THE CROATIAN PARLIAMENT

1666

Pursuant to Article 89 of the Constitution of the Republic of Croatia, I hereby issue the

DECISION

PROMULGATING THE MANDATORY HEALTH INSURANCE ACT

I hereby promulgate the Mandatory Health Insurance Act, passed by the Croatian Parliament at its session on 21 June 2013.

Class: 011-01/13-01/157

Reg. No: 71-05-03/1-13-2

Zagreb, 24 June 2013

President of the Republic of Croatia

Ivo Josipović, m.p

MANDATORY HEALTH INSURANCE ACT

I GENERAL PROVISIONS

Article 1

(1) This Act governs mandatory health insurance in the Republic of Croatia, the scope of the right to health care and other rights and obligations of persons who are mandatorily insured in accordance with this Act, the conditions and method of exercising and financing these rights, as well as the rights and obligations of mandatory health insurance providers, including the rights and obligations of health care providers contracted with insurance providers to provide health care under mandatory health insurance.

(2) The terms used in this Act in a gender-specific form, be it masculine or feminine, shall refer to both male and female genders alike.

Article 2

This Act transposes into the legal order of the Republic of Croatia Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border health care (OJ L 88, 4.4.2011) – hereinafter: Directive 2011/24/EU.

Article 3

(1) Mandatory health insurance shall be provided by the Croatian Health Insurance Fund (hereinafter: the Fund).

(2) Mandatory health insurance shall ensure, to all persons insured with the Fund (hereinafter: insured persons), rights and obligations under mandatory health insurance on the basis of the principles of reciprocity, solidarity and equality, in the manner and under the conditions laid down in Regulation (EC) No. 883/2004 as last amended by Regulation EU No 1124/2012 (hereinafter: European Union regulations), in Directive 2011/24/EU, in this Act, in a special law and in regulations made under this Act.

(3) The rights ensured under mandatory health insurance shall also include rights ensured in case of accidents at work and occupational diseases, which shall also cover measures to provide specific health care for workers and diagnostic procedures when an occupational disease is suspected, in accordance with the Health Care Act and special laws and ordinances adopted under these laws.

(4) The scope of the rights under mandatory health insurance, which are ensured under equal conditions to all insured persons, is laid down in the provisions of this Act and regulations made under this Act.

II MANDATORY HEALTH INSURANCE

Article 4

(1) All persons domiciled in the Republic of Croatia and foreigners who have been granted a permanent stay in the Republic of Croatia shall be obliged to be insured under mandatory health insurance, under one of the bases for insurance determined by this Act, unless otherwise provided for in an international agreement or in a special law.

(2) The insured, children up to the age of 18 years, family members of the insured and other insured persons who, in certain circumstances, have mandatory health insurance shall be considered insured persons for whom rights and obligations are ensured under mandatory health insurance within the meaning of this Act.

Article 5

Nationals of other Member States of the European Union (hereinafter: Member States) and nationals of a country other than a Member State (hereinafter: third country) who have been granted a temporary stay in the Republic of Croatia by virtue of an employment relationship with an employer established in the Republic of Croatia or by virtue of pursuing an economic or professional activity in the Republic of Croatia shall also be obliged to be insured under mandatory health insurance in accordance with the provisions of this Act, if the conditions laid down in special regulations governing the issue of foreigners' stay and work in the Republic of Croatia are met and if the European Union regulations or an international agreement do not provide otherwise.

Article 6

(1) The rights and obligations conferred on insured persons referred to in Article 4, paragraph 2 of this Act and in regulations made under this Act may neither be transferred to other persons nor inherited.

(2) By way of derogation from the provision of paragraph 1 of this Article, rights to cash benefits that fell due for payment but remained unpaid on account of death of the insured person shall be inheritable.

III INSURED PERSONS

1. The insured

Article 7

(1) The following persons shall be insured pursuant to this Act on a compulsory basis under mandatory health insurance and shall acquire the status of an insured:

1. persons employed with a legal or natural person established in the Republic of Croatia,

2. persons elected or appointed to a permanent position in certain government bodies, or units of local and regional self-government, provided that they receive salary for this work,

3. persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and are employed in another Member State or a third country and do not have health insurance with a health insurance provider in that Member State or third country, or who do not have mandatory health insurance in accordance with the legislation of the country of work in the manner prescribed by the European Union regulations or an international agreement,

4. members of the board of directors of companies and executive directors of companies, unless they are insured under mandatory health insurance by virtue of being employed with another legal or natural person in the Republic of Croatia or another Member State,

5. persons undergoing occupational training without commencing employment, or those undergoing occupational training which may involve the use of active employment policy measures, in accordance with special regulations,

6. persons engaged in the economic activity of crafts or activities considered equivalent to crafts in the territory of the Republic of Croatia, persons who independently carry out their professional activity as a liberal profession, as well as persons carrying out the activity of agriculture and forestry as their sole or main occupation in the territory of the Republic of Croatia, if they are taxpayers liable to pay income or profit tax and are not insured on the basis of their work or are beneficiaries of the right to a pension,

7. farmers carrying out agricultural activity in the Republic of Croatia as their sole or main occupation, if they are owners, holder or lessees and they are not taxpayers liable to pay income or profit tax and are not insured on the basis of their work or are beneficiaries of the right to a pension,

8. persons carrying out agricultural activity as their sole or main occupation who are registered in the Family Farms Register as the holder or member of the family farm, if they do

not carry health insurance on the basis of their work or are beneficiaries of the right to a pension or are in full-time education,

9. priests or other servants of religious communities registered in the register of religious communities kept by the competent state authority, unless they are insured on the basis of their work,

10. pension beneficiaries in accordance with the pension insurance legislation of the Republic of Croatia, if they are domiciled or have been granted a permanent stay in the Republic of Croatia,

11. beneficiaries of the right to occupational rehabilitation in accordance with the pension insurance legislation of the Republic of Croatia, if they are domiciled or have been granted a permanent stay in the Republic of Croatia,

12. pension beneficiaries and disability benefit beneficiaries who exercise this right exclusively with respect to a foreign pension or disability insurance provider, unless otherwise provided for in the European Union regulations or in an international agreement, and if they are domiciled or have been granted a permanent stay in the Republic of Croatia,

13. persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and do not have mandatory health insurance on some other ground, but have registered with the Fund within:

a) 30 days after ceasing to be employed or ceasing to pursue their activity or ceasing to receive the salary compensation to which they are entitled under this Act or under regulations made under this Act,

b) 30 days after the date of early termination of military service or voluntary military service, or the date of expiry of the period prescribed for military service or voluntary military service,

c) 30 days after the date of discharge from an institution for the execution of criminal and misdemeanour sanctions, from a health care institution or from other specialised institution, if the safety measure of compulsory psychiatric or addiction treatment in a health care institution has been applied,

d) 30 days after the date of reaching 18 years of age, unless they carry health insurance on some other ground,

e) 90 days after the date of the end of the school year in which they completed their full-time education in accordance with the legislation governing full-time education in the Republic of Croatia or other Member State, or within 30 days after the date of passing the final examination,

14. full-time high school students, and full-time students at higher education institutions over 18 years of age, who are citizens of the Republic of Croatia and are domiciled or reside in the Republic of Croatia, or citizens of the Republic of Croatia who are domiciled in another Member State and have been granted a temporary stay in the Republic of Croatia, provided that they are not compulsorily insured under health insurance in another Member State, and foreigners who have been granted a permanent stay in the Republic of Croatia; they may

exercise this right not later than the end of the school or academic year in which they completed their full-time education, but not after reaching the age of 26 years,

15. full-time high school students and full-time students at higher education institutions in other Member States over 18 years of age, who are citizens of the Republic of Croatia and are domiciled in the Republic of Croatia, and foreigners who have been granted a permanent stay in the Republic of Croatia; they may exercise this right not later than the end of the school or academic year in which they completed their full-time education in accordance with legislation of the country of education, but not after reaching the age of 26 years,

16. persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and are over 18 years of age and who, according to the education legislation of the Republic of Croatia or other Member State, have lost their high school student status or full-time student status, provided that they registered with the Fund within 30 days following the date of losing their high school student status or full-time student status, and also provided that they cannot exercise the right to mandatory health insurance on some other ground,

17. the deceased insured person's spouse who, after the death of his or her spouse, did not acquire the right to a survivors' pension, provided that he or she registered with the Fund within 30 days following the spouse’s death, and that the right to mandatory health insurance cannot be exercised on some other ground,

18. persons domiciled in the Republic of Croatia and foreigners granted a permanent stay in the Republic of Croatia, who have been granted the status of a military or civilian war-disabled person or peacetime disabled military person, or the status of a beneficiary of the disability benefits payable to survivors, in accordance with the Act on the Protection of Military and Civilian War-Disabled, provided that they cannot exercise the right to mandatory health insurance on some other ground,

19. Croatian Homeland War veterans, provided that they cannot exercise the right to mandatory health insurance on some other ground,

20. persons providing care and assistance to Croatian Homeland War veterans pursuant to the legislation governing the rights of Croatian Homeland War veterans and their family members, if they are not exercising the right to mandatory health insurance on some other ground,

21. persons serving military service or voluntary military service (conscripts), cadets and reservists during their service in the Armed Forces of the Republic of Croatia, if they are not exercising the right to mandatory health insurance on some other ground,

22. persons who discontinued their work because a legal or natural person sent them to continue education or join professional training, during the period of this education or professional training,

23. persons to whom a legal or natural person has granted scholarships, before their entering into employment contract, for practical work training with another legal or natural person for the purpose of obtaining professional or further training, during the period of this practical work training,

24. persons sent abroad as a part of international technical, educational and cultural co-operation, during their stay abroad on that basis,

25. persons who have been granted the status of parent caregiver pursuant to a special law,

26. members of the family of a perished, imprisoned or missing Croatian veteran, during the period in which they are receiving a cash benefit in accordance with the legislation governing the rights of Croatian Homeland War veterans and their family members, if they are not exercising the right to mandatory health insurance on some other ground,

27. members of the family of a perished, imprisoned or missing Croatian veteran who are domiciled or have been granted a permanent stay in the Republic of Croatia, provided that they registered with the Fund within 30 days following the date on which they ceased to receive a cash benefit in accordance with the legislation governing the rights of Croatian Homeland War veterans and their family members, if they cannot exercise the right to mandatory health insurance on some other ground,

28. persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and who have been deprived of liberty pursuant to a decision of the competent court and have been detained in an organisational unit of the Ministry of Justice, based on a notification by the Ministry of Justice.

(2) The term "employed", referred to in paragraph 1, item 1 of this Article, shall imply the relationship between an employer and an employee, in accordance with the labour legislation and other regulations governing employment issues.

(3) The activities of persons, referred to in paragraph 1, item 6 of this Article are the following: registered activity of crafts, agriculture and forestry, liberal profession (professional activity) and other self-employed activities which were approved by the competent authority for self-employed activities of natural persons, registered in the appropriate register of that authority, as well as an activity with characteristics of independency, permanency and intention of creating a permanent source of revenue of a taxpayer enrolled in the register of taxpayers liable to pay income tax, in accordance with the income tax legislation in the case of self-employed activities for which no approval or registration requirement is prescribed.

(4) The insured referred to in paragraph 1, items 1 to 6 and items 8, 9, 20 and 25 of this Article shall be also insured, on a mandatory basis, against accidents at work and occupational diseases.

(5) With respect to persons referred to in paragraph 1, items 13, 16, 17 and 19 of this Article and persons referred to in Article 11, paragraph 1, item 3 of this Act, the Fund and the Croatian Employment Service shall exchange information on unemployed persons registered in the records of the Croatian Employment Service.

(6) With respect to persons referred to in paragraph 5 of this Article who are registered in the records of the Croatian Employment Service as unemployed persons, the status of an insured person shall be determined upon a notification to the Fund.

(7) The conditions for and the manner of obtaining the status of an insured in accordance with paragraph 1 of this Article shall be specified in more detail by the Fund by way of a general by-law.

Article 8

(1) The rights under the mandatory health insurance enjoyed by the insured shall be granted to the same extent, unless otherwise provided for in this Act, to persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and for whom, on the basis of earnings used to determine other income in accordance with the income tax legislation, one-off or multiple payments of the mandatory health insurance contribution have been made in the past five years for a period of six months, in the amount at least equal to the amount of the contribution calculated using the lowest base for the calculation of the mandatory health insurance contribution, in accordance with the legislation governing mandatory insurance contributions, unless they exercise the right to mandatory health insurance on some other ground.

(2) Persons referred to in paragraph 1 of this Article shall retain their status of an insured with the Fund for the entire period during which their monthly contribution for mandatory health insurance, calculated applying at least the lowest base for the calculation of the contribution, is paid on the basis of contributions paid on other earnings.

2. Children up to the age of 18 years and family members of the insured

Article 9

Children up to the age of 18 years who are domiciled or have been granted a permanent stay in the Republic of Croatia shall be insured under mandatory health insurance and shall acquire the status of an insured person.

Article 10

(1) Pursuant to this Act, the status of an insured person – a family member of the insured, as a holder of mandatory health insurance, may be acquired by the following persons:

1. spouse (married or common-law, in accordance with family law legislation),

2. children (born in marriage and outside of marriage, adopted children and step children), and other children without parents, if they are dependents of the insured, at the request of the insured,

3. parents (father, mother, stepfather, stepmother, adoptive parent), if they are incapacitated for independent life and work, have no means of subsistence and are dependents of the insured,

4. grandchildren, brothers, sisters, grandfather and grandmother, if they are incapacitated for independent life and work, have no means of subsistence and are dependents of the insured.

(2) Family members of the insured, referred to in paragraph 1 of this Article, shall acquire the status of an insured person in accordance with paragraph 1 of this Article, provided that they

cannot acquire the status under mandatory health insurance on one of the grounds specified in Article 7 of this Act, and that they are domiciled or have been granted a permanent stay in the Republic of Croatia, unless otherwise provided for in the European Union regulations or in an international agreement.

(3) The Fund shall specify, by way of a general by-law, the conditions under which it is considered that a person referred to in paragraph 1 of this Article is incapacitated for independent life and work, has no own means of subsistence and is a dependent of the insured.

Article 11

(1) A spouse shall retain the status of a person insured with the Fund upon divorce, as a family member of the divorced spouse:

1. if a court ruling has granted him/her the right to maintenance, for the duration of this maintenance,

2. if, at the time of divorce, he/she was completely and permanently incapacitated for work, in accordance with the pension insurance legislation,

3. if the court's decree on divorce entrusted him/her with the care of children, provided that he/she registers with the Fund within 30 days after the court's decree has become final, unless the right to mandatory health insurance can be achieved on some other ground.

(2) Persons referred to in paragraph 1, item 1 of this Article shall retain the status of the insured persons as family members even upon the termination of maintenance, provided that they register with the Fund within 30 days after the court's decree has become final, unless the right to mandatory health insurance can be achieved on some other ground.

Article 12

(1) The insured's children referred to in Article 10, paragraph 1, item 2 of this Act who, as family members of the insured, acquired the status of an insured person may retain this status up to a maximum age of 18.

(2) The insured's children referred to in paragraph 1 of this Article who, before reaching the age of 18, become completely and permanently incapacitated for independent life and work, in accordance with special regulations, shall retain the status of an insured person as family members of the insured throughout the period of such incapacity, unless they can exercise the right to mandatory health insure on some other ground.

(3) The insured's children who become completely and permanently incapacitated for independent life and work, in accordance with special regulations, after they have reached 18 years of age may also acquire the right to mandatory health insurance as family members of the insured, provided that they are dependents of the insured and cannot exercise the right to mandatory health insure on some other ground.

3. Other insured persons

Article 13

(1) Persons who are domiciled or have been granted a permanent stay in the Republic of Croatia and who cannot acquire the right to mandatory health insurance on one of the grounds set out in Articles 7 to 12 and Articles 14 and 15 of this Act shall be obliged to be insured under mandatory health insurance as the insured persons.

(2) Persons referred to in paragraph 1 of this Article shall acquire the rights and obligations arising from mandatory health insurance provided that they have previously made a one-off payment of mandatory health insurance contribution in the amount determined by applying the lowest base for the calculation of the mandatory health insurance contribution for a period beginning on the date of cessation of the previous status of insured person and lasting not more than 12 months.

Article 14

Holders of mandatory health insurance referred to in Article 10, paragraph 1 of this Act who work in a third country with which the Republic of Croatia has not concluded an international agreement, or an international agreement has been concluded but does not regulate the health insurance issue, shall be obliged to take out mandatory health insurance and pay the prescribed mandatory health insurance contribution for every member of his/her family who is domiciled or has been granted a permanent stay in the Republic of Croatia and who does not have health insurance with a health insurance provider in the country in which the insurance holder works, and who, before the insurance holder left for the third country in order to work there, had mandatory health insurance in the Republic of Croatia as a member of the family of the insurance holder in accordance with Article 10 of this Act.

Article 15

(1) Persons who are domiciled or have been granted a permanent stay in the Republic of Croatia, and who are incapacitated for independent life and work and have no means of subsistence shall have the right to mandatory health insurance as the insured persons, on the basis of a decision issued by the state administration office competent for social welfare activities, unless they can exercise the right to mandatory health insurance on some other ground.

(2) The minister responsible for social welfare activities shall issue an ordinance laying down the criteria for establishing incapacity for independent life and work and a lack of means of subsistence, as referred to in paragraph 1 of this Article.

