THE NATIONAL ASSEMBLY
No: 25/2008/QH12

SOCIALIST REPUBLIC OF VIET NAM
Independence - Freedom - Happiness
Ha Noi, day 14 month 11 year 2008

LAW

ON HEALTH INSURANCE

Pursuant to the 1992 Constitution of the Socialist Republic of Vietnam, which was amended and supplemented under Resolution No. 51/2001/QH10;
The National Assembly promulgates the Law on Health Insurance.

Chapter I

GENERAL PROVISIONS

Article 1. Governing scope and subjects of application

1. This Law provides the health insurance regime and policies, including participants, premium rates, responsibilities and methods of payment of health insurance premiums; health insurance cards; eligible health insurance beneficiaries; medical care for the insured; payment of costs of medical care covered by health insurance; health insurance fund; and rights and responsibilities of parties involved in health insurance.

2. This Law applies to domestic and foreign organizations and individuals in Vietnam that are involved in health insurance.

3. This Law does not apply to commercial health insurance.

Article 2. Interpretation of terms

In this Law, the terms below are construed as follows:

1. *Health insurance* is a form of insurance applied in the health care sector for non-profit purposes, organized by the State and joined by responsible persons under this Law.

2. *All-people health insurance* means health insurance joined by all persons prescribed in this Law.

3. *Health insurance fund* means a financial facility set up from health insurance premium payments and other lawful collections, which is used to cover costs of medical care for the insured, managerial costs of health insurance institutions and other lawful costs related to health insurance.

4. *Employers* include state agencies, public non-business units, people's armed forces units, political organizations, socio-political organizations, socio-political-professional organizations, social organizations, socio-professional organizations, enterprises, cooperatives, individual

business households and other organizations; foreign organizations; and international organizations operating in the Vietnamese territory, which are responsible for making health insurance contributions.

5. *Health insurance-covered primary care provider* means the first medical examination and treatment establishment registered by an insured and indicated in the health insurance card.

6. *Health insurance assessment* means professional activities conducted by a health insurance institution to evaluate the reasonableness of medical care services provided to an insured serving as a basis for the payment of costs of health insurance-covered medical care.

Article 3. Health insurance principles

1. Ensuring the sharing of risks among the insured.

2. Health insurance premiums shall be determined in percentage of wage, remuneration, pension, allowance or minimum salary in the administrative sector (below referred to as the minimum salary).

3. Health insurance benefits shall be based on the seriousness of sickness and category of beneficiaries within the scope of the insured's benefits.

4. Costs of health insurance-covered medical care shall be jointly paid by the health insurance fund and the insured.

5. The health insurance fund shall be managed in a centralized, unified, public and transparent manner, ensuring the balance between revenue and expenditure, and be protected by the State.

Article 4. State policies on health insurance

1. The State pays, or assists payment of, health insurance premiums for people with meritorious services to the revolution and a number of social beneficiary groups.

2. The State adopts preferential policies for the health insurance fund's investments in order to preserve and increase the fund. The fund's revenues and profits from its investments are tax-free.

3. The State creates favorable conditions for organizations and individuals to join health insurance or pays health insurance premiums for several beneficiary groups.

4. The State encourages investment in technological development and advanced technical facilities for health insurance management.

Article 5. State management agencies in charge of health insurance

1. The Government performs the unified state management of health insurance.

2. The Ministry of Health shall take responsibility before the Government for performing the state management of health insurance.

3. Ministries and ministerial-level agencies shall, within the ambit of their tasks and powers, coordinate with the Ministry of Health in performing the state management of health insurance.

4. People's Committees at all levels shall, within the ambit of their tasks and powers, perform the state management of health insurance in localities.

Article 6. The Ministry of Health's responsibilities for health insurance

To assume the prime responsibility for, and coordinate with other ministries, ministerial-level agencies and relevant agencies and organizations in. performing the following tasks:

1. Formulating health insurance policies and law, organizing the health care system, professional and technical lines and financial sources for the protection, care and improvement of people's health, based on all-people health insurance;

2. Formulating strategies, planning and master plans on development of health insurance;

3. Promulgating lists of drugs, medical supplies and technical services which the insured is entitled to, and professional and technical regulations on health insurance-covered medical care;

4. Working out and submitting to the Government solutions to ensure the balance of the health insurance fund;

5. Popularizing and disseminating health insurance policies and law;

6. Directing and guiding the implementation of the health insurance regime;

7. Inspecting, examining and handling violations in, and settling complaints and denunciations about, health insurance;

8. Monitoring, assessing and reviewing activities in the health insurance domain;

9. Organizing scientific research and international cooperation on health insurance.

Article 7. The Finance Ministry's responsibilities for health insurance

1. To coordinate with the Ministry of Health, concerned agencies and organizations in formulating health insurance-related Financial policies and regulations.

