republic in accordance with law, i.e.**

receiving pension from a country no bilateral agreement on social insurance is signed with or if otherwise provided for by a bilateral agreement, i.e. if the entitlements deriving from health care insurance under the bilateral agreement may not be exercised in the territory of the Republic due to certain legal impediments;

24) foreign citizens 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.

(2) The insured status referred to in paragraph 1 above, may be obtained on the grounds of one insurance type only.

(3) Notwithstanding paragraph 1, item 16) above, persons receiving 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, item 14) above, pension beneficiaries or persons at schooling, shall become the insured in accordance with paragraph 1, item 24) above.

Article 18

The term ‘carry out certain work’ referred to in Article 17, paragraph 1, item 17) hereof means representation of and acting for a 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 Company Act.

Article 19

The insured status of an entrepreneur referred to in [Article 17](#), paragraph 1, item 18) hereof shall cease for the period of temporary termination of the economic activity, if throughout such period he/she doesn’t pay compulsory health care insurance contributions, except for the period of temporary incapacity to work which occurred before such termination, in accordance with this Act.

Article 20

- (1) The insured status of a person referred to in [Article 17](#), paragraph 1, item 21) hereof, who is over 65, shall cease provided that:
 - 1) such person cannot exercise the right to pension in accordance with law;
 - 2) such person's income is under the level prescribed by regulation referred to in [Article 22](#), paragraph 2 below;
- (2) In the cases referred to in paragraph 1 above, related to termination of the insured status, at the request of the insured a new basis for compulsory health care insurance shall be established, in accordance with [Article 22](#), herein.

Article 21 H M S

- (1) If the insured referred to in [Article 17](#) hereof complies with the requirements for obtaining the status of the insured on different insurance grounds, the prioritized insurance ground, excluding all others, is determined according the following priorities:
 - 1) employment or pension insurance ([Article 17](#), paragraph 1, items 1) to 12) and 22) to 23) herein);
 - 2) insurance on the grounds of companies foundation, entrepreneurship and self-employment ([Article 17](#), paragraph 1, items 17) to 20) herein);
 - 3) insurance on the grounds of agricultural activities ([Article 17](#), paragraph 1, item 21) herein);
 - 4) insurance on the grounds of other prescribed insurance grounds ([Article 17](#), paragraph 1, items 13) to 16), 24) and 25) herein).
- (2) The person who fulfils all conditions to obtain the status of the insured, referred to in [Article 17](#), paragraph 1, items 1) to 12), items 17) to 20) and items 22) to 23) hereof, on different insurance grounds, shall choose one of the insurance grounds to be insured, i.e. to exercise the entitlements deriving from compulsory health care insurance .
- (3) The insured, referred to in paragraph 1 above, exercise the entitlements deriving from compulsory health care insurance according to determined prioritized insurance grounds.

Article 22 H M S P

- (1) The insured, in terms of this Act and under conditions prescribed by this Act, also include any persons belonging to population groups at higher risk of illness; persons who require health care with respect to prevention, suppression, early detection 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](#) hereof, or if such persons do not exercise entitlements deriving from compulsory health care insurance as family members of the insured, that is:

- 1) children up to 18 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 pregnancy, delivery and maternity up to 12 months after delivery;
- 3) the elderly over 65 years of age;
- 4) people with physical and mental disabilities, under pension and disability regulations, and the mentally underdeveloped as well;
- 5) HIV-positive persons and those suffering from other communicable diseases as provided by a *lex specialis* governing the protection of the population against communicable diseases, 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, persons suffering from rare disease, including the persons covered by health care in relation to donating and receiving tissues and organs;
- 6) monks and nuns;
- 7) persons without income who are receiving social welfare, i.e. who are beneficiaries of family disability allowance in accordance with the regulations governing social welfare, i.e. welfare for soldiers, disabled veterans and civil invalids of war;
- 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 monthly income is below 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 place of domicile, i.e. residence in the Republic due to traditional way of life;
- 12) victims of domestic violence;
- 13) victims of trafficking in human beings;

14) persons covered by mandatory immunization in accordance with the regulations governing the protection of the population against communicable diseases;

15) persons covered by targeted preventive examinations, i.e. screening according to the relevant republican programmes;

16) single parents with children under the age of seven whose monthly income is below the income level established by this Act;

(2) The monthly income as the threshold for a citizen to obtain the insured person status referred to in paragraph 1, items 9) and 16) above is prescribed by mutual agreement by the Minister of Health (hereinafter referred to as: the Minister) and the Minister of Social Affairs.

(3) 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 consanguinity.

(4) The insured, in terms of this Act, is also a person whom a competent republican authority has awarded the status of a refugee, i.e. expellee from the former Yugoslav republics, if complies with requirements referred to in paragraph 2 above, and resides in the territory of the Republic.

(5) Budget of the Republic provides funds for compulsory health care insurance contributions to be paid for persons referred to in paragraphs 1 and 4 hereof, under insurance-benefit basis and compulsory health care insurance contributions' rate prescribed by this Act.

(6) The insured, referred to in paragraphs 1 and 4 above, exercise entitlements deriving from compulsory health care insurance with regard to type, scope, manner and procedure thereof in accordance with this Act and other regulations passed to implement this Act.

2. Persons who are to be Included in Compulsory Health Care Insurance

Article 23

(1) Persons who are not insured under the compulsory health care insurance in terms of this Act may be included in coverage by such insurance in order to provide the entitlements deriving from compulsory health care insurance for themselves and members of their

nuclear family, under conditions, in the manner, content and scope prescribed by this Act.

- (2) Persons, referred to in paragraph 1 hereof, have the status of the insured, i.e. the insured person.
- (3) Status of the insured is obtained, i.e. terminated by the date a request has been filed, in accordance with this Act.
- (4) Persons, referred to in paragraph 1 hereof, having the status of the insured pay contributions by themselves, out of own income, in accordance with the act governing contributions for compulsory social insurance.

3. Family Members of the Insured

Article 24

- (1) Entitlements deriving from compulsory health care insurance, established under this Act, are provided to family members of the insured referred to in [Article 17](#), paragraph 1 hereof, except for paragraph 1, items 24) and 25) of that Article.
- (2) Entitlements deriving from compulsory health care insurance, established under this Act, are provided to members of nuclear family of the insured referred to in [Article 22](#), paragraph 1, items 7) to 9), 11) and 16) hereof, as well as in Article 23, paragraph 1 herein.
- (3) Entitlements deriving from compulsory health care insurance, established under this Act, are provided to members of nuclear family of the insured referred to in [Article 22](#), paragraph 4, under conditions prescribed for the insured.
- (4) Family members, in terms of this Act, are considered to be:
 - 1) members of nuclear family (spouses or common-law spouses, children born in or out of wedlock, adoptive children, stepchildren and foster children;
 - 2) members of wider family (parents, stepfather, stepmother, adoptive parent, grandfather, grandmother, grandchildren, brothers and sisters, maintained by the insured, in terms of the regulations governing family welfare and citizens' social welfare and social security guarantee).
- (5) A common-law spouse, with whom the insured 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

- (1) A spouse or common-law spouse of the insured has the right to entitlements deriving from compulsory health care 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.
- (2) Divorced spouse who obtained by final court order the right to alimony, has the right to entitlements deriving from health care insurance if at the time of divorce she/he was over 45 (woman), i.e. 55 (man), or regardless of age, if at the time of divorce his/her total work incapacity was determined in terms of the regulations governing pension and disability insurance issues.

Article 26

- (1) A child of the insured has the right to entitlements deriving from compulsory health care insurance until the age of 18, i.e. until the end of prescribed secondary education, i.e. tertiary education, but not later than the age of 26.
- (2) The child, referred to in paragraph 1 above, who came to recess in schooling due to illness, has the right to entitlements deriving from compulsory health care insurance throughout the period of illness, and in the case of continuing the schooling he/she has the right to entitlements deriving from compulsory health care insurance even after the age limit, referred to in paragraph 1 above, 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.
- (3) If the child, referred to in paragraph 1 above, 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 compulsory health care insurance during the period of time such incapability lasts.
- (4) The child, referred to in paragraph 1 above, 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 above, has the right to entitlements deriving from compulsory health care insurance throughout the period of such incapacity if maintained by the insured due to lack of own financial means.

Article 27

- (1) Parents, brothers and sisters, stepfather and stepmother, adoptive 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 care insurance if they are over 65 or if younger but incapable to work, whereas such incapacity corresponds total work incapacity in terms of the regulations governing disability insurance.
- (2) Grandfather and grandmother of the insured have the right to entitlements deriving from compulsory health care insurance under conditions referred to in paragraph 1 above.

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

Article 28 M

Entitlements deriving from compulsory health care insurance established under this Act, in the event of a work-related injury or disease only, are provided to:

- 1) school children and university students who are attending, in accordance with law, any compulsory production labour, professional practice and training;
- 2) persons who are not receiving, in accordance with law, any income i.e. agreed compensation 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 at the request of a competent employment organization;
- 5) persons involved in organized public works for the common good;
- 6) persons involved in rescue operations or in protection and rescue operations during any natural disasters and other accidents;
- 7) persons engaged in fire departments on fire fighting and persons undergoing fire fighting training;
- 8) persons undergoing any training and qualifying activities with regard to defence, or any other training necessary for the defence of the country;
- 9) persons engaged in securing the public rallies, cultural and sports events and other public gatherings of citizens;

10) persons serving a sentence in a prison while working in any facility of such penitentiary institution (workshop, work site, etc.) and in any other working place.

5. Foreign Citizens, i.e. Insured, of Countries with which an International Agreement on Social Insurance has been Signed

Article 29

- (1) Foreign citizens, i.e. the insured, with whose countries an international agreement on social insurance has been signed, exercise the entitlements deriving from compulsory health care insurance the content and scope of which governed by this Act, unless otherwise provided by the agreement thereof.
- (2) Health care expenses relating to foreign citizens, i.e. the insured referred to in paragraph 1 above, if the international agreement provides for reciprocal payments, are paid in accordance with law, i.e. international agreement.
- (3) Health care expenses relating to foreign citizens, i.e. the insured, with whose countries an international agreement on social insurance has been signed, if such agreement determines a compensation of actual expenses, are borne entirely by the Republican Fund which shall reimburse such expenses from the foreign health care insurance carrier.

3) ENTITLEMENTS DERIVING FROM COMPULSORY HEALTH CARE INSURANCE

Article 30

- (1) Entitlements deriving from compulsory health care insurance are as follows:
 - 1) right to health care;
 - 2) entitlement to benefits for the period of temporary incapacity of the insured (hereinafter referred to as: benefit);
 - 3) entitlement to transportation benefit relating to the use of health care services (hereinafter referred to as: transportation benefit);
- (2) Entitlements deriving from health care insurance referred to in paragraph 1 above are exercised only if due health care insurance contributions have been paid, unless otherwise provided by this Act.

Article 31

- (1) The insured referred to in [Article 17](#), paragraph 1 hereof are provided with the entitlements deriving from compulsory health care insurance referred to in Article 30 paragraph 1, items 1) to 3) hereof, unless otherwise provided by this Act.
- (2) The insured referred to in [Article 17](#), paragraph 1, items 24) and 25) are provided with the entitlements deriving from compulsory health care insurance referred to in Article 30 paragraph 1, items 1) to 3) herein.
- (3) The insured referred to in [Article 22](#), paragraphs 1 and 4 hereof are provided with the entitlements deriving from compulsory health care insurance referred to in Article 30, paragraph 1, items 1) to 3) herein.
- (4) The persons who are to be included into compulsory health care insurance referred to in Article 23, paragraph 1 hereof, are provided with the entitlements deriving from compulsory health care insurance referred to in Article 30, paragraph 1, items 1) and 3) herein.
- (5) The insured, referred to in [Article 17](#), paragraph 1 hereof, are entitled to benefits under the conditions prescribed by this Act, if during the temporary incapacity they lose their salary or a part of salary gained in accordance with the regulations related to labour issues.
- (6) Family members, referred to in [Articles 24 to 27](#) hereof, are provided with entitlements deriving from compulsory health care insurance referred to in Article 30, paragraph 1, items 1) and 3) herein.
- (7) Persons referred to in Article 28 hereof are provided with entitlements deriving from compulsory health care insurance referred to in Article 30, paragraph 1, items 1) and 3) herein.
- (8) Foreign citizens, i.e. the insured, with whose countries an international agreement on social insurance, referred to in Article 29 hereof, has been signed, are provided with entitlements deriving from compulsory health care insurance in accordance with such agreement.

1. Prior Health Care Insurance Coverage

Article 32

- (1) In order to exercise the entitlements referred to in [Article 30](#) hereof, prior to using the entitlements deriving from compulsory health care insurance, the insured must have, in accordance with this Act, at least three-months of prior creditable compulsory health care insurance coverage (hereinafter referred to as: the creditable coverage) within three consecutive months or within six months with interruptions in the last 18 months, prior to the exercise of a certain entitlement deriving from compulsory health care insurance.
- (2) The creditable coverage 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.
- (3) Notwithstanding paragraph 1 above, the insured exercises the entitlements deriving from compulsory health care insurance even in the case when creditable coverage requirements are not met, that is:
 - 1) in the case of work-related injury or disease of the insured referred to in [Articles 17 and 23](#) herein;
 - 2) in the case of emergency medical aid and exercising of pecuniary benefits referred to in [Article 30](#) hereof, the insured is entitled to;
 - 3) in order to exercise the right to benefits in the amount of minimum salary in accordance with the labour regulations for the month the benefit is paid.
- (4) Family members of the insured exercise the entitlements deriving from compulsory health care insurance provided that the insured under whose insurance they exercise such rights meets the requirements with regard to creditable coverage.

2. Entitlement to Health Care

Article 33 H M S

- (1) Entitlement to health care in the event of an injury or disease not related to work covers health care with regard to prevention, early detection, health care with respect to family planning, in the course of pregnancy, delivery 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, depending on the health status of the insured person, in accordance with this Act and other regulations passed to implement this Act.
- (2) Right to health care in the event of a work-related injury or disease covers the health care in the case of work-related diseases and injuries provided at primary, secondary and tertiary level.

- (3) The health care referred to in paragraphs 1 and 2 above is provided in the manner to preserve, restore or improve health status of the insured person and his/her work capability and to satisfy his/her personal needs, in accordance with this Act and other regulations passed to implement this Act.
- (4) A work-related injury, pursuant to this Act, is every injury, illness or death caused by an accident at work, i.e. or which occurred as a result of any unexpected or unplanned event, including acts of violence which are engendered by work or related to work and which led to the injury, illness or death of the insured which occurred immediately or within a period of 12 months from the date of the work-related injury occurred.
- (5) A work-related injury in terms of paragraph 4 above does not include occupational diseases, including injuries which occurred upon arrival, or coming home from work.
- (6) A work-related disease pursuant to this Act is a disease caused by prolonged exposure to hazards in the workplace.
- (7) A work-related injury is determined on the basis of a report on the injury occurred at work (hereinafter referred to as: the Report of Claimed Work-Related Injury) which is under the employer's direct or indirect control, which is submitted to the Republican Fund, i.e. the parent branch to exercise the entitlements deriving from compulsory health care insurance in accordance with this Act.
- (8) Content and form of the Report of Claimed Work-Related Injury and the manner of filling it in, i.e. submission, processing of data from the Report of Claimed Work-Related Injury, including other issues relevant to the determining of work-related injury, are prescribed by ministers in charge of occupational health and safety. Under Decision of the Constitutional Court IUz-314/2011 ("Official Gazette of the Republic of Serbia" No. 110/12) it was established that the provision of Article 33, paragraph 5 of the Health Care Insurance Act ("Official Gazette of the Republic of Serbia" Nos. 107/05, 109/05, 106/06 and 57/11) is not consistent with the Constitution and the ratified international agreement and that it expires on the date of publication of the Decision in the "Official Gazette of the Republic of Serbia", i.e. on 20 November 2012.

Article 34 

- (1) Right to health care provided by virtue of compulsory health care insurance referred to in Article 33 hereof includes:

- 1) preventive health care and early detection measures;
 - 2) medical examinations and treatment of women relating to family planning, in the course of pregnancy, delivery and postnatal period up to 12 months after delivery;
 - 3) medical examinations and treatment in case of disease or injury;
 - 4) examinations and treatment of oral and dental diseases;
 - 5) medical rehabilitation in case of disease or injury;
 - 6) medicines and medical devices;
 - 7) prosthetic, orthotic and other devices for moving, standing and sitting, sight, hearing and speech devices, dentures and other auxiliary devices (hereinafter referred to as: medical-technical aids).
- (2) For, the Republican Fund may prescribe a prior consent of the first-instance medical commission for using health care referred to in paragraph 1 above, and in particular for certain types of diagnostic and therapeutic procedures, inpatient facility treatments or home care.

Preventive Health Care and Early Detection Measures

Article 35 **H** **M**

- (1) For the purpose of health preservation and improvement, prevention, suppression and early detection of diseases and other health disturbances, the insured persons are provided with the following measures:
- 1) health education consisting of special lectures or advisory sessions given by health professionals with regard to protection, preservation and improvement of health, gaining healthy lifestyle knowledge and habits and discovering and mitigating risk factors;
 - 2) general and other medical examinations of children under the age of 18, i.e. until the end of prescribed secondary education, i.e. tertiary education, but not later than the age of 26, women with regard to pregnancy and adults in accordance with national programme relating to prevention and early detection of diseases of major social and medical importance and screening programmes;
 - 3) preventive dental and prophylactic measures for oral and dental diseases prevention in pregnant women, children under the age of 18, i.e. until the end of prescribed secondary education, i.e. tertiary education, but not later than the age of 26;

- 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 suppression, discovering and treatment of HIV infection and other contagious diseases in order to be prevented from spreading.
- (2) The Government shall develop the national programme relating to prevention and early detection of diseases of major social and medical importance, national programme relating to dental health protection of children under the age of 18, i.e. until the end of prescribed secondary education, i.e. tertiary education, but not later than the age of 26, and pregnant women, as well as the national programme relating to immunization of the population against certain contagious diseases, and 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

- (1) 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 gynaecologist 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.

- (2) Medical examination in terms of paragraph 1, item 1) above is considered to be prenatal and genetic testing and other preventive measures, in accordance with medical standards.

Illness and Injury-Related Medical Examinations and Treatments

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 care service (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 home of the insured by a chosen physician;
- 5) ambulatory medical examinations and treatments provided by a specialist and health care associate, 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 care facilities;
- 8) right to an escorting person for the insured person under the age of 15, as well as for older persons with severe physical or mental disability, i.e. any persons who in the course of their life lost some bodily or mental functions due to illness or injury preventing them from performing everyday activities independently, inclusive of the blind, visually impaired and deaf persons, for the period of inpatient medical treatment and rehabilitation, when medically necessary, unless otherwise provided by this Act;
- 9) home treatment, when justified and medically necessary.

Article 38

- (1) Emergency medical transportation referred to in Article 37, item 1) hereof 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.
- (2) Non-emergency medical transportation referred to in Article 37, item 3) hereof includes transportation to a health care facility qualified to provide justified and medically necessary health care, as well as transportation from such a health care facility to the insured person's home.
- (3) Non-emergency medical transportation is justifiable and medically necessary in the case any other type of transportation may endanger the insured persons' life and health.

Article 39

- (1) Treatment in inpatient health care facilities referred to in [Article 37](#), item 7) hereof is justified and medically necessary if the necessary health care (diagnostic, treatment or rehabilitation) or a part of it may be delivered only in inpatient care facilities, i.e. if it may not be delivered in outpatient health care facilities or at home.
- (2) Notwithstanding paragraph 1 above, the terminally ill and disabled insured persons, i.e. persons able to move only with other people's 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 a general act of the Republican Fund.

Article 40

- (1) Home treatment referred to in [Article 37](#), paragraph 1, item 9) hereof is justifiable and medically necessary where parenteral medicines administration or medical and rehabilitation procedures, which may be delivered by health professional to disabled or assisted insured persons at home are indicated by a chosen physician or physician specialist.
- (2) Home treatment is carried out as a continuation of the treatment in an inpatient health care facility, as well.

Examination and Treatment of Oral and Dental Diseases

Article 41

- (1) Insured persons are provided with examination and treatment of oral and dental diseases in outpatient, polyclinic and inpatient facilities, i.e. at least:
- 1) examinations and treatment of oral and dental diseases in children under the age of 18, i.e. until the end of prescribed secondary education, i.e. tertiary education, but not later than the age of 26, the elderly with severe mental and physical disability, as well as persons with inborn and acquired serious facial and mandible malformation;
 - 2) examinations and treatments of oral and dental diseases, excluding prosthetic care, in pregnant women and 12 months after delivery;
 - 3) emergency dental aid for adults;
 - 4) examinations and treatment of oral and dental diseases, excluding prosthetic care, before kidney 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 in persons over the age of 65;
 - 8) necessary dental treatment including fixed orthodontic appliances within pre- and post-surgery treatment of persons with inborn and acquired serious facial and mandible malformation;
 - 9) facial and mandible prosthetic implants (post-resection intraoral prosthesis and facial prosthesis) within post-timorous rehabilitation and reconstruction including fixed on implants.
 - 10) examinations and treatment of oral and dental diseases in persons who in the course of their life lost some bodily or mental functions due to illness or injury preventing them from performing everyday activities independently;
 - 11) examination and treatment of oral and dental diseases of the insured referred to in [Article 22](#) herein.
- (2) The persons referred to in paragraph 1, items 10) and 11) above have the right of examination and treatment of oral and dental diseases if the income of the insured person is below the threshold specified in the act referred to in Article 22, paragraph 2 herein.

Medical Rehabilitation in the Case of Disease and Injury

Article 42 H M P

- (1) Insured persons are provided with medical rehabilitation for the purpose of improving or restoring to a pre-existing state a body function lost or impaired due to an acute disease or injury, deterioration of chronic disease or medical intervention, congenital anomaly or developmental disorder.
- (2) Medical rehabilitation is provided by the establishment, application and evaluation of rehabilitation procedures which encompass kinesiotherapy and all forms of physical therapy, occupational therapy, speech and vocal therapy, as well as certain types of medical-technical aids, fixing, application and training for the use of such medical-technical aids.
- (3) Occupational therapy provides the insured person with medical rehabilitation procedures after a disease and injury, which are aimed to enable the insured person to be autonomous, i.e. to improve his/her functioning in other activities of everyday life.
- (4) Rehabilitation of voice and speech provides the insured with medical procedures and use of appropriate devices necessary for diagnosis and treatment of diseases and injuries or congenital anomalies resulting in impairment of voice, speech and language which prevent the insured person from communicating, i.e. cause impairment of deglutination following an illness or injury.
- (5) Physical therapy implies establishment, application and evaluation of all relevant physical agents including natural salubrious factor in treatment of the injured or ill insured person.
- (6) The insured person is provided with medical rehabilitation in outpatient, polyclinic and hospital facilities, when justified and necessary for treatment of conditions of the insured person.
- (7) Rehabilitation of insured persons in inpatient health care facilities (early rehabilitation) entails an intensive rehabilitation programme, within basic medical treatment, which requires multidisciplinary team work, in order to improve the health status and remove functional disorders.
- (8) Inpatient health care facilities specialized in rehabilitation provide the insured persons with rehabilitation (extended rehabilitation) as continuous extension of treatment and rehabilitation, within an indicative area, when functional disorders cannot be alleviated or removed with equal efficiency in outpatient or polyclinic health facilities and within hospital treatment of the basic illness.