(3) The right to be insured under mandatory health insurance, on the ground laid down by the provision of paragraph 1 of this Article, shall last for as long as there is no change in the circumstances on the basis of which the person concerned was granted this right.

Article 16

(1) In addition to the insured referred to in Article 7, paragraph 4 of this Act, the following persons shall also be insured, on a compulsory basis, under mandatory health insurance pursuant to this Act against accidents at work and occupational diseases:

1. pupils and students in full-time education in accordance with the legislation governing full-time education in the Republic of Croatia, during practical courses, professional practice, professional study tours, or during work for which they have been recruited through a mediator in the employment of pupils and students,

2. persons sent by the Croatian Employment Service to attend training programmes that are organised by the Croatian Employment Service or the costs for which are borne by the Croatian Employment Service,

3. children having impaired physical and mental development, during practical courses and during compulsory practical work in a legal person in charge of training,

4. persons who assist police services in performing work within their fields of competence,

5. persons who participate in rescue operations or in protection and rescue activities in the event of natural and other disasters,

6. persons who, upon an invitation by a state body or other authorised body, perform duties in the interest of the Republic of Croatia,

7. athletes, coaches and organisers involved in an organised amateur sport activity,

8. persons who are members of the Croatian Mountain Rescue Service or divers that save lives or eliminate and prevent hazards that directly threaten the lives and property of citizens,

9. persons who, as members of field teams, participate in rescuing and health protection operations in the event of natural or other disasters (floods, earthquakes, etc.),

10. persons serving military service or voluntary military service (conscripts), cadets and reservists during their service in the Armed Forces of the Republic of Croatia,

11. persons participating in organised public works in the Republic of Croatia,

12. persons who fulfil the obligation to take part in civil protection or the obligation to participate in monitoring and information services,

13. persons who, as members of operational teams of voluntary fire-fighting organisations, are engaged in performing fire-extinguishing tasks and protection and recue tasks in the event of other disasters, securing sites where a fire hazard is present, educating people in fire safety, and participating in drill demonstrations during presentations to the public,

14. pension beneficiaries referred to in Article 7, paragraph 1, items 10 and 12 of this Act who are employed in temporary or occasional seasonal jobs in agriculture in accordance with a special law,

15. persons referred to in Article 7, paragraph 1, items 13, 16, 17 and 19 of this Act who are employed in temporary or occasional seasonal jobs in agriculture in accordance with a special law, provided that they are registered in the records of the Croatian Employment Service as unemployed persons,

16. persons performing community service work in accordance with the Probation Act, and persons assigned to perform work while serving a custodial sentence, being held in pre-trial detention or serving a correctional measure of referral to a correctional institution.

(2) Legal and natural persons and state authorities are obliged to insure persons referred to in paragraph 1 of this Article against accidents at work and occupational diseases under mandatory health insurance.

IV RIGHTS ARISING FROM MANDATORY HEALTH INSURANCE

Article 17

In accordance with this Act, rights arising from mandatory health insurance, including rights in cases of accidents at work and occupational diseases, shall include:

1. the right to health care,

2. the right to cash benefits.

1 THE RIGHT TO HEALTH CARE

Article 18

(1) The right to health care under mandatory health insurance referred to in Article 17, item 1 of this Act shall, within the scope provided for in this Act and regulations made under this Act, include the right to:

1. primary health care,

2. specialist and consultative health care,

3. hospital health care,

4. medicinal products included in the Fund's basic and supplementary reimbursement lists of medicinal products,

5. dental devices included in the Fund's basic and supplementary reimbursement lists of dental devices,

6. orthopaedic aids and other devices included in the Fund's basic and supplementary reimbursement lists of orthopaedic aids and other devices,

7. health care in other Member States and third countries.

(2) The right of the insured persons to health care, referred to in paragraph 1, items 1 to 6 of this Article, shall be ensured by the implementation of health care measures.

(3) The health care measures referred to in paragraph 2 of this Article shall be determined on the basis of the plan and programme of health care measures, adopted by the minister responsible for health on a proposal from the Fund and the Croatian Institute of Public Health

and after obtaining an opinion from the competent chambers, in accordance with the allocated financial resources and the available health care capacity.

(4) The insured persons may receive health care referred to in paragraph 1, items 1 to 5 of this Article, at the expense of the Fund, from health care institutions and private health care providers that are contracted with the Fund to provide health care (hereinafter: entities contracted with the Fund) in a manner and under the conditions determined by this Act and the general by-laws of the Fund.

(5) The insured persons shall use health care referred to in paragraph 1, item 6 of this Article at the expense of the Fund when it is provided by legal and natural persons who are authorised to manufacture or retail orthopaedic aids and other devices in accordance with a special regulation, and in pharmacies with which the Fund, under the conditions and in the manner laid down in a general by-law of the Fund, has concluded contracts for the supply of orthopaedic aids and other devices to the insured persons (hereinafter: contracted medical device suppliers).

Article 19

(1) The right to health care referred to in Article 18 of this Act shall be ensured under the same conditions to all insured persons.

(2) For insured persons who exercise their right to health care under mandatory health insurance as referred to in Article 18 of this Act, the Fund shall ensure payment for health care services in their entirety for:

1. overall health care of children until they have reached the age of 18, and of insured persons referred to in Article 12, paragraphs 2 and 3 and Article 15 of this Act,

2. preventive and specific health care of school children and university students,

3. preventive health care of women,

4. health care of women concerning the monitoring of pregnancy and childbirth,

5. health care concerning medically assisted fertilisation, in accordance with a special law,

6. preventive health care of persons over the age of 65,

7. preventive health care of persons with disabilities entered in the register of persons with disabilities established by a special regulation,

8. overall health care in relation to HIV infections and other infectious diseases for which the implementation of measures to prevent their spread is prescribed by law,

9. compulsory vaccination, immunoprophylaxis and chemoprophylaxis,

10. overall treatment of chronic psychiatric illnesses,

11. overall treatment of malignant diseases,

12. overall treatment resulting following a recognised accident at work or occupational disease,

13. haemodialysis and peritoneal dialysis,

14. health care concerning the retrieval and transplantation of human body parts for the purpose of treatment,

15. out-of-hospital emergency medical care provided by the emergency medical service, including emergency transport (by land, water or air), in accordance with an ordinance issued by the minister responsible for health,

16. home visits and home treatment,

17. health visiting service,

18. ambulance transport for special categories of patients, in accordance with an ordinance issued by the minister responsible for health,

19. prescribed medicinal products from the Fund's basic reimbursement list of medicinal products,

20. medical care at the patient’s home,

21. laboratory diagnostics at the primary health care level,

22. palliative health care.

(3) The insured persons shall make a co-payment towards health care costs by paying 20 % of the full health care price, but not less than the amount obtained by applying the respective percentage of the calculation base specified in items 1 to 8 of this paragraph for the following**:**

1. specialist-consultative health care, including day hospitals and surgical procedures in day hospitals, excluding outpatient physical medicine and rehabilitation – 0.75 % of the calculation base defined in the State Budget,

2. specialist diagnostics which is not at the primary health care level – 1.50 % of the calculation base defined in the State Budget,

3. orthopaedic aids and other devices included in the basic reimbursement list of orthopaedic aids and other devices – 1.50 % of the calculation base defined in the State Budget,

4. specialist-consultative health care in outpatient physical medicine and rehabilitation, and physical medicine and rehabilitation at the patient's home – 0.75 % of the calculation base defined in the State Budget, per day,

5. medical treatment in other Member States and third countries in accordance with the European Union regulations, international agreements, Directive 2011/24/EU, this Act and the Fund's general by-law, unless otherwise provided for in the European Union regulations or in an international agreement,

6. costs of hospital health care – 3.01 % of the calculation base defined in the State Budget, per day,

7. dental devices included in the basic reimbursement list of dental devices for adult persons between the ages of 18 and 65 years – 30.07 % of the calculation base defined in the State Budget,

8. dental devices included in the basic reimbursement list of dental devices for adult persons over the age of 65 – 15.03 % of the calculation base defined in the State Budget.

4) The insured persons shall make a co-payment amounting to 0.30 % of the calculation base defined in the State Budget for:

1. health care provided by the chosen primary care doctor of family (general) medicine, gynaecology and dental medicine, in accordance with the Fund's general by-law,

2. a medicinal product dispensed, per prescription.

(5) The maximum co-payment towards health care costs referred to in paragraphs 3 and 4 of this Article that the insured persons is required to pay shall amount to not more than 60.13 % of the calculation base defined in the State Budget, per an invoice issued for the health care provided.

(6) The list of the type and number of therapeutic and diagnostic procedures that shall be ensured to the insured persons under health care referred to in paragraphs 2, 3 and 4 of this Article shall be established by the Fund by way of a general by-law referred to in Article 33 of this Act.

1 Medicinal products

Article 20

(1) The Fund's basic and supplementary reimbursement lists of medicinal products referred to in Article 18, paragraph 1, item 4 of this Act shall contain medicinal products that obtained authorisation to be placed on the market in the Republic of Croatia.

(2) The Fund's reimbursement lists of medicinal products referred to in paragraph 1 of this Article shall contain medicinal products identified by a code according to the Anatomic Therapeutic Chemical (ATC) Classification System drawn up by the World Health Organisation , the common (non-proprietary) name of a medicinal product, the brand (proprietary) name of a medicinal product, the manufacturer's name, the name of the marketing authorisation holder, the dosage form, the method of administration, the price of a medicinal product per defined daily dose, the price per packaging and the price per dosage form unit, as well as the rules for prescribing medicinal products that may be applied in treatment within the health care under mandatory health insurance.

(3) The Fund's basic reimbursement list of medicinal products shall contain the most effective medicinal products, from medico-economic perspective, for treatment of all diseases.

(4) The supplementary reimbursement list of medicinal products shall contain medicinal products the price of which is higher compared to the prices in the basic reimbursement list of medicinal products, and the Fund shall cover the costs up to the lowest price of an equivalent medicinal product included in the basic reimbursement list of medicinal products.

(5) The Fund's supplementary reimbursement list of medicinal products shall, in addition to indicating the full price of a medicinal product, indicate the amount of co-payment to be paid by the insured person of the Fund either directly or through supplementary health insurance in accordance with the Voluntary Health Insurance Act.

(6) The method of including medicinal products in the basic and supplementary reimbursement lists and the method of determining the prices of medicinal products shall be laid down in an ordinance issued by the minister responsible for health, in accordance with a special law.

(7) The basic and supplementary reimbursement lists of medicinal products shall be adopted by the Governing Council of the Fund after obtaining an opinion from the Croatian Medical Chamber.

(8) If the Chamber referred to in paragraph 7 of this Act fails to deliver to the Fund an opinion on the basic or the supplementary reimbursement list of medicinal products within 8 days from the day when request for an the opinion was received, it shall be deemed that a favourable opinion has been given.

(9) The form and content of prescriptions for the medicinal products included in the Fund's basic and supplementary reimbursement lists shall be prescribed by the Fund by way of a general by-law in accordance with an ordinance issued by the minister responsible for health.

Article 21

(1) As part of his/her right to health care under mandatory health insurance, an insured person shall be entitled to receive, at the expense of the Fund's funds, a medicinal product included in the Fund's basic or supplementary reimbursement list, under the conditions and in the manner laid down in general by-laws of the Fund.

(2) Exceptionally, if for medical reasons an insured person cannot be treated with a medicinal product included in the Fund's basic and supplementary reimbursement lists of medicinal products, he/she may claim a right to receive a medicinal product not included in these lists, provided that the need to use this medicinal product has been approved by the commission for medicinal products in the inpatient health care institution in which the insured person is being treated, at the expense of the inpatient health care institution’s funds, which shall be obliged to procure this medicinal product.

(3) Under the conditions and in the manner laid down in paragraph 2 of this Article, an insured person may also claim a right to use a medicinal product that is included in the Fund's basic and supplementary reimbursement lists of medicinal products, but for which the insured person does not fulfil conditions with respect to medical indications specified in the lists of medicinal products referred to in paragraph 1 of this Article.

(4) The medical specialist in the inpatient health care institution who proposed that the insured person be treated with a medicinal product referred to in paragraphs 2 and 3 of this Article shall forward his/her proposal to the inpatient health care institution's commission for medicinal products.

2 Orthopaedic aids and other devices and dental devices

Article 22

(1) As part of his/her right to health care under mandatory health insurance, an insured person shall be entitled to orthopaedic aids and other devices (hereinafter: medical devices) included in the Fund's basic and supplementary lists of orthopaedic aids and other devices.

(2) The Fund's basic and supplementary lists of medical devices contains medical devices that are intended to help improve damaged functions, to remedy or eliminate a bodily injury or a lack of organs and organ systems, and to supplement anatomical or physiological functions of organs after damage caused by disease or injury.

(3) The method of including medical devices in the Fund's basic and supplementary reimbursement lists of medical devices and the method of determining the prices of medical devices shall be laid down in an ordinance issued by the minister responsible for health, in accordance with a special law.

(4) The supplementary reimbursement list of medical devices shall contain medical devices the price of which is higher compared to the prices in the basic reimbursement list of medical devices, and the Fund shall, at the expense of the mandatory health insurance scheme, cover the costs up to the price of an equivalent medical device included in the basic reimbursement list of medical devices, reduced by the amount of co-payment to be paid by the insured person for the price of the medical device included in the basic reimbursement list of medical devices either directly or through supplementary health insurance in accordance with the Voluntary Health Insurance Act.

(5) An insured person may take out additional health insurance in accordance with the Voluntary Health Insurance Act to cover the difference between the price of a medical device included in the supplementary reimbursement list of medical devices and the price of an equivalent medical device included in the basic reimbursement list of medical devices.

Article 23

(1) As part of his/her right to health care under mandatory health insurance, an insured person shall be entitled to dental devices included in the Fund's basic and supplementary reimbursement lists of dental devices.

(2) The Fund's basic and supplementary reimbursement lists of dental devices contain dental devices intended for enabling dental-prosthetic, surgical-prosthetic, orthodontic and periodontal rehabilitation.

(3) The method of including dental devices in the Fund's basic and supplementary reimbursement lists of dental devices and the method of determining the prices of dental

devices shall be laid down by the Fund by way of a general by-law in accordance with Article 19, paragraph 6, Article 33 and Article 88 of this Act.

(4) The supplementary reimbursement list of dental devices shall contain dental devices the price of which is higher compared to the prices in the basic reimbursement list of dental devices, and the Fund shall, at the expense of the mandatory health insurance scheme, cover the costs up to the price of an equivalent dental device included in the basic reimbursement list of dental devices, reduced by the amount of co-payment to be paid by the insured person for the price of the dental device included in the basic reimbursement list of dental devices either directly or through supplementary health insurance in accordance with the Voluntary Health Insurance Act.

(5) An insured person may take out additional health insurance in accordance with the Voluntary Health Insurance Act to cover the difference between the price of a dental device included in the supplementary reimbursement list of dental devices and the price of an equivalent dental device included in the basic reimbursement list of dental devices.

Article 24

(1) The insured persons shall be entitled to medical devices referred to in Article 22 of this Act and dental devices referred to in Article 23 of this Act provided that they meet the condition of previous mandatory health insurance with the Fund for a continuous period of at least nine months, or 12 months in the case of interruptions in the last two years prior to the occurrence of the insured event.

(2) The provision of paragraph 1 of this Article shall not apply to insured persons under 18 years of age, to insured persons referred to in Article 12, paragraphs 2 and 3 of this Act and to other insured persons who, according to a decision issued by the competent authority, are completely and permanently incapacitated for independent life and work, and to insured persons who need such health care because of a recognised accident at work or occupational disease.

(3) The insured persons shall use the health care referred to in Articles 22 and 23 of this Act in accordance with a general by-law of the Fund.

Article 25

The form and content of prescriptions for medical and dental devices referred to in Articles 22 and 23 of this Act shall be laid down by the Fund by way of a general by-law.

3 Cross-border health care

Article 26

(1) The insured persons shall be entitled to use health care in other Member States and in third countries at the expense of the mandatory health insurance scheme.

(2) The health care referred to in paragraph 1 of this Article shall include the right to be referred for treatment, the right to use health care during a temporary stay in countries referred to in paragraph 1 of this Article and the right to other health care in accordance with

the provisions of the European Union regulations, Directive 2011/24/EU, this Act, international agreements and general by-laws of the Fund.

(3) The right to be referred for treatment may be exercised by the insured person only if the necessary treatment is not performed in contracted health care institutions the Republic of Croatia, but may be successfully performed in countries referred to in paragraph 1 of this Article.

(4) The rights, terms and conditions and the manner of using health care referred to in paragraphs 2 and 3 of this Article shall be laid down by the Fund by way of a general by-law, with the consent of the minister responsible for health.

Article 27

(1) In accordance with this Act, the insured person shall be entitled to cross-border health care, which comprises health care to which the insured person is entitled to receive under mandatory health insurance in contracted health care institutions in the Republic of Croatia, but which has been received by the insured person from a contracted or private health care provider in the territory of another Member State.

(2) The health care referred to in paragraph 1 of this Article shall include planned health care for which the insured person must obtain a prior authorisation from the Fund, planned specialist-consultative health care for which no prior authorisation needs to be obtained from the Fund, and health care which needs to be provided without delay.

Article 28

(1) Planned health care in another Member State for which the insured person must obtain a prior authorisation from the Fund shall be health care which:

– involves overnight hospital accommodation of the insured person for at least one night, or

– requires use of highly specialised and cost-intensive medical infrastructure or medical equipment.

