THE GOVERNMENT	THE SOCIALIST REPUBLIC OF VIETNAM Independence - Freedom - Happiness
No. 146/2018/ND-CP	*Hanoi, October 17, 2018*

DECREE

Detailing, and guiding measures to implement, a number of articles of the Law on Health Insurance[1]

Pursuant to the June 19, 2015 Law on Organization of the Government;

Pursuant to the November 14, 2008 Law on Health Insurance, which was amended and supplemented under the June 13, 2014 Law on Health Insurance;

At the proposal of the Minister of Health;

The Government promulgates the Decree detailing, and guiding measures to implement, a number of articles of the Law on Health Insurance.

Chapter I

THE INSURED

Article 1. The insured with health insurance premiums paid by employees and employers

1. Employees working under indefinite-time labor contracts or labor contracts of a term of at least full 3 months; salaried managers of enterprises, non-public non-business units and cooperatives; and cadres, civil servants and public employees.

2. Part-time officers in communes, wards or townships as defined by law.

Article 2. The insured with health insurance premiums paid by social insurance agencies

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

2. Persons receiving monthly social insurance allowance for occupational accidents or diseases, and rubber workers receiving monthly allowance under the Government's regulations.

[1] *Công Báo Nos 1019-1020 (2/11/2018)*

3. Employees who have retired and currently receive sickness allowance for suffering a disease on the Ministry of Health-issued list of diseases requiring a long treatment period.

4. Commune, ward or township cadres who have retired and currently receive monthly social insurance allowance.

5. Employees taking maternity leave for childbirth or child adoption.

6. Persons on unemployment allowance.

Article 3. The insured with health insurance premiums contributed by the state budget

1. Commune, ward and township cadres who have retired and currently receive monthly allowance from the state budget.

2. Persons who currently receive monthly allowance from the state budget after receiving working capacity loss allowance.

3. Persons with meritorious services to the revolution as defined in the Ordinance on Preferential Treatment of Persons with Meritorious Services to the Revolution.

4. War veterans, including:

a/ War veterans who participated in resistance wars until April 30, 1975, as defined in Clauses 1 thru 4, Article 2 of the Government's Decree No. 150/2006/ND-CP of December 12, 2006, detailing and guiding the implementation of a number of articles of the Ordinance on War Veterans (below referred to as Decree No. 150/2006/ND-CP), which was amended and supplemented under Clause 1, Article 1 of the Government's Decree No. 157/2016/ND-CP of November 24, 2016, amending and supplementing the Government's Decree No. 150/2006/ND-CP of December 12, 2006, detailing and guiding the implementation of a number of articles of the Ordinance on War Veterans (below referred to as Decree No. 157/2016/ND-CP).

b/ War veterans who participated in resistance wars after April 30, 1975, as defined in Clause 5, Article 2 of Decree No. 150/2006/ND-CP and in Clause 1, Article 1 of Decree No. 157/2016/ND-CP, including:

- Army men and defense workers and employees who have received allowances under the Prime Minister's Decision No. 62/2011/QD-TTg of November 9, 2011, on regimes and policies toward persons who participated in the war for national salvation or performed international duties in Cambodia or Laos after April 30, 1975, and have been demobilized or retired (below referred to as Decision No. 62/2011/QD-TTg);

- Officers, professional army men, non-commissioned officers, soldiers, and defense workers and employees who personally participated in the war for national salvation, performed international duties in Cambodia or Laos after April 30, 1975, and moved to work in agencies, organizations or enterprises (not receiving allowances under Decision No. 62/2011/QD-TTg);

- Officers and professional army men who have completed their military service in the period of national construction and defense and have been demobilized or retired or moved to work in agencies, organizations or enterprises;

- Members of militia and self-defense forces who have personally engaged in or served combat after April 30, 1975, and received allowances under Decision No. 62/2011/QD-TTg.