2. To inspect and examine the implementation of legal provisions on financial mechanisms applicable to health insurance and the health insurance fund.

Article 8. Responsibilities of People's Committees at all levels for health insurance

1. Within the ambit of their tasks and powers, People's Committees at all levels shall:

a) Direct and organize the implementation of policies and law on health insurance;

b) Ensure funding to pay health insurance premiums for persons eligible for premium payment or support from the state budget under this Law;

c) Popularize and disseminate health insurance policies and law;

d) Inspect, examine and handle violations of, and settle complaints and denunciations about, health insurance.

2. Apart from the responsibilities defined in Clause 1 of this Article, People's Committees of provinces and centrally run cities shall also manage and use funding sources under Clause 2, Article 35 of this Law.

Article 9. Health insurance institutions

1. Health insurance institutions function to implement health insurance regimes, policies and law, and manage and use the health insurance fund.

2. The Government shall specify the organization, functions, tasks and powers of health insurance institutions.

Article 10. Audit of the health insurance fund

Once every three years, the State Audit shall audit the health insurance fund and report the results to the National Assembly.

If requested by the National Assembly, the National Assembly Standing Committee or the Government, the State Audit shall conduct extraordinary audit of the health insurance fund.

Article 11. Prohibited acts

1. Failing to pay or fully pay health insurance premiums under this Law.

2. Committing fraud related to or forging health insurance files or cards.

3. Using collected health insurance premiums or the health insurance fund for improper purposes.

4. Obstructing, troubling or causing harms to the insured and parties involved in health insurance in the exercise of their lawful rights and enjoyment of their benefits.

5. Deliberately making false reports or providing false information and data on health insurance.

6. Abusing one's position, power or professional operations to act in contravention of the health insurance law.

Chapter II

THE INSURED, RATES, LIABILITIES AND METHODS OF PAYMENT OF HEALTH INSURANCE PREMIUMS

Article 12. The insured

1. Laborers working under indefinite-term labor contracts or labor contracts of full three-month or longer term according to the labor law; business managers who enjoy salaries or remunerations under the salary and remuneration law; cadres, civil servants and employees prescribed by law (below collectively referred to as employees).

2. Professional officers and non-commissioned officers and officers and non-commissioned officers specialized in technical areas who are serving in the people's security force.

3. Persons on pension or monthly working capacity loss allowance.

4. People on monthly social insurance allowance for labor accident or occupational disease.

5. People who have stopped enjoying working capacity loss allowances and are enjoying monthly allowances from the state budget.

6. Commune, ward or township cadres who have stopped working and are enjoying monthly social insurance allowances.

7. Commune, ward or township cadres who have stopped working and are enjoying monthly allowances from the state budget.

8. People on unemployment allowance.

9. People with meritorious services to the revolution.

10. War veterans as defined by the war veteran law.

11. People who personally participated in the anti-US resistance war for national salvation under the Government's regulations.

12. Incumbent National Assembly deputies and People's Council deputies at all levels.

13. People on monthly social welfare allowance as prescribed by law.

14. Poor household members; ethnic minority people living in areas with difficult or exceptionally difficult socio-economic conditions.

15. Relatives of people with meritorious services to the revolution as prescribed by the law on preferential treatment toward people with meritorious services to the revolution.

16. Relatives of the following people as prescribed in the laws on People's Army officers, military service, people's public security and cipher officers:

a) On-service officers, career army men of the People's Army; non-commissioned officers and soldiers who are serving in the People's Army;

b) Professional officers and non-commissioned officers and specialized technical officers and non-commissioned officers who are working in the people's security force; non-commissioned officers and soldiers who are serving in the people's security force for a given period;

c) Career officers and army men doing cipher work in the Government Cipher Committee and those doing cipher work and salaried according to the stafe payroll of People's Army officers or the state payroll of People's Army career men who are neither army men nor policemen.

17. Children aged under 6 years.

18. People who have donated parts of their bodies under the law on donation, taking and transplantation of tissues and human organs and donation and taking of cadavers.

19. Foreigners studying in Vietnam who are granted scholarships from the Vietnamese State's budget.

20. Members of households living just above the poverty line.

21. Pupils and students.

22. Members of agricultural, forestry, fishery and salt-making households.

23. Relatives of employees defined in Clause 1 of this Article whom the employees have to rear and who live together with them in the same families.