- (9) Insured persons under the age of 15, as well as older persons with severe physical or mental disability, i.e. any persons who in the course of their life lost some bodily or mental functions due to illness or injury preventing them from performing everyday activities independently, inclusive of the blind, visually impaired and deaf persons are entitled to an escorting person;
- (10) The Republican Fund under its general act determines the types of indications for medical rehabilitation to be used, duration of such rehabilitation, the manner and procedure of exercising such rehabilitation and rehabilitation referral procedure referred to in paragraph 1 above.
- (11) The general act referred to in paragraph 1 above shall be published in the “Official Gazette of the Republic of Serbia”.

Medicines and Medical Devices

Article 43

- (1) Right to medicines and medical devices 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 care insurance funds (hereinafter referred to as: the List of Medicines);
 - 2) right to medical devices which are provided from the compulsory health care insurance funds, i.e. which are prescribed by order or implanted in the insured person’s body.
- (2) Notwithstanding paragraph 1 above, the insured person is provided with a medicine which is not on the List of Medicines, but is medically necessary for treatment, under the conditions established by the general act of the Republican Fund.
- (3) The Republican Fund adopts a general act establishing the List of Medicines which contains a list of minimum medicines needs - essential medicines for treatment of diseases and injuries, regardless of cause, in accordance with the World Health Organization Model List of Essential Medicines.
- (4) The Republican Fund adopts a general act establishing the conditions, criteria, manner and procedure for putting medicines on the List of Medicines, amendments to the List of Medicines, i.e. their deletion from the List of Medicines.**

- (5) The Republican Fund adopts a general act establishing type and standard of medical devices for implantation in the insured person's body (hereinafter referred to as: implants), as well as other types of necessary medical devices.
- (6) The Government gives consent on the general act of the Republican Fund referred to in paragraph 3 above.
- (7) The general acts of the Republican Fund referred to in paragraphs 3, 4 and 5 above shall be published in the "Official Gazette of the Republic of Serbia".

Article 43a

- (1) For the purpose of performing activities in the procedure of placing medicines on the List of Medicines, amending the List of Medicines, i.e. removal of medicines from the List of Medicines, the Central Commission for Medicines shall be established in the Republican Fund under the decision of the Management Board of the Republican Fund.**
- (2) The Central Commission for Medicines has 11 members, consisting of experts in the fields of medicine, dentistry and pharmacy, among whom president and vice president are elected.**
- (3) The line minister for health care and the Director of the Republican Fund appoint five members of the Central Commission for Medicines, and one member is appointed by the community of faculties of medicines.**
- (4) The President, Vice President and members of the Central Commission for Medicines are appointed for a four years term of office and may not be elected for two consecutive terms.**
- (5) The Central Commission for Medicines adopts its rules of procedure.**
- (6) The Central Commission for Medicines makes decisions by a majority vote of the members.**
- (7) The President and members of the Central Commission for Medicines shall, prior to beginning to work at the Central Commission for Medicines, sign a declaration that they and their blood relatives in the direct line of descent, regardless of the degree of consanguinity, collateral relatives up to second degree of consanguinity, spouses and relatives by marriage up to the first degree of consanguinity, directly or through a third natural or legal person, are not owners of shares, shareholders in the legal person which produces and sells, i.e. they are not members of**

management bodies and other bodies of the holder of a marketing authorization to place a medicinal product on the market.

- (8) The President, Vice President and members of the Central Commission for Medicines who have in any way been involved in the performance of professional and other work for marketing authorization holders, pursuant to the law regulating medicines and medical device, may not participate the decision-making of the Central Commission for Medicines relating to the placing of medicines on the List of Medicines, i.e. amendments to the List of Medicines, i.e. removal of the medicine from the List or Medicines.

Article 43b

- (1) The Central Commission for Medicines drafts the List of Medicines, i.e. its amendments and the proposal for the removal of certain medicines from the List of Medicines, which is adopted by the Management Board of the Republican Fund.
- (2) Republican expert commissions established for certain fields of medicine and dentistry participate in the procedure of placing of medicines on the List of Medicines, or in the procedure of removal of medicines from the List of Medicines, in accordance with this Act.
- (3) The Central Commission for Medicines compiles the draft referred to in paragraph 1 this Article on the basis of the opinion of the competent republican expert commission, which is established for the specific field of medicine or dentistry, regarding the justifiability of placing a medicine on the List of Medicines and its amendments, i.e. of its amendments, i.e. of the removal of a medicine from the List of Medicines, accordance with the act referred to in Article 43, paragraph 4 herein.
- (4) Members of the Republican Expert Commission shall sign a declaration referred to in Article 43a, paragraph 7 hereof, provided that Article 43a, paragraph 8 hereof applies accordingly to their work.
- (5) The members of the Central Commission for Medicines, as well as of the Republican Expert Commission who are involved in the procedure of placing the medicines on the List of Medicines, amending List of Medicines or removal of a certain medicine from the List of Medicines, are entitled to remuneration from the funds of the Republican Fund.

- (6) The amount of remuneration referred to in paragraph 5 above establishes the Management Board of the Republican Fund.

Article 43c

- (1) The marketing authorization holder submits to the Republican Fund an application containing the required documentation to place a medicine on the List of Medicines, amend the List of Medicines, i.e. remove the medicine from the List of Medicines.
- (2) The marketing authorization holder shall, together with the application referred to in paragraph 1 above, submit proof of payment of stamp duty for the assessment of compliance with the requirements and criteria, referred to in [Article 43](#), paragraph 4 of the Act, for placing a medicine on the List of Medicines, i.e. amending the List of Medicines, i.e. removal of the medicine from the List of Medicines, to the account of the Republican Fund.
- (3) The due amount of stamp duty is determined by the Management Board of the Republican Fund, and approved by the minister in charge of finance.
- (4) The Republican Fund shall, within 30 days from the date of filing of the application referred to in paragraph 1 above, make a formal assessment the documentation.
- (5) If the application, referred to in paragraph 1 above, is not complete the Republican Fund shall inform the applicant to supplement the application within 30 days of receiving the written notice.
- (6) The Republican Fund shall, within 90 days from the date of submission of the complete application for placing a medicine on the List of Medicines, i.e. removal from the List of Medicine of a generic medicine which international non-proprietary name (hereinafter referred to as: INN), and the same or similar pharmaceutical form is on the List of Medicines, pass a ruling on whether the requirements and criteria referred to in [Article 43](#), paragraph 4 hereof, have been complied with.
- (7) The Republican Fund shall, within 90 days from the date of submission of the complete application for placing a medicine on the List of Medicines, amending the List of Medicines, i.e. removal from the List of Medicine of a generic medicine which INN is not on the List of Medicines, and of a generic medicine which INN is not the List of Medicines but in a different pharmaceutical form, pass a ruling on

whether the requirements and criteria referred to in [Article 43](#), paragraph 4 hereof, have been complied with.

- (8) The Republican Fund shall within 120 days from the date of submission of the complete application for placing a medicine on the List of Medicines, amending the List of Medicines, i.e. removal from the List of Medicine of an innovative or original medicine, pass a ruling on whether the requirements and criteria referred to in [Article 43](#), paragraph 4 hereof, have been complied with.
- (9) Unless otherwise provided by this Act, the procedure of issuing a ruling, referred to in paragraphs 6 to 8 above, is subject to the act governing general administrative procedure.
- (10) The ruling referred to in paragraphs 6 to 8 above, is final in the administrative procedure and administrative proceedings may not be instituted against it.

Medical-Technical Aids

Article 44 H M P

- (1) Insured persons are provided with medical-technical aids 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.
- (2) Insured persons are provided with medical-technical aids 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 deterioration of health status or death of an insured person.
- (3) The Republican Fund determines under a general act the type of medical-technical aids and indications for their use, standards for materials such appliances are made of, lifetime, i.e. purchase, maintenance and renewal as well as the manner and procedure of exercising the right to medical-technical devices.
- (4) The general act of the Republican Fund referred to in paragraph 3 above shall be published in the “Official Gazette of the Republic of Serbia”.

Health Care Services Covered by Compulsory Health Care Insurance

Article 45 H M

(1) Insured persons, while exercising the entitlement to health care deriving from compulsory health care insurance referred to in [Articles 34 to 44](#) hereof, are provided with the following:

- 1) 100% coverage – payment of services out of compulsory health care insurance for:
 - preventive health care and early detection measures;
 - medical examinations and treatments with regard to family planning, pregnancy, delivery and postnatal period including pregnancy termination for medical reasons,
 - illness and injury-related medical examinations, treatments and medical rehabilitation of children, school children and university students until the end of prescribed schooling period but not later than the age of 26, i.e. the elderly persons with severe physical and mental disability;
 - medical examinations and treatment of oral and dental diseases in persons referred to in [Article 41](#), items 1), 10) and 11) hereof, and in women with regard to pregnancy and 12 months after delivery;
 - 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 diseases, 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, systemic autoimmune disease, rheumatic illness 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 providing health care to insured persons;
 - medical examinations, treatment and rehabilitation following work-related injuries and diseases;
 - providing emergency medical and dental aid, as well as emergency medical ambulance transportation services;
 - medical-technical aids, implants and medical devices with regard to treatment of diseases and injuries referred to in this item.

- 2) At least 95% of the cost of health care service covered compulsory health care insurance for:
 - intensive care in an inpatient health care facility,
 - surgical operations performed in a surgical room, including implants 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 persons referred for treatment abroad;

- 3) At least 80% from the cost of health care service covered by compulsory health care insurance for:
 - medical examinations and treatment by a chosen physician and physician specialist;
 - laboratory, x-ray and other diagnostic and therapeutic procedures not encompassed by item 2) above;
 - 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 production of mobile orthodontic devices;
 - inpatient care treatment, as well as inpatient health care facility rehabilitation;
 - medical examinations and treatment in a day hospital including surgery outside of a surgical room;
 - medical rehabilitation in outpatient facilities;
 - medical-technical aids, implants and medical devices not encompassed by item 1) above;

- 4) At least 65% of the costs of services covered by compulsory health care insurance for:
 - diagnostic and treatment of infertility;
 - total and partial acrylate prosthesis for persons over the age of 65;
 - ocular and auricular appliances for adults;
 - gender reassignment for medical reasons;

- non-emergency medical transportation.
- (2) For health care services that are provided on the basis of entitlements deriving from compulsory health care insurance in accordance with paragraph 1 this Article, for which the Republican Fund does not make payments based on the price of health care services, but calculates the costs and makes payments in a different way (per the insured person's visit to a health professional, per diagnosis-related groups of health care services, per program, per hospital day, etc.), insured persons have the right to payment of health care service out of compulsory health care insurance funds in percentages specified in paragraph 1 this Article.
- (3) Notwithstanding paragraph 1, item 1), indent four of the Act, the Republican Fund may prescribe, under the general act, referred to in [Article 48](#), paragraph 3 hereof, participation to be paid in order to exercise the entitlements to dental health care deriving from compulsory health care insurance, if the insured person fails to honour the chosen physician's summons to a preventive examination, or if they are not entitled to preventive dental services in accordance with this Act, or republican dental health care program passed by the Government in accordance with this Act.

Article 46 H P

In the List of Medicines referred to in [Article 43](#), paragraph 3 hereof, the Republican Fund shall establish the amount of funds to be provided for medicines from the List out of the compulsory health care insurance, i.e. the amount to be provided by the insured person.

Article 47 H P

- (1) The content, scope and standards of entitlements to health care deriving from compulsory health care insurance referred to in [Article 45](#) hereof, for certain types of health care services and certain types of diseases, percentages to be paid out of the compulsory health care insurance funds up to the total amount of health care service price, percentage to be paid by the insured person are determined by the Republican Fund in the adopted general act for each calendar year.
- (2) The general act referred to in paragraph 1 above shall be aligned with the plan of health care covered by compulsory health care insurance funds and annual financial plan of the Republican Fund

- (3) Under the general act referred to in paragraph 1 above the Republican Fund may determine to pay to the insured out of compulsory health care 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, items 2) to 4) herein.
- (4) In the general act referred to in paragraph 1 above, the Republican Fund establishes the highest annual amount, i.e. the highest amount per certain type of health care service, which the insured person 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 the successful carrying out of the insured person's health care.
- (5) The Republican Fund shall adopt a general act referred to in paragraph 1 above by 31 December of the current year for the next one, at the latest.
- (6) The Government gives consent to the act referred to in paragraph 1 above.
- (7) The act referred to in paragraph 1 above is published in the "Official Gazette of the Republic of Serbia".

Participation

Article 48 H P

- (1) The amount covering the remaining amount up to the total price of health care service referred to in [Article 45](#), paragraph 1, items 2) to 4) hereof, as well as the pecuniary amount referred to in [Article 46](#) hereof (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 a voluntary health care insurance policy to the insured person.
- (2) The Republican Fund may establish, under the general act referred to in [Article 47](#), paragraph 1 hereof, for the participation which is borne by the insured person to be paid in a fixed amount, whereas such fixed amount cannot be higher than the percentage amount prescribed in accordance with this Act. ^[3]
- (3) Under the general act referred to in [Article 47](#), paragraph 1 hereof, the Republican Fund 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.

- (4) 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. Republican Fund 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 care insurance the participation amounts which differ from the amounts prescribed in [Articles 45 to 47](#) hereof, as well as to charge participation to the insured person who paid the highest annual amount of participation or the highest amount of participation for certain type of health care service.
- (5) The insured person is entitled, on the basis of own funds, i.e. voluntary health care insurance funds, to qualify for a higher content, scope and standard of entitlements referred to in [Articles 45 and 46](#) hereof, which are provided out of compulsory health care insurance funds in accordance with this Act and the regulations passed to implement this Act, by paying the difference in price determined in accordance with this Act and the regulations passed to implement this Act, and the actual price of entitlements referred to in [Articles 45 and 46](#) herein.
- (6) The Republican Fund shall under a general act specify the conditions, manner and procedure for exercising the entitlements, referred to in paragraph 5 above, deriving from compulsory health care insurance prescribed by [Articles 45 and 46](#) herein.
- (7) The general act referred to in paragraph 6 above is published in the "Official Gazette of the Republic of Serbia".

Article 49 H

- (1) Health care service provider shall issue to the insured person a receipt for the health care service provided with the data on the amount to be provided by the Republican Fund on the grounds of the entitlements deriving from compulsory health care insurance and the amount of participation to be paid by the insured person.
- (2) A model of receipt referred to in paragraph 1 above is prescribed by the Republican Fund.
- (3) The act referred to in paragraph 2 above is published in the "Official Gazette of the Republic of Serbia".
- (4) The insured person shall keep all receipts for participation paid during one calendar year, which shall serve as evidence in the procedure of establishing the right not to pay participation in the course of such calendar year, as well as other receipts for charged

health care services, in order to exercise the entitlements deriving from voluntary health care insurance.

Ban on Charging for Health Care Services Covered by Compulsory Health Care Insurance

Article 49a

- (1) A health care service provider, or a person employed by the health care service provider, or other person who performs certain tasks within the health care service providers, is prohibited from billing an insured person for health care services to which are covered under compulsory health care insurance, or from soliciting or receiving, or in any other manner lead the insured person or members of his family, or any other legal or natural person to pay, or provide any tangible or intangible benefits for the provision of such services to an insured person, unless otherwise provided by law.
- (2) An employer may, in accordance with the act governing labour, cancel the contract or terminate other types of agreements pursuant to which a person is engaged by a health care service provider to perform certain tasks, if such a person acts in contravention of paragraph 1 this Article.
- (3) Only those health care services that are not covered by compulsory health care insurance and co-payments, as determined in accordance with this Act and the regulations passed to implement this Act, may be charged to insured persons and other legal entities and individuals by health care service providers.

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 compulsory health care insurance funds, without having to pay any participation, that is:

- 1) disabled war veterans, peacetime veterans and civil invalids of war;
- 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 aids 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 aids and implants.

Article 51 H M

- (1) The insured referred to in [Article 22](#), paragraphs 1 and 4 hereof, are provided with health care which is fully covered by compulsory health care insurance funds without paying participation.
- (2) Members of nuclear family of the insured referred to in [Article 22](#), **paragraph 1, items 7) to 9) and 11) and 16)** hereof, as well as members of nuclear family of the insured referred to in paragraph 4 of that Article, are provided with health care which is fully covered by compulsory health care insurance funds without paying participation.

Health Care Content, Scope and Standards

Article 52 P

- (1) Health care content in terms of this Act entails diagnostic, treatment and rehabilitation procedures and methods for the purpose of prevention, suppression, early detection and treatment of diseases, injuries and other health disturbances which are covered by compulsory health care insurance.
- (2) Health care scope, in terms of this Act, entails the number and duration of diagnostic, treatment and rehabilitation procedures and methods, as well as other references by which the scope of certain health care contents may be expressed (systemic health care services delivery in a certain period of time, etc.), and which are encompassed by the entitlements deriving from compulsory health care insurance.
- (3) Health care standards, in terms of this Act, imply conditions for using procedures and methods which are encompassed by the entitlements deriving from compulsory health care insurance, including limitations for using and the manner of providing such health care services.

Emergency Medical Aid and Necessary Health Care

Article 53

- (1) Emergency medical aid is, in terms of this Act, immediate-instant medical aid provided in order to prevent the life of the insured person to be endangered, i.e. irreparable or serious impairment of health or death of the insured person.
- (2) Emergency medical aid, in terms of this Act, is considered to be medical aid provided within 12 hours from the moment of admittance of the insured in order to prevent an emergency situation.
- (3) Necessary health care, in terms of this Act, encompasses health care which is adequate, i.e. necessary for diagnostic, i.e. treatment of diseases or injuries of the insured person, 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.
- (4) In the procedure of the insured person's exercising of entitlements deriving from compulsory health care 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 Care Insurance

Article 54 H P

- (1) The entitlements of the insured person to health care referred to in [Articles 34 to 45](#) hereof are determined on the grounds of the health care programme relating to health care deriving from compulsory health care insurance which is developed on the basis of the following:
 - 1) health needs of insured persons;
 - 2) allocated funds for carrying out compulsory health care insurance;
 - 3) priorities set for carrying out health care at primary, secondary and tertiary level;
 - 4) the available capacities of the health care service.
- (2) The programme referred to in paragraph 1 above is developed by the Republican Fund for each calendar year, by 31 December of previous year, at the latest.
- (3) The Minister gives consent for the programme referred to in paragraph 1 above.

- (4) The programme referred to in paragraph 1 above is published in the “Official Gazette of the Republic of Serbia”.

Nomenclature and Health Care Services Price

Article 55 H P

- (1) Health care services nomenclature referred to in [Article 45](#) hereof, is established by the minister.
- (2) The Republican Fund adopts the act which specifies the following: costs of health care services, health care programme, cost of diagnosis-related groups of health care services, hospital day, the insured person’s visits to a health care professional, costs per patient, including other costs of health care services covered on the basis of entitlements deriving from compulsory health care insurance in accordance with this Act and regulations passed to implement this Act.
- (3) The Minister gives consent on the act referred to in paragraph 2 above.
- (4) Rates and costs of health care services referred to in paragraph 2 above are determined on the basis of the following:
 - 1) health care services’ nomenclature
 - 2) norms and standards of work, where required to determine the rates and costs;
 - 3) costs of the work invested by the employed in the provision of health care services which are covered by compulsory health care insurance, in accordance with law and concluded collective agreements, other than the rights provided by the employer deriving from collective agreements concluded with the employer;
 - 4) analysis of health care costs;
 - 5) depreciation prescribed by law, i.e. other regulations;
 - 6) other statutory obligations.
- (5) In order to establish rates and costs referred to in paragraph 2 above the Republican Fund establishes norms and standards of work referred to in paragraph 4, item 2) above, if they are not regulated in a different way.
- (6) The costs of treatment of blood and blood components are determined under the act of the Republican Fund, referred to in paragraph 2 above, based on the methodology for calculating the cost of treatment of blood and blood components.

- (7) The act referred to in paragraphs 2 and 5 above is published in the “Official Gazette of the Republic of Serbia”.

Waiting list

Article 56

- (1) For certain types of health care services which are covered by compulsory health care insurance and which are not urgent, an order of use may be established depending on medical indications and health status of the insured person, 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 person (hereinafter referred to as: the waiting list).
- (2) The Republican Fund adopts a general act 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 placing patients on the waiting list, the longest waiting time for health care services to be delivered, necessary data and methodology for creating such waiting lists.
- (3) The act referred to in paragraph 2 above is adopted by the Republican Fund on the basis of the professional-methodological instruction given by the Minister.
- (4) The act referred to in paragraph 2 above, prescribes the way of informing the patient, physician who referred a patient and the Republican Fund about important data from the waiting list, amendments as well as removal of insured persons from the waiting list, control over the waiting list as well as the manner of use of health care regardless of the waiting list.
- (5) Health care services provider which entered into an agreement with the respective branch, i.e. Republican Fund regarding health care delivery covered by compulsory health care insurance shall make a waiting list pursuant to paragraphs 1 to 4 above, and to deliver health care service to the insured person in accordance with such waiting list.

Prior Notification of the Insured Person

Article 57

- (1) If any health care services provider which entered into an agreement with the Republican Fund, i.e. the respective branch, establishes that a health care service is not medically

necessary, i.e. justified in terms of the health status of the insured person, such provider shall issue a written notification to the insured person (hereinafter referred to as: prior notification) before providing health care.

- (2) Prior notification shall be given by a health care services provider to the insured person who is placed on the waiting list, as well, in accordance with [Article 56](#) herein.
- (3) Prior notification contains a written information given by a health care services provider about the reasons such health care service is not medically necessary, i.e. justified for health status of the insured person, as well as the reasons why the insured person is placed on the waiting list, and about the established order of such waiting list.
- (4) If the insured person is provided with certain health care service at the personal request of the insured person regardless of the prior notification referred to in paragraph 1 above, all expenses relating to the health care service delivered thereof shall be borne by the insured person.