5. Persons participating in resistance wars for national salvation, including:

a/ Persons participating in the anti-US resistance war and receiving allowances under one of the following documents:

- The Prime Minister's Decision No. 290/2005/QD-TTg of November 1, 2005, on regimes and policies toward persons who participated in the anti-US resistance war but have not received any Party and State policies;

- The Prime Minister's Decision No. 188/2007/QD-TTg of December 6, 2007, amending the Prime Minister's Decision No. 290/2005/QD-TTg of November 1, 2005, on regimes and policies toward persons who participated in the anti-US resistance war but have not received any Party and State policies;

- The Prime Minister's Decision No. 142/2008/QD-TTg f October 27, 2008, on implementation of regimes toward army men who participated in the anti-US resistance war and had worked in the army for less than 20 years before being demobilized;

b/ Persons who are not war veterans defined in Clause 4 of this Article but have received allowances under Decision No. 62/2011/QD-TTg;

c/ Officers and soldiers of the People's Public Security force who participated in the anti-US resistance war and had worked in the People's Public Security force for less than 20 years before being demobilized and have received allowances under the Prime Minister's Decision No. 53/2010/QD-TTg of August 20, 2010, on regimes toward officers and soldiers of the People's Public Security force who participated in the

anti-US resistance war and had worked in the People's Public Security force for less than 20 years before being demobilized;

d/ Youth volunteers who have received allowances under the Prime Minister's Decision No. 170/2008/QD-TTg of December 18, 2008, on health insurance regimes and funeral allowances for youth volunteers in the anti-French resistance war period; the Prime Minister's Decision No. 40/2011/QD-TTg of July 27, 2011, on regimes toward youth volunteers who fulfilled their tasks in the resistance war period; and the Government's Decree No. 112/2017/ND-CP of October 6, 2017, on regimes and policies toward youth volunteers in Southern Vietnam who participated in the resistance war during 1965-1975;

dd/ Conscripted laborers who participated in the anti-French or anti-US resistance war for national salvation and performed international duties, and received allowances under the Prime Minister's Decision No. 49/2015/QD-TTg of October 14, 2015, on regimes and policies toward conscripted laborers who participated in the anti-French or anti-US resistance war for national salvation and performed international duties.

6. Incumbent deputies to the National Assembly and People's Councils at all levels.

7. Under-6 children.

8. Persons entitled to monthly social protection allowance under the law on the elderly, people with disabilities or social protection beneficiaries.

9. Poor household members; ethnic minority people living in areas with socio-economic difficulties; persons living in areas with extreme socio-economic difficulties; persons living on island communes or districts, and other persons, specifically as follows:

a/ Members of poor households measured by income, and members of households living in multidimensional poverty and lacking health insurance as defined in the Prime Minister's Decision No. 59/2015/QD-TTg of November 19, 2015, promulgating multidimensional approach-based poverty standards applied for the 2016-2020 period, and other decisions issued by competent agencies amending, supplementing or replacing poverty standards applied in each period;

b/ Ethnic minority people living in areas with socio-economic difficulties as prescribed by the Government or Prime Minister;

c/ Persons living in areas with extreme socio-economic difficulties as prescribed by the Government or Prime Minister;

d/ Persons living in island communes or districts as prescribed by the Government or Prime Minister.

10. Holders of the people's artisan or outstanding artisan title who are members of households with a monthly per-capital income lower than the base salary level prescribed by the Government.

11. Natural fathers, natural mothers, spouses, or children of martyrs; or persons who nurtured martyrs during their childhood.

12. Relatives of persons with meritorious services to the revolution other than those defined in Clause 11 of this Article, including:

a/ Natural fathers, natural mothers, spouses, children aged between over 6 years and under 18 years or children aged over 18 years but still going to school or suffering severe disabilities or extremely severe disabilities, of the following persons: persons participating in revolutionary activities before January 1, 1945; persons participating in revolutionary activities between January 1, 1945, and the August 1945 Uprising date; heroes of the People's Armed Force or labor heroes in the resistance war period; war invalids or diseased soldiers suffering a working capacity decrease of 61% or more; or persons participating in resistance wars and suffering a working capacity decrease of 61% or more due to toxic chemical infection;

b/ Natural children aged 6 years or older of persons participating in resistance wars and suffering deformities due to toxic chemical infection and being unable to wholly or partially support themselves in daily-life activities and currently receiving a monthly allowance.