24. Members of cooperatives or individual business households.

25. Other persons according to the Government's regulations.

Article 13. Health insurance premium rates and responsibilities to pay health insurance premiums

1. Health insurance premium rates and responsibilities to pay health insurance premiums are

prescribed as follows:

a) The monthly premium rate applicable to persons defined in Clauses 1 and 2, Article 12 of this Law is equal up to 6% of the employee's monthly salary or remuneration, with the employer paying two thirds of the amount and the employee one-third. In the period when the employee takes maternity leave or rears an adopted child of under 4 months according to the social insurance law, the employee and employer are not required to pay health insurance premium and this period is still counted in their consecutive health insurance participation time for entitlement to health insurance benefits;

b) The monthly premium rate applicable to persons defined in Clause 3, Article 12 of this Law is equal up to 6% of their pension or working capacity loss allowance, and such premiums shall be paid by the social insurance institution;

c) The monthly premium rate applicable to persons defined in Clauses 4,5 and 6, Article 12 of this Law is equal up to 6% of the minimum salary and such premiums shall be paid by the social insurance institution;

d) The monthly premium rate applicable to persons defined in Clause 8, Article 12 of this Law is equal up to 6% of their unemployment allowance and such premiums shall be paid by the social insurance institution;

e) The monthly premium rate applicable to persons defined in Clauses 7, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18, Article 12 of this Law is equal up to 6% of the minimum salary and such premiums shall be paid by the state budget;

f) The monthly premium rate applicable to persons defined in Clause 19, Article 12 of this Law is equal up to 6% of the minimum salary and such premiums shall be paid by the scholarship-awarding agencies, organizations or units;

g) The monthly premium rate applicable to persons defined in Clauses 20, 21 and 22, Article 12 of this Law is equal up to 6% of the minimum salary and such premiums shall be paid by these persons;

The state budget shall pay part of health insurance premiums for persons defined in Clauses 20 and 21, Article 12 of this Law and those defined in Clause 22, Article 12 of this Law who have average living standards;

h) The monthly premium rate applicable to persons defined in Clause 23, Article 12 of this Law is up to 6% of the minimum salary and paid by the employees;

i) The monthly premium rate applicable to persons defined in Clause 24, Article 12 of this

Law is equal up to 6% of the minimum salary and such premiums shall be paid by these persons;

j) The monthly premium rate applicable to persons defined in Clause 25, Article 12 of this Law

is equal up to 6% of the minimum salary.

2. In case an insured concurrently belongs to different categories specified in Article 12 of this Law, he)she shall pay health insurance premiums like those in the first category which he)she belongs to in the order of priority defined in Article 12 of this Law.

In case a person defined in Clause 1, Article 12 of this Law has additionally one or several indefinite-term labor contracts or labor contracts of 3-month or longer term, he)she shall pay health insurance premium according to the contract with the highest salary or remuneration level.

3. The Government shall specify premium and support rates referred to in Clause 1 of this Article.

Article 14. Salaries, remuneration, allowances serving as a basis for health insurance premium payment

1. Employees salaried under state regulations shall pay health insurance premiums based on their monthly salaries paid according to their ranks or grades, and position, extra-seniority or trade seniority allowances (if any).

2. Employees salaried or remunerated according to their employers' regulations shall pay social insurance premiums based on their monthly salaries or remunerations indicated in their labor contracts.

3. Persons on monthly pension, working capacity loss allowance or job-loss allowance shall pay health insurance premiums based on their monthly pensions, working capacity loss allowances or job-loss allowances.

4. Other persons shall pay health insurance premiums based on the minimum salary.

5. The maximum remuneration or salary level used for the calculation of health insurance premiums is 20 times the minimum salary.

Article 15. Methods of payment of health insurance premiums

1. Monthly, employers shall pay health insurance premiums for employees and make deductions from the latter's salaries and remuneration for payment of health insurance premiums into the health insurance fund.

2. For agricultural, forestry, fishery and salt-making enterprises which do not pay salaries on a monthly basis, employers shall, once every three or six months, pay health insurance premiums for employees and make health insurance premiums from the latter's salaries or remuneration for paying into the health insurance fund.

3. Monthly, social insurance institutions shall pay health insurance premiums for persons defined in Clauses 3, 4, 5, 6 and 8, Article 12 of this Law, into the health insurance fund.

4. Annually, agencies and organizations managing persons defined in Clauses 7, 9, 10, 11. 12, 13, 14, 17 and 18, Article 12 of this Law shall pay health insurance premiums for these persons into the health insurance fund.