Right of the Republican Fund to Refuse to Pay certain Health Care Services

Article 58 H

The Republican Fund is entitled to refuse to pay the costs of health care services delivered by health care service providers for medical-technical aids, medicines, medical devices, implants, as well as other types of health care services which are not established as entitlements deriving from compulsory health care insurance, i.e. which are not in accordance with the content, scope and standards of health care covered by compulsory health care insurance.

Exercising the Rights Deriving from Compulsory Health Care Insurance in Special Circumstances

Article 59 H

- (1) If the content and scope of the entitlements to health care covered by compulsory health care insurance, established in accordance with this Act and regulations passed to implement this Act, may not be exercised due to insufficient income realized by the Republican Fund, i.e. due to any other special circumstances, the Government may pass an act by which priorities in ensuring and providing health care shall be established.

- (2) The budget of the Republic of Serbia provides funds for the treatment of patients with certain types of rare diseases if the Republican Fund cannot provide sufficient funds for the treatment of these diseases out of contributions for compulsory health care insurance, as well as other sources of funding in accordance with law.
- (3) At the proposal of the Minister of Health, for every calendar year, the Government adopts an act stipulating the rare diseases, as well as other issues of importance for the treatment of patients suffering from these diseases for which funds are provided from the budget of the Republic of Serbia.

State Guarantee for Performance of the Republic Fund's Obligations

Article 60 H

The Republic is the guarantor for the performance of the Republican Fund's obligations regarding the exercise of entitlements deriving from compulsory health care insurance (state guarantee), for emergency medical aid and health care provided to the insured persons in inpatient health care facilities, which is established as priority in accordance with Article 59 herein.

Health Care not Provided under the Compulsory Health Care Insurance

Article 61 H M S

- (1) The insured persons exercising their entitlements deriving from compulsory health care 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 in proceedings before any competent body, except examinations performed on the basis of the referral issued by a professional medical body in the procedure of exercising any entitlement deriving from health care insurance, i.e. in order to exercise certain entitlements before 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 the health status of the insured person upon the request of other bodies, i.e. not upon request of professional medical bodies in the proceedings in accordance with this Act (before insurance companies, courts, criminal proceeding and pre-trial procedures of criminal cases, issuing certificates for drivers of motor vehicles, determining medical fitness at the proposal of the employer, measures related to occupational health and safety, etc), unless otherwise provided by this Act;
- 4) the employer's obligations to provide own funds for specified health care for employees as health related social care at the level of employer in accordance with the act governing health care;
- 5) exercising health care contrary to the manner and procedure prescribed by this Act and regulations passed to implement this Act;
- 6) personal comfort and special accommodation and personal care in inpatient health care facilities, i.e. accommodation in single or double hospital room with separate bathroom, TV set, telephone and other non-standard conditions of accommodation, which is medically unnecessary or provided upon personal request;
- 7) services related to treatment of acute alcohol intoxication;
- 8) cosmetic surgical procedures aiming to improve appearance without establishing or restoring bodily functions, as well as aesthetic surgical corrections of organs and body parts except for: correction of congenital abnormalities that cause functional problems, cosmetic breast reconstruction following mastectomy and cosmetic correction following serious injuries or illnesses 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 a certain job;
- 11) dental services not established as entitlements deriving from compulsory health care insurance in accordance with this Act and other regulations passed to implement this Act;
- 12) diagnosis and treatment of sexual dysfunction or sexual inadequacy, including impotence, health care services, medicines and medical-technical aids relating to gender reassignment, unless otherwise provided by this Act and reversion of previously voluntary surgical sterilization;
- 13) surgical or invasive treatment (including gastric balloon) related to weight reduction, except if medically needed, dietary counselling and weight loss programmes for

- persons over the age of 15, except dietary nutrition to be prescribed to newly diagnosed patients with diabetes and patients with terminal 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 herein), i.e. medicines obtained without a prescription, prophylactic medicines and medicines aimed to change athletic capabilities, medicines prescribed for cosmetic reasons, for smoking cessation, 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 medicines and medical devices which are currently under clinical trial, diagnosis, treatment and rehabilitation, medicines and medical-technical aids which are 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 eligible for compulsory health care insurance, i.e. sports medicine programmes aiming to improve sports skills;
 - 18) radial keratotomy or any other surgical procedure to improve vision, where the vision may adequately be improved with glasses or contact lenses;
 - 19) ambulance transportation services in the event the insured person may safely be transported in other adequate manner, and emergency air transportation in the event the insured person may safely be transported by road or other transport;
 - 20) hydrotherapy, hypnosis therapy, electrohypnosis, electrosleep therapy, electronarcosis and narcosynthesis;
 - 21) psychological counselling related to behaviour change, treatment of bad family and work relationships, and incapacity to memorize and learn;
 - 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 regular personal care and recovery, i.e. to care and assist the insured person in performing everyday activities, such as walking, getting in and out of bed, bathing, dressing, food preparation, supervision of medicine administration, and not aimed at diagnosis, therapy or rehabilitation due to disease or injury;
 - 23) medical-technical aids and implants which exceed functional standards medically necessary for treatment of disease or injury ;

- 24) treatment of complications resulting from health care services health care services not covered by compulsory health care insurance, in accordance with this Act;
- 25) other types of health care services not established as entitlements deriving from the compulsory health care insurance, in accordance with the Republican Fund's general act.
- (2) The costs of services referred to in paragraph 1 this Article shall be borne by the insured person from their own funds at prices determined by the provider of health care services.

Health Care of Insured Persons Abroad

Article 62

- (1) The insured referred to in [Article 17](#) hereof, 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 care insurance funds, in accordance with the said signed international agreement on social insurance.
- (2) The insured referred to in paragraph 1 above shall use health care abroad in the content, scope, and manner and through procedure prescribed by this Act and regulations passed to implement this Act, as well as by international agreement on social insurance signed between the relevant countries.
- (3) Members of nuclear family of the insured referred to in paragraph 1 of above, who reside with the insured abroad, shall use health care under the same conditions as the insured referred to in paragraph 1 above.

Article 63

- (1) The insured sent abroad by employer, with registered office in the territory of the Republic, to a country which has not concluded an international agreement on social insurance with the Republic, is entitled to health care covered by compulsory health insurance if:
- 1) sent to work as an employee in a local company or mixed company, institution, other organizations or with an entrepreneur (seconded 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 a business trip.

- (2) For the period of their sojourn abroad, persons referred to in paragraph 1 above, are entitled to use health care only in the event of a medical emergency in order to remove an immediate threat to the life and health of the insured person.
- (3) Members of nuclear family while residing abroad with the insured, except in the event of a business trip of the insured, are entitled to health care abroad under the same conditions as the insured to in paragraph 1 above.

Article 64 S

For the period of a private sojourn abroad (tourist travels, etc.), the insured person is entitled to health care only in the event of a medical emergency in order to remove an immediate threat to the life and health of the insured person.

Article 65 H S

- (1) Insured persons are entitled to health care abroad covered by compulsory health care insurance where prior to their departure it has been established that in the last 12 months they have not suffered from any acute diseases or chronic diseases in acute phase which require a longer treatment or permanent treatment, i.e. that the status of the insured person does not require, soon after arrival abroad, longer treatment or accommodation in inpatient health care facilities, including pregnancy and other health care services.
- (2) Health status referred to in paragraph 1 above is determined by first-instance medical commission of the respective branch which issues a certificate on the health status of the insured person for the purpose of using health care abroad (hereinafter referred to as: the certificate on the use of health care abroad).
- (3) Certificate on the Use of Health Care Abroad is issued based on the findings and opinions of the chosen physician stating that in the last 12 months they have not suffered from any acute diseases or chronic diseases in acute phase which require a longer treatment or permanent treatment, i.e. that the status of the insured person does not require, soon after arrival abroad, longer treatment or accommodation in inpatient health care facilities, including pregnancy and other health care services.

- (4) In order to issue the Certificate on the Use of Health Care Abroad, a first-instance medical commission may require the insured person to undergo certain medical examinations in order to establish the health status of the insured person.
- (5) Findings and opinions of the chosen physician, i.e. establishment of the health status of the insured person by the first-instance medical commission, issuance of the Certificate on the Use of Health Care Abroad provided to the insured person are covered by compulsory health care insurance funds.
- (6) Certificate on the Use of Health Care Abroad is issued on the basis of a direct medical examination of the insured person by the 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 that in the last 12 months the insured person has not suffered from any acute diseases or chronic diseases in acute phase which require a longer treatment or permanent treatment, i.e. that the status of the insured person does not require, soon after arrival abroad, longer treatment or accommodation in inpatient health care facilities, including pregnancy and other health care services, as well as a certificate of the chosen physician-dentist with regard to dental status.
- (7) The respective branch issues a Certificate on the Use of Health Care Abroad in the form prescribed by the Republican Fund with detailed explanation of the manner, procedure and conditions of using health care abroad.

Article 66

- (1) Certificate on the Use of Health Care Abroad is valid until the expiration of the period for which it is issued, but not longer than 12 months from the date of issuance, i.e. for the shorter period of time the insured shall spend abroad, and cannot be issued to the insured person where the first-instance medical commission has found impediments relating to the health status of the insured person.
- (2) Notwithstanding paragraph 1 above, the Certificate on the Use of Health Care Abroad in the course of a private sojourn abroad, referred to in Article 64 hereof, is issued for the 90 days period at the most from the date of issuance.

Article 67

The insured person who has resided abroad without predetermined health status by the first-instance medical commission, i.e. without an issued Certificate on the Use of Health Care

Abroad, is not entitled to reimbursement of costs incurred by using emergency medical aid during the sojourn abroad.

Article 68

- (1) If the insured person uses emergency medical aid in inpatient health care facility during a sojourn abroad, he/she may use it abroad only for such a time as is necessary to qualify for safe return to the country of origin.
- (2) Whether the hospital treatment referred to in paragraph 1 above 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 person may use health care covered by the compulsory health care insurance only in health care institutions which are a part of the public health system of such foreign country.

Article 70

Whether temporary incapacity of the insured, which ensued during the temporary sojourn abroad, in a country which has not concluded an international agreement on social insurance with the Republic, is justifiable shall be assessed by the medical commission of the respective branch on the basis of a proposal of the chosen physician at the request of the insured and the enclosed medical documentation from the first day of such incapacity.

Article 71 M

- (1) The insured persons exercise abroad the right to purchase medical-technical aids, as well as implants, which are necessary in the event of a medical emergency, in the same manner as the insured in the country, upon prior approval of the medical commission of the respective branch.
- (2) The right referred to in paragraph 1 above is exercised on the basis of the medical documentation and cost estimate and specification to be enclosed upon the request of the medical commission.
- (3) Total expenses to be reimbursed from compulsory health insurance funds for exercising the right referred to in paragraphs 1 and 2 above, shall not be higher than such expenses relating to the exercise of the rights in the country, under conditions prescribed by this Act.

Referral for Treatment Abroad

Article 72 **H P**

- (1) Referral for treatment abroad covered by compulsory health care insurance may be exceptionally approved to the insured person, for treatment of diseases, conditions or injuries which cannot be successfully treated in the Republic, where there is a possibility of successful treatment of such disease, condition or injury abroad.
- (2) The Republican Fund passes the general act governing details relating to conditions, the manner and procedure as well as type of diseases, conditions or injuries for which a treatment abroad may be approved.
- (3) The general act referred to in paragraph 2 hereof, is published in the “Official Gazette of the Republic of Serbia”.

3. Entitlement to Benefits for the Period of Temporary Incapacity

Eligibility for Benefits

Article 73 **M**

The following insured are entitled to the benefits covered by compulsory health care insurance:

- 1) the employed referred to in [Article 17](#), paragraph 1, items 1) to 7) herein;
- 2) entrepreneurs referred to in [Article 17](#), paragraph 1, item 18) herein;
- 3) priests and church officials referred to in [Article 17](#), paragraph 1, item 20) herein.

Article 74 **H M P**

- (1) The insured referred to in [Article 73](#) hereof, are entitled to temporary incapacity benefits if the health status of the insured ,i.e. of a member of his/her nuclear family is such that the insured are prevented from working for reasons prescribed by this Act, regardless of the benefit payer, i.e. in the following situations:
 - 1) temporary incapacity due to disease or injury not related to work;
 - 2) temporary incapacity due to a work-related disease or injury;

- 3) temporary incapacity due to a disease or complication relating to pregnancy maintenance;
- 4) temporary incapacity due to prescribed compulsory isolation measure as germ carriers or due to contagious diseases in his/her environment;
- 5) temporary incapacity due to care for an ill nuclear family member under conditions prescribed by this Act;
- 6) temporary incapacity due to voluntary organs and tissue donation, excluding voluntary blood donation;
- 7) temporary incapacity due to being appointed as an escorting person to a sick insured person referred for treatment or medical examination to another location, i.e. while staying as an escorting person in an inpatient health care facility, in accordance with the general act of the Republican Fund;

- (1) Duration of temporary incapacity is assessed by the professional medical body of the Republican Fund, i.e. of the respective branch, on the basis of medical-doctrinal standards for establishing temporary incapacity.
- (2) Medical-doctrinal standards, referred to in paragraph 2 above, are established by the Republican Fund on the proposal of the republican expert commissions for certain types of disease.
- (3) The chosen physician or a member of the expert-medical body of the Republican Fund, i.e. of the respective branch, is prohibited from establishing temporary incapacity in any insured where the requirements referred to in paragraph 1, items 1) to 7) above are not met.

Article 75

- (1) The insured without creditable coverage, referred to in [Article 32](#) hereof, at the time of occurrence of temporary incapacity, is entitled to benefits covered by compulsory health care insurance in the amount of minimum salary determined in accordance with regulations governing labour issues for the month such benefits are paid.
- (2) When the insured has complied with the conditions in regard to creditable coverage, and earned the salary which constitutes the basis for benefits calculation, in accordance with this Act, the insured is entitled to benefits which are calculated and paid under the conditions prescribed by this Act.

Consecutive Temporary Incapacity

Article 76

- (1) In the event the insured is temporarily incapacitated for one of the reasons referred to in [Article 74](#), paragraph 1 hereof, and then without interruption (the next day) he/she becomes temporarily incapacitated for another reason of temporary incapacity referred to in [Article 74](#), paragraph 1 hereof, days of temporary incapacity of the insured are not adjoined in regard to the grounds, amount and payer of benefits.
- (2) In the event the insured is temporarily incapacitated due to one disease or injury, and the other day (without interruption), i.e. no later than six days from the last day of previous temporary incapacity, the insured is unable to work due to the same or a different disease or injury, days of temporary incapacity are adjoined in regard to the grounds, amount and payer of benefits.
- (3) In the event the insured is temporarily incapacitated due to the same or two different diseases, i.e. injuries, with an interruption between temporary incapacities which is longer than six days from the last day of previous incapacity, days of temporary incapacity are not adjoined in regard to the grounds, amount and payer of benefits.
- (4) In the event referred to in paragraph 2 above, the chosen physician shall refer the insured to a first-instance medical commission after 30 days of the total period of temporary incapacity.
- (5) In the event referred to in paragraph 3 above, the chosen physician shall refer the insured to the first-instance medical commission if the insured was temporarily incapacitated for a total of 30 days within the period of 45 days from the first day of incapacity.

Duration of Entitlement to Temporary Incapacity Benefit

Article 77

- (1) Incapacity starts on the day when a chosen physician establishes that the insured is unable to perform his/her work due to disease or injury, i.e. on the day when the chosen physician establishes a need of a member of nuclear family of the insured to be cared for or when he/she establishes any other prescribed cause for temporary incapacity of the insured.
- (2) Notwithstanding paragraph 1 above, a chosen physician may evaluate temporary incapacity 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 no more than three days retroactively from the day the insured has appeared before a chosen physician.

- (3) If the insured was in inpatient health care treatment or if temporary incapacity occurred during his/her sojourn abroad, as well as in other justifiable cases when the insured could not visit the chosen physician, i.e. could not notify such physician of the reasons for the incapacity to work, upon the proposal of the chosen physician a medical commission may evaluate such incapacity of the insured for the period longer than three days prior to his/her appearance before a chosen physician.

Article 78 M

- (1) A chosen physician, i.e. medical commission establishes temporary incapacity of the insured as of the date such temporary incapacity starts and by the date such temporary incapacity ends.
- (2) The right of the insured to a benefit for the period of temporary incapacity may last only until causes of such work incapacity are removed, depending on the type and cause of disease, i.e. injury, in accordance of this Act.
- (3) The entitlement to benefit is exercised from the first day of such work incapacity and throughout its duration, but only for the period of employment the insured would receive the salary for, in accordance with the regulations governing labour issues, i.e. for the period of time he/she would have performed entrepreneurial activity had the temporary incapacity not occurred.
- (4) Notwithstanding paragraph 3 above, if temporary incapacity is caused by a work-related injury or occupational disease, the insured is entitled to benefit from the first day of such incapacity and throughout its duration, as well as following the termination of employment of the insured, until the chosen physician, i.e. medical commission has established that the cause of such temporary incapacity is removed.

Article 79

- (1) The insured referred to in [Article 73](#) hereof, is entitled to benefit due to care for a sick nuclear family member under the age of seven or an elderly nuclear family member with severe physical and mental disability, not longer than 15 calendar days in every single case of illness, whereas such sick i.e. injured nuclear family member is over the age of seven, not longer than 7 calendar days.

- (2) Notwithstanding paragraph 1 above, when there are justifiable reasons relating to health status of a nuclear family member, the first-instance medical commission may extend the duration of temporary incapacity due to care for a nuclear family member up to 30 days as the most, for the care of a child under the age of seven or an elderly nuclear family member with severe physical and mental disability, i.e. up to 14 days for the care of a nuclear family member over the age of seven.
- (3) In the case of severe health impairment of a child under the age of 18 due to severe brain structure damage, malignant disease or any other serious deterioration of the child's health, the second-instance medical commission may, upon the proposal of health care institution at tertiary level responsible for treatment of such child and the referral of the chosen physician, extend the entitlement to benefit for care for a nuclear family member up to 4 months.

Article 80

The insured is entitled to benefit for care of a child if both parents are employed, i.e. if both parents perform an entrepreneurial activity on the basis of which they are insured, or if such child has only one parent, i.e. if one parent is unemployed, i.e. does not perform an entrepreneurial activity, but is incapable of taking care of the ill child due to health reasons.

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

Article 81

- (1) Regardless of duration and causes of temporary incapacity of the insured, a chosen physician, i.e. medical commission shall forthwith refer the insured to the body competent work capability, i.e. disability assessment in accordance with the regulations governing pension and disability insurance (hereinafter referred to as: Disability Commission), if such chosen physician i.e. medical commission evaluates that health status of the insured indicates work capability loss, i.e. that improvement of health status of the insured, which would enable him/her to restore work capability, is not expected.
- (2) In the event of longer incapacity to work due to disease or injury, but not longer than 6 months of continuous incapacity, i.e. where in the last 18 months, the insured has been incapacitated for 12 months with interruptions, a chosen physician i.e. medical

commission shall refer the insured with necessary medical documentation to Disability Commission for work capability assessment.

Article 82

- (1) Where in the course of temporary incapacity, the insured is referred to Disability Commission, referred to in Article 81 hereof, he/she is entitled to benefit covered by compulsory health care insurance not longer than 60 days from the date of filing a request for instituting proceedings before the competent compulsory pension and disability insurance organization.
- (2) The competent compulsory pension and disability insurance organization shall assess, within the period, referred to in paragraph 1 above, in accordance with regulations governing pension and disability insurance, whether or not the insured referred to such assessment in accordance with Article 81 hereof, have sustained the loss of work capability.
- (3) Should the competent compulsory pension and disability insurance organization fail to issue the ruling, referred to in paragraph 2 above, within 60 days from the date of filing the request for instituting proceedings in accordance with Article 81 hereof, as of the 61 day the insured is entitled benefit which shall be covered the competent compulsory pension and disability organization out of its own funds.
- (4) Notwithstanding paragraph 1 above, should the complete loss of work capability be established before the end of the 60 days from the date of filing of the request, the benefit shall be covered by compulsory health care insurance until the date of establishing complete loss of work capability, and after such date the benefit shall be covered by the competent compulsory pension and disability insurance organization.
- (5) The claim for the paid benefit from the competent pension and disability insurance organization is due on the date when such benefit is paid, whereas the reimbursement of the benefit is made in accordance with the provisions of the Act governing contractual relations.

Article 83

For the duration of temporary incapacity, every thirty days of such incapacity a medical commission, regardless of the payer of benefit, evaluates such temporary incapacity of the insured who is referred to Disability Commission in accordance with this Act, upon the proposal of the chosen physician, in the manner and according to the procedure established

by this Act and regulations passed to implement this Act, up to the day the ruling, referred to in [Article 82](#) hereof, is served.

Article 84

- (1) The competent compulsory pension and disability insurance organization shall promptly forward to the respective branch, i.e. to the Republican Fund, the ruling on complete loss of work capability, i.e. that there is no such complete loss of work capability of the insured within 15 days from the date of issuing of such ruling.
- (2) The entitlement to benefit ceases on the day of service of final ruling referred to in paragraph 1 above.
- (3) Relations between the Republican Fund and the competent pension and disability insurance organization with regard to referral of the insured to work capability assessment, benefit payments and other issues of mutual interest, are governed by a separate agreement.

Ineligibility for Benefits

Article 85

- (1) Temporarily incapacitated insured in accordance with this Act are not entitled to benefits, regardless of payer, in the following cases:
 - 1) work incapacity deliberately caused;
 - 2) work incapacity caused by acute alcohol intoxication or the use of psychotropic substances;
 - 3) deliberately prevented restoration of health, i.e. restoration of work capability;
 - 4) if he/she refuses treatment without justified reason, except in the event that the consent provided by law is not needed for treatment;
 - 5) if he/she fails to present him/herself to a chosen physician for temporary incapacity assessment without justifiable reason, or fails to respond to the medical commission's summons, within 3 days from the date such temporary incapacity has occurred, i.e. from the date of service of the summons to appear before the medical commission, i.e. from the date the circumstances which prevented him/her from it have ceased;

- 6) if he/she carries out any economic or other activity for the period of such temporary incapacity to generate income;
 - 7) if he/she leaves the place of domicile, i.e. residence, without permission of the professional medical body of the respective branch or the Republican Fund, or if a chosen physician, i.e. a competent body for control of exercising entitlements deriving from compulsory health care insurance establishes that the insured does not comply with instructions for treatment;
 - 8) if he/she receives a benefit under any other regulations;
 - 9) if he/she abuses the entitlement to temporary incapacity leave in any other way;
- (2) The insured is not entitled to benefit from the day the circumstances referred to in paragraph 1 above have been established, and throughout the period such circumstances or their consequences remain.
- (3) Persons serving prison sentences 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 benefits.
- (4) Should the facts, referred to in paragraph 1 above, be established after starting to exercise the entitlement to benefit, i.e. after exercising the entitlement to benefit the benefit payer is entitled to reimbursement of all funds paid.