13. Relatives of officers, professional army men, non-commissioned officers or soldiers in the army, professional officers and non-commissioned officers and technical officers and non-commissioned officers in the People's Public Security force; cadets of the People's Public Security force, non-commissioned officers and persons engaged in cipher work who are salaried like army men, and cipher work cadets who currently receive regimes and policies like cadets in military or public security schools, including:

a/ Their natural fathers or natural mothers; their natural fathers-in-law or natural mothers-in-law; or their or their spouses' nurturers;

b/ Their spouses;

c/ Their natural children or lawfully adopted children aged between over 6 years and under 18 years; or their natural children or lawfully adopted children aged 18 years or older but still going to general education school.

14. Persons who have donated their body organs under the law on donation and transplantation of tissues or body organs.

15. Foreigners studying in Vietnam with scholarships granted by the Vietnamese State.

16. Attendants of persons with meritorious services to the revolution who live together with their families, including:

a/ Attendants of Vietnamese heroic mothers;

b/ Attendants of war invalids or diseased soldiers suffering a working capacity decrease of 81% or more;

c/ Attendants of persons participating in resistance wars and suffering a working capacity decrease of 81% or more due to toxic chemical infection.

17. Persons aged full 80 years or older who currently receive a monthly survivorship allowance under the law on social insurance.

Article 4. The insured with health insurance premiums partially contributed by the state budget

1. Members of households living in near poverty measured based on near-poverty criteria prescribed by the Government or Prime Minister.

2. Members of households living in multidimensional poverty other than those defined at Point a, Clause 9, Article 3 of this Decree.

3. Pupils and students.

4. Members of agriculture, forestry, fishery and salt-making households with an average living standard prescribed by the Government or Prime Minister.

Article 5. The insured paying household-based health insurance premiums

1. Persons named in household books, except those defined in Articles 1, 2, 3, 4 and 6 of this Decree.

2. Persons named in temporary residence registration books, except those defined in Articles 1, 2, 3, 4 and 6 of this Decree and those already covered by health insurance under Clause 1 of this Article.

3. The following persons may participate in household-based health insurance:

a/ Religious dignitaries, officers and clergypersons;

b/ Persons living in social protection establishments, except those defined in Articles 1, 2, 3, 4 and 6 of this Decree and receiving no state budget support for paying health insurance premiums.

Article 6. The insured with health insurance premiums paid by employers

1. Relatives of defense workers and employees serving in the Army, including those defined at Points a, b and c, Clause 13, Article 3 of this Decree.

2. Relatives of public security workers serving in the People's Public Security force, including those defined at Points a, b and c, Clause 13, Article 3 of this Decree.

3. Relatives of persons doing other jobs in cipher organizations, including those defined at Points a, b and c, Clause 13, Article 3 of this Decree.

Chapter II

HEALTH INSURANCE PREMIUM RATES, STATE BUDGET SUPPORT RATES, AND METHODS OF PAYING HEALTH INSURANCE PREMIUMS FOR CERTAIN CATEGORIES OF THE INSURED

Article 7. Rates of and responsibility to pay health insurance premiums

1. The monthly health insurance premium rate is prescribed below:

a/ 4.5% of employees' monthly salary, for those defined in Clause 1, Article 1 of this Decree.

- An employee who has taken a sickness leave for 14 days or more in a month under the law on social insurance is not required to pay health insurance premiums but still enjoying health insurance benefits;

- For an employee being in temporary detention or custody or suspended from work to serve investigation for concluding whether he/she commits violations, the monthly premium rate is 4.5% of 50% of his/her monthly salary. If a competent agency concludes that he/she commits no violation, he/she shall retrospectively pay health insurance premiums based on the salary amount he/she retrospectively receives;

b/ 4.5% of pension or working capacity loss allowance, for those defined in Clause 1, Article 2 of this Decree;

c/ 4.5% of employees' monthly salary before their maternity leave, for those defined in Clause 5, Article 2 of this Decree;

d/ 4.5% of unemployment allowance, for those defined in Clause 6, Article 2 of this Decree;

dd/ 4.5% of base salary, for other persons;

e/ The health insurance premium rates applicable to the persons defined in Article 5 of this Decree are prescribed as follows: The first person shall pay 4.5% of base salary; the second, third and fourth persons, 70%, 60% and 50%, respectively, of the rate applicable to the first person; and the fifth person and others, 40% of the rate applicable to the first person.