5. Annually, agencies and organizations managing people with meritorious services to the revolution and persons defined at Points a, b and c, Clause 16, Article 12 of this Law shall pay health insurance premiums for their relatives into the health insurance fund.

6. Monthly, scholarship-awarding agencies, organizations and units shall pay health insurance premiums for persons defined in Clause 19, Article 12 of this Law, into the health insurance fund.

7. The Government shall specify methods of payment of health insurance premiums for persons defined in Clauses 20, 21, 22, 23, 24 and 25, Article 12 of this Law.

Chapter III

HEALTH INSURANCE CARDS

Article 16. Health insurance cards

1. A health insurance card is granted to an insured as a basis for enjoying health insurance benefits under this Law.

2. Everyone may be granted only one health insurance card.

3. The time when a health insurance card becomes valid is prescribed as follows:

a) For an insured defined in Clause 3, Article 50 of this Law who pays health insurance premiums continuously from the second time on or an insured defined in Clause 2, Article 51 of this Law, his)her health insurance card will become valid on the date of payment of health insurance premiums.

b) For an insured defined in Clause 3, Article 50 of this Law who pays health insurance premiums for the first time or fails to pay health insurance premiums continuously, his)her health insurance card will become valid 30 days after the date of payment of health insurance premiums; particularly for entitlement to hi-tech services, his)her health insurance card will become valid 180 days after the date of payment of health insurance premiums;

c) With regard to a child under 6 years, his)her health insurance card is valid until he)she reaches full 72 months of age.

4. A health insurance card is invalid in the following cases:

a) Its validity duration expires;

b) It has been modified or erased;

c) The card holder no longer joins health insurance.

5. Health insurance institutions shall provide the model of health insurance card, manage health insurance cards uniformly nationwide, and issue health insurance cards attached with photos of the insured by January 1, 2014 at the latest.

Article 17. Grant of health insurance cards

1. A dossier of request for the grant of a health insurance card comprises:

a) A written registration of health insurance participation by an agency or organization responsible for paying health insurance premiums defined in Clause 1, Article 13 of this Law;

b) A list of the insured, made by the agency or organization responsible for paying health insurance premiums defined in Clause 1, Article 13 of this Law or by the representative of the voluntary insured;

c) A written declaration of the individual or household participating in health insurance.

2. A dossier of request for the grant of a health insurance card to an under-6 child comprises:

a) A copy of the birth proof paper or birth certificate. In case the child has no such a paper or certificate, a written certification by the People's Committee of the commune, ward or township where the child's father, mother or guardian resides is required;

b) A list or written request for the grant of health insurance cards by the People's Committee of the commune, ward or township where the child resides.

3. Within 10 working days after receiving a complete dossier prescribed in Clauses 1 and 2 of this Article, the health insurance institution shall grant a health insurance card to the insured.

Article 18. Re-grant of health insurance cards

1. Health insurance cards may be re-granted to replace the lost ones.

2. A person who loses his)her health insurance card shall file a written request for the re-grant of the card.

3. Within 7 working days after receiving a written request for the re-grant of a card, the health insurance institution shall re-grant the card to the insured. Pending the re-grant of a card, the card holder is still entitled to health insurance benefits.

4. A person who is re-granted a health insurance card shall pay a charge. The Minister of Health

shall set charge rates for the re-grant of health insurance cards.

Article 19. Exchange of health insurance cards

1. A health insurance card may be exchanged in the following cases:

a) It is torn, rumpled or damaged:

b) The registered primary care provider is changed;

c) The information printed in the card is incorrect:

2. A dossier of request for the exchange of a health insurance card comprises:

a) The insured's written request for card exchange;

b) The health insurance card.

3. Within 7 working days after receiving a complete dossier prescribed in Clause 2 of this Article, the health insurance institution shall exchange the card for the insured. Pending the card exchange, the card holder is still entitled to health insurance benefits.

4. A person who has a torn, rumpled or damaged health insurance card exchanged shall pay a charge. The Minister of Finance shall set charge rates for the exchange of health insurance cards.

Article 20. Revocation, seizure of health insurance cards

1. A health insurance card may be revoked in the following cases:

a) There is fraud in its grant;

b) The card holder no longer joins health insurance.

2. A health insurance card shall be seized when a person seeks medical care services with another's card. A person whose health insurance card is seized shall show up in order to receive back the card and pay a fine in accordance with law.