(2) The prior authorisation referred to in paragraph 1 of this Article must be also obtained for the use of cross-border health care which:

– involves treatments presenting a particular risk for the insured person or the population, or

– is provided by a health care provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of health care which is subject to the European Union regulations ensuring a minimum level of safety and quality in its territory.

(3) The Fund shall issue a general by-law specifying the types of health care referred to in paragraphs 1 and 2 of this Article, as well as a list of highly specialised and cost-intensive medical infrastructure and medical equipment referred to in paragraph 1, sub-paragraph 2 of this Article.

(4) When acting upon a request for prior authorisation, the Fund's authorised person carrying out the procedure shall ascertain whether the applicant meets the conditions for granting prior authorisation as laid down in the European Union regulations and, where the conditions laid down in the European Union regulations are met, the prior authorisation shall be granted pursuant to those regulations unless the insured person requests otherwise.

(5) The insured person's request for prior authorisation shall be decided upon by the Fund by way of a decision.

Article 29

The Fund shall have the right to refuse to grant prior authorisation for cross-border health care if:

– the insured person will, according to a clinical evaluation, be exposed with reasonable certainty to a safety risk that cannot be regarded as acceptable, taking into account the potential benefit for the insured person of the sought cross-border health care,

– the citizens of the Republic of Croatia will be exposed with reasonable certainty to a substantial safety hazard as a result of the cross-border healthcare in question,

– this healthcare can be provided by an entity contracted with the Fund within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of the insured person.

Article 30

(1) The insured person may use planned specialist-consultative health care not covered by Articles 28 and 29 of this Act in other Member States without prior authorisation from the Fund.

(2) The insured person may, in the manner provided for in paragraph 1 of this Article, use health care that is medically necessary and cannot be delayed until his/her planned return to the Republic of Croatia (necessary health care).

Article 31

(1) An insured person who used health care in accordance with Articles 27, 28 and 30 of this Act shall have the right to reimbursement of the costs he/she paid for this healthcare.

(2) The reimbursement of costs referred to in paragraph 1 of this Article shall not exceed the amount determined by a general by-law of the Fund for this health care provided by entities contracted with the Fund referred to in Article 18 of this Act.

(3) The Fund shall issue a decision deciding on the right to reimbursement of health care costs referred to in paragraph 1 of this Article.

(4) An insured person who used health care referred to in paragraph 1 of this Article shall not be entitled to have reimbursed by mandatory insurance scheme for his/her travel costs or other costs incurred in relation to this health care.

Article 32

The Fund shall be the National Contact Point for providing information on insured persons' rights relating to receiving health care in another Member State in accordance with the European Union regulations and Directive 2011/24/EU.

4 Standards and norms for health care

Article 33

The standards and norms for health care under mandatory health insurance, including a list of the type and number of therapeutic and diagnostic procedures per insured person at annual level, the amount of the required funds relative to the allocated funds, as well as the method of exercising the rights of the insured persons to health care under mandatory health insurance shall be adopted, as a general rule, by the Governing Council of the Fund for each calendar year, upon the approval of the minister responsible for health and a prior opinion of the competent chambers.

5 Health care not covered by mandatory health insurance

Article 34

For persons insured with the Fund, the right to health care under mandatory health insurance shall not include the coverage of costs of health care services delivered in a manner and using a procedure not prescribed by the European Union regulations, Directive 2011/24/EU, an international agreement, this Act or subordinate legislation made under this Act, as well as for the following:

1. difference for the increased treatment costs which resulted from a personal request of the insured person due to his/her religious or other beliefs or any other reason, representing a treatment that goes beyond the established standard right to health care under mandatory health insurance which is provided to all the insured persons under the same conditions,

2. experimental medical treatment, experimental medical products, medical devices, dental devices and medicinal products which are at clinical trials stage,

3. therapeutic and diagnostic procedures and medicinal products applied at the insured person's request, in circumstances where these procedures and medicinal products are not prescribed by a contracted health institution or contracted private practitioner, as a part of exercising the rights under mandatory health insurance, or they do not represent the right under mandatory health insurance with respect to their type and quantity,

4. cosmetic procedures, except for aesthetic reconstructive surgery of congenital anomalies, breast reconstruction after mastectomy, and aesthetic reconstruction after severe injuries,

5. treatment of voluntarily acquired sterility,

6. health care used by by-passing an established list of appointments within the standards of health care provided under mandatory health insurance, according to a personal wish of the insured person, as evidenced by his/her written statement,

7. surgical treatment of obesity, except in cases of pathological obesity when body mass index (BMI) exceeds 40, or when BMI exceeds 35, provided that the insured person suffers from other concomitant diseases,

8. treatment of medical complications resulting from the use of health care outside of the scope of mandatory health insurance,

9. health care which, as required by laws and other regulations, is to be ensured by employers, the Republic of Croatia or units of local and regional self-government.

6 Co-payment towards health care costs

Article 35

(1) Insured persons shall make co-payments towards health care costs as referred to in Article 19, paragraphs 3 and 4, Article 20, paragraph 5, Article 22, paragraph 4 and Article 23, paragraph 4 of this Act.

(2) The insured person shall pay health care costs referred to in paragraph 1 of this Article directly when using health care or through supplementary health insurance in accordance with the Voluntary Insurance Act.

(3) Co-payments made by an insured person towards health care costs referred to in Article 19, paragraph 3, Article 20, paragraph 5, Article 22, paragraph 4, and Article 23, paragraph 4 of this Act shall constitute revenue of entities contracted with the Fund, contracted medical device suppliers, or health care institutions in other Member States or third countries in which the insured persons used health care in accordance with Article 26 of this Act, while co-payments referred to in Article 19, paragraph 4 shall constitute revenue of the Fund.

(4) Children up to the age of 18 years and insured persons referred to in Article 12, paragraphs 2 and 3 and Article 15 of this Act shall not be required to make co-payments towards health care costs referred to in Article 19, paragraphs 3 and 4, Article 22, paragraph 4 and Article 23, paragraph 4 of this Act.

2 ENTITLEMENT TO CASH BENEFITS

Article 36

(1) Within the scope of rights under mandatory health insurance, the insured shall be entitled to:

1. salary compensation during the time of temporary incapacity, i.e. inability to work on account of utilising health care or due to other circumstances as referred to in Article 39 of this Act (hereinafter: salary compensation),

2. cash benefit on account of inability to carry out activities that give rise to other earnings that are used to determine other income pursuant to the legislation governing contributions to mandatory insurance schemes,

3. compensation for transportation costs related to the use of health care under mandatory health insurance,

4. compensation for accommodation costs for one of a child's parents or person taking care of a child during hospital treatment received by the child, in the amount and under the conditions laid down in a general by-law of the Fund.

(2) Other insured persons shall also be entitled to the right referred to in paragraph 1, items 3 and 4 of this Article.

(3) Cash benefits referred to in paragraph 1 of this Article, and cash payments received as reimbursement of costs incurred in relation to the rights under mandatory health insurance which an insured person exercised on the basis of a decision by the Fund shall be exempt from execution.

Article 37

(1) Entitlement to cash benefits in case of a recognised accident at work or occupational disease shall include:

1. salary compensation during the time of temporary inability to work due to a recognised accident at work or occupational disease,

2. compensation for travel costs related to the use of health care under mandatory health insurance due to a recognised accident at work or occupational disease,

3. compensation for funeral costs in case of death of the insured person if such a death was a direct result of a recognised accident at work or occupational disease.

(2) The insured referred to in Article 7, paragraph 1, items 1 to 4 and items 6, 8, 9, 20 and 25 of this Act shall be entitled to the salary compensation referred to in paragraph 1, item 1 of this Article.

(3) The insured referred to in paragraph 2 of this Article and the insured referred to in Article 16, as well as the insured referred to in Article 69 of this Act shall be entitled the compensation for travel costs and compensation for funeral costs referred to in paragraph 1, items 2 and 3 of this Article.

1 Entitlement to salary compensation

Article 38

(1) The insured referred to in Article 7, paragraph 1, items 1 to 4 and items 6, 8, 9, 20 and 25 of this Act shall be entitled to receive salary compensation due to a temporary incapacity or inability to work on account of using health care or due to other circumstances set out in Article 39 of this Act (hereinafter: temporary incapacity), unless otherwise provided for in a special regulation.

(2) Temporary incapacity referred to in paragraph 1 of this Article, during which the insured shall be entitled to salary compensation within the meaning of this Act, shall be considered to

be absence from work due to illness or injury, or other circumstances provided for in Article 39 of this Act, on account of which the insured is prevented from fulfilling his/her work obligation under the employment contract, other contract or legal document.

(3) The period of temporary incapacity referred to in paragraph 2 of this Article, during which the insured is entitled to salary compensation in accordance with this Act, shall be proved by a temporary incapacity report issued by the chosen primary health care physician in a healthcare institution or private practice (hereinafter: chosen physician).

(4) The chosen physician shall indicate, in a specifically designated section of the temporary incapacity for work report, the period of temporary incapacity for which, pursuant to the provisions of this Act, the insured is not entitled to salary compensation.

(5) The Fund shall issue a general by-law specifying the content and format of the pre-printed form to be used for temporary incapacity report referred to in paragraph 3 of this Article.

Article 39

The insured shall be entitled to salary compensation in relation to the use of health care under mandatory health insurance, or other circumstances provided for in this Act, if he/she is:

1. temporarily incapacitated for work due to illness or injury, or admitted to a health care institution for treatment or medical examinations,

2. temporarily prevented from working due to a specific treatment or medical examination which cannot be done outside the working time of the insured,

3. isolated as a carrier or due to an outbreak of a contagion in his/her environment, or temporarily incapacitated for work as a result of donating live tissue or organs for transplantation to another insured person of the Fund,

4. designated to accompany the insured person referred for treatment or medical examination provided by an entity contracted with the Fund outside the place of domicile or residence of the insured person being referred,

5. designated to care for a sick immediate family member (child or spouse), under conditions prescribed by this Act,

6. temporarily incapacitated for work due to pregnancy- and childbirth-related illness and complications,

7. temporarily prevented from working on account of taking maternity leave and the right to work half the full-time working hours, in accordance the legislation governing maternity and parental benefits,

8. temporarily incapacitated for work on account of using leave for the death of a child, the birth of a stillborn child or the death of the child during maternity leave,

9. temporarily incapacitated for work due to a wound, injury or illness which is a direct consequence of participating in the Homeland War,

10. temporarily incapacitated for work due to a recognised accident at work or occupational disease.

Article 40

The salary compensation related to the use of health care as referred to in Article 39, items 1 and 2 of this Act shall be paid to the insured by the following persons, from their own funds:

1. legal or natural person – employer, for the first 42 days of sick leave, as well as during the insured's work in a third country where he/she was sent by the legal or natural person or is self-employed there;

2. legal person for professional rehabilitation and employment of persons with disabilities, or legal or natural person – employer for the insured worker who is occupationally disabled, for the first seven days of sick leave.

Article 41

(1) Salary compensation during temporary incapacity as referred to in Article 39, items 3 to 8 and item 10 of this Act shall be paid to the insured at the expense of the Fund, as of the first day of exercising the right.

(2) The salary compensation referred to in Article 39, item 9 of this Act shall be paid to the insured by the Fund by debiting the funds of the State Budget.

(3) From the 43rd or the eighth day of temporary incapacity, salary compensation during temporary incapacity referred to in Article 39, items 1 and 2 of this Act shall be calculated and paid out by the legal or natural person – employer, and the Fund shall be obliged to refund the paid compensation within 45 days following the day of receipt of a refund request.

(4) Salary compensation during temporary incapacity referred to in Article 39, items 4, 5 and 10 of this Act shall be calculated and paid out, from the first day of temporary incapacity, by the legal or natural person – employer, and the Fund shall be obliged to refund the paid compensation within 30 days following the day of receipt of a refund request in the cases referred to in Article 39, items 4 and 5 of this Act and within 45 days in the case referred to in Article 39, item 10 of this Act.

(5) If, after receiving the refund request referred to in paragraphs 3 and 4 of this Article, the Fund finds that the insured to whom salary compensation was paid out by the legal or natural person – employer is not entitled to salary compensation pursuant to the provisions of this Act, the Fund shall immediately inform the employer thereof in writing and shall return him the request.

(6) If the legal or natural person – employer is not able, due to insolvency, to pay out the salary or salary compensation for at least two calendar months, the salary compensation referred to in paragraphs 3 and 4 of this Article, which is to be paid at the expense of the Fund or the State Budget, shall be paid to the insured by the Fund.

(7) The Fund shall adopt a general by-law specifying in more detail the manner of exercising the entitlement to salary compensation.

Article 42

If the employer is in bankruptcy proceedings, the salary compensation on account of temporary incapacity as referred to in Article 39, items 1 and 2 and items 4, 5 and 10 of this Act, which is to be paid at the expense of the Fund, shall be paid to the insured by the Fund.

Article 43

(1) Where the legal or natural person – employer has failed to determine the salary compensation for the insured in a manner and in the amount determined by this Act and the implementing regulation adopted under this Act within 30 days of the date on which the salary fell due for payment by the employer, the insured shall have a right to file with the Fund a request for calculation of the salary compensation to which he/she is entitled.

(2) After receiving the request referred to in paragraph 1 of this Article, the Fund shall calculate the salary compensation and shall deliver the calculation to the insured and to employer within 15 days of receiving the request.

(3) The employer shall pay the salary compensation to the insured in accordance with the calculation delivered by the Fund, no later than 15 days following receipt of the calculation.

Article 44

(1) The insured shall be entitled to salary compensation on account of temporary incapacity during the entire period of temporary incapacity, and for a maximum period prescribed by this Act.

(2) The insured shall be entitled to salary compensation only for the days, or hours, for which, in accordance with the labour legislation, the insured would have been entitled to salary had he/she worked, unless otherwise provided for in this Act.

Article 45

(1) During temporary inability to work due to caring for an insured person – child, the insured referred to in Article 39, item 5 of this Act shall be entitled to receive salary compensation for a maximum period of 60 days for any confirmed disease when caring for a child under the age of seven, and for a maximum period of 40 days when caring for a child between seven and 18 years of age.

(2) By way of derogation from paragraph 1 of this Article, if, according to an evaluation of a primary healthcare physician, the state of health of a family member – child under the age of 18 is such that the period of caring specified in paragraph 1 of this Article would not be sufficient, the required duration of care for the child shall be determined by a medical commission of the Fund.

(3) The term „child” as referred to in paragraphs 1 and 2 of this Article shall be understood to include, in addition to a biological child, an adopted child, a stepchild, and a child of whom custody has been entrusted to the insured by a decision of the competent authority.

(4) During temporary inability to work due to caring for an insured person – child over the age of 18 or spouse, the insured shall be entitled to salary compensation for a maximum period of 20 days for any confirmed disease.

(5) Caring for a family member referred to in paragraph 4 of this Article may only be approved if the family member has a serious health condition caused by an illness or injury.

(6) The Fund shall adopt a general by-law, with the consent of the minister responsible for health, specifying a serious health condition of a family member, referred to in paragraph 5 of this Article, for which the need for care by the insured may be approved.

(7) The insured may exercise the right referred to in paragraphs 1 and 2 of this Article provided that the other parent is not employed or the insured lives alone with the child (e.g. single or divorced parent), that this right is not exercised at the same time in respect of another child and that the insured is not given the status of a parent caregiver in respect of the child needing care.

(8) During the period of temporary inability to work due to caring for a family member, the insured shall also be entitled to work half the full-time working hours.

Article 46

(1) The start and duration of temporary incapacity shall be confirmed by the chosen physician.

(2) The chosen physician shall confirm the duration of temporary incapacity depending on the nature of the illness giving rise to temporary incapacity, in accordance with the medical indication and the guidelines prescribed by an ordinance issued by the minister responsible for health upon a prior opinion of the professional societies of the Croatian Medical Association, or depending on other reasons for temporary incapacity as specified in Article 39 of this Act.

(3) When the chosen physician establishes that the health status of an insured whose temporary incapacity has lasted for a continuous period of at least six months has improved and that half-time work would be beneficial to the insured in regaining full fitness for work more quickly, the chosen physician may determine that the insured is to work half-time for a given period of time, but no longer than 60 days.

(4) If in its findings and opinion the competent expertise body of the pension insurance authority confirms that the insured suffers from disability on account of general inability to work or occupational incapacity for work, the chosen physician shall determine that the insured's temporary incapacity ceased on the date of receipt of a notification from the competent body of the pension insurance authority referred to in Article 48, paragraph 2 of this Act, and the insured shall exercise his/her entitlement to salary compensation during this temporary incapacity in accordance with Article 48, paragraph 1 of this Act.

(5) After determining that temporary incapacity ceased in accordance with paragraph 4 of this Article, the chosen physician may determine that temporary incapacity is present again, but only in respect of the insured who has been confirmed to suffer from disability on account of occupational incapacity for work, and only if the illness based on which his/her disability was confirmed has aggravated or if an illness with another medical diagnosis has occurred.

(6) The Fund shall supervise the utilisation of the insured's temporary incapacity leave or the determination of the existence of medical indications or other reasons for temporary incapacity, in accordance with the provisions of this Act and regulations made under this Act.

(7) The supervision of the utilisation of the temporary incapacity leave shall include inspection in the chosen physician's office and a direct examination of the insured within or outside the chosen physician's office, including a home visit.

(8) For the entire period of the insured's temporary incapacity, the employer of the insured may request the Fund to make checks to verify that this temporary incapacity is justified.