The reduction of health insurance premium rates prescribed at this Point is applied when all family members buy health insurance in the same fiscal year.

2. For persons having their health insurance premiums paid by the state budget, the premium rate reduction prescribed at Point e, Clause 1 of this Article shall not be applied.

3. In case a person defined in Clause 1, Article 1 of this Decree additionally signs one or more than one labor contract of an indefinite term or a term of at least full 3 months, he/she shall pay health insurance premiums based on the highest salary offered under one of these labor contracts.

4. In case a person defined in Article 6 of this Decree falls into different categories of the insured as prescribed in Articles 1 thru 4 of this Decree, he/she shall pay health insurance premiums in the following order: the insured with health insurance premiums paid by employees and employers; the insured with health insurance premiums paid by social insurance agencies; the insured with health insurance premiums paid by the state budget; and the insured with health insurance premiums paid by employers.

5. The Ministry of Health shall assume the prime responsibility for, and coordinate with the Ministry of Finance in, proposing the Government to adjust health insurance premium rates to ensure the balance of the health insurance fund and suit the capacity of the state budget and contributions of health insurance premium payers prescribed in the Law on Health Insurance.

Article 8. Levels of state budget support

1. From the effective date of this Decree, levels of state budget support for certain categories of the insured are prescribed below:

a/ 100% of health insurance premiums, for persons of households living in near poverty in poor districts under the Government's

Resolution No. 30a/2008/NQ-CP of December 27, 2008, on the program on rapid and sustainable poverty reduction support, and districts eligible for application of the mechanisms and policies under Resolution No. 30a/2008/NQ-CP;

b/ At least 70% of health insurance premiums, for the persons defined in Clauses 1 and 2, Article 4 of this Decree;

c/ At least 30% of health insurance premiums, for the persons defined in Clauses 3 and 4, Article 4 of this Decree.

2. In case a person falls into different categories eligible for state budget support as prescribed in Clause 1 of this Article, the highest support level shall be applied.

3. Based on their local budget capacity and other lawful funding sources, including 20% of the amount (if any) prescribed at Point a, Clause 3, Article 35 of the Law on Health Insurance, provincial-level People's Committees may propose to provincial-level People's Councils for decision a state budget support rate higher than the minimum rate prescribed in Clause 1 of this Article.

Article 9. Methods of paying health insurance premiums for certain categories of the insured

1. For persons receiving pension, working capacity loss allowance or monthly social insurance allowance from the state budget as prescribed in Article 2, and Clause 2, Article 3, of this Decree: The social insurance agency shall monthly pay health insurance premiums for them from the state budget fund for payment of pension or social insurance allowance.

2. For the persons defined in Clauses 3, 8, 11, 12 and 16, Article 3 of this Decree: The labor, war invalids and social affairs agency shall quarterly transfer money from the funding source for implementation of preferential policies toward persons with meritorious services to the revolution or the funding source for implementation of social protection policies to the health insurance fund. By December 15 every year at the latest, the labor, war invalids and social affairs agency shall complete the payment and transfer of money of that year to the health insurance fund.

3. For the persons defined in Clauses 1, 4, 6, 7, 10, 13, 14 and 17, Article 3, and the persons defined in Clauses 1 and 2, Article 4, of this Decree, who are entitled to 100% of health insurance premiums paid by the state budget: The social insurance agency shall quarterly sum up the number of health insurance cards issued and health insurance premiums wholly or partially paid by the state budget according to Form No. 1 in the Appendix to this Decree, and send it to the finance agency for

transferring money to the health insurance fund under Clause 9 of this Article. The time for calculating payable health insurance premiums is prescribed as follows: For the insured included in a list every year, health insurance premiums shall be calculated from January 1; for the persons additionally included in the list in the year, health insurance premiums shall be calculated from the date stated in the competent state agency's decision approving such list.