Chapter IV

SCOPE OF HEALTH INSURANCE BENEFITS

Article 21. Scope of health insurance benefits

1. The insured has the following costs covered by the health insurance fund:

a) Costs of medical examination and treatment, function rehabilitation, regular pregnancy check-

ups and birth giving;

b) Costs of medical examination for screening and early diagnosis of some diseases;

c) Costs of transferal from district hospitals to higher-level hospitals, for persons defined in Clauses 9, 13. 14, 17 and 20, Article 12 of this Law in case of emergency or for inpatients who need technical transferal.

2. The Minister of Health shall specify Point b, Clause 1 of this Article: and assume the prime responsibility for. and coordinate with relevant agencies in. promulgating lists of medicines, chemicals, medical supplies and equipment as well as technical services which the insured is entitled to.

Article 22. Levels of health insurance benefits

1. An insured who uses medical care services defined in Articles 26, 27 and 28 of this Law has medical care costs covered by the health insurance fund at the following levels:

a) 100% of the costs, for persons defined in Clauses 2, 9 and 17, Article 12 of this Law;

b) 100% of the costs, for cases in which the cost of a check-up is below the level prescribed by the Government and conducted at a commune hospital;

c) 95% of the costs, for persons defined in Clauses 3, 13 and 14, Article 12 of this Law;

d) 80% of the costs, for other persons.

2. If the insured belongs to different categories, he)she is eligible for the highest benefit for an insured of a category.

3. The Government shall specify levels of medical care costs paid for the cases of transferal to higher-level hospitals, medical examination and treatment at upon request, and use of hi-tech and expensive services and other cases not specified in Clause 1 of this Article.

Article 23. Cases not eligible for health insurance benefits

1. Cases specified in Clause 1 of Article 21 in which costs have been paid by the state budget.

2. Convalescence at sanatoria or convalescence establishments.

3. Medical check-up.

4. Prenatal tests and diagnosis for non-treatment purposes.

5. Use of obstetric supportive techniques, family planning services or abortion services, except for cases of discontinuation of pregnancy due to fetal or maternal diseases.

6. Use of aesthetic services.

7. Treatment of squint, short-sightedness and refractive defects.

8. Use of prostheses including artificial limbs, eyes, teeth, glasses, hearing aids or movement aids in medical examination, treatment and function rehabilitation.

9. Medical examination, treatment and function rehabilitation in case of occupational diseases, labor accidents or disasters.

10. Medical examination and treatment in case of suicide or self-inflicted injuries.

11. Medical examination and treatment for addiction to drugs, alcohol or other habit-forming substances.

12. Medical examination and treatment of physical or mental injuries caused by the injured's law-breaking acts.

13. Medical assessment, forensic examination, forensic mental examination.

14. Participation in clinical trials or scientific research.

Chapter V

ORGANIZATION OF MEDICAL CARE FOR THE INSURED

Article 24. Health insurance-covered medical care providers

1. A health insurance-covered medical care provider is a health establishment which signs a medical care contract with a health insurance institution.

2. Health insurance-covered medical care providers include:

a) Commune health stations and the equivalent, maternity houses;

b) General and specialized clinics;

c) General and specialized hospitals.

Article 25. Contracts on health insurance-covered medical care

1. A health insurance-covered medical care contract is a written agreement between a health insurance institution and a medical establishment on the provision of health insurance-covered medical care services and payment for these services.

2. A health insurance-covered medical care contract has the following principal details:

a) Service beneficiaries and quality requirements;

b) Method of payment of medical care costs;

c) Rights and duties of the contractual parties;

d) Term of the contract;

e) Liabilities for breach of the contract;

f) Conditions for modification, liquidation and termination of the contract.

3. Any agreement on conditions for modification, liquidation and termination of a contract defined at Point e. Clause 2 of this Article must not interrupt medical care for the concerned insured.

4. The Ministry of Health shall provide a model contract on health insurance-covered medical care.

Article 26. Registration for health insurance-covered medical care services

1. The insured may register for health insurance-covered primary care services at medical establishments of commune and district or equivalent levels, except for cases in which they are entitled to register at provincial or central medical establishments under regulations of the Minister of Health.

If an insured works on a mobile basis or moves in a different locality, he)she may seek primary care services at a medical establishment of corresponding technical line in the locality where he)she works or resides under regulations of the Minister of Health.

2. The insured may change the registered primary care provider at the beginning of every quarter.

3. The name of the primary care provider shall be specified in a health insurance card.

Article 27. Treatment-line transfer

For a case falling beyond the professional and technical capacity of a health insurance-covered medical care provider, such provider may transfer the patient to another provider according to regulations on technical transfer.

Article 28. Procedures for health insurance-covered medical care

1. An insured seeking medical care service shall present his)her health insurance card attached with his)her photo; a card without photo must be produced together with a written proof of persona identity of the card holder; for children under 6 years, only health insurance cards need to be produced.