(9) The minister responsible for health shall issue an ordinance on the controls concerning the insureds' temporary incapacity for work.

Article 47

(1) An insured who is not satisfied with a decision of the chosen physician relating to the cessation of temporary incapacity shall be issued, at his/her request, and for the purpose of protecting his/her rights under mandatory health insurance, a decision in administrative proceedings, on the basis of the previously obtained findings, opinion and assessment of a medical commission of the Fund, which shall be obliged to examine the insured prior to issuing its findings, opinion and assessment.

(2) The request referred to in paragraph 1 of this Article shall be dealt with under the urgent procedure.

Article 48

(1) During the time of the temporary incapacity referred to in Article 39, items 1 to 6 and items 9 and 10 of this Act, the insured shall be entitled to receive salary compensation at the expense of the Fund or the State Budget until his/her chosen physician determines that he/she is fit for work or until the competent expertise body of the pension insurance authority confirms in its findings and opinion that the insured suffers from disability on account of general inability to work or occupational incapacity for work.

(2) If, according to the chosen physician's assessment, after treatment and medical rehabilitation, the insured's health status is such that it cannot be improved by further treatment and the insured has become permanently incapable of carrying out the duties of his/her post, as well as in the case the insured's sick leave lasts for a continuous period of 12 months for the same diagnosis, the chosen physician shall work up the insured for referral for fitness-for-work and disability evaluation and shall refer the insured, with all the prescribed documentation, to the competent expertise body of the pension insurance authority, which shall issue its findings and opinion about the insured's fitness for work and disability not later than 60 days from the date of receipt of the proposal of the chosen physician and shall inform thereof the chosen physician, the insured's employer and the Fund within eight days of issuing the findings and opinion.

(3) If the competent expertise body of the pension insurance authority establishes that the insured suffers from occupational incapacity for work or that he/she is in immediate danger of disability, it shall indicate in its findings and opinion the tasks and duties that the insured is

able to perform, or the tasks and duties that he/she is not able to perform, taking into account his/her remaining capacity for work.

(4) If the competent expertise body of the pension insurance authority fails to issue its findings and opinion and does not inform the chosen physician, the insured's employer and the Fund within the time limit specified in paragraph 2 of this Article, salary compensation for the insured concerned shall be at the expense of the Croatian Pension Insurance Fund as of the first day following the end of the 60-day period referred to in paragraph 2 of this Article.

(5) The work-up of the insured for referral for fitness-for-work and disability evaluation shall be at the expense of the Fund only if the chosen physician has referred the insured for fitness-for-work and disability evaluation in accordance with paragraph 2 of this Article.

Article 49

(1) In the case of an insured in respect of whom the competent expertise body of the pension insurance authority established in its findings and opinion that he/she suffers from disability on account of occupational incapacity for work, and who is found to be suffering from temporary incapacity again, regardless of whether this temporary incapacity occurred because of the aggravation of the illness based on which his/her disability was confirmed or because of an illness with another medical diagnosis, and to whom the employer has not offered, and has not concluded with him, a written labour contract for the performance of tasks which he/she is able to perform in accordance with labour laws and regulations, salary compensation during such temporary incapacity shall be paid out to the insured by the employer from its own funds.

(2) In the case of an insured who has been found to be in immediate danger of disability and the employer has not offered to the him/her, and has not concluded with him/her, a written labour contract for the performance of tasks which he/she is able to perform in accordance with labour laws and regulations, salary compensation during temporary incapacity shall also be at the expense of the employer from the date when the immediate danger of disability was confirmed. Salary compensation shall be at the expense of the employer until the conclusion of a written labour contract for the performance of tasks which the insured is able to perform.

(3) If the insured does not accept the employer's offer referred to in paragraphs 1 and 2 of this Article and does not conclude with the employer a labour contract for the performance of tasks which he/she is able to perform, he/she shall not, from the date of receipt of the employer's offer, be entitled to salary compensation as provided for by this Act during the time of temporary incapacity.

(4) The insured referred to in Article 7, paragraph 1, items 6, 8 and 9 of this Act in respect of whom it is established in the findings and opinion of the competent expertise body of the pension insurance authority that he/she suffers from disability on account of occupational incapacity for work or that he/she is in immediate danger of disability shall not be entitled to salary compensation at the expense of the mandatory health insurance funds from the date his/her disability, or immediate danger of disability, was established.

Article 50

An insured who has reached the age of 65 years and has completed 15 years of pension qualifying periods on the basis of employment or self-employment shall, during the time of his/her temporary incapacity, be entitled to salary compensation not at the expense of the mandatory health insurance funds, but at the expense of the employer or of the insured liable to pay contributions.

Article 51

(1) The insured whose employment or self-employment terminated during the time of temporary incapacity shall be entitled to salary compensation for a maximum period of 30 days following the date of termination of employment or self-employment, provided that his/her temporary incapacity was diagnosed by his/her chosen physician at least eight days before the termination of employment or self-employment and that at the time of termination of employment or self-employment the insured was entitled to salary compensation in accordance with the provisions of this Act.

(2) Exceptionally, under the conditions laid down in paragraph 1 of this Article, the insured whose employment or self-employment terminated during the time of temporary incapacity which is a direct consequence of participation in the Homeland War, or a consequence of a recognised accident at work or occupational disease, shall be entitled to salary compensation even after the termination of employment or self-employment, until he/she is fit for work again or until the competent expertise body of the pension insurance authority confirms in its findings and opinion that the insured suffers from disability in accordance with Article 48 of this Act.

(3) During the time of temporary incapacity for work due to pregnancy- and childbirth-related illness and complications referred to in Article 39, item 6 of this Act, the time of exercising the right to take maternity leave, the right to work half the full-time working hours referred to in Article 39, item 7 of this Act and the right to take leave for the death of a child referred to in Article 39, item 8 of this Act, the insured exercising one of the aforementioned rights shall be entitled to salary compensation even after the termination of employment or self-employment, until the expiry of that right.

(4) An insured who, during the time of exercising the rights referred to in paragraphs 1, 2 and 3 of this Article, enters into a full-time or part-time employment relationship or starts pursuing an activity as self-employed, shall no longer be entitled to salary compensation received in accordance with this Article.

Article 52

(1) The insured shall be entitled to exercise the entitlement to salary compensation, at the expense of the Fund or the State Budget, during the temporary incapacity referred to in Article 39, items 1 to 5 and items 9 and 10 of this Act for a maximum period of 18 months for the same diagnosis, without interruptions, in an amount determined in accordance with this Act and general by-laws of the Fund.

(2) After the expiry of the period specified in paragraph 1 of this Article, the insured shall receive salary compensation amounting to 50 % of the last salary compensation paid for the temporary incapacity concerned, as long as there is a medical indication justifying this temporary incapacity.

(3) The provision of paragraph 2 of this Article shall not apply to the insured whose temporary incapacity is confirmed to be due to his/her undergoing treatment for a malignant disease, the insured who has been granted the status of a caregiver of a family member – child suffering from a malignant disease, the insured whose temporary incapacity is related to haemodialysis and peritoneal dialysis and the insured whose temporary incapacity is related to the retrieval and transplantation of human body parts.

Article 53

(1) The insured shall not be entitled to salary compensation if:

1. he/she has deliberately caused temporary incapacity,

2. he/she has failed to notify the chosen physician of his/her illness within three days following the onset of illness, or within three days following the cessation of the reasons preventing him/her from making such notification,

3. he/she has deliberately prevented recovery or his/her becoming capable of work,

4. he/she has worked during sick leave, or has performed tasks based on which he/she is covered by mandatory health insurance, or has performed tasks on the basis of a service contract or any other tasks (e.g. agricultural work etc.),

5. he/she has failed, for no justified reason, to appear when summoned for a medical examination by the chosen physician, a physician-controller of the Fund or a body of the Fund authorised to carry out controls on temporary incapacity,

6. the chosen physician, a physician-controller or a body of the Fund authorised to carry out controls on temporary incapacity have established that he/she has not followed the treatment instructions, or that he/she has left the place of domicile or residence without the consent of the chosen physician or has abused temporary incapacity in some other manner.

(2) In the cases referred to in paragraph 1 of this Article, the insured shall not be entitled to salary compensation from the day these events occurred until the day of their cessation, or until the cessation of their consequences.

Article 54

(1) The salary compensation shall be determined with respect to the compensation base, consisting of the average salary paid to the insured in the last six months preceding the month in which the event on the basis of which a right to compensation is acquired has occurred, regardless of whose account is being debited, except where prescribed otherwise by a special law.

(2) The salary on the basis of which the salary compensation is determined shall imply, in terms of this Act, a regular monthly salary of the insured determined in accordance with the provisions of labour laws and regulations, as well as the salary compensation paid during absence from work (annual leave, paid leave and temporary incapacity), which is paid by debiting the legal or natural person with which the insured is employed.

(3) For the insured referred to in Article 7, paragraph 1, items 3, 4, 6, 8 and 9 of this Act, the monthly base used for the calculation and payment of mandatory health insurance contribution in the last six months preceding the month in which the insured event on the basis of which the entitlement to salary compensation is acquired has occurred, reduced by the legally prescribed mandatory contributions, taxes and surtaxes, shall be used as the salary compensation base.

(4) Exceptionally, for the insured exercising the right to salary compensation during temporary incapacity at the expense of the Fund or the State Budget, the salary compensation base referred to in paragraph 1 of this Article shall also encompass other income realised with respect to the earnings that are used to determine other income pursuant to the income tax legislation, in accordance with the legislation governing mandatory insurance contributions, provided that it has been paid over the six-month period on the basis of which the compensation base is determined, and that the insured has completed the qualifying periods of insurance with the Fund as specified in Article 56, paragraph 1 of this Act.

(5) Where the salary compensation base cannot be determined in accordance with paragraph 1 of this Article, the salary compensation base shall consist of the salary paid until the day of the occurrence of the event on the basis of which the entitlement to salary compensation is acquired, or the relevant salary in the month for which the salary compensation is determined, provided that, in the case when the compensation is paid by debiting the funds of the Fund, the base determined in this manner cannot exceed the lowest insurance base which is used for the calculation of the mandatory health insurance contribution and which is applicable for the month preceding the month in which the insured event occurred.

(6) By way of derogation from paragraph 5 of this Article, when the base for calculating the salary compensation to which the insured is entitled in case of temporary incapacity resulting from a recognised accident at work or occupational disease cannot be determined in accordance with paragraph 1 of this Article, the relevant salary for the month for which the salary compensation is determined shall be used as the base for calculating the salary compensation.

(7) In the case the insured receives salary compensation for a continuous period of more than three months, the base for determining the compensation referred to in paragraph 1 of this Article shall increase in accordance with the rise in salaries of the employed in the Republic of Croatia, if such a rise exceeds 5 %.

(8) The insured shall be entitled to salary compensation in accordance with paragraph 7 of this Article as of the first day of the following month after the expiry of three months of continuous temporary incapacity, provided that the condition for the salary compensation increase has been met.

(9) The Fund shall issue a general by-law specifying the method of determining the salary compensation base referred to in paragraph 3 of this Article.

Article 55

(1) The salary compensation may not be less than 70 % of the salary compensation base, unless otherwise provided for in this Act, and, as a monthly amount on a full-time work basis, it may not be less than 25% of the calculation base defined in the State Budget.

(2) The salary compensation shall be 100 % of the salary compensation base during:

1. temporary incapacity due to a wound, injury or illness which is a direct consequence of participating in the Homeland War,

2. temporary incapacity due to pregnancy- and childbirth-related illness and complications,

3. maternity leave, and while exercising the right to work half the full-time working hours as referred to in Article 39, item 7 of this Act,

4. leave taken following the death of a child as referred to in Article 39, item 8 of this Act,

5. leave taken to nurse a sick child under the age of three,

6. temporary incapacity on account of donating live tissue and organs for transplantation to another person,

7. the period the insured is isolated as a carrier or due to an outbreak of a contagion in his/her environment,

8. temporary incapacity due to a recognised accident at work or occupational disease.

(3) The amount of the salary compensation that is to be paid by debiting the funds of the Fund shall be determined by the Fund, with the highest monthly amount of salary compensation, calculated in accordance with the provisions of this Act and regulations made under this Act, not exceeding, on a full-time work basis, the calculation base defined in the State Budget, increased by 28 %, with the exception of the salary compensation referred to in paragraph 2, items 3, 4 and 8 of this Article.

(4) For the purposes of this Act, full-time work shall mean work of 40 hours per week, unless otherwise laid down in a special regulation, employment rules, a collective agreement, an agreement between the workers' council and the employer or a labour contract.

Article 56

(1) Salary compensation that is to be paid by debiting the funds of the Fund shall be payable to the insured in the amount prescribed by this Act or regulations and general by-laws adopted under this Act, provided that, prior to the date of occurrence of the insured event giving rise to the entitlement to salary compensation, the insured has completed, by virtue of being employed or by virtue of pursuing an economic activity or a professional activity independently as his/her occupation, or by virtue of receiving salary compensation pursuant to this Act after the termination of employment or self-employment, a period of insurance with the Fund of at least nine months without interruption or 12 months with interruptions in the past two years (prior insurance), unless otherwise provided for in a special law.

(2) The provisions of paragraph 1 of this Article shall not apply to salary compensation payable in the event of an accident at work or occupational disease.

(3) An insured who does not meet the requirement concerning prior insurance referred to in paragraph 1 of this Article shall be entitled, during the entire period of temporary incapacity,

to salary compensation in the amount of 25 % of the calculation base defined in the State Budget for full-time work.

2. Cash benefit payable on account of inability to carry out activities giving rise to earnings that are used to determine other income pursuant to the legislation governing contributions for mandatory insurance

Article 57

(1) The cash benefit payable on account of inability to carry out activities giving rise to earnings that are used to determine other income pursuant to the legislation governing contributions for mandatory insurance shall be determined based on the average base for the payment of contributions for mandatory health insurance.

(2) The average base referred to in paragraph 1 of this Article shall mean the average of the insurance bases for which contributions have been paid for mandatory health insurance in the six months preceding the month in which the insured person became unable to carry out activities giving rise to earnings that are used to determine other income.

Article 58

The cash benefit referred to in Article 57, paragraph 1 of this Act shall amount to 70 % of the average base, with its monthly amount not exceeding the maximum amount of the salary compensation referred to in Article 55, paragraph 3 of this Act, and shall be paid at the expense of the Fund as of the first day of exercising the right and for a period of not more than six consecutive months.

Article 59

An insured person shall receive the cash benefit referred to in Article 57, paragraph 1 of this Act provided that he/she is temporarily incapable of carrying out contracted activities as the result of an illness, which is to be confirmed by a medical commission of the Fund.

Article 60

An insured receiving the cash benefit on account of his/her inability to carry out activities giving rise to earnings that are used to determine other income pursuant to the legislation governing contributions for mandatory insurance, whose status of an insured has ceased in accordance with Article 8, paragraph 2 of this Act, shall continue to receive the cash benefit for a maximum period of 30 days from the date of cessation of the status of an insured, provided that at least eight days before the cessation of this status the medical commission of the Fund has confirmed that the insured is incapable of carrying out contracted activities due to his/her state of health.

Article 61

The Fund shall issue a general by-law on the manner of exercising the entitlement to cash benefits on account of inability to carry out activities giving rise to earnings that are used to determine other income pursuant to the legislation governing contributions for mandatory insurance.

3. Compensation for transportation costs related to the exercise of the right to health care under mandatory health insurance

Article 62

(1) For the purpose of exercising the right to health care under mandatory health insurance, an insured person shall be entitled to compensation for transportation costs, provided that he/she was referred to a place outside his/her place of domicile or residence in order to obtain health care and that, according to the criteria prescribed by an ordinance of the minister responsible for health and specified in a general by-law issued by the Fund, he/she does not qualify for ambulance transport as referred to in Article 19, paragraph 2, item 18 of this Act.

(2) The insured person referred to in paragraph 1 of this Article shall be entitled to compensation for transportation costs if he/she was referred for receiving health care services at a contracted health care institution or a contracted private practitioner's office or a contracted medical device supplier at a place located 50 or more kilometres away from his/her place of domicile or residence because, taking account of his/her state of health, the appropriate health care treatment could not have been obtained at a nearer contracted health care institution or private practitioner’s office contracted to provide this type of health care service, or at a nearer contracted medical device supplier.

(3) Subject to the requirement of paragraph 2 of this Article concerning distance, an insured person summoned by the Fund for the purpose of determining entitlements under mandatory health insurance shall also be entitled to compensation for transportation costs.

(4) An insured person up to the age of 18, an insured person referred to in Article 12, paragraphs 2 and 3 of this Act, an insured person travelling to receive radiotherapy and chemotherapy treatment or to receive dialysis due to chronic kidney disease, an insured person travelling to use health care due to a recognised accident at work or occupational disease, an insured person who is an organ, tissue or cell donor and uses health care in relation to donating organs, tissues or cells, and an insured person referred for treatment to another Member State or a third country pursuant to this Act and a general by-law of the Fund shall be entitled to compensation for transportation costs irrespective of the distance referred to in paragraph 2 of this Article.

(5) An insured person who, in order to shorten a waiting list, accepted to use health care services at a contracted health care institution or contracted private practitioner's office that is not located at or nearest to his/her place of domicile or residence shall also be entitled to compensation for transportation costs in accordance with paragraph 2 of this Article.