Article 86 M

- (1) The insured, referred to in [Article 17](#), paragraph 1, item 18) hereof, is not entitled to benefits covered by compulsory health care insurance, if for the period of such temporary incapacity he/she has not temporarily terminated his/her economic activity, regardless of the benefit payer.
- (2) In the event referred to in paragraph 1 above, the insured who employs one or more workers is entitled to 50% of the benefit to which he/she would have been entitled had he/she terminated the economic activity.

Benefit Basis

Article 87

The basis for benefit for the employed insured referred to in [Article 73](#), item 1) hereof, which is paid by employer from own funds, is established in accordance with the regulations governing labour issues.

Article 88

- (1) The basis for calculation of benefit (hereinafter referred to as: benefit basis), which is covered by compulsory health care insurance, for the insured referred to in [Article 73](#), item 1) hereof, includes the average salary of the insured in the last three months preceding the month in which temporary incapacity has occurred.
- (2) Salary in terms of paragraph 1 above includes 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 service in employment relationship.
- (3) For the period of benefit coverage by compulsory health care insurance, for the insured with creditable coverage, the benefit basis is established in accordance with paragraph 1 above.
- (4) For the insured who is not eligible in regards to creditable coverage at the time he/she starts to exercise the entitlement to benefit covered by compulsory health care insurance, the benefit basis is established in accordance with paragraph 1 above from the moment such requirements in regard to the creditable coverage have been met as well as in regard to earning the salary referred to in paragraph 2 above.

Article 89

- (1) The benefit basis to be calculated for each month included in average salary referred to in Article 88 hereof, may not exceed the highest monthly basis on which the contributions, which are included in the average salary, are paid for the month, in accordance with the act governing compulsory social insurance contributions.
- (2) The highest benefit basis is the sum of the highest monthly bases on which contributions have been paid for each of three months entering into the average salary.
- (3) Should the insured who is eligible in regards to creditable coverage fail to earn a salary in three calendar months preceding the month when temporary incapacity has occurred,

the benefit basis shall comprise the average salary, referred to in Article 88, paragraph 2 hereof, for the period the insured earned a salary in, subject to the highest benefit basis referred to in paragraph 2 above.

- (4) Should the insured eligible in regards to creditable coverage fail to earn a salary in any of the three calendar months preceding the month before temporary incapacity has occurred, the benefit basis shall comprise the salary which the insured would have earned in accordance with Article 88, paragraph 2 hereof, in the month for which benefit is paid had it not been for temporary incapacity.

Article 90

- (1) The benefit basis for the insured, referred to in [Article 73](#), items 2) and 3) hereof, who are eligible in regards to creditable coverage, is the average monthly basis on which contributions for compulsory health care insurance have been paid in accordance with law, established in the calendar trimester preceding the trimester when situation occurred on the basis of which the right to benefit is obtained, whereas if he/she has been insured on that grounds for a shorter period in the previous trimester, the benefit basis shall be the basis on which contributions for compulsory health care insurance are paid, established according to the period of time he/she has been insured in the previous trimester.
- (2) If the insured, referred to in paragraph 1 above, has not performed an entrepreneurial activity, i.e. a religious function, the benefit basis shall be the basis referred to in paragraph 1 above established for the current calendar trimester.

Article 91

For the insured who had worked with two or more employers, or performed an entrepreneurial activity and worked with an employer before temporary incapacity occurred, the benefit basis is determined by the total sum of benefit bases referred to in Articles [88](#) and [90](#) hereof, which sum cannot exceed the highest benefit basis referred to in [Article 89](#), paragraph 2 herein.

Benefit Basis Adjustment

Article 92

- (1) When the insured, referred to in [Article 73](#), item 1) hereof, receives the benefit covered by compulsory health care insurance longer than two calendar months, he/she is entitled to benefit basis adjustment.
- (2) Benefit basis adjustment is performed as of the first day of the calendar month following the end of the second calendar month of continuous work incapacity.
- (3) The benefit basis, referred to in paragraph 1 above, is harmonized with fluctuation of salaries at the employer's company in the month preceding the month from which the insured is entitled to benefit basis adjustment (first benefit basis adjustment).
- (4) Each consecutive benefit basis adjustment is carried out monthly according to fluctuation of salaries at the employer's company.

Article 93

- (1) When the insured, referred to in [Article 73](#), items 2) and 3) hereof, receives the benefit covered by compulsory health care insurance longer than two calendar months, he/she is entitled to benefit basis adjustment.
- (2) Benefit basis adjustment is performed from the first day of the calendar month following the end of the second calendar month of continuous work incapacity.
- (3) The benefit basis, referred to in paragraph 1 above, is harmonized with fluctuation of average monthly salary per employee on the territory of the Republic according to the latest data of the republican authority in charge of statistics, in the month preceding the month as of which the insured is entitled to benefit base adjustment (first benefit basis adjustment).
- (4) Each subsequent benefit basis adjustment is carried out monthly according to fluctuation of average monthly salary per employee on the territory of the Republic according to the latest data of the republican authority in charge of statistics.

Article 94

The adjusted amount of benefit basis, referred to in Articles [92](#) and [93](#) hereof, may not exceed the highest benefit basis, referred to in [Article 89](#), paragraph 2 herein.

Benefit Amount

Article 95 M

The amount of benefit covered by employer from own funds for the first 30 days of work incapacity in the cases referred to in [Article 74](#), paragraph 1 hereof, is determined in accordance with the regulations governing labour issues, and this Act.

Article 96

- (1) The amount of benefit covered by compulsory health care insurance, as well as by employer from own funds in the cases referred to in [Article 74](#), paragraph 1, items 1), 4), 5) and 7) hereof, is equivalent to 65% of the benefit basis.
- (2) The amount of benefit covered by compulsory health care insurance, as well as by employer from own funds, in the cases referred to in [Article 74](#), paragraph 1, items 2) and 6) hereof, is equivalent to 100% of the benefit basis.
- (3) In the event of temporary incapacity due to illness or complications associated with the maintenance of pregnancy, in the first 30 days of temporary incapacity, benefit covered by employer from own funds shall be equivalent to 100% of the benefit basis.**
- (4) In the event of temporary incapacity due to illness or complications associated with the maintenance of pregnancy, from 31 days of temporary incapacity, benefit shall be equivalent to 100% of benefit basis, whereas 65% of the benefit basis shall be covered by compulsory health care insurance and 35% of the benefit basis shall be covered by the Republican budget.**
- (5) Funds in the amount of 35% of the benefit basis, referred to in paragraph 4 above, shall be transferred to the Republican Fund, which in the name and for the account of the Republican budget credits the funds to the account of the insured referred to in paragraph 3 above.**

Article 97

The amount of benefit covered by compulsory health care insurance can neither be lower than minimum salary determined pursuant to the regulations governing labour issues for the month for which the calculation of benefit is made, nor can it exceed 65%, i.e. 100% of the highest benefit basis established in accordance with this Act.

Article 98

- (1) The insured is entitled to benefit covered by compulsory health care insurance in the amount of minimum salary for the month in which payment of benefit is made, in

accordance with the regulations governing labour issues, for the period when his/her employer does not pay any salary to employees but calculates and pays contributions - but not longer than three calendar months.

- (2) If the employer subsequently pays the salary to employees, the insured referred to in paragraph 1 above is entitled to re-calculation of benefit covered by compulsory health care insurance, under conditions provided by this Act.

Benefit in Special Cases

Article 99 H

- (1) When the expert-medical body of the respective branch, i.e. of the Republican Fund, establishes during the treatment of the insured receiving benefit, that his/her health status is improved and the work would help the insured to better recover his/her work capability in full, it may decide for the insured to work part-time, i.e. minimum four hours a day.
- (2) Part-time work, referred to in paragraph 1 above, may not exceed three consecutive months or twelve months with interruptions from the day such part-time work commenced.
- (3) The employer with whom the insured is employed shall provide the employed an opportunity to work part-time in accordance with paragraphs 1 and 2 above.

Article 100

The insured working part-time during temporary incapacity, in accordance with Article 99 hereof, is entitled to benefit in proportion to the time spent working full-time.

Article 101

- (1) If in the course of exercising entitlement to benefit, the insured is suspended from work under a decision relating to criminal proceedings instituted against him/her, in the event of detention, or any other event stipulated by law, benefit shall be paid in the amount of one fourth of the prescribed benefit, and if he/she maintains the nuclear family members, in the amount of one third of such benefit.
- (2) If the proceedings against the insured, referred to in paragraph 1 above, are suspended, i.e. if the insured is acquitted, i.e. if no disciplinary measure is pronounced against the insured for breach of duty or breach of working discipline, such insured shall be paid a part of the benefit up to the full amount established in accordance with this Act.

Benefit Payment

Article 102 H M

- (1) Benefit in the cases of temporary incapacity referred to in [Article 74](#) hereof, for the first 30 days of such incapacity is covered by employer from own funds, whereas from the 31st day, such benefit is covered by the Republican Fund, i.e. the respective branch.
- (2) Notwithstanding paragraph 1 above, the benefit covered by compulsory health care insurance is provided from the first day of work incapacity for the insured whose work incapacity is due to voluntary tissue and organs donation, as well as for the insured mother, i.e. father, adoptive parent or other insured who provides care to a child, during the period of temporary incapacity due to care for a sick child under the age of three.
- (3) Notwithstanding paragraph 1 above, the benefit in the event of temporary incapacity of the insured due to work-related injury or occupational disease, referred to in [Article 73](#), item 1) hereof, shall be covered by the employer from own funds for the duration of employment of the insured, from the first day of temporary incapacity for the duration of such incapacity of the insured.
- (4) The benefit of the insured, whose employment is terminated while exercising the entitlement to benefit due to a work-related injury or occupational disease, shall be covered by the respective branch, or the Republican Fund, from the day of employment termination.
- (5) The benefit of the insured referred to in [Article 73](#), items 2) and 3) hereof, due to work-related injury or occupational disease shall be covered by the respective branch, i.e. the Republican Fund, from the thirty-first day of the continuous work incapacity and for the duration of such incapacity of the insured.

Article 103 M

- (1) The employer pays to employees a benefit which is covered by compulsory health care insurance, in accordance with this Act.
- (2) The employer makes an account of the benefit, referred to in paragraph 1 above, in accordance with this Act and submits it to the respective branch.
- (3) The respective branch establishes the entitlement to benefit and benefit amount and within 30 days from the date it receives the account, referred to in paragraph 2 above, transfers the appropriate funds into the employer's special account.

- (4) The funds, referred to in paragraph 3 above, which are not paid to the insured within 30 days from the date such funds are received, shall be returned by the employer to the respective branch with interest by which such funds have increased while being on the employer's separate account.
- (5) The funds, referred to in paragraph 3 above, may not be used otherwise than for the purpose referred to in paragraph 1 above.
- (6) Benefits of entrepreneurs and their employees, provided that entrepreneurs do not have a separate account, including priests and church officials, which are covered by the funds of the respective branch are calculated and paid by such respective branch.
- (7) The employer may pay the benefit from own funds even when such benefit is covered by compulsory health care insurance, whereas the respective branch shall reimburse such paid amounts to the employer within 30 days from the day a request is submitted to such respective branch.

4. Entitlement to transportation benefit

Article 104

- (1) Transportation benefit relating to the use of health care is provided for insured persons, as well as for an escorting person of the insured person in the event of referral to a health care institution outside of the respective branch territory, if such health care institution is located at least 50 km from his/her place of residence, in accordance with provisions herein. ^[3]
- (2) The insured person is entitled to transportation benefit when such insured person has been referred or invited by the chosen physician, health care institution or competent medical commission to another place within the territory of the respective branch for health care delivery or temporary capability assessment.
- (3) Notwithstanding paragraph 1 above, the insured person referred to haemodialysis, as well as chemo and radio therapy, a child under the age of 18 and the elderly with severe physical and mental disability referred to daily treatment and rehabilitation in a health care institution, i.e. private practice outside of his/her place of domicile, to another place within the territory of the respective branch, is entitled to transportation benefit on the basis of an opinion of the medical commission.

Article 105

- (1) Insured persons are entitled to transportation benefit by the shortest route in the amount equivalent to the price of bus or second class train fare.
- (2) Notwithstanding paragraph 1 above, considering the nature of disease or injury, the insured person is entitled to transportation benefit for other means of public transport if such transportation is necessary.
- (3) 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 person is entitled to actual transportation costs reimbursement not exceeding 10 % of the price of one litre of petrol for each kilometre.

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 to the place of employment or domicile, unless special transportation is necessary due to the health status of the insured person, which shall be decided by the first-instance medical commission.

Article 107

If the insured person is entitled to transport free of charge, pursuant to other regulations, such insured person is not entitled to transport benefit, and if he/she is entitled to transport with a discount, he/she is entitled to coverage of a part of transportation costs equal to the difference, up to full transportation costs.

Article 108

- (1) The insured person be designated an escorting person while travelling, or while travelling and staying in another place, if necessary.
- (2) An escorting person is entitled to transportation costs reimbursement under the same conditions as prescribed for the insured person.
- (3) An escorting person is entitled to transportation costs reimbursement of both the costs of returning to his/her place of domicile, i.e. residence or going to another place with the insured person in the escorting capacity.
- (4) An escorting person is considered necessary where a child under the age of 18, or an elderly person with severe physical or mental disability is sent to a medical treatment or medical examination in another place.

5. Due Entitlements and Time Period for Exercising thereof

Article 109

- (1) A benefit is due following the last day the insured is entitled to such benefit for temporary incapacity lasting less than a month, and where it is over one month, following the last day in a month for each month the insured is entitled to benefit.
- (2) Transportation costs reimbursement is due on the day of termination of travel for purposes of medical treatment.
- (3) The branch carries out payment of benefits, referred to in paragraphs 1 and 2 hereof, within 30 days from the day a request for such payment of benefits has been presented.

Article 110

A request for exercising benefit entitlements and other entitlements deriving from health care 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 ENTITLEMENTS DERIVING FROM COMPULSORY HEALTH CARE INSURANCE

1) Establishing the Status of the Insured Person

Article 111 H

- (1) The status of the insured person is established by the respective branch which is considered as such in terms of this Act.
- (2) The status of the insured person is established upon one basis only.
- (3) The status of the insured person ceases on the day the basis upon which such status is recognised has ceased.

Article 112 H P

- (1) A person recognised the status of the insured person is issued by the respective branch a prescribed document on health care insurance (hereinafter referred to as: insurance document). ^[1]

- (2) A person provided with entitlements deriving from compulsory health care insurance in particular circumstances, referred to in [Article 28](#) hereof, is issued a special document for using health care only in the event of a work-related injury or disease. ^[1]
- (3) The insurance document, referred to in paragraphs 1 and 2 above, also includes the health card which contains a space for contact microcontroller (chip) and a machine-readable zone for automatic reading of data, containing all data from the insurance document and the data maintained in the Central Registry in accordance with this Act and the regulations adopted to implement this Act.
- (4) Health card issuing costs referred to in paragraph 3 above shall be borne by the insured for themselves and their families.
- (5) Notwithstanding paragraph 4 above, the contribution payers, i.e. other legal or natural person, i.e. the Republican Fund may undertake to reimburse the costs of issuing health cards.
- (6) The costs referred to in paragraph 4 above are prescribed by the Republican Fund.
- (7) The funds collected in accordance with paragraph 6 above shall constitute the revenue of the Republican Fund.
- (8) The Government gives consent on the act referred to in paragraph 6 above.
- (9) The Republican Fund shall prescribe the content and form of the insurance document, health card, i.e. the special document for using health care referred to in paragraphs 1 to 3 above, its authentication and other relevant issues for the use of such documents.
- (10) The act referred to in paragraphs 6 and 9 above is published in the ‘‘Official Gazette of the Republic of Serbia’’.

Article 113

- (1) Legal and natural persons shall present the respective branch all information in regard to the compulsory health care insurance application, change and cancellation in order to establish the status of the insured person, or to discontinue or enter changes to the status of such person.
- (2) Based on the data, referred to in paragraph 1 above, the respective branch establishes facts for acquiring the status of the insured person on a compulsory basis.
- (3) The deadline for submitting the health care insurance application, change or cancellation form is eight days as of the date of compliance with the necessary requirements.
- (4) Notwithstanding paragraphs 1 to 3 above, the respective branch may, ex officio, discontinue compulsory health insurance in the event natural or legal person, who is subject to the submission of health insurance cancellation form, has ceased to exist , i.e.

passed away, or where at the time of filing of health insurance application, the discontinuation date of insurance basis on which such person has acquired the status of an insured in accordance with this Act, provided that the person who is subject to the submission of health insurance cancellation form fails to submit such form.

Article 114

- (1) If the respective branch does not recognise the status of the insured person to the person for whom the compulsory health care insurance application has been submitted, or recognises the status upon some other basis, the respective branch shall issue a ruling thereon which shall be serviced to the applicant.
- (2) The respective branch shall issue a ruling on the established status of the insured person deriving from compulsory insurance, or its cancellation, or any changes in the status of such person, upon the request of the insured person, or another competent authority.
- (3) Should a legal or natural person fail to submit the compulsory health insurance application within the period prescribed by this Act, the respective branch shall ex officio establish the status of the insured person, and issue a ruling thereof.
- (4) In the ruling, referred to in paragraph 3 above, the respective branch defines the date of acquiring the status of the insured person and due liabilities in respect of payment of contributions as of the date of the ruling.

2) Central Registry of Insured Persons and Exercise of Entitlements deriving from Compulsory Health Care Insurance

Article 115 H M

- (1) The status of the insured person covered by compulsory health care insurance is established on the basis of data kept in by the Central Registry in regard to the insured persons and exercise of entitlements deriving from compulsory health care insurance (hereinafter referred to as: the Central Registry) which is integrally governed and organized by the Republican Fund for the entire territory of the Republic.
- (2) The respective branch carries out certain activities relevant to the Central Registry, in accordance with this Act and other regulations passed to implement this Act.

Article 116 H P

- (1) The Central Registry keeps data on the insured, i.e. insured persons, contribution payers and exercise of entitlements deriving from compulsory health care insurance.
- (2) The Central Registry is kept according to the prescribed unified methodological standards.
- (3) Data are entered into the Central Registry according to the prescribed unified code system.
- (4) Data are entered in the Central Registry on the basis of applications submitted on the prescribed forms which may be submitted via means of electronic data transfer.
- (5) Where the health care insurance applications, reports of changes in insurance and insurance cancellations are submitted via means of electronic data transfer, applicants shall, upon the request of the Republican Fund, i.e. of the respective branch, submit them on the form prescribed for such purpose.
- (6) The unified methodological standards for keeping the Central Registry, unified code system and insurance application forms in regard to insurance request, cancellation or changes, and other issues relevant for the keeping of the Central Registry– are regulated by the Government.

Article 117

The Central Registry is organized by entering information about the insured and other contribution payers, on the basis of the data from the health care insurance application, as well as of other data in accordance with this Act.

Article 118

- (1) The following data are entered into the Central Registry:
 - 1) data about the insured,
 - 2) data about family members of the insured,
 - 3) data about compulsory health care insurance contribution payers,
 - 4) data about exercise of entitlements deriving from compulsory health care insurance,
- (2) The data, referred to in paragraph 1, item 4) hereof, constitute official secrets and are kept separately from other data, and such they may be entered, i.e. controlled, by a specially authorized official of the respective branch, i.e. the Republican Fund

Article 119

- (1) The following data about the insured are entered in the Central Registry:
- 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 acquisition, i.e. termination of the insured status, as well as any changes of status;
 - 9) creditable coverage;
 - 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 basis on which contributions are calculated and paid;
 - 13) amount of contribution paid;
 - 14) place of domicile, address;
 - 15) name of the employer, registration number of the employer, activity code and the employer's registered office;
 - 16) municipality the real estate is located;
 - 17) citizenship.
- (2) In addition to the data about the insured, referred to in paragraph 1 above, 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 domicile and address;
 7. occupation;
 8. citizenship.

(3) Data about work-related injuries, i.e. occupational diseases, of the insured are entered in the Central Registry as well.

Article 120

- (1) Data on insured persons, prescribed by the act governing record keeping in health care, are entered in the Central Registry as well.
- (2) The data on exercised entitlements deriving from compulsory health care insurance are entered in the Central Registry, and in particular:
 - 1) type of entitlements deriving from health care insurance provided to the insured person;
 - 2) health care services delivered;
 - 3) benefits;
 - 4) medical-technical aids and implants;
 - 5) prescription medications;
 - 6) annual amount of paid participation;
 - 7) chosen physician of the insured person;
 - 8) exercised entitlements before medical commissions;
 - 9) exercised entitlements concerning work-related injuries and diseases of the insured person;
 - 10) referrals to a Disability Commission in accordance with this Act.
- (3) The Republican Fund may by general act prescribe other data to be maintained in the Central Registry regarding exercised entitlements deriving from compulsory health care insurance, as well as special forms for keeping records on exercised entitlements deriving from compulsory health care insurance (receipts and other specific documentation which is not prescribed by the act governing health records).
- (4) Data about health care services providers, who have entered into an agreement with the branch, i.e. the Republican Fund for the purpose of health care delivery to insured persons covered by compulsory health care insurance, are entered in the Central Registry, as well.
- (5) The general act referred to in paragraph 3 above is published in the “Official Gazette of the Republic of Serbia”.

Article 121

The Republican Fund, i.e. the respective branch is entitled to obtain ex officio all data, referred to in [Articles 119](#) and 120 hereof, which are maintained by other competent government authorities and organizations relating to insured persons.

Article 122

- (1) The Republican Fund allocates a registration number to contributions payers.
- (2) The registration number, referred to in paragraph 1 hereof, consists of the mark of the Republican Fund, i.e. the branch, municipality, current registry number and control number.