2. In case of emergency, an insured may seek medical care services at any medical establishment and shall produce his)her health insurance card together with papers defined in Clause 1 of this Article before he)she is discharged from hospital.

3. In case of treatment-line transferal, an insured shall obtain a transferal dossier from the concerned medical establishment.

4. In case of re-examination to meet treatment requirements, an insured shall obtain a note of appointment from the concerned medical establishment.

Article 29. Health insurance assessment

1. Health insurance assessment covers:

a) Scrutinizing medical care procedures;

b) Checking and evaluating the order of treatment, prescription, and the use of medicines, chemicals, medical supplies and technical services for patients;

c) Inspecting and determining costs of health insurance-covered medical care.

2. Health insurance assessment must ensure accuracy, publicity and transparency.

3. Health insurance institutions shall conduct health insurance assessment and take responsibility before law for assessment results.

Chapter VI

PAYMENT OF COSTS OF HEALTH INSURANCE-COVERED MEDICAL CARE

Article 30. Methods of payment of costs of insured medical care

1. Costs of health insurance-covered medical care shall be paid by one of the following methods:

a) Rate-based payment, which means payment according to medical care cost norms and the premium rate fixed on each health insurance card as registered with a health insurance-covered medical care provider during a certain period;

b) Service charge-based payment, which means payment on the basis of costs of medicines, chemicals, medical supplies and equipment as well as technical services provided for patients;

c) Disease-based payment, which means payment according to medical care costs pre-determined for each case based on diagnosis.

2. The Government shall specify the application of methods of payment of health insurance-covered medical care costs defined in Clause 1 of this Article.

Article 31. Payment of costs of health insurance-covered medical care

1. Health insurance institutions shall pay costs of health insurance-covered medical care to medical care providers according to health insurance-covered medical care, contracts

2. Health insurance institutions shall pay medical care costs directly to health insurance card holders who use medical care services in the following cases:

a) At a health insurance-covered medical care provider which has no health insurance-covered medical care contract;

b) The medical care is provided not in accordance with Articles 26, 27 and 28 of this Law;

c) In foreign countries;

d) Other special cases as specified by the Minister of Health.

3. The Ministry of Health shall assume the prime responsibility for, and coordinate with the Ministry of Finance in, specifying payment procedures and levels for cases defined in Clause 2 of this Article.

4. Health insurance institutions shall pay medical care costs on the basis of hospital charges according to the Government's regulations.

Article 32. Advancement, payment, settlement of costs of health insurance-covered medical care

1. Health insurance institutions shall quarterly pay in advance to health insurance-covered medical care providers at least 80% of the costs of health insurance-covered medical care of the preceding quarter which have been settled. With regard to a health insurance-covered medical care provider which signs a health insurance-covered medical care contract for the first time, the first advance will at least equal 80% of the medical care cost of one quarter under the signed contract.

2. An health insurance-covered medical care provider and a health insurance institution shall make payment and settlement on a quarterly basis as follows:

a) In the first month of every quarter, the health insurance-covered medical care provider shall send a report on settlement of costs of health insurance-covered medical care in the previous quarter to the health insurance institution;

b) Within 30 days after receiving the settlement report from the health insurance-covered medical care provider, the health insurance institution shall consider and notify the latter of the results of settlement. Within 15 days after notifying the settlement results, the health insurance institution shall complete the settlement with the health insurance-covered medical care provider.

3. Within 40 days after receiving a complete dossier of request for payment of medical care costs from an insured under Points a and b, Clause 2, Article 31 of this Law or 60 days, for cases defined at Points c and d. Clause 2, Article 31 of this Law, the health insurance institution shall pay the medical care costs to that insured.

Chapter VII

HEALTH INSURANCE FUND

Article 33. Sources for setting up the health insurance fund

1. Health insurance premiums prescribed in this Law.

2. Profits from investments by the fund.

3. Financial aid from domestic and foreign organizations.

4. Other lawful revenues.

Article 34. Management of the health insurance fund

1. The health insurance fund shall be managed in a centralized, uniform, public and transparent manner with management decentralization within the system of health insurance institutions.

2. The Government shall specify the management of the health insurance fund; decide on financial sources to ensure health insurance-covered medical care in case the health insurance fund faces a revenue-expenditure imbalance.