(6) An insured person wishing to receive health care at a contracted health care institution or contracted private practitioner's office or contracted medical device supplier in the territory of the Republic of Croatia other than that to which he/she has been referred, shall be entitled to receive this health care at the expense of mandatory health insurance funds, but shall not be entitled to compensation for transportation costs or to ambulance transport.

Article 63

(1), The Fund shall bear the actual costs of transportation of the remains of a deceased insured person who was referred for treatment outside the place of his/her domicile or residence in accordance with Article 62 of this Act.

(2) The Fund shall bear the costs of transportation of the remains of a deceased insured person to the place of his/her place of domicile or residence, if organs for transplantation were obtained from that person at a contracted health care institution outside the place of his/her place of domicile or residence.

(3) The compensation for transportation costs referred to in paragraphs 1 and 2 of this Article shall be paid to a legal or natural person who incurred the transportation costs, upon request and proof that this person paid for transportation.

Article 64

(1) One person designated to accompany an insured person referred to in Article 62 of this Act shall be entitled to compensation for transportation costs, provided that the chosen primary health care physician confirms that the patient needs to be accompanied and that, according to the criteria prescribed by an ordinance of the minister responsible for health and specified in a general by-law issued by the Fund, the insured person does not qualify for ambulance transport as referred to in Article 19, paragraph 2, item 18 of this Act.

(2) It shall be considered that children up to the age of 18 and insured persons referred to in Article 12, paragraphs 2 and 3 of this Act need be accompanied regardless of whether they qualify for ambulance transport or not.

Article 65

(1) The compensation for transportation costs referred to in Article 62 of this Act shall mean the compensation for the costs of transport by means of public transport at the lowest price and for the shortest route according to the official distance tables of the public transport operator.

(2) By way of derogation from paragraph 1 of this Article, an insured person may, on a proposal from his/her chosen physician and subject to prior approval by a medical commission of the Fund, be granted the right to use more expensive means of public transport due to his/her health condition.

(3) An insured person who has been approved, in accordance with paragraph 2 of this Article or on the basis of a decision by the Fund on referral for treatment to another Member State or third country in accordance with Article 26, paragraph 3 of this Act, and based on the findings, opinion and assessment of a medical commission of the Fund, to travel by plane due to his/her health condition, shall be entitled to compensation for transportation costs at the level of the lowest economy class airfare.

(4) An insured person shall receive compensation for transportation costs on the basis of a pre-printed travel order form issued by his/her chosen primary health care physician or dentist, or by an authorised officer of the Fund in the case of an insured person being summoned by the Fund for the purpose of exercising rights under mandatory health insurance, and on the basis of a decision by the Fund on referral for treatment in accordance with Article

26, paragraph 3 of this Act, or on the basis of a certificate issued by a health care institution of haemodialysis treatments undertaken.

(5) The Fund shall issue a general by-law specifying the content and format of the pre-printed travel order form referred in paragraph 5 of this Article.

V ACCIDENT AT WORK AND OCCUPATIONAL DISEASE

Article 66

Pursuant to this Act, an accident at work shall be considered to mean:

1. an injury caused by an immediate and short-term mechanical, physical or chemical action, and an injury caused by an abrupt change in body position, sudden strain on the body or other changes in the physiological condition, if such injury is causally linked to the performance of the job or of the activity on the basis of which the injured person is insured under mandatory health insurance, as well as an injury occurring during the mandatory fitness training related to the maintenance of mental and physical fitness for performing particular duties, in accordance with special laws and regulations,

2. a disease caused directly and exclusively by an accident or *force majeure* during work, or during or in relation with the performance of the activity on the basis of which the injured person has been insured under mandatory health insurance,

3. an injury occurring in the manner described in paragraph 1 of this Article, sustained by an insured person during regular travel from home to work and *vice versa*, and on his or her way to take up the employment or to the employment on the basis of which he or she is insured under mandatory health insurance,

4. an injury or disease referred to in items 1 and 2 of this Article, sustained by an insured person under the circumstances referred to in Article 16 of this Act.

Article 67

Within the meaning of this Act, accidents at work shall not be considered to include injuries or diseases caused by:

1. culpable, negligent or irresponsible behaviour in the workplace or while performing the activity, as well as during regular travel from home to work and *vice versa* (e.g. fighting in the workplace or during a daily rest break at work, the deliberate infliction of injury on oneself or on others, performing activities under the influence of alcohol or narcotic drugs, driving under the influence of alcohol or narcotic drugs, etc.),

2. activities that are not connected with the performance of work activities (e.g. taking a rest break at work outside the prescribed times, using a break for purposes other than to restore mental and physical fitness and work capacity necessary to continue the work process, physical activities that are not related to employment, etc.),

3. the deliberate infliction of injury by another person, as a result of a personal relationship with the insured person, which is outside the context of an employment activity,

4. chronic disease attacks,

5. a congenital or acquired health-related predisposition that may lead to a disease.

Article 68

(1) Pursuant to this Act, an occupational disease is a disease caused by a long-term direct exposure to the work processes and working conditions in a specific job.

(2) A list of occupational diseases and jobs in which these diseases occur, as well as the criteria to be used to identify them as occupational diseases shall be laid down in a special law.

Article 69

(1) The insured referred to in Article 7, paragraph 1, item 10 of this Act and the insured referred to in Article 7, paragraph 1, items 13, 16, 17 and 19 of this Act shall also be granted rights under mandatory health insurance in the case of an occupational disease resulting from their having been occupationally exposed to fibrogenic dusts or carcinogens while working for a legal or natural person who has a registered activity in the Republic of Croatia.

(2) In the case of exposure to fibrogenic dusts or carcinogens, the insured referred to in paragraph 1 of this Article shall be entitled, as part of his/her rights under mandatory health insurance, to medical check-ups even after his/her employment has ended.

1. Entitlement to compensation for funeral expenses

Article 70

(1) In the event of the death of an insured referred to in Article 7, paragraph 1, items 1 to 6 and items 8, 9, 20 and 25, or of an insured person referred to in Article 16, or of an insured referred to in Article 69 of this Act, there shall be an entitlement to compensation for funeral expenses, if the death of the insured or of the insured person was a direct consequence of a recognised accident at work or occupational disease.

(2) Compensation for funeral expenses, in the amount of one calculation base defined in the State Budget, shall be payable to a legal or natural person who incurred the costs of the funeral of the insured person referred to in paragraph 1 of this Article.

2. Specific health care

Article 71

In addition to the rights under mandatory health insurance that are granted in the case of a recognised accident at work or occupational disease as provided for in Article 17 of this Act, the insured referred to in Article 7, items 1 to 6 and items 8, 9, 20 and 25 of this Act shall also be entitled to specific occupational healthcare measures, which are implemented by occupational medicine specialists, in accordance with the Health Care Act and special laws and regulations made under these laws.

VI MANDATORY HEALTH INSURANCE FUNDING

1. Sources of funds

Article 72

(1) Mandatory health insurance revenue shall include:

1. contributions for mandatory health insurance,

2. contributions for mandatory health insurance against accidents at work and occupational diseases,

3. contributions for mandatory health insurance of unemployed persons referred to in Article 7, paragraph 1, items 13, 16, 17 and 19 and Article 11, paragraph 1, item 3 of this Act who are registered in the register of unemployed persons in accordance with employment regulations,

4. contributions for mandatory health insurance of insured persons who have been deprived of liberty pursuant to a decision of the competent court, as referred to in Article 7, paragraph 1, item 28 of this Act,

5. contributions for mandatory health insurance of other persons liable to pay contributions as provided for in this Act and other laws,

6. special contribution for the utilisation of health care abroad,

7. revenue from the State Budget,

8. proceeds from co-payments made by insured persons or their supplementary health insurance providers,

9. proceeds from dividends, interest and other receipts,

10. revenue from the proceeds of the excise tax on tobacco products,

11. proceeds from mandatory vehicle liability insurance.

(2) The revenue referred to in paragraph 1, item 10 of this Article, representing 32 % of the total proceeds of the excise tax on tobacco products, shall be transferred from the State Budget to the Fund's account by the fifth day of the month for the preceding month.

(3) The proceeds referred to in paragraph 1, item 11 of this Article shall be paid by insurance companies in the amount equal to 4 % of the functional insurance premium paid from motor vehicle liability insurance. This amount represents an advance payment payable to the Fund in the cases referred to in Article 140 of this Act as compensation for damage caused by the owners or users of the insured motor vehicle.

(4) An insurance company shall pay to the Fund's account the proceeds referred to in paragraph 1, item 11 of this Article in the manner prescribed in paragraph 3 of this Article by

the tenth day of the month for the preceding month in respect of the total amount of the functional insurance premium paid from motor vehicle liability insurance.

(5) For each accounting period (month), an insurance company shall submit, by the fifteenth day of the month for the preceding month, a report on the monthly funds calculated and paid as proceeds referred to in paragraph 1, item 11 of this Article.

(6) An insurance company and the Fund shall prepare the final statement of payments made and actual expenditures referred to in paragraph 3 of this Article, and shall submit to the ministry responsible for finance an annual report on the final statement of payments made and actual expenditures referred to in paragraph 3 of this Article by April 30 of the current calendar year for the preceding calendar year.

(7) If an insurance company and the Fund fail to prepare the final statement of payments and actual expenditures within the time limit specified in paragraph 6 of this Article, the Tax Administration of the Ministry of Finance (hereinafter: Tax Administration) shall issue a decision requiring the insurance company to pay funds to the Fund, or requiring the Fund to return to the insurance company the funds paid, on the basis of the Fund's information on actual expenditures.

(8) The minister responsible for finance shall issue an ordinance specifying the method of payment, calculation and reporting, the method of preparing annual statements and reports on payments and actual expenditures, as well as the procedure and authority for supervising the implementation of the provisions of paragraphs 4, 5, 6 and 7 of this Article.

(9) The calculation of interest on late payment, the limitation period for the right to calculate and collect proceeds from mandatory motor vehicle liability insurance, the recovery of sums paid in excess, the supervision, the conduct of second-instance proceedings and infringement proceedings shall be subject to the provisions of the General Tax Act.

(10) The Tax Administration of the Ministry of Finance shall supervise the implementation of this Act in the part relating to the mandatory health insurance revenue from proceeds from mandatory motor vehicle liability insurance.

(11) Contributions and other mandatory health insurance revenue provided for in paragraph 1 of this Article shall be paid into the Fund's account and shall be the revenue of the Fund.

Article 73

Mandatory health insurance expenditures shall include expenditures for:

1. health care under mandatory health insurance,

2. specific health care referred to in Article 71 of this Act,

3. salary compensations during temporary incapacity,

4. cash benefits on account of inability to carry out activities that give rise to earnings that are used to determine other income pursuant to the legislation governing contributions to mandatory insurance schemes,

5. compensations for transportation costs related to the use of health care under mandatory health insurance,

6. compensations for accommodation costs referred to in Article 36, paragraph 1, item 4 of this Act,

7. compensations for funeral expenses referred to in Article 70 of this Act,

8. the implementation of mandatory health insurance,

9. the operation of the management bodies of the Fund,

10. other expenditures.

Article 74

Mandatory health insurance expenditures incurred in one calendar year shall be covered by the revenues generated in the same calendar year.

2. Contributions and persons liable to pay contributions

Article 75

(1) Contribution bases and rates, calculation method and payment deadlines, contribution levels and persons liable to calculate and pay contributions for mandatory health insurance and mandatory health insurance against accidents at work and occupational diseases shall be regulated by a special law, unless otherwise provided for in this Act.

(2) The Tax Administration shall submit to the Fund, by the twentieth day of the month for the preceding month, all records relating to payments of contributions and other revenue of mandatory health insurance and mandatory health insurance against accidents at work and occupational diseases which fall within its remit and on which it keeps records.

(3) The contribution rates for mandatory health insurance and mandatory health insurance against accidents at work and occupational diseases shall be determined in such a manner that, according to the Fund's data, the expected expenditures are covered by the expected proceeds from contributions and other revenue.

Article 76

Unless otherwise provided for in this Act or in a special law, contribution bases, the method of calculation and payment of contributions, contribution levels and persons liable to calculate and pay contributions for mandatory health insurance and mandatory health insurance against accidents at work and occupational diseases shall be determined by a general by-law to be issued by the Fund.

Article 77

The funds for mandatory health insurance of the insured's family members referred to in Article 10 of this Act shall be derived from the same sources of funds as the funds for

mandatory health insurance of the insured, unless otherwise provided for in this Act or in a special law.

Article 78

Farmers referred to in Article 7, paragraph 1, item 7 of this Act who have reached the age of 65 years shall be exempt from paying mandatory health insurance contributions if they meet the requirements prescribed in an ordinance issued by the minister responsible for health with the agreement of the minister responsible for social welfare.

Article 79

(1) Persons specified in a special law as being liable to pay special contributions for the use of health care abroad may be exempt from paying such contribution for an insured who is not insured with a health insurance provider in the country of work, if they pursue their activity in a third country with which the Republic of Croatia has not concluded an international agreement or an international agreement provides otherwise, provided that they ensure health care abroad at their own expense.

(2) The Fund shall, on application by a person liable to pay contributions as referred to in paragraph 1 of this Article, issue a decision on exemption from the payment of contributions.

(3) An insured person travelling for private purposes to a third country with which the Republic of Croatia has not concluded an international agreement, or an international agreement has been concluded but does not regulate the health insurance issue, may report to the Fund his/her stay in the third country and pay a special contribution for the use of health care in third countries at the expense of the Fund.

(4) The insured person referred to in paragraph 3 of this Article who did not report to the Fund his/her stay in a third country, and had not previously paid a special contribution for using health care in the third country during the planned stay in the third country, shall not be entitled to receive compensation for the costs of this health care at the expense of the mandatory health insurance funds, unless otherwise provided for in a general by-law of the Fund.

(5) The contribution base and rate and the method of calculation and payment of a special contribution for the use of health care in a third country, which are applicable to insured persons staying in a third country for private purposes, shall be determined by the Fund by way of a general by-law, unless otherwise provided for in a special law.

Article 80

(1) For the purpose of verifying the accuracy of the data and facts on which the exercise of the rights under mandatory health insurance depends, the Fund shall be entitled to examine business books, financial documents and other records kept by persons liable to pay contributions.

(2) The Tax Administration, the Central Register of Insured Persons, state authorities and other competent authorities shall submit to the Fund the information that they have in their

possession and of which they keep official records required for the exercise of rights under mandatory health insurance.

(3) If during the verification referred to in paragraph 1 of this Article the Fund discovers irregularities, it shall draw up a report thereon and shall submit that report to the Tax Administration, which shall take action falling within its competence in accordance with the procedure laid down in a regulation issued by the minister responsible for finance.

(4) The Fund shall issue a general by-law specifying the manner in which the examination referred to in paragraph 1 of this Article is to be conducted.

Article 81

(1) For the insured referred to in Article 7, paragraph 1, items 3, 4, 6, 7, 8 and 9 of this Act, pension beneficiaries and disability benefit beneficiaries who exercise this right exclusively with respect to a foreign pension or disability insurance provider as referred to in Article 7, paragraph 1, item 12 of this Act, the insured referred to in Article 13 of this Act and other persons insured under mandatory health insurance in accordance with a special law, who are liable to calculate and pay contributions for mandatory health insurance, but who have not paid contributions for a period of at least 30 days, rights under mandatory health insurance shall be limited to the right to urgent medical assistance.

(2) Urgent medical assistance shall mean the provision of diagnostic and therapeutic procedures that are necessary to eliminate imminent danger to life and health.

(3) The rights referred to in paragraph 1 of this Article shall be fully recovered for a future period starting from the day when the overdue contributions and the relevant interest have been paid.

3. Allocation of funds in the State Budget

Article 82

(1) The Republic of Croatia shall allocate special funds in the State Budget for rights under mandatory health insurance, for the following:

1. funds for salary compensations during temporary incapacity referred to in Article 39, item 9 and Article 52, paragraph 2 of this Act,

2. health care costs for:

a. the insured referred to in Article 7, paragraph 1, items 13, 16, 17 and 19 and Article 11, paragraph 1, item 3 of this Act for whom contributions are not paid in accordance with Article 72, paragraph 1, item 3 of this Act, and the insured referred to in Article 7, paragraph 1, items 14, 15, 18, 20, 21, 25, 26 and 27 of this Act,

b. insured persons referred to in Article 15 of this Act,

c. insured persons referred to in Article 78 of this Act,

d. preventive and specific health care of school children and university students,

e. preventive health care of insured persons over the age of 65,

f. preventive health care of insured persons with disabilities entered in the register established by a special regulation,

g. funds to cover the difference in the costs of organising primary health care that goes beyond the established standards due to demographic features (islands, population density),

h. funds to cover the difference in the costs of health care contracted and paid according to the population size, and not according to the number of insured persons (emergency medical services, health visiting service, hygiene-epidemiology services),

i. the provision of health care services on the basis of international social security agreements.

(2) The funds referred to in paragraph 1 of this Article shall be paid into the Fund's account by the tenth day of the month for the previous month, and shall be the revenue of the Fund.

Article 83

The Fund shall have business funds for:

1. rights arising from mandatory health insurance,

2. rights arising from mandatory health insurance against accidents at work and occupational diseases,

3. supplementary health insurance pursuant to a special law,

4. additional health insurance pursuant to a special law.

Article 84

(1) The Fund shall have a reserve for the implementation of rights arising from mandatory health insurance.

(2) If the final accounts reveal a surplus of revenue, at least 50 % of this surplus shall be placed in the reserve.

(3) The Governing Council of the Fund shall supervise the use of the reserve.