Article 123

The following entities submit to the respective branch, i.e. the Republican Fund, the forms with the data to be entered in the Central Registry:

- 1) employer,
 - (1) form with the data about the contribution payer, including the date of commencement of the activity, changes and cessation of the activity;
 - (2) form with the data on health care insurance application, health care insurance change and health care insurance cancellation for the insured referred to in [Article 17](#), paragraph 1, items 1) to 8), item 10) and items 13) and 14) herein;
 - (3) form with data for establishing creditable coverage, data on salary and benefits which are used to establish the basis and the amount of the contribution paid,
 - (4) form with the data on the contributions paid on the basis of agreed compensation and the amount of such compensation;
- 2) competent public revenue office: form with data for establishing creditable coverage, basis for insurance and the amount of contribution paid – for the self-employed insured (entrepreneurs), insured farmers, priests and other church officials, as well as a notification on changes in such data;
- 3) organisations, associations and societies – health care insurance application or cancellation 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 compulsory health care insurance, except for the insured referred to in items 2) and 3) above:
 - (1) form with data about the contribution payer;
 - (2) health care insurance application, change or cancellation form;
- 5) Employment Agency:
 - (1) health care insurance application and cancellation form for the insured for which the Agency is the compulsory health care insurance contributions payer, in accordance with law, as well as the notification of any changes of such data.
 - (2) form with data for establishing creditable coverage, data on benefit and the amount of the contribution paid for the persons referred to in sub-item (1) of this item, as well as notification of any change in such data;
- 6) Pension and Disability Insurance Organization:
 - (1) health care insurance application, change and cancellation form for the insured for which, in accordance with law, such organization pays compulsory health care insurance contributions;
 - (2) form with data for establishing creditable coverage and the amount of contributions paid for persons referred to in sub-item (1) of this item, as well as changes of such data;
- 7) The Republican Fund :
 - (1) enters into the Central Registry data about health care insurance applications, changes and cancellations, in accordance with this Act, about health care insurance creditable coverage, salary, benefits, bases for insurance, agreed compensation and other allowances which are 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 item 1), sub-item (4) above.

Article 124 H P

- (1) For the insured referred to in [Article 22](#) hereof, the health care insurance application, change and cancellation forms are submitted by the insured together with the necessary evidence for establishing the insured status, except for the insured referred to in items 7)

and 8) thereof for whom such application, change and cancellation forms are submitted by the payer of social welfare i.e. permanent financial aid.

- (2) For a person to be included compulsory health care insurance referred to in [Article 23](#) hereof, compulsory health care insurance application, change and cancellation form are submitted by such person along with necessary evidence for establishing the status of the insured.
- (3) The Republican Fund keeps separate records of the insured, referred to in [Articles 22 and 23](#) herein.
- (4) The manner and procedure, as well as necessary evidence for establishing the status of the insured of the person referred to in [Article 22](#) hereof shall be regulated under a general act issued by the Republican Fund.
- (5) The manner and procedure, as well as necessary evidence for inclusion into compulsory health care insurance of persons referred to in [Article 23](#) hereof, shall be regulated under a general act issued by the Republican Fund.
- (6) General acts referred to in paragraphs 4 and 5 hereof are published in the “Official Gazette of the Republic of Serbia”

Article 125

The forms with data to be entered into the Central Registry are to contain only data based on public documents and records prescribed by law and the regulations passed to implement this Act.

Article 126

- (1) The submitter of forms with the data to be entered into the Central Registry is held accountable for the validity of the data.
- (2) The respective branch shall verify the validity of the data in the forms with the data to be entered in the Central Registry, require evidence and examine the records and documentation underlying the data in the forms, and obtain the necessary data, when necessary.
- (3) The submitter of forms shall provide the insured, i.e. beneficiary of compulsory health care insurance, accurate information and data relevant to determining the facts relevant for the acquisition and exercise of the entitlements deriving from compulsory health care

insurance, and provide the respective branch all evidence and allow records and documentation to be examined.

Article 127 H M

- (1) Status of the insured of persons for whom the insurance application has been submitted is established by entering their data in the Central Registry and by confirming the receipt on the insurance application form.
- (2) At receiving the insurance application form, the data provided in the form are checked and evidence, upon which the data provided are based, is required.
- (3) Provisions of paragraphs 1 and 2 above apply to insurance cancellation, i.e. insurance change forms received.
- (4) The applicant shall provide the person for whom the insurance change or cancellation form has been submitted, a certified photocopy of the receipt of such forms, within 8 days of its issuance.
- (5) If it has been established on the basis of the submitted insurance application form that the conditions for recognising the insured status are not met, the applicant is to be provided with a written ruling thereof.
- (6) For the self-employed beneficiaries (entrepreneurs), farmers and other persons on whom a competent tax authority maintains records, the respective branch i.e. the Republic Fund shall provide such tax authority with a copy of receipt of such insurance application, cancellation forms by the 5th of the month for the previous one.
- (7) Data submission referred to in paragraph 6 above may be carried out in electronic form as well, whereas there is obligation for submitting a copy of confirmation of the application i.e. cancellation form receipt within 8 days.

Article 128 H

- (1) Persons for whom no insurance application forms have been submitted to the Republican Fund, i.e. the respective branch, by the person obligated to submit the insurance application form, may themselves apply for the designation of the insured status.
- (2) The application, referred to in paragraph 1 above, may be submitted to the person obligated to submit the insurance application form, as well.
- (3) The respective branch shall institute proceedings for defining the insured status when it has been established through a control or in any other way that no insurance application form has been submitted for persons entitled to compulsory health care insurance.

- (4) In the cases referred to in paragraphs 1 to 3 above, the respective branch issues a ruling on establishing the insured status.
- (5) On the basis of the ruling on establishing the insured status referred to in paragraph 4 of above, any person obligated to submit the insurance application form shall do so.
- (6) Provisions of paragraphs 1 to 5 above also apply in the event the person obliged to submit an insurance cancellation, i.e. change form, has failed to do so.

Article 129

- (1) Forms with data to be entered into the Central Registry are submitted to the respective branch, as follows:
 - 1) for the insured referred to in [Article 17](#), paragraph 1, items 1) and 2), items 4) to 8), items 10), 11) and 13) items 15) to 18) and item 24) hereof, where the employer's place of domicile and registered office are located at the territory of the same branch – according to the registered office of the contribution payer;
 - 2) for the insured referred to in [Article 17](#), paragraph 1, item 3) hereof, where the place of domicile of the insured is other than the registered office of the contribution payer – according to the registered office of the contribution payer;
 - 3) for the insured referred to in [Article 17](#), paragraph 1, item 9) and items 19) to 22) hereof – according to the place of domicile of the insured in the Republic;
 - 4) for the insured referred to in [Article 17](#), paragraph 1, item 12 hereof – according to the place of domicile of the insured or the last place of employment termination;
 - 5) for the insured referred to in [Article 17](#), paragraph 1, item 14) hereof, where the place of domicile of the insured is other than the registered office of the contribution payer – according to the registered office of the youth or student cooperative;
 - 6) for the insured referred to in [Article 17](#), paragraph 1, item 23) hereof – according to the place of residence or domicile;
 - 7) for the insured referred to in [Article 17](#), paragraph 1, item 25) hereof – according to registered seat of the school or higher education institution.
- (2) Notwithstanding paragraph 1, item 1) above, where the place of domicile of the insured is at the territory of one branch and the registered office of the contribution payer at the territory of another branch, submission of forms with the data to be entered in the Central Registry to the respective branch shall be performed according to the place of domicile of the insured in the Republic.

- (3) For family members of the insured, forms with data to be entered into the Central Registry shall be submitted to the respective branch, i.e. the branch, in the manner prescribed in paragraphs 1 and 2 above.

Article 130

- (1) Forms with data to be entered into the Central Registry regarding the insured referred to in [Article 22](#), paragraph 1 hereof, are submitted to the respective branch according to the place of domicile, whereas regarding the insured referred to in items 11) to 13) of that Article, according to place of domicile, i.e. residence.
- (2) Forms with data to be entered into the Central Registry for persons who are to be included in compulsory health care insurance referred to in [Article 23](#) hereof, are submitted according to the person's place of domicile.
- (3) For family members of the insured referred to in paragraphs 1 and 2 above, forms with the data to be entered into the Central Registry are submitted to the respective branch which established the status of the insured for persons referred to in paragraphs 1 and 2 above.

Article 131

Status of the insured, salary, benefits and other earnings which serve as insurance basis 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](#) herein.

Article 132

Should the respective branch, while verifying the data, establish that the data supplied about the creditable coverage, salary, benefits, insurance basis on which contributions are calculated and paid, agreed compensation and amount of paid contributions, have not been stated correctly or in accordance with the legislation governing compulsory health care insurance, it shall order the applicant to correct them within a period which may not exceed 30 days.

Article 133

- (1) The respective branch shall, on personal request of the insured person, issue a certificate on the data entered into the Central Registry.

(2) The certificate referred to in paragraph 1 above is considered to be a public document.

Article 134

(1) Data entered in the Central Registry, 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, creditable coverage, salary, benefits, agreed compensations, insurance bases and rate, i.e. amount of paid contributions, as well as other data maintained in the Central Registry, have been entered in the Central Registry on the basis of presented false documents;
- 3) if subsequently, while verifying the data or in any other manner, it is found that incorrect or incomplete data have been entered in the Central Registry.

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

Article 135 M

- (1) Data to be entered in the Central Registry, 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.
- (2) Data on creditable coverage, salary, benefits, insurance basis or the agreed compensation which are used for contribution payment are supplied upon the payment.
- (3) 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 ruling on such alterations.
- (4) The respective branch shall enter the aforesaid data in the Central Registry within 60 days of receipt, or by the end of the current year at the latest for the previous one.

Article 136

(1) Submitted forms with the data to be entered in the Central Registry shall be kept for at least ten years from the date of their last entry in the Central Registry.

- (2) Instead of originally supplied forms, they may be stored on a microfilm, or any means of electronic data processing.

Article 137

Destruction of the original forms on the basis of which the data have been entered in the Central Registry is performed by a commission appointed by the Republican Fund.

Article 138

- (1) The data kept in the Central Registry are used solely for purposes of compulsory health care insurance, unless otherwise provided by this Act.
- (2) The data in the Central Registry relating to an individual insured person, i.e. to the exercise of entitlements deriving from compulsory health care insurance, are personal data considered to be official secret and cannot be disclosed or publicised.
- (3) The data contained in the Central Registry may be used for statistical purposes in accordance with law.
- (4) Protection of data contained in the Central Registry is to be provided in the manner prescribed in accordance with law.

3. Providing and Exercising Entitlements Deriving from Compulsory Health Care Insurance

Article 139

- (1) It is ensured that the insured may exercise entitlements deriving from compulsory health care insurance at the respective branch, unless otherwise prescribed hereby.
- (2) Funds for providing the exercise of entitlements deriving from compulsory health care insurance for the insured persons on the territory of the respective branch are transferred by the Republican Fund to the branch in accordance with law and regulations passed to implement this Act.
- (3) Family members of the insured are provided with entitlements deriving from compulsory health care insurance at the respective branch where such entitlements are provided for the primary insured from whom the members draw their secondary health care insurance.
- (4) Entitlements deriving from the compulsory health care insurance are provided to the insured, referred to in [Article 22](#) hereof, persons who are to be included in compulsory

health care insurance, referred to in [Article 23](#) hereof, as well as the persons referred to in [Article 28](#) hereof, at the branch on which territory they are domiciled or resident.

Article 140

- (1) Entitlements deriving from health care insurance are provided to:
 - 1) the insured referred to in [Article 17](#), paragraph 1, items 1) to 8), items 10) and 11), items 13) to 16) and item 24) hereof – in the branch on which territory is the registered office of their employer, and for those employed in the business unit outside of the registered office of the employer – in the branch according to the registered office of the business unit of the employer;
 - 2) the insured referred to in [Article 17](#), paragraph 1, item 17) hereof – in the branch according to the registered office of the company, and to the insured referred to in item 18) according to the place of economic activity;
 - 3) the insured referred to in [Article 17](#), paragraph 1, item. 25) hereof – in the branch according to the registered seat of the school or higher education institution;
 - 4) other insured – in the branch according to the place of domicile.
- (2) Notwithstanding paragraph 1 above, the insured referred to in [Article 17](#), paragraph 1, item 21) hereof, exercise their entitlements to health care insurance at the branch on which territory the greater part of their farming land, where agricultural activities are carried out, is located.
- (3) The insured person who is not domiciled at the territory of the respective branch where his/her entitlement to health care insurance is exercised, may exercise such entitlements, pursuant to the general act of the Republican Fund, at the branch of his/her domicile.
- (4) The insured persons who are pupils and students exercise their entitlements to health care deriving from compulsory health care insurance, pursuant to the general act of the Republican Fund, at the branch according to the registered seat of the school or higher education institution.
- (5) Business unit, within the meaning of paragraph 1, item 1) above, is a plant, shop, warehouse, representative office etc.
- (6) Business unit established for performing economic activities up to six months is not considered a business unit within the meaning of paragraph 1, item 1) above.

Article 141 H M P

- (1) The insured person receives health care at a health care facility or other provider of health care services, having registered office on the territory of the respective branch, with which a contract on providing health care services to insured persons has been concluded.
- (2) The insured person receives 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 to implement this Act.
- (3) While exercising health care entitlements the insured person is entitled to a free choice of a health care facility and a free choice of a physician (hereinafter referred to as: chosen physician), with whom the Republican Fund has entered into a contract for the provision of health care.
- (4) The Republican Fund adopts a general act regulating in detail the manner and procedure of exercising entitlements deriving from compulsory health care insurance.
- (5) The general act referred to in paragraph 4 above is published in the “Official Gazette of the Republic of Serbia”.

Article 142 H M S

- (1) Entitlements deriving from health care insurance are exercised subject to a certified insurance document, i.e. health card, i.e. special document on exercising of health care.
- (2) Certification of documents referred to in paragraph 1 above performed by the respective branch based upon the available information, i.e. evidence of payment of the due contribution, in accordance with law, as well as the employer whom the respective branch, on the basis of evidence of payment of due contributions, has issued a special tool (stamp, etc) to certify the insurance document in accordance with regulations passed to implement this Act.
- (3) Certification of health cards referred to in Article 112, paragraph 3 hereof is performed by the respective branch by entering the data on paid due contributions, in accordance with law, in the space of machine readable zone for automatic reading of data.
- (4) Subsequent certification of insurance documents and health cards and special documents on exercising of health may be performed provided that the insured person decided on the chosen physician in accordance with this Act and the regulations passed to implement this Act.

- (5) Where the insurance document, i.e. health card, i.e. document on exercising of health care, is not certified due to failure to pay a due contribution, subsequent certification shall be performed when such contribution is paid in full.
- (6) In the event that the due compulsory health care insurance contribution has not been paid, or has not been paid in full, the exercise of entitlement to health care in accordance with this Act and regulations passed to implement this Act may be covered by compulsory health care insurance only in the event of medical emergency.

Article 143

- (1) Costs accrued at a health care institution upon the use of health care by insured persons for whom health care insurance contribution has not been paid, or has not been paid in full, are covered by the insured person using health care, except in the event of medical emergency.
- (2) If the employer, or another contribution payer in accordance with law, has failed to exact the due payment, the insured person is entitled to compensation of the accrued costs for the use of health care, referred to in paragraph 1 above, by the employer, or another contribution payer.
- (3) The employer, or another contribution payer, from whom the insured claims compensation for the costs accrued for exercising health care entitlements deriving from compulsory health care insurance, shall pay the accrued costs to the account of the insured person, or in any other adequate manner within 30 days from the day the claim has been submitted.
- (4) The insured person is also entitled to the calculation of statutory interest on the due amount referred to in paragraph 3 above.

Article 144

- (1) The insured person exercises his/her entitlement to health care in the manner and the procedure established by this Act and the regulations passed to implement this Act.
- (2) Health care costs which are not accrued in the manner and procedure set in accordance with paragraph 1 above, are borne by the insured person.
- (3) While exercising the entitlement to health care, the insured person is provided with the use of health care, in accordance with law, with application of all safe, secure and successful medical measures and procedures, medicines, medical devices, implants and medical-technical aids.

- (4) Exercise of entitlement to health care as well as other entitlements deriving from the compulsory health care insurance by the insured persons 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 Expert-Medical Bodies in the Proceedings

Article 145

- (1) In determining the type, scope and content, manner and proceedings of exercising entitlements to health care by insured persons, in assessing the temporary incapacity of the insured, and in exercising entitlement to transportation benefit, the following expert-medical bodies of the respective branch, i.e. Republican Fund, are included in the proceedings:
- 1) chosen physician,
 - 2) first-instance medical commission,
 - 3) second-instance medical commission
- (2) The physician who has performed a medical examination, i.e. a physician who is treating the insured person, cannot be a member of the first-instance or second-instance medical commission which gives the assessment on the insured person.
- (3) Republican Fund under a general act regulates the manner of work, composition, organisation, territorial distribution, first-instance or second-instance medical commission assessment control, as well as remuneration of the members of the commission which is covered by compulsory health care insurance.
- (4) The general act referred to in paragraph 3 above, is published in the “Official Gazette of the Republic of Serbia”.

Chosen Physician

Article 146

- (1) 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 or a dentist specialist in paediatric or preventive dentistry.
- (2) Notwithstanding paragraph 1 above, the chosen physician may an MD of any other specialisation, under conditions prescribed by the Minister pursuant to the act governing health care.
 - (3) An insured person may have only one chosen physician from the fields of medicine referred to in paragraphs 1 and 2 above.
 - (4) The insured person shall at the first visit to health facilities at primary health care level in which tasks are carried out by the chosen physician, and no later than six months from the date of acquisition of an insured person status in accordance with this Act, make the selection of the chosen doctor.
 - (5) Should the insured person fail to select the chosen doctor referred to in paragraph 4 above, such person shall be entitled only to emergency medical care until it makes the selection in accordance with this Act.
 - (6) Under the general act, referred to in [Article 141](#), paragraph 4 hereof, the Republican Fund specifies in detail the manner and procedure of exercising health care entitlements and other entitlements deriving from compulsory health care insurance with the chosen physician, as well as the manner and procedure of the free choice of the physician, and standard number of the insured persons per one chosen physician.
 - (7) The Minister gives prior approval of the standard number of the insured persons per one chosen physician referred to in paragraph 4 above.

Article 147

- (1) A contract entered into between the respective branch and a health care provider establishes individual physicians who are authorised to be chosen physicians.
- (2) The health care provider referred to in paragraph 1 above, shall post at a prominent place a list of physicians whom the insured person may choose for her/his chosen physician.
- (3) A chosen physician enters into a special contract with the respective branch on the performance of activities of the chosen physician for the needs of the persons covered by compulsory insurance.

Article 148

A physician, who meets the requirements prescribed hereby for a chosen physician, shall receive every insured person who chooses such physician, unless the number of insured persons registered with such physician is already higher than the standard number of insured persons per a chosen physician.

Article 149

- (1) At the first visit to the chosen physician, the insured person signs a document on physician selection.
- (2) The insured person selects or changes the physician, referred to in paragraph 1 above, for a period of at least one calendar year. The insured person may change the chosen physician before the expiry of the period for which said physician has been selected.
- (3) The manner and procedure of selection or change of the chosen physician, and the form of the document referred to in paragraph 1 above are regulated by the Republican Fund under the general act referred to in [Article 141](#), paragraph 4 herein.

Article 150

- (1) The document on physician selection, referred to in [Article 149](#) hereof, contains a declaration by which the insured person allows the competent authorised health care worker – a compulsory health care insurance supervisor, may have access to personal data of the insured person relating to exercise of entitlements deriving from compulsory health care insurance.
- (2) Should the insured person fail to sign the declaration referred to in paragraph 1 above, the respective branch is not obliged to bear the costs of health care which cannot be verified by the authorised health care worker – the compulsory health care insurance supervisor.
- (3) The authorised health care worker – the compulsory health care insurance supervisor, as well as other competent officers of the Republican Fund, or a branch, shall keep confidential all personal data of the insured persons, referred to in paragraph 1 above.

Article 151

- (1) The chosen physician:
 - 1) organises and carries out measures for maintaining and improving health of insured persons, for discovering and preventing risk factors for diseases, performs preventive

examinations, applies measures and procedures, including health care education, which are entitlements deriving from compulsory health care insurance;

- 2) performs examinations and diagnostics;
- 3) determines the manner and type of treatment, monitors the course of treatment and synchronises opinions and proposals for further treatment of the insured person;
- 4) renders emergency medical assistance;
- 5) refers the insured person to out-patient or specialist examinations, or other appropriate health care facility, or other health care service providers with whom contract on rendering health care services has been closed, according to medical indications, monitors the course of treatment and synchronises opinions and proposals for further treatment of the insured person, or refers the insured person to secondary or tertiary level of health care;
- 6) determines the type and length of the treatment at home and monitors its progress;
- 7) prescribes medicines, medical devices and certain types of medical-technical aids;
- 8) practices health care in the field of mental health;
- 9) keeps an accurate medical documentation on the treatment and health status of the insured person, in accordance with law;
- 10) gives assessment of the health status of the insured person and refers such a person to work capability assessment, in accordance with law;
- 11) determines the length of temporary incapacity of the insured due to disease and injury up to 30 days of incapacity and proposes to the first-instance medical commission an extension of such temporary incapacity, unless otherwise prescribed by this Act;
- 12) proposes to a first-instance medical commission to determine the necessity for the insured to work part-time during the treatment, in accordance with this Act;
- 13) determines the need for the insured person to have an escort while travelling;
- 14) determines the 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 herein;
- 15) gives an opinion on whether an insured has intentionally caused work incapacity, or intentionally hindered health improvement;
- 16) gives an opinion on health status of the insured person on which grounds the certificate on health status of the insured person is issued for purposes of using health care abroad;

- 17) determines the use and type of the means of transportation of a patient, according to his/her health status;
- 18) performs other activities in regard to exercising entitlements deriving from health insurance, in accordance with a contract between the Republican Fund, i.e. the branch, and the health care service provider.
- (2) In addition to activities referred to in paragraph 1 above, the chosen physician, as part of the compulsory health care insurance, determines the advancement of pregnancy for the purpose of exercising the entitlement to pregnancy and parental leave, gives opinion on the health status of the child for purposes of exercising entitlements to absence from work due to the necessary special child care, in accordance with law, and establishes temporary incapacity of the insured in accordance with regulations on employment and unemployment insurance.
- (3) The chosen physician assesses temporary incapacity based on a direct examination of the insured person and on the medical documentation.

Article 152

- (1) The authorities referred to in Article 151 hereof, relating to diagnostics and treatment, including prescribing of prescription medicines (for TB, HIV, substance abuse, treatment of psychiatric disorders, treatment of rare diseases and other illnesses in accordance with this Act and regulations passed to implement this Act), may at the proposal of a physician specialist in the relevant field of medicine, who is treating the insured person, be transferred by the chosen physician to such physician specialist if it is necessary due to the health status of the insured person and practical purposes in rendering health care.
- (2) Under the act referred to in Article 141, paragraph 4 hereof, the Republican Fund provides for the manner of transferring authority, other diseases for which authority referred to in paragraph 1 above may be transferred, including the form on the basis of which transfer of authority is made.