Article 35. Use of the health insurance fund

1. The health insurance fund is used for the following purposes:

a) Payment of health insurance-covered medical care costs;

b) Payment of costs of organizational management of health insurance institutions, according to the administrative spending norms applicable to state agencies;

c) Investment for preservation and growth purposes on the principle of safety and efficiency;

d) Setting up of a provision fund for health insurance-covered medical care. The provision must be at least equal to the total costs of health insurance-covered medical care of the two consecutive previous quarters and not exceed the total health insurance-covered medical care costs of the two last consecutive years.

2. In case a province or centrally run city's health insurance premium payments are bigger than the health insurance-covered medical care costs, the locality may use part of the balance for the provision of medical care services.

3. The Government shall detail this Article.

Chapter VIII

RIGHTS AND RESPONSIBILITIES OF PARTIES INVOLVED IN HEALTH INSURANCE

Article 36. Rights of the insured

1. To be granted health insurance cards if paying health insurance premiums.

To select a primary care provider under Clause 1, Article 26 of this Law.

3. To be entitled to medical care.

4. To get medical care costs paid by health insurance institutions.

5. To request health insurance institutions, health insurance-covered medical care providers and relevant agencies to explain and provide information on health insurance.

6. To complain about or denounce violations of the health insurance law.

Article 37. Responsibilities of the insured

1. To pay health insurance premiums fully and on time.

2. To use health insurance cards for proper purposes, not to lend their cards to others.

3. To abide by the provisions of Article 28 of this Law when using medical care services.

4. To comply with regulations and guidance of health insurance institutions and medical establishments when using medical care services.

5. To pay medical care costs to medical establishments, in addition to the costs-covered by the

health insurance fund.

Article 38. Rights of organizations and individuals paying health insurance premiums

1. To request health insurance institutions and competent state agencies to explain and provide information on health insurance regimes.

2. To complain about and denounce violations of the health insurance law.

Article 39. Responsibilities of organizations and individuals paying health insurance premiums

1. To make dossiers of request for the grant of health insurance cards.

2. To pay health insurance premiums fully and on schedule.

3. To hand health insurance cards to the insured.

4. To provide full and accurate information and documents related to the health insurance duties of employers and their representatives to the insured upon request of health insurance institutions, employees or their representatives.

5. To be subject to examination and inspection of the observance of the health insurance law.

Article 40. Rights of health insurance institutions

1. To request employers, representatives of the insured and the insured to provide full and accurate information and documents related to their health insurance duties.

2. To inspect and evaluate the provision of health insurance-covered medical care services; to revoke or seize health insurance cards, for cases defined in Article 20 of this Law.

3. To request health insurance-covered medical care providers to provide patient files and records and medical care documents for health insurance assessment.

4. To refuse payment of costs of health insurance-covered medical care which violate this Law or the health insurance-covered medical care contracts.

5. To request persons who are liable to pay damages to the insured to refund medical care costs which have been paid by health insurance institutions.

6. To propose competent state agencies to revise health insurance policies or law and handle organizations and individuals that violate the health insurance law.

Article 41. Responsibilities of health insurance institutions

1. To popularize and disseminate health insurance policies and law.

2. To provide dossier and procedural guidance, to organize the implementation of health insurance regimes in a quick, simple and convenient manner for the insured.

3. To collect health insurance premiums and grant health insurance cards.

4. To manage and use the health insurance fund.

5. To sign health insurance-covered medical care contracts with medical establishments.

6. To pay health insurance-covered medical care costs.

7. To provide information on health insurance-covered medical care providers and guide the insured in selecting primary care providers.

8. To check the quality of medical care services; to conduct health insurance assessment.

9. To protect interests of the insured: to settle according to their competence petitions, complaints and denunciations on health insurance regimes.

10. To archive files and data on health insurance according to law; to apply information technology to health insurance management and establish a national database on health insurance.

11. To organize statistics and reporting work, provide professional guidance on health insurance; to make reports on the management and use of the health insurance fund on a periodical basis or upon request.

12. To organize professional training and retraining, scientific research and international cooperation on health insurance.

Article 42. Rights of health insurance-covered medical care providers

1. To request health insurance institutions to provide full and accurate information on the insured and the fund allocated to them for the provision of medical care for the insured.

2. To be entitled to fund advance and payment of medical care costs by health insurance institutions in accordance with the signed health insurance-covered medical care contracts.

3. To propose competent state agencies to handle organizations and individuals that violate the health insurance law.

Article 43. Responsibilities of health insurance-covered medical care providers

1. To provide quality medical care services according to simple and convenient procedures for the insured.

2. To provide patient files and records and documents on medical care and the payment of medical care costs at the request of health insurance institutions and competent state agencies.