Article 85

(1) The reserve referred to in Article 84 of this Act may not exceed one twelfth of the expenditures planned in the current year for the implementation of the set scope of rights arising from mandatory health insurance.

(2) During the year the reserve may be used as working capital for settling current liabilities of the Fund, and as a loan, provided that the funds plus interest be repaid by the end of the following year at the latest.

(3) The reserve shall be used to cover an excess of expenditures over revenues and to cover losses of the Fund.

Article 86

(1) The Fund shall keep records in order to have available the information necessary for the implementation of mandatory health insurance and for the supervision of the exercise of rights arising from mandatory health insurance.

(2) The Governing Council of the Fund shall issue general by-laws specifying the manner and place of keeping records, their form, content and related time limits, as well as persons required to keep records.

VII RELATIONSHIP BETWEEN THE FUND AND HEALTH CARE INSTITUTIONS, HEALTH CARE PROFESSIONALS IN PRIVATE PRACTICE AND MEDICAL DEVICE SUPPLIERS

1. Contracting of health care services

Article 87

(1) With the consent of the minister responsible for health and after obtaining an opinion from the competent chambers, and in accordance with the established scope of rights to health care referred to in Articles 19, 20 and 23 of this Act and the established standards and norms of health care under mandatory health insurance as provided for in Article 33 of this Act, the Fund shall issue a general by-law specifying the manner in which health care is to be provided, the elements and criteria for launching calls for tenders and the bases for concluding contracts with health care institutions and private health care professionals that participate in the public health service network, the emergency medicine network and the network of contracted occupational medicine providers, the full price of individual health care services under mandatory health insurance, the maximum annual amount of funds for the provision of contracted hospital services, and the method and time limits for paying bills for health care services provided under mandatory health insurance.

(2) With the consent of the minister responsible for health, and in accordance with the established scope of rights to health care referred to in Articles 19, 20 and 22 of this Act and the established standard of the right to orthopaedic aids and other devices pursuant to a general by-law of the Fund, the Fund shall issue a general by-law specifying the bases for concluding contracts with suppliers of orthopaedic aids and other devices who meet the conditions for the manufacture or supply of medical devices as provided for in a special law, as well as the prices for medical devices and the method and time limits for paying bills for devices supplied.

(3) General by-laws referred to in paragraphs 1 and 2 of this Article shall specify the beginning and end of the contractual period for which a call for tenders for the conclusion of contracts on the provision of health care under mandatory health insurance is launched.

Article 88

(1) In accordance with the by-law referred to in Article 87, paragraph 1 of this Act, and in accordance with the identified needs for supplementing the public health service network, the emergency medicine network and the network of contracted occupational medicine providers, the Fund shall, as a rule, call for tenders every three years, unless otherwise provided for in the general by-law referred to in Article 87, paragraph 1 of this Act, for the purpose of concluding contracts with health care institutions and private health care professionals for the provision of health care under mandatory health insurance at the primary, secondary and tertiary levels of care, and at the level of health institutes, unless otherwise provided for in a special law.

(2) In accordance with the by-law referred to in Article 87, paragraph 2 of this Act, the Fund shall, as a rule, call for tenders every three years, unless otherwise provided for in the general by-law referred to in Article 87, paragraph 2 of this Act, for the purpose of concluding contracts with suppliers of orthopaedic aids and other devices.

(3) On the basis of the tenders for the provision of health care, which have been received under a call for tenders referred to in paragraphs 1 and 2 of this Article, the Fund shall, with the consent of the minister responsible for health, issue a decision on the selection of the most favourable tenderers.

(4) A tenderer whose tender submitted under a call for tenders referred to in paragraphs 1 and 2 of this Article has not been accepted may lodge an appeal with the minister responsible for health within 15 days from the day of being notified that the tender has not been accepted.

(5) The appeal referred to in paragraph 4 of this Article shall be determined by way of a decision against which an administrative dispute may be initiated.

Article 89

In accordance with the decision referred to in Article 88, paragraph 3 of this Act, or in accordance with the decision referred to in Article 88, paragraph 5 of this Act, by which an appeal is upheld and a tender accepted, the Fund shall conclude contracts on the provision of the established scope of rights to health care referred to in Article 87, paragraphs 1 and 2 of this Act.

Article 90

(1) The contract referred to in Article 89 of this Act shall specify the type, scope and quality of health care under mandatory health insurance in accordance with the standards and norms applicable to specific activities, the time limits within which the contracted health care is to be provided to an insured person at the primary, secondary and tertiary care levels and at the level of health institutes in accordance with an ordinance issued by the minister responsible for health determining a medically justifiable time limit within which the necessary health care must be provided, the prices at which the health care contracted and provided under mandatory health insurance is to be invoiced by entities contracted with the Fund, the method of calculation, the time limits for submitting invoices and the time limits for payment of invoices for the health care provided, supervision of the performance of contractual obligations, the contractual penalties and other measures to be applied in the case of non-

performance of contractual obligations, the conditions under which a contract may be terminated, as well as other rights and obligations of contracting parties.

(2) The provisions of paragraph 1 of this Article shall apply *mutatis mutandis* to contracts for the supply of orthopaedic aids and other devices.

Article 91

Contracts referred to in Article 89 of this Act shall be concluded no later than 60 days after the date of entry into force of the decision referred to in Article 88, paragraph 3 of this Act, or no later than 60 days after the date on which the decision referred to in Article 88, paragraph 5 became enforceable.

Article 92

Contracts referred to in Article 89 of this Act shall be concluded in advance, and shall be valid for no longer than until the expiry of the time limit specified in Article 91 of this Act.

Article 93

The director of the contracted health care institution, or the contracted private health care professional, and the head of an organisational unit of the health care institution shall ensure, each within his/her competence, that insured persons are provided with health care contracted with the Fund, within the funds contracted, and shall be liable if the funds allocated for the provision of health care under mandatory health insurance are used for purposes other than those for which they are intended.

2. Supervision of the performance of contractual obligations of entities contracted with the Fund

Article 94

(1) During the contracting period the Fund shall supervise on an on-going basis the performance of contractual obligations of health care institutions, private health care professionals and contracted medical device suppliers.

(2) The supervision referred to in paragraph 1 of this Article shall be carried out in accordance with the provisions of this Act and general by-laws of the Fund:

1. by inspecting and examining financial, medical and other documents at a health care institution, private health care professional or contracted medical device supplier,

2. by inspecting and examining the submitted documents at organisational units of the Fund.

(3) During the process of supervision referred to in paragraph 1 of this Article, it shall be verified in particular whether or not the chosen physician or dentist, a health care professional employed by a health care institution or a private health care professional:

1. implements health care measures arising from mandatory health insurance at his/her level of health care activity defined by the scope of rights to health care as referred to in Articles 19, 20, 22 and 23 of this Act,

2. abides by the rules of the profession and, when prescribing medicinal products, complies with recommendations on pharmacotherapy, clinical guidelines and principles of pharmacoeconomy taking into account interactions and contraindications in individual cases,

3. acts contrary to the provisions of this Act, the Health Care Act, other laws, special regulations, subordinate legislation and general by-laws of the Fund,

4. uses only for designated purposes the funds received under the contract concluded with the Fund for the provision of health care under mandatory health insurance,

5. confirms temporary incapacity of the insured in accordance with the provisions of Article 46 of this Act, or whether he/she complies with the provision of Article 52, paragraph 1 of this Act when establishing diagnoses of diseases in the insured.

(4) If the verification referred to in items 4 and 5 of paragraph 3 of this Article reveals that the funds received for the provision of health care under mandatory health insurance are used by an entity contracted with the Fund for purposes other than those for which these funds are intended, or that the chosen physician confirms temporary incapacity in the insured contrary to the provisions of Article 46 of this Act, or acts contrary to the provisions of Article 52 of this Act by changing disease diagnoses for the insured and confirming that the period of temporary incapacity has ended, for the purpose of avoiding the application of paragraph 2 of the same Article of this Act, the Fund may initiate the procedure to terminate the contract with this contracted entity.

Article 95

For the purpose of supervision of the performance of contractual obligations, entities contracted with the Fund shall submit reports on their operations in accordance with a general by-law of the Fund referred to in Article 87 of this Act.

Article 96

The manner in which the supervision of the performance of contractual obligations of health care institutions, private health care professionals and contracted medical device suppliers is to be carried out shall be determined by the Fund in a special by-law or in the contract itself.

VIII CROATIAN HEALTH INSURANCE FUND

Article 97

(1) Tasks in the implementation of the mandatory health insurance rights provided for in this Act shall be carried out by the Croatian Health Insurance Fund.

(2) The Fund shall be a public institution to which the legislation governing institutions shall apply, unless otherwise provided for in this Act.

(3) The Fund shall be a legal person with rights, obligations and responsibilities laid down in this Act and in its Statute.

(4) The Fund shall have public authority in deciding on the rights and obligations of insured persons under mandatory health insurance.

(5) The registered office of the Fund shall be in Zagreb.

Article 98

(1) In implementing rights under mandatory health insurance, the Fund shall perform, in particular, the following tasks:

1. pursue a policy to develop and improve health care under mandatory health insurance,

2. perform activities related to the exercise of rights of insured persons, ensure that such rights are exercised legally, and provide the necessary expert assistance to insured persons in the exercise of their rights and in the protection of their interest,

3. create the financial plan for the mandatory health insurance scheme and pay for the services provided by entities contracted with the Fund on the basis of submitted invoices, medical histories, discharge summaries, and other relevant documents,

4. propose to the minister responsible for health the scope of rights to health care referred to in Articles 19, 20, 22 and 23 of this Act,

5. provide the minister responsible for health with a proposal for the development of a plan and programme of health care measures under mandatory health insurance, and a plan and programme of specific health care measures,

6. give an opinion to a founder of health care institution on the justification of founding a health care institution in the public health service network, and give an opinion to a health care professional on the justification of founding private practice in the public health service network,

7. perform activities related to contracting with health care providers,

8. fix the price of health care in the total amount for the full value of an individual health care service under mandatory health insurance, with the consent of the minister responsible for health,

9. ensure the implementation of the European Union regulations and international agreements in the part relating to mandatory health care,

10. supervise the performance of contractual obligations of entities contracted with the Fund in accordance with this Act, regulations made under this Act, general by-laws of the Fund and concluded contracts,

11. carry out research, perform statistical processing and prepare reports relating to the exercise of rights under mandatory health insurance,

12. regulate other issues related to the exercise of rights under mandatory health insurance.

(2) In addition to the tasks specified in paragraph 1 of this Article, the Fund shall perform certain tasks relating to the maintenance of the information system for the purpose of implementing health care, pursuant to a special order of the minister responsible for health.

1. Internal organisation of the Croatian Health Insurance Fund

Article 99

(1) The Fund shall perform activities falling within its remit in the following organisational units:

1. central organisational unit,

2. regional organisational units.

(2) Organisational units of the Fund shall perform the activities of the Fund under the name of the Fund and under their own name, stating the registered office of the Fund and their registered office.

Article 100

(1) The central organisational unit of the Fund shall be the Directorate, with its seat in Zagreb.

(2) Regional organisational units of the Fund shall be the regional offices of the Fund.

Article 101

The scope of operations of organisational units, the names of internal organisational units, as well as other issues relevant for the performance of the activities of the Fund shall be specified in the Fund's Statute.

2. Bodies of the Fund

Article 102

(1) The Fund shall be managed by the Governing Council.

(2) The Governing Council shall be composed of nine members appointed by the Government of the Republic of Croatia on a proposal from the minister responsible for health, as follows:

a) two representatives of persons insured with the Fund,

b) two representatives of health care providers – health care professionals,

c) three representatives of the Economic and Social Council,

d) one representative of the ministry responsible for health,

e) one representative of the employees of the Fund, appointed or elected in accordance with labour legislation.

(3) The Chairperson of the Governing Council shall be elected by the members of the Governing Council.

(4) The term of office for members of the Governing Council shall be four years.

(5) The Governing Council shall take its decisions by a simple majority of the total number of its members.

(6) The scope of activities, authorities and responsibilities of the Governing Council shall be established by the Statute.

Article 103

(1) The Fund's Governing Council shall perform the following activities:

1. adopt the Statute of the Fund,

2. adopt the financial plan and the annual statement of accounts of the Fund,

3. adopt measures aimed at balancing revenues and expenditures when the operations of the Fund within a three-month period have resulted in a surplus of expenditures over revenues,

4. adopt decisions and general by-laws, and perform other activities provided for in this Act and in the Statute of the Fund.

(2) The Fund's Statute shall be approved by the Government of the Republic of Croatia.

Article 104

(1) The Fund's Statute shall specify in particular: the internal organisation of the Fund, the scope of operations of organisational units, the names of internal organisational units, the rights, obligations and responsibilities of the bodies of the Fund, the accessibility to public scrutiny of the activities of the Fund and its bodies, the manner in which administrative, technical and other tasks are to be performed, as well as other issues relevant for the performance of the activities of the Fund.

(2) The Statute and general by-laws of the Fund governing the rights and obligations of persons insured under mandatory health insurance shall be published in the Official Gazette.

Article 105

(1) The activities of the Fund shall be managed by the Director.

(2) The Director shall have a graduate university degree and at least five years of experience in a management position.

(3) The Director of the Fund shall be aided by a Deputy Director and Assistant Directors.

Article 106

(1) The Director of the Fund shall be appointed on the basis of a public vacancy competition.

(2) The Director of the Fund shall be appointed and removed from office by the Government of the Republic of Croatia on a proposal from the minister responsible for health.

(3) The Director of the Fund shall be appointed for a term of four years.

Article 107

(1) The Director of the Fund shall be responsible for financial operations of the Fund.

(2) The Director of the Fund shall be responsible for balancing the revenues of the Fund with expenses as well as for delivering quarterly reports on financial operations of the Fund to the minister responsible for health and the minister responsible for finance.

Article 108

(1) The Director of the Fund may be removed from office even before the expiry of the term for which he/she was appointed.

(2) A proposal to remove the Director from office before the expiry of the term for which he/she was appointed may be submitted to the Government of the Republic of Croatia by at least one third of the members of the Governing Council and by the minister responsible for health.

Article 109

(1) The Governing Council of the Fund shall propose to the minister responsible for health and to the Government of the Republic of Croatia to remove the Director from office before the expiry of the term for which he/she was appointed:

1. if such removal is requested by the Director himself,

2. if any of the reasons specified in special regulations or regulations governing labour relations for the termination of the employment contract occur,

3. if the operations of the Fund within a period of six months have resulted in a surplus of expenditures over revenue,

4. if he/she performs his/her duties in an irresponsible or unlawful manner which has caused considerable damage to the Fund, neglects or negligently performs his/her duties, which has resulted or may result in major disturbances in the performance of the activities of the Fund, in performing his/her duties he violates the provisions of this Act and regulations made under this Act, of other primary and subordinate legislation, and of general by-laws of the Fund, or fails to execute the decisions of the Fund's Governing Council, or acts contrary to them, without a justified reason.

(2) Prior to the adoption of a decision proposing removal from office, the Fund's Governing Council shall notify the Director of the reasons for removal and shall give him an opportunity to present his arguments in writing.

Article 110

(1) The Deputy Director shall have a graduate university degree and at least five years of experience in a management position.

(2) The Deputy Director of the Fund shall be appointed on the basis of a public vacancy competition.

(3) The Deputy Director of the Fund shall be appointed and removed from office by the Government of the Republic of Croatia on a proposal from the minister responsible for health.

(4) The Deputy Director of the Fund shall be appointed for a term of four years.

Article 111

(1) The Deputy Director of the Fund may be removed from office even before the expiry of the term for which he was appointed, for reasons specified in Article 109, paragraph 1 of this Act.

(2) A proposal to remove the Deputy Director from office before the expiry of the term for which he/she was appointed may be submitted to the Government of the Republic of Croatia by the minister responsible for health, by at least one third of the members of the Governing Council and by the Director of the Fund.

Article 112

(1) The Governing Council of the Fund shall propose to the minister responsible for health and to the Government of the Republic of Croatia to remove the Deputy Director from office before the expiry of the term for which he/she was appointed if any of the reasons specified in Article 109 of this Act occur.

(2) Prior to the adoption of a decision proposing removal from office, the Fund's Governing Council shall notify the Deputy Director of the reasons for removal and shall give him an opportunity to present his arguments in writing.

Article 113

(1) The number of Assistant Directors of the Fund and the conditions that they must meet shall be laid down in the Statute of the Fund.

(2) Assistant Directors shall be appointed and removed from office by the Government of the Republic of Croatia on a proposal from the Director of the Fund.

Article 114

The manner in which the head of a regional office of the Fund is to be appointed and removed from office shall be laid down in the Statute of the Fund.

Article 115

The scope of activities, authorities and responsibilities of the Fund's Director, Deputy Director and Assistant Directors and of the head of a regional office of the Fund shall be laid down in the Statute of the Fund.

3. Supervision of the work of the Fund

Article 116

(1) The ministry responsible for health shall supervise the legality of operations and general by-laws of the Fund.

(2) When conducting the supervision referred to in paragraph 1 of this Article, the ministry responsible for health may:

1. request reports, data and other information concerning the performance of activities,

2. propose to the Government of the Republic of Croatia to initiate proceedings before the Constitutional Court of the Republic of Croatia to assess whether general by-laws of the Fund are in compliance with the law and the Constitution,

3. examine the organisation and the manner of operation and recommend measures for the performance of particular activities,

4. undertake other measures provided for in this Act and other legislation.