Article 153

Should the chosen physician abuse his/her authority in the process exercise of entitlements of the insured person, the branch shall terminate the contract with the chosen physician and file a motion with the competent medical chamber for revocation of the independent practice licence of such chosen physician.

First-Instance Medical Commission

Article 154

- (1) The first-instance medical commission includes two physicians and a corresponding number of substitutes, who are appointed by the Director of the Republican Fund.
- (2) At least one member of the commission referred to in paragraph 1 above, is employed on a full-time basis at the respective branch.

Article 155

- (1) A first-instance medical commission:
 - 1) assesses and determines the length of temporary incapacity of the insured, at a recommendation from the chosen physician, for the period of more than 30 days of temporary incapacity, or in the event of temporary incapacity due to care for a member of the nuclear family for the period of more than 15 days, or more than seven days, in accordance with this Act;
 - 2) assesses complaints of the insured or employer on the chosen physician's work capability assessment due to an illness or injury up to 30 days, or temporary incapacity due to care for a member of the nuclear family, in accordance with this Act;
 - 3) assesses the need to provide an escort to patient for the period of his/her stay at an inpatient health care facility, under conditions set by the general act of the Republican Fund;
 - 4) assesses the justifiability of prescribing certain medical-technical aids or production of new medical-technical aids before the end of shelf life of the old ones;
 - 5) assesses claims for medical treatment costs and travel benefit;
 - 6) assesses medical justifiability of use of health care contrary to the conditions and manner established by this Act and regulations passed to implement this Act;
 - 7) gives an opinion on referral of insured person to treatment in healthcare facilities specialising in rehabilitation, or on referral of insured persons to treatment outside of the territory where the respective branch is located;
 - 8) proposes referral of the insured in the event of longer incapacity, in accordance with this Act, to the competent authority for assessing the work capability, or incapacity, pursuant to regulations on pension and disability insurance;
 - 9) evaluates the opinion of the chosen physician;

- 10) determines the health status of the insured person for the purpose of issuing the certificate of in order to issue a certificate on the use of health care abroad, in accordance with this Act;
 - 11) determines the necessity for the insured to work part-time during the treatment, in accordance with this Act;
 - 12) performs other activities related to exercising entitlements deriving from health care insurance.
- (2) In addition to activities referred to in paragraph 1 above, the first-instance medical commission performs other activities relating to [Article 151](#), paragraph 2 herein.
 - (3) The first-instance medical commission assesses temporary incapacity based on a direct examination of the insured person and medical documentation.

Second-Instance Medical Commission

Article 156

- (1) The second-instance medical commission examines the regularity of assessments of the first-instance medical commission.
- (2) The second-instance medical commission includes three physicians and a corresponding number of substitutes, who are appointed by the Republican Fund.
- (3) At least one member of the commission referred to in paragraph 2 above, is employed on a full-time basis at the Republican Fund, i.e. respective branch.

Article 157

- (1) 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 person, the territorial branch, or the employer assesses the regularity of the final assessment of the first-instance medical commission, and gives its opinion thereon.
 - 3) makes assessment of extension of an entitlement to benefit in accordance with [Article 79](#), paragraph 3 herein.
- (2) The second-instance medical commission may conduct an audit of all entitlements, i.e. expert-assessment relating to all entitlements deriving from compulsory health care

insurance which were decided upon by the chosen physician, i.e. the first-instance medical commission, upon request of the insured person, employer, the respective branch, i.e. the Republican Fund.

5. Complaints in the Course of Exercising Entitlements to Health Care Insurance

Article 158

- (1) When the insured person is not satisfied with the assessment given by the chosen physician, he/she may make a complaint with the first-instance medical commission.
- (2) The complaint is made 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 made, or directly to the medical commission.
- (3) The chosen physician to whom the complaint has been made orally, and if he/she does not alter the given assessment, shall make a record of the complaint, which is also signed by the insured person.
- (4) The chosen physician to whom the complaint has been made shall immediately refer the case to the competent medical commission.

Article 159

- (1) The first-instance medical commission shall immediately take the complaint for consideration in order to make an assessment decision.
- (2) If the complaint is made against a work capability assessment of the insured, the medical commission shall immediately summon the insured for an examination. In other cases the medical commission shall immediately summon the insured to an examination if it deems it necessary for making the assessment. If the medical commission deems an additional medical examination necessary, it shall, without delay, specify necessary medical examinations which the chosen physician is to carry out.
- (3) Assessment of the health status and temporary incapacity of the insured must be complete, reasoned and in accordance with the documentation that serves as a basis of the assessment.
- (4) Assessment of the first-instance medical commission carried out on the basis of a complaint by the insured against the chosen physician's opinion referred to in paragraph 1 above, is final.

- (5) The insured, chosen physician, respective branch and employer are to be notified in writing about the medical commission's assessment results.

Article 160

- (1) A complaint to the second-instance medical commission may be made by the insured person who is dissatisfied with the first-instance medical commission's assessment, if it has been passed without prior assessment by the chosen physician, within three days as of the date of declaring the first-instance medical commission assessment.
- (2) The complaint is made either orally in the minutes, or in writing to the first-instance medical commission against whose assessment the complaint is made. The commission shall urgently forward both the complaint and the case to the second-instance medical commission. The complaint may also be made in writing and directly to the second-instance medical commission.

Article 161

- (1) The second-instance medical commission shall immediately take the case in consideration, in order to give its assessment.
- (2) If the complaint has been made against an assessment on temporary incapacity, the second-instance medical commission shall summon the insured immediately in order to perform an examination. In other cases, the commission makes its assessment based on medical documentation, and may, if necessary, summon the insured person for examination. If the medical commission deems an additional medical examination necessary, it shall, without delay, specify necessary medical examinations which are to be performed.
- (3) Assessment of the second-instance medical commission upon the complaint against the opinion of the first-instance medical commission is final.
- (4) The insured, first-instance medical commission against whose assessment the complaint has been made, the respective branch and employer shall be notified in writing about the second-instance medical commission's assessment results.
- (5) If the insured person is dissatisfied with the assessment results of the second-instance medical commission, he/she may require from the branch to issue a decision on the matter.

Article 162

Timely filed complaints to the assessment of the chosen physician, or of the first-instance medical commission, delay execution of the assessment.

6. Renewal of Work Capability Assessment Procedure

Article 163

- (1) The Republican Fund, or respective branch, or employer may require that the insured, whose temporary incapacity was evaluated by the chosen physician, or the first-instance medical commission, be subjected to re-examination by the first-instance medical commission, or the second-instance medical commission in order to re-evaluate his/her temporary incapacity. Re-examination may not be required if the insured is undergoing an inpatient treatment, except in the event of treatment in a day hospital.
- (2) The chosen physician, i.e. the second-instance medical commission may also request re-examination of the insured referred to in paragraph 1 above.
- (3) The re-examination may be required within 30 days from date of completed evaluation by the expert-medical body.
- (4) The insured is obligated to report to the first-instance medical commission, or the second-instance medical commission, for examination within a time period prescribed by either body. Should the insured fail to appear for examination without justified cause, his/her benefits shall be suspended, and no benefits are to be appropriated until he/she appears for examination.

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

Article 164

- (1) The Republican Fund, i.e. the respective branch, may ex officio or upon the request of an employer, place a request for an expert assessment in relation to exercise of all entitlements deriving from compulsory health care insurance by the insured persons, including expert assessment of the health status of the insured person.
- (2) The expert assessment in the case referred to in paragraph 1 above is performed by: the first-instance medical commission – if the original assessment came from the 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.

- (3) Renewal of the assessment may be required within one year as of the date of the exercise of entitlement deriving from compulsory health care insurance which has been assessed by an appropriate professional medical body.

Article 165 H

The Republican Fund may require an expert assessment in regard to exercised entitlements deriving from compulsory health care insurance by the insured person, to be conducted by independent experts from appropriate health care facilities, or expert commissions from particular branches of medicine.

Article 166 H

On the basis of conducted expert assessment proceeding in regard to exercise of certain entitlements deriving from compulsory health care insurance, the Republican Fund may negate the entitlement to exercise such entitlements by requiring compensation of damages from the insured person, or other responsible person, in accordance with indemnity proceedings as prescribed by this Act.

8. Exercise of Entitlements to Pecuniary Benefits

Article 167

- (1) The respective branch, i.e. employer decides on the entitlements to pecuniary benefit.
- (2) Pecuniary benefits are paid on the basis of the evidence presented.
- (3) At the request of the insured person, pecuniary benefit payer shall issue a ruling thereupon.

Article 168

- (1) The employer shall decide on the entitlement to benefit if such benefit is to be borne by the employer, or the respective branch if the benefit is to be borne by the branch.
- (2) Benefit is paid on the basis of evidence presented, without filing an application thereto.

Article 169

Benefit established in accordance with this Act may be subject to enforcement and security only against claims of maintenance which has been established by a court decision or court settlement.

Article 170

- (1) Benefit is paid based on a report on temporary incapacity (medical leave pay voucher) issued by an expert-medical body.
- (2) Work capability assessment is done by an expert-medical body in a procedure, according to the respective branch of the insured.
- (3) If the work capability assessment has not been performed by the body referred to in paragraph 2 above, the branch, i.e. employer shall decide on benefit for the given period, on the basis of a subsequent assessment of the body referred to in paragraph 2 above.

Article 171

- (1) The chosen physician performs an independent work capability assessment up to 30 days of work incapacity, except in the cases of necessary care for a member of the nuclear family, in accordance with this Act.
- (2) Work capability assessment after the 30th day of work incapacity is performed by the first-instance medical commission.
- (3) Work capability assessment of the insured undergoing treatment in an inpatient health care facility is performed by a chosen physician.

Article 172

- (1) The chosen physician performs an independent work capability assessment up to 30 days of work incapacity due to rendering necessary care to a nuclear family member under seven years of age or an elderly nuclear family member with severe physical and mental disability - up to 15 days of incapacity, and for a nuclear family member over the age of seven - up to seven days of incapacity, in accordance with [Article 79](#), paragraph 1 herein.
- (2) Work capability assessment after the 15th, or 7th day of incapacity is performed by the first-instance medical commission.

9. Protection of Entitlements of Insured Persons

Article 173

- (1) The respective branch decides on entitlements deriving from compulsory health care insurance on the basis of evidence presented, without issuing a ruling, unless otherwise established by this Act, i.e. by a general act of the Republican Fund, or if such ruling is requested by the insured person, i.e. an employer.
- (2) The provisions of the act regulating general administrative proceedings apply to the exercise of entitlements established by this Act, unless otherwise provided by this Act.

Article 174

- (1) The insured person who deems that a decision issued on her/his entitlements deriving from compulsory health care insurance is contrary to this Act and the regulations passed to implement this Act, is entitled to institute proceedings for the protection of the entitlements before a competent body.
- (2) Protection of entitlements may be sought by the employer as well, in accordance with this Act.
- (3) In the first instance, the entitlements regulated under this Act are decided upon by the respective branch and in the second instance by the Republican Fund, or Provincial Fund for the territory of the autonomous province, unless otherwise provided by this Act..
- (4) The entitlement to health care services abroad and to referrals to treatments abroad, in the first instance, are decided upon by the Republican Fund Commission, appointed by the Management Board of the Republican Fund, and in the second instance by the Director of the Republican Fund.

Article 175

Administrative proceedings may be instituted against the final act of the Republican Fund which sets decision on an entitlement deriving from compulsory health care insurance.

Article 176

- (1) The respective branch, i.e. the Republican Fund, as well as the Provincial Fund shall provide insured persons with professional and legal assistance in the cases when the insured person deems that the health service provider unjustifiably prevented her/him from exercising entitlements deriving from compulsory health care insurance, or that

her/his entitlements have been provided contrary to this Act and contrary to regulations passed to implement this Act.

- (2) In the case referred to in paragraph 1 above, the respective branch, or the Republican Fund, i.e. the Provincial Fund shall provide the insured person advice and directions on exercising the entitlements deriving from compulsory health care insurance, or take action against health care service provider which does not comply with this Act and the regulations passed to implement this Act.
- (3) The respective branch, or the Republican Fund, i.e. the Provincial Fund shall consider all complaints filed by insured persons in regard to the cases referred to in paragraph 1 above.

5) HEALTH CARE SERVICES CONTRACTING

1. Entering into a Contract

Article 177 H A

- (1) The Contract, entered into for the period for which the budget memorandum, i.e. financial plan of the Republican Fund, is adopted of one calendar year, and in exceptional cases it may be entered into for a period of one calendar year, governs relationships between the respective branch, i.e. the Republican Fund and health care services providers in order to enable the insured person to exercise entitlements to health care.
- (2) The contract referred to in paragraph 1 above is entered into on the basis of an offer of a health care services provider regarding the provision of health care programmes and services covered by compulsory health care insurance, presented in the form of a working plan of such health care services provider.
- (3) Term of the contract referred to in paragraph 1 above may be extended by an annex to the contract for the next calendar year, but not after the entry into force of the general act regulating remuneration for the work of health care providers referred to in [Article 179](#), paragraph 1 herein.
- (4) The contract entered into for a period in line with the adoption of the budget memorandum, i.e. which is entered into for a period of several years pursuant to

paragraph 1 above, is adjusted for each fiscal year to the allocated funds in the financial plan of the Republican Fund.

- (5) The contract referred to in paragraph 1 above governs relationships between the respective branch, i.e. the Republican Fund and providers of health care services, in the provision of health care services covered by the compulsory health care insurance and in particular: type, scope and quantity of health care services provided, measures necessary to provide good quality health care to insured persons, staff based on the norms and standards of human resources required for the exercise of health care of the insured, benefits, i.e. costs paid by the respective branch, i.e. the Republican Fund for health care services provided, the method of calculation and payment, control and responsibility for compliance with obligations under the contract, 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 of parties to the contract.

Article 177a

- (1) The Republican Fund may, in the name and on behalf of the health care provider, with which it has entered into a contract referred to in [Article 177](#) hereof, make payments for goods and services procured via centralized public procurements in accordance with law.**
- (2) The procedure and method of payment referred to in paragraph 1 above shall be regulated by the act referred to in [Article 179](#) herein.**

Article 178

- (1) Healthcare facilities having obtained in the course of accreditation procedure a certificate on quality, in accordance with the act governing health care, have a priority in entering into a contract with the respective branch, i.e. the Republican Fund.
- (2) Before entering into a contract with a health care services provider in regard to health care provision, the Republican Fund, i.e. the respective branch, may conduct a control of implementation and enforcement of the contracts previously entered into with such provider of health care services.
- (3) A health care services provider, with whom the respective branch, i.e. the Republican Fund entered into a contract on providing health care services, shall provide insured persons with the necessary medicines, medical devices, implants and medical-technical aids established as the entitlement deriving from compulsory health care insurance.

Article 179

- (1) The Republican Fund passes, for the period referred to in [Article 177](#) hereof, a general act which specifies terms and conditions for entering into a contract with health care services providers, criteria and standards for establishing remuneration for their work, i.e. method of payment for health care services, as well as other costs in accordance with this Act, the procedure of final settlement with the health care services providers under a contract on providing health care services following the end of the budget year, as well as other issues relevant to entering into contracts with the health care services providers.
- (2) The Republican Fund passes the general act referred to in paragraph 1 above in cooperation with the association of healthcare facilities founded in accordance with the act regulating health care, as well as with the representatives of the chamber of health professionals, founded in accordance with law
- (3) The Ministry gives an approval for the general act referred to in paragraph 1 above.
- (4) The general act referred to in paragraph 1 above is published in the ‘‘Official Gazette of the Republic of Serbia’’.

Article 180

- (1) The contract referred to in [Article 177](#) hereof is entered into on the basis of the following:
 - 1) the three-year, i.e. annual plan relating to health care deriving from the compulsory health care insurance which is adopted in accordance with this Act;
 - 2) established staff norms, working standards and health care capacities necessary for exercising entitlements to health care insurance by insured persons;
 - 3) general act of the Republican Fund referred to in [Article 179](#), paragraph 1 herein;
 - 4) the act of the Republican Fund referred to in [Article 55](#), paragraph 2 herein;
 - 5) the financial plan of the Republican Fund.
- (2) The contract entered into between the respective branch, i.e. Republican Fund, and a health care service provider may establish lower prices of health care services than those set in accordance with [Article 55](#) hereof for health care services covered by compulsory health care insurance.

Article 181

The contract referred to in [Article 177](#) hereof may define the following manners of payment for 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) payment by diagnosis related group of diseases and injuries;
- 6) any other manner established by the contract.

Article 182

- (1) The respective branch enters into a contract with a health care services provider on providing health care established as the entitlement deriving from compulsory health care insurance for insured persons on the territory of the respective branch, as well as for other insured persons, in accordance with the regulations passed to implement this Act.
- (2) The Republican Fund enters into contracts with health care services providers for certain types of health care services to be provided to all insured persons in the Republic, i.e. for implementation of particular health care programmes which are adopted in accordance with law, as well as with health care facilities which conduct doctrinal, expert-methodological and other activities of significance for providing health care insurance, i.e. with other legal entities – for exercising certain entitlements deriving from compulsory health care insurance.
- (3) Health care providers under the Network Plan shall enter into a contract primarily with the Republican Fund for available capacity in terms of space, equipment and staff, i.e. primarily execute contractual obligations to the Republican Fund, and then the obligations to other legal and natural persons with whom they have entered into contracts on providing health care services.

Article 183

- (1) Only the health care services provided to the insured persons in the event of a medical emergency, at prices established by the act referred to in [Article 55](#) hereof, may be covered by compulsory health care insurance where such health care services are provided by health care facilities, i.e. private practice, with which a contract on health care services has not been entered into.

- (2) If the insured person has paid for the provided emergency medical aid to the health care facility, i.e. private practice referred to in paragraph 1 above, he/she is entitled to reimbursement of such expenses out of the compulsory health care insurance funds up to the price of the health care service provided, established by the act referred to in [Article 55](#) herein.

2. Arbitration

Article 184

- (1) In order to resolve any disputes that have arisen between the branches, i.e. the Republican Fund, and health care providers, in regard to entering into, modifying and implementation of the contract on providing health care, arbitration may be constituted.
- (2) A health care facility, i.e. private practice, which has not entered into a contract on providing health care covered by compulsory health care insurance to insured persons, and which has rendered an emergency medical aid to the insured person, may require an agreement to be made on setting the arbitration, in accordance with this Act
- (3) Each party involved in the dispute referred to in paragraphs 1 and 2 above, may require an arbitration agreement to be made within 8 days as of the date the dispute has arisen, i.e. as of the date of service of the contract, referred to in [Article 175](#) hereof, to a health care services provider.
- (4) Arbitration shall consist of 5 members: a representative of the branch, i.e. the Republican Fund 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.
- (5) For the settlement of disputes between the branch and health care providers from the territory of the autonomous province, one member of the arbitration shall be a representative of the Provincial Fund.
- (6) 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

- (1) Proceeding before the arbitration is summary, and the award on the issue in dispute shall 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.
- (2) For the duration of arbitration, terms for bringing the case before the court are of no effect.
- (3) 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.
- (4) An award made on the basis of the settlement is effective as any other arbitration award, except that it needs not contain a rationale.
- (5) The arbitration is governed by the provisions of the act governing the elected court, i.e. arbitration, unless otherwise provided by this Act.

3. Contract Enforcement Control

Article 186

- (1) The Republican Fund shall arrange for and carry out control over enforcement of the contracts entered into with health care services providers.
- (2) The Republican Fund controls how the contracts between branches and providers of health care services are being implemented.
- (3) The control of such contracts is made by the branches and the Provincial Fund as well, in accordance with this Act.

Article 187

- (1) An officer of the Republican Fund, the branch, i.e. the Provincial Fund (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 compulsory health care insurance funds, which have been transferred to providers of health care services for purposes of exercise of statutory entitlements by insured persons.
- (2) Control of personal data related to the health status of insured persons, which are maintained in the medical record of the insured person, in accordance with law, is performed by an insurance supervisor who is an authorised MD, dentist or pharmacist.

- (3) The Republican Fund adopts a general act specifying in detail the manner and procedure of performing activities referred to in paragraphs 1 and 2 above.
- (4) The general act, referred to in paragraph 3 above is published in the “Official Gazette of the Republic of Serbia”.

Article 188

- (1) While carrying out controls an Insurance Supervisor is to have and produce an official ID document.
- (2) The official ID document is issued by the Director of the Republican Fund.
- (3) The form, appearance and contents of the ID document are prescribed by the Director of the Republican Fund.

Article 189

- (1) 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 insured persons’ exercise of entitlements deriving from compulsory health care insurance.
- (2) Upon the established state of facts in the course of control, the Insurance Supervisor makes an official record and delivers it to the provider of health care services.
- (3) 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 care services or in implementation of the contract entered into with the Republican Fund, i.e. the respective branch.
- (4) If the health care services provider fails to rectify any established irregularities in providing health care services, or in implementing the concluded contract, within the time period referred in paragraph 3 above, the Insurance Supervisor may propose for the measures referred to in [Article 190](#) hereof to be applied.

Article 190

- (1) When performing a control the Insurance Supervisor may:

1. order for the established irregularities and deficiencies, or activities which are contrary to law and the contract entered into with the provider of health care services, to be rectified within a certain time period;
 2. propose a temporary suspension of transfer of funds until the provider of health care services rectifies the established irregularities in execution of the contract;
 3. propose a termination of contract with a chosen physician;
 4. propose for the funds allocated to 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. propose 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.
- (2) A decision on the proposed measures referred to in paragraph 1 above is made by the Director of the Republican Fund, i.e. Director of the respective branch who shall notify the Director of the Republican Fund thereof.

6. COMPENSATION FOR DAMAGES IN CARRYING OUT HEALTH CARE INSURANCE

Article 191^H

- (1) The insured person, or the who has been paid a benefit out of the compulsory health care insurance to which he/she has not been entitled shall return such benefit received to the Republican Fund, i.e. the respective branch:
- 1) if the payment has been made on the basis of incorrect data which he/she knew or should have known to be incorrect, or if he/she has unlawfully exercised the right to a benefit 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 changes relevant to the loss or scope of any entitlements, 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 ruling.

- (2) Statute of limitations for claims referred to in paragraphs 1 to 3 above, shall run as of the date when the ruling, on whether the money paid does not belong to the insured or belongs but in a lesser amount, has become final in administrative proceedings, i.e. as of the date the last unwarranted payment has been made.

Article 192

- (1) The respective branch, or the Republican Fund, is entitled to claim compensation for damages from the person who has deliberately or through gross negligence caused an illness, injury or death of the insured person.
- (2) For damages sustained by the respective branch, or the Republican Fund, in the case referred to in paragraph 1 above, caused by an employee at work, or in situations pertaining to work, the employer with whom such employee is employed shall be held accountable.
- (3) The respective branch, or the Republican Fund, is entitled, in the cases referred to in paragraph 2 above, to claim compensation for damages also directly from the employee if he/she has intentionally caused illness, injury or death of the insured person.