3. To ensure necessary conditions for health insurance institutions to conduct assessment; to coordinate with health insurance institutions in propagating and explaining health insurance regimes to the insured.

4. To inspect, detect and inform health insurance institutions of the misuse of health insurance cards; to coordinate with health insurance institutions in revoking and seizing health insurance cards in cases defined in Article 20 of this Law.

5. To manage and use money from the health insurance fund strictly according to law.

6. To make statistics and reports on health insurance in accordance with law.

Article 44. Rights of organizations representing employees and those representing employers

1. To request health insurance institutions, care providers and employers to provide full and accurate information on health insurance for employees.

2. To request competent state agencies to handle violations of the health insurance law which affect the lawful rights and interests of employees and employers.

Article 45. Duties of organizations representing employees and those representing employers

1. To popularize and disseminate health insurance policies and law to employees and employers.

2. To participate in the formulation of health insurance policies and law. and propose amendments or supplements thereto.

3. To join in the supervision of enforcement of the health insurance law.

Chapter IX

INSPECTION, COMPLAINT, DENUNCIATION, SETTLEMENT OF DISPUTES AND HANDLING OF VIOLATIONS IN HEALTH INSURANCE

Article 46. Health insurance inspectorate

The health insurance inspectorate shall conduct specialized inspection in the health insurance domain.

Article 47. Complaint, denunciation on health insurance

The lodging and settlement of complaints about administrative decisions and administrative acts related to health insurance; the lodging and settlement of denunciations about violations of the health insurance law comply with the law on complaints and denunciations.

Article 48. Health insurance disputes

1. Health insurance disputes are disputes related to health insurance rights, duties and liabilities of the following:

a) The insured defined in Article 12 of this Law and their representatives;

b) Health insurance premium-paying organizations and individuals defined in Clause 1, Article 13 of this Law;

c) Health insurance institutions;

d) Health insurance-covered medical care providers.

2. Health insurance disputes shall be settled as follows:

a) The disputing parties shall reconcile their dispute;

b) In case of unsuccessful reconciliation, the disputing parties may initiate a lawsuit at a court in accordance with law.

Article 49. Handling of violations

1. Any person who violates the provision of this Law and relevant provisions of law on health insurance shall, depending on the nature and severity of their violations, be disciplined, administratively sanctioned or examined for penal liability; and, if causing damage, they shall pay compensation in accordance with law.

2. Agencies, organizations and employers that are responsible to pay health insurance premiums but fail to pay or fully pay them shall, according to law, fully pay the deficit together with the interest arising in the late payment period at the prime interest rate announced by the Slate Bank; if failing to do so, upon request of persons competent to handle administrative violations, banks or other credit institutions, the state treasury shall make deductions from their deposit accounts to pay the arrears and interest arising on these arrears into the account of the health insurance fund.

Chapter X

IMPLEMENTATION PROVISIONS

Article 50. Transitional provisions

1. Health insurance cards and free medical care cards granted to under-6 children before the effective date of this Law will be valid:

a) Until their expiration, for cards valid through

December 31, 2009;

b) Until December 31, 2009, for cards valid beyond December 31, 2009.

2. The benefits of persons who were granted health insurance cards before this Law takes effect will be effective according to current legal provisions on health insurance until December 31, 2009.

3. Persons defined in Clauses 21, 22, 23, 24 and 25, Article 12 of this Law may, pending the implementation of Points b, c, d and e, Clause 2, Article 51 of this Law, voluntarily participate in health insurance under the Government's regulations.

Article 51. Effect

1. This Law takes effect on July 1, 2009.

2. The roadmap for achieving all-people health insurance is provided for as follows:

a) Persons defined in Clauses 1 thru 20, Article 12 of this Law shall participate in health insurance from the effective date of this Law.

b) Persons defined in Clause 21, Article 12 of this Law shall participate in health insurance from January 1, 2010;

c) Persons defined in Clause 22, Article 12 of this Law shall participate in health insurance from January 1, 2012;

d) Persons defined in Clauses 23 and 24, Article 12 of this Law shall participate in health insurance from January 1, 2014;

e) Persons defined in Clause 25, Article 12 of this Law shall participate in health insurance under the Government's regulations from January 1, 2014 at the latest.

Article 52. Implementation detailing and guidance

The Government shall detail and guide the implementation of the articles and clauses of this Law as assigned, and guide other necessary provisions of this Law to meet state management requirements.

This Law was passed on November 14, 2008. by the 12th National Assembly of the Socialist Republic of Vietnam at its 4th session.

THE NATIONAL ASSEMBLY
CHAIRMAN
(signed)
Nguyen Phu Trong