Article 117

The Director of the Fund shall submit to the minister competent for health and the Government of the Republic of Croatia annual reports in relation to the operations of the Fund not later than 1 March of the current year for the previous year as well as monthly reports on the performance of contractual obligations by contractual entities of the Fund by the fifteenth day of the month for the previous month.

Article 118

If the Government of the Republic of Croatia establishes that the losses of the Fund in relation to the provision of mandatory health insurance arose due to objective circumstances, these losses shall be covered from the State Budget.

IX EXERCISE OF THE RIGHTS AND OBLIGATIONS ARISING FROM MANDATORY HEALTH INSURANCE

Article 119

(1) The right to mandatory health insurance shall be established by recognising the status of a person insured with the Fund.

(2) The status of an insured person shall terminate when the circumstances on the basis of which the person concerned acquired this status cease to exist.

(3) The status of an insured person shall be proved by a health insurance card or by a certified copy of the mandatory health insurance registration.

(4) In cross-border health care, the status of an insured person shall be proved by the European Health Insurance Card or a certificate temporarily replacing the European Health Insurance Card, or other appropriate certificate in accordance with the European Union regulations.

(5) The document referred to in paragraph 4 of this Article shall be issued by the Fund at the request of the insured person.

(6) The Fund shall issue a general by-law specifying the content and form of, and the issuance fee and procedure for issuing the documents referred to in paragraph 3 of this Article, as well as the conditions and procedure for issuing the documents referred to in paragraph 4 of this Article.

Article 120

(1) The status of an insured person shall be granted by the Fund on the basis of the registration for mandatory health insurance, which shall be submitted, in accordance with the provisions of this Act, by the person liable to pay contributions, by the insured person when he/she is the one who is liable to pay contributions or by a legal or natural person in the name of the insured person.

(2) The Fund may grant the status of an insured person *ex officio* on the basis of information submitted by the competent authority authorised to collect and submit information for the purpose of registration for mandatory health insurance.

(3) A registration for mandatory health insurance, a registration of a change in mandatory health insurance and a de-registration from mandatory health insurance shall be submitted within eight days from the date when the circumstances leading to the acquisition or loss of the status of an insured person occurred, changed or ceased to exist.

(4) A person who has not been registered or cancelled from registration for mandatory health insurance by a person liable to pay contributions shall be issued a decision by the Fund granting or terminating his or her status of an insured person *ex officio*.

Article 121

(1) A party who is liable to submit a registration shall submit to the Fund all data relating to registration, changes, and de-registration in respect of insured persons for the purpose of realising the rights and obligations arising from mandatory health insurance and issuing a document referred to in Article 119, item 3 of this Act.

(2) If the party liable to submit a registration as referred to in paragraph 1 of this Article fails to submit a registration for mandatory health insurance within 30 days from the day when the circumstances for acquiring the status of an insured person arose, the Fund shall, *ex officio*, issue a decision granting the status of the insured or the status of an insured person of the Fund.

Article 122

(1) Upon receiving a registration for mandatory health insurance, as well as throughout the duration of the status of an insured person, the Fund shall have the right and obligation to check whether the circumstances based on which the registration was submitted or based on which the person was granted this status still exist.

(2) Legal and natural persons who are liable to submit a registration for mandatory health insurance and the insured person shall present, at the request of the Fund, all the facts and evidence proving that the registration for mandatory health insurance is justified, or that the current status of an insured person is valid.

(3) If the Fund does not accept the submitted registration or establishes the status of an insured person on another basis, or denies an insured person his/her status under the mandatory health insurance because the circumstances based on which this status was granted to him/her no longer exist, it shall issue a decision to this effect and shall submit it to the party submitting registration and to the interested party.

(4) If it is suspected that the submitted registration, or the status of an insured person granted on the basis of an employment contract, is not based on true facts and there are no actual circumstances justifying the acquisition of the status under mandatory health insurance, or that the employment contract was not concluded for the purpose of performing tasks under that contract, but only for the purpose of exercising rights under mandatory health insurance, the Fund shall have the right and obligation to initiate proceedings before the competent court in order to challenge such employment contract, relying on the results of the checks referred to in paragraph 1 of this Article and the evidence collected.

(5) The Fund shall issue a general by-law specifying who shall be liable to submit a registration or de-registration in respect of an insured person, the manner of registration and de-registration of an insured person under mandatory health insurance, the granting of the status of an insured person, the dates on which the status of an insured person is to begin and end, the dates on which the exercise of the rights and obligations under mandatory health insurance is to begin and end, the manner in which circumstances leading to the acquisition or loss of the status of a person insured under mandatory health insurance are to be determined and verified, and the documents to be used to prove that there is legal basis for insurance.

Article 123

(1) Rights under mandatory health insurance referred to in Article 17 of this Act shall be granted as a rule without issuing decisions, on the basis of appropriate documents as specified in this Act and general by-laws of the Fund adopted pursuant to this Act.

(2) A decision concerning rights under mandatory health insurance shall be issued at the request of an insured person, unless otherwise provided for in this Act.

(3) In the procedures referred to in paragraph 2 of this Article the Fund shall make decisions by applying the provisions of the General Administrative Procedure Act.

Article 124

(1) For the purpose of protecting the rights arising from this Act, persons insured with the Fund shall be provided with a two-instance procedure in the proceedings initiated by an insured person.

(2) The second-instance decision of the Fund cannot be appealed against, but an administrative dispute may be initiated.

Article 125

(1) The rights under mandatory health insurance shall be decided upon:

1. in the first instance – by an organisational unit of the regional office of the Fund that is competent according to the place of domicile or residence of the insured person,

2. in the second instance – by the Directorate of the Fund.

(2) An appeal against a first-instance decision shall not stay the enforcement of the decision.

Article 126

(1) In exercising his/her right to health care under mandatory health insurance pursuant to the provisions of this Act, an insured person shall have the right freely to choose his/her primary health care physician and dentist.

(2) The insured person shall choose a primary health care physician and dentist for a period of at least one year.

(3) The Fund shall issue a general by-law specifying the manner of exercising the right to freely choose a primary health care physician and dentist as referred to in paragraph 1 of this Article and the manner of choosing an occupational medicine specialist for providing specific health care.

Article 127

(1) Medical commissions of the Fund shall participate in procedures concerning rights under mandatory health insurance.

(2) Medical commissions referred to in paragraph 1 of this Article shall perform professional and medical expert evaluations in matters concerning an insured person's right under mandatory health insurance and shall issue a decision in the form of findings, opinion and assessment.

(3) The Fund shall, with the consent of the minister responsible for health, issue a general by-law specifying the authorities and method of work of medical commissions, the scope of their

competence and the content and format of the pre-printed form to be used for indicating their findings, opinion and assessment.

Article 128

(1) The procedure for establishing and recognising an accident at work or occupational disease shall be initiated by a legal or natural person or state body in their capacity as an employer, by an organiser of particular tasks and activities referred to in Article 16 of this Act, or by a self-employed person, by submitting a report on the accident at work or occupational disease.

(2) A legal or natural person or state body in their capacity as an employer, or an organiser of particular tasks and activities shall submit the report referred to in paragraph 1 of this Article *ex officio* or at the request of the injured or diseased worker or the insured person who is granted rights under this Act in the event of an accident at work or occupational disease.

(3) If the employer or the organiser of particular tasks and activities fails to act in accordance with paragraph 2 of this Article, the report shall be submitted by the chosen general practice/family doctor at the request of the injured or diseased insured person or on a proposal from the competent occupational medicine specialist who is contracted with the Fund for the provision of specific health care for workers, and who is, in accordance with a general by-law of the Fund, competent for the provision of specific health care for workers according to the seat of the employer or of the organiser of particular tasks and activities.

(4) The Fund shall issue a general by-law specifying the content and format of the pre-printed form to be used for reporting an accident at work or occupational disease.

Article 129

(1) The Fund shall, as rule, recognise an accident at work or occupational disease without issuing a written decision, by certifying the pre-printed form used to report the accident at work or occupational disease.

(2) By way of derogation from paragraph 1 of this Article, the Fund shall issue a decision when it does not recognise an injury or disease as being an accident at work or occupational disease, and when it decides on the recognition of an accident at work or occupational disease on the basis of an application submitted by an insured person or by a family member of an insured following the death of the insured person.

Article 130

(1) A report on an accident at work or occupational disease shall be submitted:

1. in the case of an accident at work – within eight days from the day the accident at work occurred,

2. in the case of an occupational disease – within eight days from the day when the insured person received a document from a health care institution or private occupational medicine specialist participating in the network of contracted occupational medicine professionals, containing a diagnosis of the occupational disease.

(2) An insured person in respect of whom a report on an accident at work or occupational disease has not been submitted to the Fund within three years from the expiry of the time limits referred to in paragraph 1 of this Article shall lose the right to initiate the procedure for establishing and recognising this accident at work or occupational disease by the Fund.

Article 131

The Fund shall issue a general by-law, with the consent of the minister responsible for health, specifying the rights and obligations arising from mandatory health insurance against accidents at work and occupational diseases, including specific occupational healthcare measures for workers, the procedure for establishing and recognising an accident at work or occupational disease, as well as the scope of the rights and the conditions and manner of exercising these rights.

Due date for payment of entitlements and time limits

Article 132

(1) A claim for the payment of salary compensation, filed by an insured who is employed with a private or natural person– employer, shall be due for payment on the date on which the salary payable by this employer is due for payment for the month concerned.

(2) With regard to the insured referred to in paragraph 1 of this Article, his/her claim for payment of the relevant part of the salary compensation to which he/she is entitled on the basis of earnings that are used to determine other income pursuant to the income tax legislation, shall be due for payment on the thirtieth day from the date on which the employer submitted his request for the refund of paid salary compensations as referred to in Article 41, paragraphs 3 and 4 of this Act.

(3) A claim for the payment of salary compensation, filed by an insured referred to in Article 7, paragraph 1, items 3, 4, 6, 8, 9, 20 and 25 and Article 51 of this Act, shall be due for payment on the fifteenth day of the month for the preceding month.

(4) A claim for the payment of a cash benefit referred to in Article 57 of this Act, filed by an insured referred to in Article 8 of this Act, shall be due for payment on the sixtieth day from the date of filing the claim.

Article 133

(1) A claim for the payment of other cash benefits that are provided for in this Act shall be due for payment on the sixtieth day from the date on which the Fund received a claim from an insured person, or other person who is entitled to a cash benefit in accordance with the provisions of this Act.

(2) Exceptionally, in the case when an insured person has filed a claim for the payment of cash benefits referred to in paragraph 1 of this Article which, in accordance with the provisions of this Act, can be inheritable, and the death of the insured person occurs before the expiry of the payment due date, it shall be considered that the payment is due upon expiry of the period referred to in paragraph 1 of this Article.

Article 134

(1) A claim for cash benefits provided for in this Act shall be time-barred after expiry of three years after the date on which the costs were incurred by the insured person or the date of acquisition of rights under mandatory health insurance in accordance with the provisions of this Act.

(2) A request for the refund of paid salary compensations as referred to in Article 41, paragraphs 3 and 4 of this Act shall be time-barred after expiry of three years after the date on which salary compensation was due for payment as referred to in Article 132, paragraph 1 of this Act.

X COMPENSATION FOR DAMAGES

Article 135

(1) The insured person shall report to the Fund every change, within eight days from the date of occurrence of circumstances having an impact on the use of the rights recognised in accordance with this Act.

(2) The insured person shall indemnify the Fund or the State Budget for damage:

1. if he/she has realised receipts from the funds of the Fund or State Budget as a result of failing to act in accordance with paragraph 1 of this Article and failing to report a change having impact on the loss or scope of the rights under mandatory health insurance, and was aware or should have been aware of such change,

2. if he/she has realised receipts from the funds of the Fund or State Budget on the basis of false or inaccurate data for which he/she knew or should have known that they were false or inaccurate or realised receipts in some other unlawful manner or in a larger scope than he/she is entitled to.

Article 136

(1) The Fund shall claim compensation for damage from the person who caused disease, injury or death of an insured person.

(2) A legal or natural person – employer shall be liable for damage to the Fund in cases referred to in paragraph 1 of this Article caused by a worker at work or in relation to his/her work.

(3) In the cases referred to in paragraph 2 of this Article, the Fund shall also request indemnification for damage directly from the worker if the damage was caused intentionally or by gross negligence.

(4) Where the Fund claims compensation for damage from a legal person, or a natural person, and from a worker, they shall be jointly liable for damages.

Article 137

An insured person who has received funds from the Fund or from the State Budget to which he/she is not entitled shall return the received amount increased by the statutory default interest, by paying it into the account of the Fund or the State Budget within eight days from the date of receipt of a written notification from the Fund stating the findings of facts.

Article 138

(1) The Fund shall claim compensation for damage from a legal or natural person:

1. if the damage occurred as a result of failure to provide data or as a result of providing false or inaccurate data regarding the facts affecting the acquisition or scope of the rights under mandatory health insurance,

2. if the payment was made on the basis of false or inaccurate data indicated in the worker's registration when he/she started working,

3. if the payment was made because changes affecting the loss or scope of a worker's rights have not been reported, or the worker's termination of employment has not been reported, or if this was reported after the expiry of the prescribed time limit,

4. if the damage occurred because a registration for mandatory health insurance was submitted on the basis of an employment contract that was not concluded for the purpose of performing tasks under that contract, but only for the purpose of exercising rights under mandatory health insurance.

(2) Insured persons who are obligated to register by themselves or provide certain data in relation to their rights and obligations shall, in the cases referred to in paragraph 1 of this Article, compensate the Fund for damages arising from failure to register or from providing false data.

(3) A legal and natural person shall be liable for damage in cases referred to in paragraph 1 of this Article regardless of guilt, while insured persons shall be liable for damage in cases referred to in paragraph 2 if they knew or must have known that the data are false or inaccurate, or if they knew or must have known about the changes affecting the loss or scope of the rights, but did not report these changes.

Article 139

(1) The Fund shall claim compensation for damage from a legal or natural person if a disease, injury or death of an insured person occurred as a result of failure to implement measures ensuring safety at work or other measures aimed at protecting the population.

(2) The Fund shall claim compensation for damage from a legal or natural person when damages occurred because a worker started working without the prescribed prior medical examination and it has been established by a subsequent medical examination that due to his/her medical condition he/she should not perform certain activities.

Article 140

The Fund shall also claim compensation for damage in cases referred to in Article 136 of this Act directly from the insurance company with which the said persons are insured against liability for damage caused to third parties, pursuant to regulations governing mandatory insurance against such risk.

Article 141

(1) The Fund shall claim compensation for damage caused in the territory of the Republic of Croatia by the use of vehicles registered in another Member State or in a third country, which have a valid international document on motor insurance, directly from the Croatian Insurance Bureau.

(2) When the damage was caused in another Member State or in a third country, the Fund shall claim compensation for damage in accordance with the provisions of the Insurance Act and international agreements.

Article 142

The Fund shall claim compensation for damage in cases provided for in this Act, regardless of the fact that the damage occurred due to the payment of benefits which the insured person is entitled to receive from mandatory health insurance funds or from the State Budget.

Article 143

The compensation for damage that the Fund may claim in cases referred to in Articles 135 and 136 and Articles 138 to 142 of this Act shall encompass the costs of health care and other services as well as the cash benefits and other benefits paid by the Fund.

Article 144

A health care institution, a private health care professional and a contracted medical device supplier shall be liable to the Fund for damage they caused while performing or in relation to performing their activities pursuant to the provisions of the Civil Obligations Act.

Article 145

The Fund shall claim compensation for damage from:

1. a primary health care physician who confirmed temporary incapacity of an insured contrary to the provisions of Article 46 of this Act, or confirmed, without a justified reason, that the period of temporary incapacity ended, or changed, without a justified reason, disease diagnosis, for the purpose of avoiding the application of Article 52, paragraph 2 of this Act, thus making it possible for the insured to receive a salary compensation to which the insured was not entitled or to receive a higher amount of salary compensation contrary to the provisions of this Act,

2. a health care institution whose medical specialist acted contrary to the provision of Article 21, paragraph 4 of this Act, and the Fund issued a decision granting to the insured person concerned the right to be compensated for the costs of a medicinal product bought following a recommendation from this medical specialist.

Article 146

The relevant provisions of the Civil Obligations Act, as well as special regulations on compensation of damages shall apply when determining the rights to compensation for damage caused to the Fund.

Article 147

(1) Damage claims, within the meaning of the provisions of this Act, shall be time-barred upon expiry of the time limits specified in the Civil Obligations Act.

(2) The statute of limitations period for damage claims within the meaning of the provisions of this Act shall start running:

1. in cases referred to in Article 135 and Article 138, paragraph 1 of this Act, from the day when the decision establishing that there was no entitlement to payment or that the entitlement was smaller in scope becomes final,

2. in cases referred to in Articles 137 and 139 of this Act, from the day when the decision recognising the right to receive payments from the funds of the Fund becomes enforceable,

3. in other cases, when compensation is required in respect of individual benefits that have been paid as referred to in Article 142 of this Act, from the day when each individual benefit was paid.

(3) By way of derogation from paragraph 2 of this Article, the statute of limitations in respect of damage caused by a criminal offence shall be subject to time limits provided for in the Civil Obligations Act.

Article 148

(1) After having established the occurrence of damage, the Fund shall present evidence and invite the insured person, the legal or natural person, the legal person providing insurance of persons and property or other person obligated to pay compensation for damages, to pay compensation within a specified time limit.