Article 193

- (1) The respective branch, i.e. the Republican Fund, is entitled to claim compensation for damages from the employer if an illness, injury or death of the insured have occurred because no occupational health and safety measures 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.
- (2) The respective branch, i.e. the Republican Fund, is entitled to claim compensation for damages from the employer if the damages have been caused because an employee started to work without due prior medical examination, 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

- (1) The respective branch, i.e. the Republican Fund, is entitled to claim compensation 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 has been made on the basis of false data provided in the insurance application, or because no applications on changes or cancellation of insurance have been submitted, or if the submitted application forms have been submitted later than the prescribed time period;
- (2) The respective branch, i.e. the Republican Fund, is entitled to claim compensation for damages from the insured who is obliged to submit the insurance application, change or cancellation form, or to report certain data about health care insurance by him/herself, 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 H

- (1) The respective branch, i.e. the Republican Fund, is entitled to claim compensation for damages from the chosen physician who establishes work incapacity of the insured in an illegal manner, or prescribes medicines, medical-technical aids, or other entitlements deriving from compulsory health care insurance, for which no grounds in the health status of the insured person exist.
- (2) If the damages, referred to in paragraph 1 above, have been incurred due to illicit performance of the medical commission, members of the commission are accountable for such damages.
- (3) The respective branch, i.e. the Republican Fund, is entitled to claim compensation for damages from the physician, or the health care services provider, if the damages have been incurred due to malpractice i.e. negligent treatment of the insured by a physician, i.e. health care services provider.

Article 196 H

- (1) When establishing the right to compensation for damages caused to the respective branch, i.e. the Republican Fund, the act governing contractual relationships shall apply.
- (2) The amount of compensation is established according to the treatment costs and other expenses related to treatment, benefits paid to the insured person in accordance with the provisions of this Act and other benefits sustained by the respective branch, i.e. the Republican Fund.

Article 197

- (1) The respective branch, i.e. the Republican Fund, is entitled to claim compensation 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 *lex specialis*, a compulsory motorcar liability insurance policy with the person who has caused the damages to health, or caused death of the insured person.
- (2) If the damages occurred by use of an unknown motorcar, the respective branch, i.e. the Republican Fund, has the right to claim compensation directly from a reinsurance company.
- (3) The respective branch, i.e. the Republican Fund, is entitled to claim the compensation directly from the reinsurance company if damages are caused by a motorcar of foreign registration plates which is not covered by compulsory motorcar liability insurance on the territory of the Republic of Serbia.
- (4) The respective branch, i.e. the Republican Fund, is also entitled to claim the compensation for damages when such damages are caused by a motor vehicle abroad, in accordance with the act governing insurance in regard to international traffic.

Article 198

In accordance with this Act, compensation for damages may be claimed by the insured person who has suffered the damages in the course of carrying out of compulsory health care insurance, as well as the employer who has suffered the damages in the course of carrying out of compulsory health care insurance in regard to its personnel.

Article 199

- (1) When the respective branch, i.e. the Republican Fund, establishes that it has suffered damages in the course of carrying out of health care insurance, it shall order the party which has caused the damages to compensate for the damages within 30 days as of the date the compensation has been established.
- (2) If the damages are not compensated for in due term, the respective branch or the Republican Fund may bring a lawsuit before a competent court.

Article 200

- (1) Employers, health care services providers with whom the respective branch, i.e. the Republican Fund, has entered into a contract on providing health care covered by

compulsory health care insurance, 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 relevant to damages compensation in accordance with this Act, shall submit such data to the respective branch, i.e. the Republican Fund, in the event of illness, injury or death of the insured person.

- (2) The obligation referred to in paragraph 1 above, also applies to companies which, in accordance with a *lex specialis*, perform insurance activities in the event of injury or death of the insured person in a traffic accident if the insured person has closed a contract on compulsory traffic liability insurance with the insurance company.

7) COMPULSORY HEALTH CARE INSURANCE FUNDING

1. Funding of the Entitlements deriving from Compulsory Health Care Insurance

Article 201

- (1) Funding of entitlements deriving from compulsory health care insurance is provided by payments of contributions for compulsory health care insurance, and from other sources, in accordance with this Act and the act which governs compulsory social insurance contribution payments.
- (2) Funds referred to in paragraph 1 above are an income of the Republican Fund.

Article 202

- (1) Decision on the amount of funds to be transferred to the branch is made by the Republican Fund for each budget year.
- (2) The Government grants an approval for the act referred to in paragraph 1 above.
- (3) The funds referred to in paragraph 1 above have to be in accordance with activities under the competence of the branch, i.e. activities under the competence of the Republican Fund in providing and exercising of entitlements deriving from compulsory health care insurance, which are governed by this Act and by the regulations passed to implement this Act.
- (4) Decision on the funds referred to in paragraph 1 above is based upon the following:
 - 1) the financial plan of the Republican Fund;

- 2) health care programme in regard to health care deriving from compulsory health care 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 persons 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 records of paid amounts;
 - 6) activities under the competence of the respective branch in carrying out compulsory health care insurance;
 - 7) activities under the competence of the Republican Fund in carrying out compulsory health care insurance;
 - 8) indicators of shortage of funds that are paid within the territory of the respective branch for the entitlements deriving from compulsory health care insurance to be provided for;
 - 9) the funds that should be provided for regular implementation of entitlements deriving from compulsory health care insurance (hereinafter referred to as: solidarity funds) referred to in [Article 232](#) herein;
 - 10) other indicators;
- (5) The decision referred to in paragraph 1 above, shall be passed by the Republican Fund by the 31st of January at the latest for the current year.
- (6) The decision referred to in paragraph 1 above is published in the ‘‘Official Gazette of the Republic of Serbia’’.

Article 203

The funds provided out of contributions are intended for the exercise of entitlements deriving from compulsory health care insurance, in the event of disease and injury sustained out of the work place, as well as in the event of a work-related injury or occupational disease.

2. Contributions for the Insured referred to in [Article 22](#) herein

Article 204

- (1) Funds for contribution payments for the insured referred to in [Article 22](#) hereof are provided within the budget of the Republic of Serbia.
- (2) The basis for the contribution payments referred to in paragraph 1 above, is the lowest monthly basis established in accordance with the act governing compulsory social insurance contributions.
- (3) The contributions referred to in paragraph 1 above, are calculated and paid at the rate of 12.3%.
- (4) The funds obtained from the contribution payments, referred to in paragraph 1 above, constitute the income of the Republican Fund.

3. Contributions for the Insured who are to be Included in Compulsory Health Care Insurance

Article 205 P

Contributions for the insured referred to in [Article 23](#) hereof, who are to be included in compulsory health care insurance is calculated and paid on the basis and at the rate prescribed in accordance with the act governing compulsory social insurance contributions.

4. Calculation, Establishment and Payment of Contributions

Article 206

Calculation, establishment and payment of contributions referred to in [Article 204](#) hereof, is prescribed by mutual agreement of the Minister and the Minister of Finance.

Article 207

When the branch ex officio issues a ruling on establishing the insured status, an obligation to calculate and pay contributions, which are valid on the date such ruling is issued, is established as well.

III ORGANISATION OF HEALTH CARE INSURANCE

1. General Provisions

Article 208

- (1) Compulsory health care insurance is provided and carried out by the Republican Health Care Insurance Fund having a registered office in Belgrade.
- (2) The Republican Fund exercises public authority regarding the provision and carrying out of health care insurance, as well as resolving issues relating to entitlements and liabilities deriving from compulsory health care insurance, in accordance with this Act.
- (3) The Institute also performs activities relating to voluntary health care insurance, in accordance with law.

Article 209

- (1) The Republican Fund is a legal entity with the status of an organization for compulsory social insurance where the rights deriving from compulsory health care insurance are exercised and funds for compulsory health care insurance are provided in accordance with the law.
- (2) Rights, obligations and responsibilities of the Republican Fund are specified by law and the statute of the Republican Fund.
- (3) The Republican Fund is managed by the insured, who are equally represented in the Management Board of the Republican Fund in proportion to the type and number of the insured under this Act.

Article 210

- (1) In order to provide and carry out health care insurance on the territory of the Republic, the branches and the Provincial Fund are founded.
- (2) The branches are established for the territory of an administrative district, with a seat in the administrative district, i.e. for the territory of the City of Belgrade, with the seat in Belgrade, whereas municipalities of Razanj and Sokobanja pertain to the branch with the based in Nis.
- (3) Notwithstanding paragraph 2 above, in addition to the branch which is in the seat of an administrative district, a branch can be formed outside of the seat of the administrative district, as decided by the Republic Fund, with the approval of the Government.
- (4) 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 persons on the territory of the Republic.

- (5) Competences and responsibilities of a branch, territorial organisation of branch divisions, and the Provincial Fund, as well as other issues relevant for the operation of the branches, i.e. Provincial Fund, are regulated in accordance with law and the Statute of the Republican Fund.

2. The Republican Fund Funds

Article 211

The Republican Fund has a separate account for

- 1) compulsory health care insurance;
- 2) voluntary health care insurance;

3. The Republican Fund Activities

Article 212

(1) The Republican Fund:

- 1) adopts the Statute;
- 2) adopts general acts on the basis of the competencies as stipulated by this Act, which regulate in detail the carrying out of compulsory health care insurance;
- 3) plans and provides funds for carrying out compulsory health care insurance;
- 4) within available funds, makes plans and provides conditions for carrying out health care insurance on an even basis on the territory of the Republic and provides the solidarity funds for equalizing conditions for the provision of compulsory health care insurance on the territory of the branches;
- 5) provides financial and other conditions for exercising entitlements to health care abroad, i.e. for referring the insured persons to treatment abroad;
- 6) adopts a working plan for providing the entitlements deriving from compulsory health care insurance in accordance with work plans of the branches;
- 7) adopts 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 compulsory health care insurance to the branches in accordance with [Article 202](#) hereof ;
- 10) provides legal, purposeful and economical use of funds, takes care of the funds to be increased on economic grounds;

- 11) provides direct, efficient, rational and legal exercise of rights deriving from health care insurance and organises the activities to be carried out for the purposes of exercising of insurance;
 - 12) organises activities for carrying out health care insurance, which is directly exercised in the Republican Fund;
 - 13) co-ordinates work in the branches and Provincial Fund;
 - 14) organises and controls work in the branches and legal and purposeful use of funds, which are transferred to the branches for the purpose of exercising entitlements deriving from compulsory health care insurance;
 - 15) controls the implementation of the contracts entered into between the branches and the health care services providers, i.e. controls the exercise of rights deriving from compulsory health care insurance;
 - 16) establishes, organises and controls the activities of the Central Registry;
 - 17) organises, controls and harmonises work of the first and second-instance medical commissions;
 - 18) provides implementation of international contracts on compulsory health care insurance;
 - 19) keeps records and monitors collection of contributions, along with the competent bodies, exchanges data with such bodies on health care insurance contribution payers, as well as other data relating to contributions;
 - 19a) performs activities relating to the pharmaco-economic indicators in the process of placing medicines on the List of Medicines, its amendments and the removal of medicines form the List of Medications;**
 - 19b) performs centralized public procurements in accordance with law;**
 - 20) performs other activities established by law and the Statute of the Republican Fund
- (2) The Republican Fund, which carries out voluntary health insurance, organizes, controls the calculation and payment of premiums for voluntary health insurance, and supervision of voluntary health insurance in accordance with law.
- (3) **For the performance of activities referred to in paragraphs 1 and 2, the Republican Fund may establish commissions and other professional bodies, except for the fields of medicine, dentistry and pharmacy for which the republican expert commissions are established, in accordance with the act governing health care, or other expert body established by the Minister.**

- (4) In the process of issuing of decisions and general acts which provide or regulate the entitlement to health care covered by compulsory health insurance, the Republican Fund shall include in these activities, i.e. obtain expert opinion of the republican expert commissions, established in certain areas of medicine, dentistry, or pharmacy in accordance with the act governing health care, and other professional bodies established by the Minister.**
- (5) Members of the National Expert Commission are entitled to compensation for the purpose of working for the Republican Fund, which is paid out by the Republican Fund.**
- (6) The amount of compensation is determined by the Management Board of the Republican Fund.**

Article 212 P

- (1) Republican Fund conducts centralized procurements in the name and on behalf of the health institutions in the National Healthcare Institutions Network Plan which is adopted by the Government (hereinafter referred to as: the Network Plan), in accordance with this act, unless otherwise provided by the act governing public procurement, as follows:
 - 1) conducts centralized public procurements pursuant to the Plan referred to in paragraph 5 below, funds for which are provided in the financial plan of a health care institution, i.e. Republican Fund, as well as in the budget of the founder of the health care institution, in accordance with law;**
 - 2) monitors the enforcement of contracts entered into with the most successful supplier;**
 - 3) performs other activities in accordance with law.****
- (2) For the conduct of centralized procurement which the Republican Fund conducts in the name and for the account of health care institutions referred to in paragraph 1 above, prior authorization or approval of such institutions is not required.**
- (3) Health care institutions referred to in paragraph 1 above cannot procure goods and services for which the Republican Fund, in the name and for the account of such institutions, conducts centralized procurements. Public procurement procedures are conducted in accordance with the law regulating public procurements.**
- (4) The Institute of Public Health has been established for the territory of the Republic and it collects, integrates and analyzes the needs of health care institutions referred**

to in paragraph 1 above, based on which it adopts the Plan of Centralized Public Procurement of Goods and Services for Health Care Institutions in the Network Plan (hereinafter referred to as: the Centralized Procurement Plan), which is forwarded to the Republican Fund for the conduct of centralized public procurements.

- (5) The Institute of Public Health established for the territory of the Republic shall obtain the opinion of the republic expert commissions, established in accordance with the law, about the Centralized Procurement Plan, as well as conduct a compliance procedure of the Centralized Procurement Plan and opinions of republican expert commissions before submitting the same to the Republican Fund.
- (6) The Republican Fund provides funding for the Institute of Public Health established for the territory of the Republic, to perform activities in connection with the preparation of the Centralized Procurement Plan, in accordance with the law.
- (7) The Government adopts the act which specifies the terms, manner and procedures for planning the needs of health care institutions for which centralized public procurements of goods and services are conducted, the type of goods and services for which centralized public procurements are conducted and which are covered by the Centralized Procurement Plan, as well as other issues relevant for the planning, organization and conduct of centralized public procurements.

4. The Branch

Article 213

- (1) The branch:
 - 1) carries out compulsory health care insurance on its territory;
 - 2) plans the needs of the insured persons on its territory and compiles working plans in accordance with the available funds, i.e. with the financial plan of the Republican Fund;
 - 3) disposes of the transferred funds for carrying out compulsory health care insurance for the insured persons on its territory, in accordance with this Act;
 - 4) provides for the exercise of entitlements deriving from health care insurance by 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 transferred compulsory health care insurance funds on its territory;
 - 8) maintains the Central Registry on insured persons with the data necessary for carrying out compulsory health care insurance and for providing and controlling the exercise of entitlements deriving from health care insurance;
 - 9) controls insurance applications, cancellation and changes and all the data relevant for the acquisition, exercise and termination of such entitlements;
 - 10) maintains records and monitors contribution collection, along with the competent authorities, exchanges data on contribution payers with the competent authorities, as well as other data relating to contributions;
 - 11) provides the necessary professional help to insured persons in regard to exercising entitlements deriving from compulsory health care insurance, and protection of their interests related to insurance;
 - 12) performs certain activities relevant to execution of international contracts on health care insurance;
 - 13) provides conditions for the first and second-instance medical commissions to work on its territory, in accordance with acts of the Republican Fund;
 - 14) performs activities relating to the compensation of damages in exercising of compulsory health care insurance;
 - 15) performs other activities in accordance with law and the Statute of the Republican Fund.
- (2) The branch also performs certain activities relating to voluntary health care insurance which are organised and carried out by the Republican Fund.
- (3) The activities referred to in paragraphs 1 and 2 above are carried out by the branch on behalf of the Republican Fund.

Article 214

The branch submits a six-monthly work report to the Management Board of the Republican Fund.

Article 215

- (1) The branch is managed by its Director.
- (2) 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 care insurance.
- (3) The Branch Director enforces the decisions of the Republican Fund bodies.
- (4) Based on a public competition, the Branch Director is appointed by the Director of the Fund for a term of four years.
- (5) The Branch Director has to meet the requirements referred to in Article 219, paragraphs 3 to 5 herein.
- (6) While at the office, the Branch Director performs a public function.
- (7) Provisions of the law regulating the work of the Anti-Corruption Agency apply to the performance of a public function for the purpose of preventing the conflict of private and public interest.
- (8) At the end of his/her term, the Branch Director continues to perform activities in accordance with the law and the Statute of the Republican Fund until the date of appointment of another Branch Director in the manner prescribed by this Act.

Article 216

- (1) The branch establishes its Council.
- (2) The Branch Council is a counselling body of the Branch Director and consists of representatives of the insured and employers from the branch territory.
- (3) The Branch Council consists of nine members at the most, of which six are representatives of the insured and three representatives of employers, whereas municipalities covered by the branch should be evenly represented.
- (4) One representative of the insured in the Branch Council comes from an association of persons with disabilities on the territory of the branch.
- (5) Branch Council members have to comply with the conditions referred to in [Article 219](#), paragraphs 3 to 5 herein.
- (6) The branch council:
 - 1) proposes measures for carrying out and improvement of health care 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 ensuring the entitlements deriving from health care insurance and to contracts entered into with the health care services providers;
- 4) submits proposals for rational disposal and spending of health care insurance funds;
- 5) gives opinion on the Report the branch submits to the Management Board of the Republican Fund;
- 6) performs other activities set by the Statute of the Republican Fund.

5. The Provincial Fund

Article 217 H

The Provincial Fund is an organisational unit of the Republican Fund, which performs the following activities:

- 1) co-ordinates work of branches organized on the territory of the autonomous province, in co-operation with the Republican Fund, in accordance with law;
- 2) controls work of branches and purposeful use of funds provided for the branches which are transferred by the Republican Fund to the branches for exercising entitlements deriving from compulsory health care insurance on the territory of the autonomous province;
- 3) controls execution of the contracts entered into between the branches and the health care services providers on the territory of the autonomous province;
- 4) decides in the second-instance on the entitlements sustained in the compulsory health care insurance, in accordance with this Act;
- 5) provides the necessary professional aid to insured persons in regard to exercising the entitlements deriving from health care insurance, and protection of their interests related to the insurance
- 6) provides conditions for the work of medical commissions formed on the territory of the autonomous province, 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 care insurance, in accordance with law;
- 8) conducts statistical and other research in the field of health care insurance;
- 9) co-operates with the competent provincial authorities;
- 10) performs other activities under the Statute of the Republican Fund;

11) submits the six- and twelve-month work reports to the Management and Supervisory Board of the Republican Fund.

6. The Republican Fund Administration

Article 218

The Republican Fund is managed by the representatives of the insured in accordance with this Act.

7. The Republican Fund Bodies

Article 219

- (1) The Republican Fund bodies are: the Management Board, Supervisory Board and the Director.
- (2) The Republican Fund also has a Deputy Director who is appointed and recalled under conditions, in the manner and in accordance with a procedure prescribed therefor.
- (3) Members of the Management Board, members of the Supervisory Board, Director, or Deputy Director may not directly or through any third party, natural or legal entity, participate as shareholders, stockholders, employees, or employees under a contract in any legal or natural entity being health care services providers with whom contracts are entered into for providing entitlements deriving from compulsory health care insurance, or in any insurance companies operating in the voluntary health care insurance, all for the purposes of preventing a conflict of public or private interest. ^[2]
- (4) Notwithstanding paragraph 3 above, members of the Management Board, members of the Supervisory Board, Director, i.e. Deputy Director may, in addition to the activities in the Republic Fund conduct scientific research, teach, work in a cultural-artistic, humanitarian and sports organizations, without the consent of the Anti-Corruption Agency, provided that they do not jeopardize impartial performance of duties and the reputation of the Republican Fund's bodies
- (5) The person referred to in paragraph 3 above 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 self - government, or any body of an authorised initiator referred to in [Articles 222](#) and [225](#) herein.

- (6) The person referred to in paragraph 3 above shall sign an affidavit declaring that there is no conflict of public and private interest referred to in paragraph 3 above.
- (7) The person referred to in paragraph 3 above performs a public office.
- (8) Performance of public office by persons referred to in paragraph 3 above in relation to the prevention of conflict of public and private interest in performing public offices, is governed by the provisions of the act governing the operation of the Anti-Corruption Agency.
- (9) Persons referred to in paragraph 3 above may be appointed to a public office in the Republican Fund bodies twice at the most.
- (10) At the end of their mandate Republican Fund bodies shall continue to perform their activities in accordance with law and the Statute of the Republican Fund until the date of appointment of new bodies in the manner prescribed by this Act.

Article 220 H

In the Republican Fund bodies referred to in Article 219 hereof, the representatives of insured persons must be equally represented in terms of gender, age, professional education, and the branches must be equally represented as well.

Management Board

Article 221 H M P

- (1) Management Board:
 - 1) adopts the Statute and other general acts of the Republican Fund;
 - 2) decides on the Republican Fund operation, as well as on other issues relevant for its operation;
 - 3) adopts a financial plan and the financial statement of the Republican Fund;
 - 4) deliberates on and adopts a work report;
 - 5) organises a public competition for the appointment of the Director of the Republican Fund;
 - 6) performs other activities in accordance with law and the Statute;
- (2) The Statute of the Republican Fund specifies the activities of the Republican Fund, internal organisation, administration, business, conditions for the appointment of the

Director and Deputy Director, as well as other issues relevant for the Republican Fund operating.

- (3) The activities of the Republican Fund, which are governed by the Statute referred to in paragraph 2 above include: carrying out compulsory health care insurance, as well as voluntary health care insurance which is organised and carried out by the Republican Fund, 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 persons.
- (4) The Government gives an approval on the Statute of the Republican Fund.
- (5) The Management Board submits the work report to the Government by 31st March of the current year for the previous one.

Article 222

- (1) The Management Board consists of 21 members, 14 of which are representatives of the insured employees, 2 representatives from each rank i.e. rank of the insured pensioners, rank of the insured farmers and rank of the insured self-employed and 1 representative of the association of persons with disabilities who has the status of the insured in terms of this Act.
- (2) Members of the Management Board represent the interests of insured persons in the provision and exercise of entitlements deriving from compulsory health care insurance, in accordance with this Act.
- (3) Members of the Management Board are appointed and dismissed by the Government upon a proposal of: the representative trade unions on the level of the Republic, in accordance with the act governing labour – 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 insured pensioners; of the farmers' associations, having more than 50,000 registered members – for the insured farmers; of the Serbian Chamber of Commerce – for the self-employed insured 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.
- (4) The number of members of the associations referred to in paragraph 3 above, is established on the basis of evidence of the number of registered members.