(2) If the damages are not compensated within the set time limit, the Fund shall bring an action before the competent court in order to resolve its claim.

(3) The Fund shall be entitled to charge default interest at the rate prescribed by the Act on Default Interest Rates, as from the date the damage occurred.

(4) The Fund shall not be entitled to realise compensation for damages by suspending payments or denying cash benefits to which the insured person is entitled in connection with the exercise of rights under the mandatory health insurance, without the expressed consent of the insured person.

XI MISDEMEANOUR PROVISIONS

Article 149

(1) An insurance company shall be guilty of a misdemeanour and shall be fined a sum between HRK 500 000.00 and HRK 1 000 000.00 for failing to pay, within the prescribed time limit, the amount equal to 4 % of the total functional insurance premium paid from compulsory motor vehicle liability insurance (Article 72, paragraphs 3 and 4).

(2) The responsible person in the insurance company shall be fined a sum between HRK 30 000.00 and HRK 50 000.00 for committing a misdemeanour referred to in paragraph 1 of this Article.

(3) An insurance company shall be guilty of a misdemeanour and shall be fined a sum between 5 000.00 and HRK 100 000.00 for failing to submit, within the prescribed time limit, a monthly report referred to in Article 72, paragraph 5 of this Act.

(4) An insurance company shall be guilty of a misdemeanour and shall be fined a sum between 5 000.00 and HRK 100 000.00 for failing to submit, within the prescribed time limit, an annual report referred to in Article 72, paragraph 6 of this Act.

(5) The responsible person in the insurance company shall be fined a sum between HRK 5 000.00 and HRK 20 000.00 for committing a misdemeanour referred to in paragraphs 3 and 4 of this Article.

Article 150

(1) A legal person shall be guilty of a misdemeanour and shall be fined a sum between HRK 70 000.00 and HRK 100 000.00 for failing to submit to the Fund a registration for mandatory health insurance within the prescribed time limit (Article 120, paragraph 3).

(2) A legal person shall be guilty of a misdemeanour and shall be fined a sum specified in paragraph 1 of this Article for submitting a registration for mandatory health insurance on the basis of an employment contract that was not concluded for the purpose of performing tasks under that contract, but only for the purpose of exercising rights under mandatory health insurance (Article 122, paragraph 4).

(3) The responsible person in the legal person, as well as a natural person, shall be fined a sum between HRK 8 000.00 and HRK 15 000.00 for committing a misdemeanour referred to in paragraphs 1 and 2 of this Article.

(4) In addition to a fine, a prohibition to pursuit activity may also be imposed on a legal or natural person who commits a misdemeanour referred to in paragraph 1 of this Article.

Article 151

(1) A legal person shall be guilty of a misdemeanour and shall be fined a sum between HRK 10 000.00 and HRK 15 000.00 for failing to submit to the Fund, within the prescribed time limit, all data relating to registration and de-registration of an insured person for the purpose of realising the rights and obligations arising from mandatory health insurance (Article 122, paragraph 2).

(2) A natural person who is liable to submit a registration for mandatory health insurance shall be fined a sum between HRK 8 000.00 and HRK 13 000.00 for committing a misdemeanour referred to in paragraph 1 of this Article.

(3) The responsible person in the legal person shall be fined a sum between HRK 3 000.00 and HRK 5 000.00 for committing a misdemeanour referred to in paragraph 1 of this Article.

Article 152

(1) A contracted health care institution shall be guilty of a misdemeanour and shall be fined a sum between HRK 50 000.00 and HRK 250 000.00 for using the funds received for the provision of health care under mandatory health insurance for purposes other than those for which these funds are intended (Article 94, paragraph 3, item 4).

(2) The responsible person in a health care institution, and a contracted private health care professional, or the chosen primary health care physician or dentist shall be fined a sum between HRK 10 000.00 and HRK 50 000.00 for committing a misdemeanour referred to in paragraph 1 of this Article (Article 93 and Article 94, paragraph 3, item 4).

(3) The chosen physician who confirms temporary incapacity of the insured contrary to the provisions of Article 46 of this Act, or acts contrary to the provisions of Article 52 of this Act by changing disease diagnoses for the insured and confirming that the period of temporary incapacity has ended, for the purpose of avoiding the application of paragraph 2 of the same Article of this Act, shall be guilty of a misdemeanour and shall be fined a sum between HRK 5 000.00 and HRK 20 000.00 (Article 46, paragraphs 2 and 4 an Article 52, paragraph 1).

(4) A medical specialist in a contracted health care institution shall be guilty of a misdemeanour and shall be fined a sum between HRK 5 000.00 and HRK 15 000.00 for failing to submit to the inpatient health care institution's commission for medicinal products a proposal for treatment with a medicinal product (Article 21, paragraph 4).

Article 153

An insured person shall be guilty of a misdemeanour and shall be fined a sum between HRK 8 000.00 and HRK 15 000.00:

1. if he/she has deliberately caused temporary incapacity; if he/she fails to notify the chosen primary health care physician of his/her illness within three days following the onset of illness, or within three days following the cessation of the reasons preventing him/her from making such notification; if he/she has deliberately prevented recovery or his/her becoming capable of work; if he/she has worked during temporary incapacity; if he/she has failed, for no justified reason, to appear when summoned for a medical examination by the chosen physician, a physician-controller of the Fund or a body of the Fund authorised to carry out controls of sick leaves; if he/she has not followed the treatment instructions; or if he/she has left the place of domicile or residence without the consent of the chosen physician or has abused the right to use the temporary incapacity leave in some other manner (Article 53),

2. if he/she has exercised the entitlement to compensation for transportation costs related to the exercise of the right to health care under mandatory health insurance, without having a legal basis for doing so (Article 62),

3. if he/she uses a document proving the status of an insured person in a manner contrary to the provisions of this Act and regulations made under this Act, or obtains health care using someone else's document (Article 119, paragraphs 3 and 6).

XII TRANSITIONAL AND FINAL PROVISIONS

Article 154

(1) The minister responsible for health shall issue ordinances referred to in Article 19, paragraph 2, items 15 and 18, Article 46, paragraphs 2 and 9 and Article 90, paragraph 1 of this Act within 90 days from the date of entry into force of this Act.

(2) The minister responsible for social welfare activities shall issue ordinances referred to in Article 15, paragraph 2 and Article 78 of this Act within 90 days from the date of entry into force of this Act.

(3) The minister responsible for finance shall issue the ordinance referred to in Article 72, paragraph 8 of this Act within 90 days from the date of entry into force of this Act.

Article 155

(1) The Fund shall issue general by-laws referred to in Article 19, paragraph 4, Article 36, paragraph 1, item 4, Article 38, paragraph 3, Article 41, paragraph 7, Article 45, paragraph 6, Article 54, paragraph 9, Article 61, Article 79, paragraph 5, Article 119, paragraph 6, Article 122, paragraph 5, Article 126, paragraph 3, Article 127, paragraph 3, Article 128, paragraph 4 and Article 131 of this Act within 90 days from the date of entry into force of this Act.

(2) The Fund shall issue general by-laws referred to in Article 7, paragraph 7, Article 10, paragraph 3, Article 19, paragraph 6, Article 20, paragraphs 7 and 9, Article 33, Article 76, Article 86, paragraph 2 and Article 87, paragraphs 1 and 2 of this Act within 180 days from the date of entry into force of this Act, and shall bring other general by-laws into compliance with the provisions of this Act within the same period.

(3) The Fund shall issue general by-laws referred to in Article 26, paragraph 4 and Article 28, paragraph 3 of this Act no later than 25 October 2013.

(4) The Fund shall issue general by-laws referred to in Article 23, paragraph 3, Article 24, paragraph 3 and Article 25 of this Act no later than 1 January 2014.

Article 156

The content and format of prescriptions referred to in Article 20, paragraph 9, of the temporary incapacity report referred to in Article 38, paragraph 5 and of the travel order form referred to in Article 65, paragraph 5 of this Act shall be specified by the Fund by way of a general by-law within 90 days from the date of entry into force of this Act.

Article 157

Until the entry into force of the ordinances and general by-laws referred to in Articles 154, 155 and 156 of this Act, the following pieces of legislation shall apply in the part that is not contrary to the provisions of this Act:

1. Ordinance on the rights, the conditions and the manner of exercising rights under mandatory health insurance (Official Gazette 67/09, 116/09, 4/10, 13/10, 88/10, 131/10, 1/11, 16/11, 87/11, 137/11, 39/12, 69/12, 126/12 and 38/13.);

2. Ordinance on the rights, the conditions and the manner of exercising rights under mandatory health insurance in the case of an accident at work and occupational disease (Official Gazette 1/11, 153/11, 51/12, 126/12, 147/12, 38/13 and 67/13);

3. Ordinance on the manner of exercising the right freely to choose a primary health care physician and dentist (Official Gazette 41/07, 4/10, 13/10, 41/12 and 50/13);

4. Ordinance on the manner and procedure of choosing an occupational medicine specialist (Official Gazette 48/11, 51/12 and 147/12);

5. Ordinance on the conditions and the manner of exercising the right under mandatory health insurance to hospital medical rehabilitation and physical therapy at home (Official Gazette 26/96, 79/97, 31/99, 51/99, 73/99, 40/07, 46/07 – consolidated text, 64/08, 91/09 and 118/09);

6. Ordinance on the authorities and method of work of authorised doctors and medical commissions of the Croatian Health Insurance Fund (Official Gazette 113/09, 126/09, 4/10, 88/10, 1/11, 50/11 and 87/11);

7. Ordinance on the manner of prescribing and issuing medicinal products on prescription (Official Gazette 17/09, 46/09, 4/10, 110/10, 131/10, 1/11 and 52/11);

8. Ordinance on orthopaedic aids and other devices (Official Gazette 7/12, 14/12, 23/12, 25/12, 45/12, 69/12, 85/12, 92/12, 119/12, 147/12, 21/13 and 38/13);

9. Ordinance on dental health care under mandatory health insurance (Official Gazette 38/13 and 49/13);

10. Ordinance on the rights, conditions and manner of using health care abroad (Official Gazette 50/09, 118/09, 4/10, 13/10, 14/10, 1/11, 16/11, 31/11, 93/11, 145/11, 41/12, 76/12 and 129/12);

11. Ordinance on the manner of registering, de-registering and obtaining the status of a person insured under mandatory health insurance (Official Gazette 31/07, 56/07, 96/07, 130/07, 33/08, 91/09, 4/10, 69/10, 1/11 and 48/11);

12. Ordinance on the conditions for and the manner of exercising the right to health care at home under mandatory health insurance (Official Gazette 88/10, 1/11, 87/11, 38/13 and 49/13);

13. Ordinance on time limits for the duration of sick leave depending on the type of disease (Official Gazette 153/09);

14. Ordinance on the authorities and method of work of controllers of the Croatian Health Insurance Fund (Official Gazette 59/09 and 48/11);

15. Ordinance on the criteria and the procedure for determining the inability for independent life and work and a lack of sufficient means of subsistence for persons who are domiciled in the Republic of Croatia whose health insurance is not provided on another basis (Official Gazette 39/02);

16. Ordinance on the conditions for exemption from paying contributions for basic health insurance of farmers over the age of 65 years (Official Gazette 122/02);

17. Ordinance on sick leave controls (Official Gazette 123/11);

18. Ordinance on ambulance transport (Official Gazette 123/09);

19. Ordinance on the European Health Insurance Card (Official Gazette 153/11);

20. Decision on establishing the basic reimbursement list of medicinal products of the Croatian Health Insurance Fund (Official Gazette 47/13, 49/13, 50/13 and 54/13);

21. Decision on establishing the supplementary reimbursement list of medicinal products of the Croatian Health Insurance Fund (Official Gazette 47/13 and 49/13);

22. Decision on establishing a list of particularly expensive drugs identified by the Decision on establishing the basic reimbursement list of medicinal products of the Croatian Health Insurance Fund (Official Gazette 67/13);

23. Decision on the content and form of the document certifying the status of a person insured with the Croatian Health Insurance Fund (Official Gazette 4/07, 91/09, 113/09, 140/09, 4/10, 13/10, 43/10 and 29/11);

24. Decision setting the level of the fee for the issuance of a health card for a person insured under mandatory health insurance (Document 2) (Official Gazette 113/09);

25. Decision on the bases for concluding contracts for the provision of health care under mandatory health insurance (Official Gazette 23/13, 38/13, 50/13 and 51/13);

26. Decision on special standards and criteria of their implementation in the provision of primary health care under mandatory health insurance (Official Gazette 38/13);

27. General terms and conditions of contracts for the provision of primary health care under mandatory health insurance (Official Gazette 34/13);

28. General terms and conditions of contracts for the provision of specialist-consultative health care under mandatory health insurance (Official Gazette 34/13);

29. General terms and conditions of contracts for the provision of hospital health care under mandatory health insurance (Official Gazette 34/13);

30. Decision on the establishment of the list of diagnostic and therapeutic treatments in health care activities - time and staffing standards (Official Gazette 15/92, 29/93, 65/93, 31/95, 73/99, 3/00, 18/00, 118/01, 44/02, 76/02, 85/02, 92/02, 130/02, 151/02, 11/03, 32/03, 43/03, 203/03, 30/05, 88/05, 136/06, 16/07, 40/07, 57/07, 80/07, 84/07, 98/07, 111/07, 130/07, 54/08, 85/08, 133/08, 2/09, 10/09, 17/09, 110/10, 49/13 and 65/13);

31. Decision on the standards and norms for the rights to health care under mandatory health insurance against an accident at work and occupational disease, and bases for concluding contracts (Official Gazette 1/11, 6/11, 31/11, 78/11, 153/11, 38/12, 61/12, 118/12, 147/12 and 38/13);

32. Decision on the special standard and the criteria for its implementation in the provision of specific health care (Official Gazette 126/12 and 38/13);

33. Decision on the calculation base and rate of a special contribution for the use of health care abroad by persons insured with the Croatian Health Insurance Fund who are staying abroad for private purposes (Official Gazette 93/11).

Article 158

The Fund shall harmonise its operations with the provisions of this Act within 180 days from the date of entry into force of this Act.

Article 159

In exercising the rights and obligations under mandatory health insurance, all legal and natural persons shall harmonise their operations with the provisions of this Act within 180 days from the date of entry into force of this Act.

Article 160

(1) Insured persons who started exercising rights under mandatory health insurance in accordance with the provisions of the Mandatory Health Insurance Act (Official Gazette 150/08, 94/09, 153/09, 71/10, 139/10, 49/11, 22/12, 57/12, 90/12 – Decision of the Constitutional Court of the Republic of Croatia, 123/12 and 144/12) shall, from the date of entry into force of this Act, exercise the rights under mandatory health insurance in accordance with the provisions of the latter.

(2) Insured persons who, on the date of entry into force of this Act, had the status of a family member of the insured in accordance with Article 10, paragraph 1 of the Mandatory Health Insurance Act (Official Gazette 150/08, 94/09, 153/09, 71/10, 139/10, 49/11, 22/12, 57/12, 90/12 – Decision of the Constitutional Court of the Republic of Croatia, 123/12 and 144/12), shall maintain this status until the end of the current school or academic year.

Article 161

For the insured whose temporary incapacity was confirmed after the entry into force of the Mandatory Health Insurance Act (Official Gazette 150/08, 94/09, 153/09, 71/10, 139/10, 49/11, 22/12, 57/12, 90/12 – Decision of the Constitutional Court of the Republic of Croatia, 123/12 and 144/12), and who were confirmed to suffer from disability on account of general

inability to work or occupational incapacity for work before the entry into force of this Act, the chosen physician shall determine that temporary incapacity has ended on the date of entry into force of this Act.

Article 162

Administrative proceedings initiated before the date of entry into force of this Act shall be finalised in accordance with the provisions of the Mandatory Health Insurance Act (Official Gazette 150/08, 94/09, 153/09, 71/10, 139/10, 49/11, 22/12, 57/12, 90/12 – Decision of the Constitutional Court of the Republic of Croatia, 123/12 and 144/12) and regulations and general by-laws adopted pursuant to that Act.

Article 163

Contributions and other revenue of the mandatory health insurance scheme laid down in Article 72, paragraph 1 of this Act, and funds referred to in Article 137 of this Act shall be paid to the State Budget until 31 December 2014, and from 1 January 2015 they shall be paid into the account of the Fund and shall be the revenue of the Fund.

Article 164

On the day of entry into force of this Act, the Mandatory Health Insurance Act (Official Gazette 150/08, 94/09, 153/09, 71/10, 139/10, 49/11, 22/12, 57/12, 90/12 – Decision of the Constitutional Court of the Republic of Croatia, 123/12 and 144/12) shall cease to have effect.

Article 165

This Act shall be published in the Official Gazette and shall enter into force on the day of accession of the Republic of Croatia to the European Union, with the exception of the provisions of:

– Articles 2 and 3 and Article 34, in the part relating to the application of Directive 2011/24/EU, and Articles 26 to 32, which shall enter into force on 25 October 2013,

– Article 18, items 5 and 6, and Article 19, 22, 23 and 25, in the part relating to the basic and supplementary lists of orthopaedic aids and other devices, and dental devices, which shall enter into force on 1 January 2014,

– Article 82, paragraph 2, which shall enter into force on 1 January 2015.

Class: 022-03/13-01/148

Zagreb, 21 June 2013

THE CROATIAN PARLIAMENT

President of the Croatian Parliament

Josip Leko, m. p.