Article 223

- (1) The Government appoints and revokes the President and the Deputy President of the Management Board among the members of the Management Board.
- (2) Members of the Management Board, the President and the Deputy President of the Management Board are appointed for a term of four years.
- (3) The performance of activities, powers and responsibilities of the Management Board members, as well as other issues significant to the operation of the Management Board are governed by the Statute of the Republican Fund.

Supervisory Board

Article 224

- (1) The Supervisory Board:
 - 1) supervises financial operations of the Republican Fund;
 - 2) supervises financial operations of the branches;
 - 3) controls effectuation of legal obligations of the Republican Fund and the Provincial Fund;
 - 4) controls implementation of the Management Board decisions;
 - 5) performs other activities in accordance with law and the Statute of the Republican Fund.
- (2) At least once a year, the Supervisory Board submits a report on supervision to the Management Board and the Government.

Article 225

- (1) The Supervisory Board consists of seven members, three of which are representatives of the employed insured, one 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 Republican Fund, i.e. branch or in the Provincial Fund.
- (2) 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 act governing labour – 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 Serbian Chamber of Commerce – for the self-employed insured and the Director of the Republican Fund – for the member from the employees in the Republican Fund, i.e. branch or in the Provincial Fund.

- (3) The Government appoints and revokes the President of the Supervisory Board among the members of the Supervisory Board
- (4) The number of members of the associations referred to in paragraph 2 above, is established on the basis of evidence of the number of registered members.

Article 226 H

- (1) Members and the President of the Supervisory Board are appointed for a term of four years.
- (2) The performance of activities, powers and responsibilities of the Management Board members, as well as other issues relevant for the operation of the Supervisory Board are governed by the Statute of the Republican Fund.

Director of the Republican Fund

Article 227 H

- (1) Director of the Republican Fund:
 - 1) organises work and operation of the Republican Fund;
 - 2) represents and acts for the Republican Fund;
 - 3) ensures the legality of the operation of the Republican Fund and is accountable for the legality thereof;
 - 4) enforces the decisions of the Management Board;
 - 5) adopts the act on the organization and job classification in the Republican Fund;
 - 6) prescribes the form of an official ID card for the Insurance Supervisor, as well as its appearance and content;
 - 7) manages the work of the employees of the Republican Fund;
 - 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.
- (2) the Director of the Republican Fund, upon a public competition, appoints the Management Board, after having obtained the approval of the Government.

- (3) The Director of the Republican Fund is appointed for a term of office of four years.

Director of the Provincial Fund

Article 228

- (1) Director of the Provincial Fund is appointed by the Management Board upon a public competition of the Republican Fund on the proposal of a competent body of the autonomous province.
- (2) Director of the Provincial Fund is appointed for a term of office of four years.
- (3) At the end of his/her mandate the Director of the Republican Fund shall continue to perform activities in accordance with law and the Statute of the Republican Fund until the date of appointment of the new Director of the Provincial Fund in the manner prescribed by this Act.
- (4) Director of the Provincial Fund participates in the Management Board work, without voting rights.
- (5) Director of the Provincial Fund upon a public competition 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.
- (6) The Provincial Fund Director is subject to the provisions of [Article 219](#), paragraphs 3 to 7 herein.

8. The Republican Fund Expert Service

Article 229

- (1) Expert, administrative and financial activities related to the activities and operation of the Republican Fund and carrying out of health care insurance are performed by the employees of the Republican Fund.
- (2) Issues in regard to entitlements, obligations and responsibilities of the employees of the Republican Fund, are governed by the act governing labour.

9. The Republican Fund Funds

Article 230

Revenues of the Republican Fund consist of the following:

- 1) contributions for compulsory health care insurance;
- 2) premiums for voluntary health care insurance organised and carried out by the Republican Fund;
- 3) obtained from assets disposed of by the Republican Fund;
- 4) domestic and foreign credits and loans;
- 5) other funds, in accordance with law.

Article 231

The funds of the Republican Fund may be used only for the purposes prescribed by law, that is:

- 1) for exercising entitlements of insured persons deriving from compulsory health care insurance;
- 2) for the health care insurance system improvement;
- 3) for exercising entitlements of insured persons deriving from voluntary health care insurance, organised and carried out by the Republican Fund;
- 4) for covering the costs of carrying out health care insurance;
- 5) for other expenditures in accordance with law.

Article 232

In the Republican Fund, on the basis of the decision of the Management Board referred to in [Article 202](#) hereof, solidarity funds are allocated within the available funds for carrying out compulsory health care insurance on an even basis on the territory of the Republic and for equalising the conditions for providing the entitlements deriving from compulsory health care insurance on the territory of the branches.

Article 233

The Republican Fund invests its own revenues at a bank, in securities and other uses to obtain profit, or issues specified-purpose loans to health care facilities in accordance with law.

IV SUPERVISION OF OPERATION OF THE REPUBLICAN FUND

Article 234

- (1) In supervising the operation of the Republican Fund, the Ministry is empowered to:
 - 1) require work reports and data;
 - 2) establish the effectiveness of operation, caution about irregularities and establish measures and deadlines for their removal;
 - 3) issue instructions;
 - 4) order for the activities to be undertaken if finds it necessary;
 - 5) institute proceedings for establishing responsibility;
 - 6) directly perform certain activities if it finds there is no other way for the law or any general act to be enforced;
 - 7) propose to the Government to undertake measures within its competencies.

- (2) The work report contains an overview of performance of activities, measures undertaken and their effect, as well as other information.

Article 235

- (1) As the holder of public powers in carrying out the state administration tasks, the Republican Fund shall obtain from the Ministry, before publishing the regulations which it is empowered by this Act to pass, an opinion on constitutionality and legality of such regulations, while the Ministry shall deliver to the Republican Fund a reasoned proposal of how to harmonise the regulation with the Constitution, law, other regulations or a general act of the National Assembly and the Government.
- (2) If the Republican Fund does not proceed as proposed by the Ministry, it shall propose to the Government to issue a ruling on the suspension of enforcement of the regulation and all single acts based on it and to institute the proceedings for assessment of constitutionality and legality of the regulations, in accordance with the act governing the state administration.

V VOLUNTARY HEALTH CARE INSURANCE

Article 236

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

Article 237 H M

Voluntary health care insurance may be organised and carried out by investment funds for voluntary health care insurance, in accordance with a *lex specialis*.

Article 238 P

- (1) Upon a proposal of the Minister, the Government regulates the types of the voluntary health care insurance, conditions, the manner and procedure of organising and carrying out voluntary health care insurance.
- (2) If the voluntary health care insurance is regulated differently by another act, the provisions of this Act and the regulations passed to implement this Act shall apply.

VI SUPERVISION OF ENFORCEMENT OF THE ACT

Article 239

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

VII PENALTY CLAUSES

Offences

Article 240 H

- (1) A fine of RSD 300,000 to RSD 1,000,000 shall be imposed for an offence committed by a health care facility, or any other legal entity, with which the Republican Fund i.e. a branch, has entered into a contract on providing health care services covered by compulsory health care insurance in the following cases:

- 1) If it fails to provide the insured person with the health care services that are covered by compulsory health care 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 ([Articles 34 – 46](#));

- 2) If an insured person is charged participation in the amount other than the one prescribed by this Act and regulations passed to implement this Act ([Article 48](#), paragraphs 4 and 5);
- 3) If it fails to issue an insured person a receipt on collected participation on a prescribed form ([Article 49](#), paragraph 1);
- 3a) If contrary to [Article 49a](#) hereof charges for a health care service to which an insured person is entitled under compulsory health care insurance, or if it requests or receives or in any other way prompts an insured person or a member of his/her family or other legal or natural person to pay, or provide any tangible or intangible benefits for the provision of such services to an insured person, unless otherwise provided by law ([Article 49a](#));
- 4) If it collects participation from an insured person whose health care is covered in full by compulsory health care insurance ([Articles 50 – 51](#));
- 5) If it fails to establish a waiting list for certain types of health care services, which are covered by compulsory health care insurance, or if it establishes waiting lists contrary to this Act or regulations passed to implement this Act, or if it fails to render health care services to an insured person in accordance with the waiting list ([Article 56](#), paragraph 5);
- 6) If the health care services which are not covered by compulsory health care insurance are rendered against the compulsory health care insurance fund ([Article 61](#));
- 7) If it fails to provide the necessary medicines, medical devices, implants and medical-technical aids to the insured person, which are under entitlements included in compulsory health care insurance ([Article 178](#), paragraph 3);
- 7a) If it fails to enter into a contract with the Republican Fund for available capacity in terms of space, equipment and staff, i.e. primarily execute contractual obligations to the Republican Fund, and then the obligations to other legal and natural persons with whom it has entered into a contract on providing health care services ([Article 182](#), paragraph 3).

(2) A fine of RSD 400,000 to RSD 500,000 shall be imposed on an entrepreneur for the offence referred to in paragraph 1 above.

- (3) A fine of RSD 40,000 to RSD 50,000 shall be imposed on a responsible person within a legal entity for the offence referred to in paragraph 1 above.
- (4) If the offence referred to in paragraph 1 above caused material damage to an insured person, or the respective branch, i.e. the Republican Fund, 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

- (1) A fine of RSD 200,000 to RSD 500,000 shall be imposed on a health care facility, or other legal entity, with whom the Republican Fund, i.e. the branch, has entered into a contract on rendering health care services covered by compulsory health care insurance in the following cases:
 - 1) If it fails to issue prior notification in writing on the reasons why a health care service is not medically necessary, i.e. justified in terms of the health status of the insured person, or if it fails to issue prior notification to a person who is placed on a waiting list on the reasons therefor ([Article 57](#), paragraphs 1 to 3);
 - 2) If it fails to post at a prominent place a list of physicians whom the insured person may choose for her/his chosen physician ([Article 147](#), paragraph 2);
 - 3) If it fails to allow an authorised Insurance Supervisor to examine the documentation relevant for the insured persons' exercise of entitlements deriving from compulsory health care insurance ([Article 189](#), paragraph 1);
 - 4) If it fails to submit to the branch, i.e. the Republican Fund, the data it collects, i.e. keeps in the event of an illness, injury or death of an insured person, for purposes of compensation for damages ([Article 200](#), paragraph 1);

- (2) A fine of RSD 300,000 to RSD 500,000 shall be imposed on an entrepreneur for offences referred to in paragraph 1 above.
- (3) A fine of RSD 30,000 to RSD 50,000 shall be imposed on a responsible person within a legal entity for offences referred to in paragraph 1 above.

Article 242

- (1) A fine of RSD 300,000 to RSD 1,000,000 shall be imposed on an employer, having a status of a legal entity, in the following cases:

- 1) If he/she fails to pay to an employee the benefit covered by compulsory health care insurance, or if he/she fails to calculate the benefit of the insured which is covered by compulsory health care insurance, or if he/she fails to pay the insured the benefit covered by compulsory health care insurance, which is transferred to a special account of the employer, within 30 days of the receipt thereof ([Article 103](#), pars. 1, 2 and 4);
 - 2) if he/she fails to present to the respective branch all data in regard to the compulsory health care insurance application, change and cancellation for his/her employees in order to establish the status of the insured person, or to discontinue or enter changes to the status of such person, or if he/she fails to present such data within eight days as of the date of compliance with the necessary requirements ([Article 113](#), paragraphs 1 and 3);
 - 3) if he/she enters false data in the Central Registry, i.e. in the manner contrary to this Act ([Article 119](#));
 - 4) if he/she fails to submit the form with the data to be entered the Central Registry, or if he/she submits it later than the time period referred to in [Article 135](#) hereof ([Articles 123](#) and [135](#));
 - 5) if he/she fails to provide the insured, user of entitlements deriving from compulsory health care insurance, accurate information and data relevant to determining the facts relevant for the acquisition and exercise of entitlements deriving from compulsory health care insurance, and provide the respective branch all evidence and allow records and documentation to be examined ([Article 126](#), paragraph 3);
 - 6) if, within 30 days from the day the claim has been submitted, he/she fails to pay the accrued costs to the account of the insured person, or fails to pay in any other adequate manner for health care services covered by compulsory health care insurance which the insured person has paid because the health care contribution has not been paid either entirely or partially ([Article 143](#), paragraphs 3 and 4);
 - 7) if he/she fails to present to the branch i.e. the Republican Fund the data he/she collects i.e. keeps in the event of illness, injury or death of the insured, for the purposes of damages compensation ([Article 200](#), paragraph 1);
- (2) A fine of RSD 40,000 to RSD 50,000 shall be imposed on a responsible person within a legal entity for offences referred to in paragraph 1 above.

- (3) A fine of RSD 300,000 to RSD 500,000 shall be imposed on an employer - entrepreneur for offences referred to in paragraph 1 above.

Article 243 H

- (1) A fine of RSD 300,000 to RSD 1,000,000 shall be imposed on the Republican Fund for the following offences:
- 1) If the data maintained in the Central Registry, pertaining to the exercise of entitlements deriving from health care insurance for the insured, are not kept separately from other data contained in the Central Registry, or if such data are entered and handled by an official not authorised for such activities ([Article 118](#), paragraph 2);
 - 2) if the Republican Fund fails to provide a copy of receipt of insurance application, change or cancellation forms by the 5th of the month for the previous one for the insured who are self-employed (entrepreneurs), or farmers, or other persons on whom a competent tax authority maintains records ([Article 127](#), paragraph 6);
 - 3) If it fails, upon request of the insured person, issue a certificate on the data supplied for the Central Registry ([Article 133](#), paragraph 1);
 - 4) If it discloses or publicises the data maintained by the Central Registry, which are related to the exercise of entitlements deriving from compulsory health care insurance for a single insured person and which constitute personal data on such insured person ([Article 138](#), paragraph 2);
 - 5) If it certifies a health care insurance document without any evidence that the contributions for compulsory health care insurance have been paid ([Article 142](#), paragraph 2);
 - 6) if it fails to accept a request for arbitration, from a health care services provider, with whom it has entered into a contract on rendering health care services covered by compulsory health care insurance ([Article 184](#), paragraphs 1 and 3);
 - 7) if the control of personal data related to health status of the insured, while exercising entitlements deriving from compulsory health care insurance, which are maintained in the medical file of the insured, is carried out by an Insurance Supervisor who is not an authorised MD, dentist or a pharmacist ([Article 187](#), paragraph 2).

(2) A fine of RSD 40,000 to RSD 50,000 shall be imposed on a responsible person within the Republican Fund for offences referred to in paragraph 1 above.

Article 244

A fine of RSD 30,000 to RSD 50,000 shall be imposed on a health care professional for the following offences:

- 1) if a chosen physician, or a member of the medical commission issues a finding and an opinion on the health status 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 enables the issuing of a Certificate on the Use of Health Care Abroad ([Article 65](#), paragraph 3);
- 2) if she/he established temporary incapacity of the insured in the manner contrary to [Article 74](#) hereof ;
- 3) if she/he fails to receive each and every insured person who has chosen her/him as the chosen physician, unless the number of insured persons registered with such physician is already higher than the standard number of insured persons per a chosen physician ([Article 148](#));
- 4) if the chosen physician abuses his/her authority in the process exercise of entitlements of insured persons ([Article 153](#)).

Article 245

A fine of RSD 30,000 to RSD 50,000 shall be imposed on an insured if she/he intentionally causes work incapacity, or intentionally hinders the process of healing, or work capability, if without any justifiable reason fails to report to the chosen physician for an assessment of a temporary incapacity, or does not appear before the medical commission, if while being temporarily incapacitated, deals in economic or any other activities in order to gain income, if without a permission from an expert medical body of the Republican Fund, leaves the place of domicile or residence, if he/she abuses the right to a sick leave (Article 85).

VIII TRANSITIONAL AND FINAL PROVISIONS

Article 246

- (1) The regulations for implementation of this Act shall be passed within 12 months from the date of entry into force of this Act, unless otherwise provided by this Act.
- (2) Until the regulations referred to in paragraph 1 above, are passed, the regulations in force before the entry into force of this Act shall apply, if not contrary to this Act.

Article 247

- (1) On the date of entry into force of this Act, the Republican Health Care Insurance Fund continues to operate with the entitlements and obligations stipulated by this Act.
- (2) The Republican Health Care Insurance Fund shall harmonise its organisation and work with the provisions of this Act within 12 months as of the date of entry into force of this Act comes.

Article 248

- (1) The Government shall appoint the Management Board and the Supervisory Board of the Republican Fund within 90 days as of the date of entry into force of this Act.
- (2) The Management Board shall appoint the Director of the Republican Fund within 60 days as of the date the Management Board has been appointed.

Article 249

- (1) The Director of the Republican Fund shall appoint the branch directors within 60 days as of the date of her/his assuming the office.
- (2) The Branch Council shall be established within 30 days as of the date of the Director's assuming the office.

Article 250

The Management Board shall adopt the Statute within 60 days as of the date of appointment of the Management Board members.

Article 251

The Republican Fund shall adopt the general act referred to in [Article 124](#), paragraph 5 above within 60 days as of the date of entry into force of this Act.

Article 252

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

Article 253

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

Article 254 M

- (1) The Republican Fund shall organise and establish activities of the Central Registry by 30th June 2006.
- (2) The respective branch shall certify the insurance documents as of 1st July 2006.

Article 255

Notwithstanding 2006 and 2007, in the event that income established by the financial plan of the Republican Fund for a certain budget year, is greater than expenditures planned to be spent for such budget year, by which income the funds for compulsory health care insurance of the insured, referred to in [Article 22](#), paragraphs 1 and 4 hereof, 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 planned as provided in [Article 22](#), paragraph 5 herein.

Article 256

On the date of entry into force of this Act, the [Health Care Insurance Act](#) ceases to have effect (“Official Gazette of the Republic of Serbia”, Nos. 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 its publication 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 care insurance funds, or the insured person’s funds, [Articles 202](#) and [204](#) hereof, which are to take effect as of 1st January 2007.

PROVISIONS NOT INCLUDED IN CONSOLIDATED TEXT

*Act on Amendments to the Health Care Insurance Act
("Official Gazette of the Republic of Serbia", No. 57/11)*

Article 50

- (1) The Republican Fund shall harmonize the Statute and other general acts and issue regulations for the implementation of this Act, by the 1st January 2013.
- (2) Until the regulations referred in paragraph 1 above have been adopted, the regulations in force before the entry into force of this Act shall apply, if not contrary to this Act.

Article 51

Until the regulations governing the methodology for calculating the cost of treatment of blood and blood components in accordance with the act governing transfusion, i.e. the act governing the costs of treatment of blood and blood components, have been issued, the Republican Fund shall establish the costs of treatment of blood and blood components by increasing the present costs of blood, i.e. labile blood products, applicable on the date of entry into force of this Act, in accordance with the funds allocated in the financial plan of the Republican Health Care Insurance Fund.

Article 52

- (1) The Republican Fund shall, not later than three years from the date of entry into force of this Act, replace the insurance document, as well as special document for using health care referred to in [Article 112](#), paragraphs 1 and 2 hereof, with the health card.
- (2) Until full replacement of the certificate of insurance, as well as the special document for using health care – with the health card, insured persons may exercise entitlements deriving from compulsory health insurance under the insurance documents, as well as the special document for using health care, issued in accordance with the regulations in force before the entry into force of this Act.

Article 53

- (1) For the insured persons for whom compulsory health care insurance contributions have not been paid regularly by the date of entry into force of this Act, the insurance document, including the special document for using health care, i.e. health card, until the date of entry into force of this Act shall be verified provided that the contribution payer started settling the due contributions for compulsory health care insurance and continued to pay them regularly and in continuity.

(2) Verification of the insurance document, i.e. special document for using health care, i.e. health card in accordance with paragraph 1 above shall be conducted in the manner prescribed by the general act of the Republican Fund.

Article 54

This Act shall enter into force on the day following its publication in the "Official Gazette of the Republic of Serbia", and the provisions of Articles [11](#), [12](#), [13](#) and [15](#) hereof, in the part which provides for a scope and content of entitlements greater than those established by the regulations in force before the entry into force of this Act shall apply from 1st January 2012.

*Act on Amendments to the Health Care Insurance Act
("Official Gazette of the Republic of Serbia", No. 119/12)*

Article 11

(1) The act referred to in [Article 4](#) hereof shall be passed by the Republican Fund within 90 days of the date of entry into force of this Act.

(2) The Central Commission for Medicines shall be established within 60 days of the date of entry into force of this Act.

(3) Until the adoption of the act referred to in paragraph 1 above the regulations in force before the entry into force of this Act shall apply.

Article 12

[Article 7](#) hereof shall apply from 1st January in 2014.

Article 13

(1) The Act referred to in [Article 10](#), paragraph 8 ([Article 212a](#)) shall be issued within 60 days of the date of entry into force of this Act.

(2) The Republican Fund shall harmonize the Statute and the act on internal organization and job classification with the provisions of this Act within 60 days from the date of entry into force of this Act.

EXPERTS'NOTE:

[1] [Article 52](#), paragraph 1 of the Act on Amendments to the Health Care Insurance Act ("Official Gazette of the Republic of Serbia", No. 57/11) stipulates that the Republican Fund shall, not later than three years from the date of entry into force of this Act (by 9th of August 2014), replace the insurance document, as well as special document for using health care as specified in [Article 112](#), paragraphs 1 and 2 hereof, with the health card.

^[2] The Constitutional Court of the Republic of Serbia rejected the proposal for establishing the unconstitutionality of [Article 219](#), paragraph 3 of the Health Care Insurance Act, under its decision IU No. 54/2006 ("Official Gazette of the Republic of Serbia", No. 38/10).

^[3] The Constitutional Court of the Republic of Serbia issued the [Decision IU No. 424/2005](#) ("Official Gazette of the Republic of Serbia", No. 106/06), in which it was held that: 1. proposals to establish the unconstitutionality of the provisions of [Article 17](#), paragraph 1, item 14), [Article 48](#), paragraphs 1 and 2 and [Article 104](#), paragraph 1 of the Health Care Insurance Act shall be rejected, 2. it shall not accept the initiative to institute proceedings for determining the constitutionality of the provisions of [Article 17](#), paragraph 1, items 13) and 14) of the Health Care Insurance Act and 3. the application to stay the execution of an individual act, or action taken under the provisions of [Article 17](#), paragraph 1, items 13) and 14) of the Health Care Insurance Act, shall be rejected.