4. For the persons defined in Clause 6, Article 3 of this Decree (except those covered by health insurance as other categories of the insured, and persons receiving pension, social insurance allowance or allowance for persons with meritorious services to the revolution): The agencies managing these persons shall pay health insurance premiums for them every 3 months, 6 months or 12 months.

5. For pupils and students defined in Clause 3, Article 4 of this Decree:

a/ Every 3 months, 6 months or 12 months, pupils and students or their parents or guardians shall pay health insurance premiums payable under Clause 2, Article 10 of this Decree to the social insurance agency;

b/ State budget support is prescribed below:

- Pupils and students of education institutions or vocational education institutions of ministries or central agencies are entitled to the central budget support for paying health insurance premiums. Every 3 months, 6 months or 12 months, the provincial-level social insurance agency shall sum up the number of health insurance cards issued, health insurance premiums collected from pupils and students, and state budget support amount according to Form No. 1 in the Appendix to this Decree, and send it to the Vietnam Social Security for summarization and sending to the Ministry of Finance for transferring money to the health insurance fund under Clause 9 of this Article.

- Pupils and students of other education institutions or vocational education institutions are entitled to the budget support, including support from the central budget (if any), of the locality where such institutions are located, regardless of where their permanent residence is registered. Every 3 months, 6 months or 12 months, the social insurance agency shall sum up the number of health insurance cards issued, health insurance premiums collected from pupils and students, and state budget support amount according to Form No. 1 in the Appendix to this Decree, and send it to the finance agency for transferring money to the health insurance fund under Clause 9 of this Article.

6. For the persons with their health insurance premiums paid by the state budget as defined in Clause 4, Article 4 of this Decree:

a/ Every 3 months, 6 months or 12 months, a household's representative shall personally pay health insurance premiums payable under Clause 2, Article 10 of this Decree to the social insurance agency;

b/ Every 3 months, 6 months or 12 months, the social insurance agency shall sum up the number of health insurance cards issued, health insurance premiums collected from the insured, and state budget support amount according to Form No. 1 in the Appendix to this Decree, and send it to the finance agency for transferring money to the health insurance fund under Clause 9 of this Article.

7. For the insured paying household-based health insurance premiums as defined in Article 5 of this Decree: Every 3 months, 6 months or 12 months, a household's representative or member shall pay health insurance premiums under Clause 3, Article 10 of this Decree to the social insurance agency.

8. For the insured defined in Article 6 of this Decree, employers shall monthly pay health insurance premiums for them together with paying health insurance premiums for other employees under regulations, specifically as follows:

a/ For units using state budget funds, health insurance premiums shall be covered by the state budget;

b/ For non-business units, they shall use their funds to pay health insurance premiums under the regulations on the autonomy mechanism of public non-business units;

c/ For enterprises, they shall use their funds to pay health insurance premiums.

9. Pursuant to the competent authority's regulations on budget management decentralization and based on the social insurance agency's list summarizing the number of the insured and state budget funds used for whole or partial payment of health insurance premiums, the finance agency shall transfer money to the health insurance fund on a quarterly basis. By December 15 every year at the latest, it shall complete the transfer of money of the year to the health insurance fund.

10. For the persons defined in Clause 15, Article 3 of this Decree, scholarship-awarding agencies, units or organizations shall quarterly pay health insurance premiums under regulations to the health insurance fund.

Article 10. Determination of health insurance premiums wholly or partially paid by the state budget for certain categories of the insured when the State adjusts health insurance premium rates and the base salary

1. For the insured defined in Article 4 of this Decree with health insurance premiums wholly paid by the state budget:

a/ The monthly health insurance premium wholly or partially paid by the state budget shall be calculated by multiplying the health insurance premium rate by the base salary. When the State adjusts the health insurance premium rate and base salary, such monthly premium shall be adjusted from the date of application of the new health insurance premium rate and base salary;

b/ The health insurance premium for an under-6 child shall be calculated from his/her birthdate to the date he/she reaches full 72 months of age. For a Vietnamese child born overseas, the health insurance premium shall be calculated from the date he/she returns to reside in Vietnam as prescribed by law.

2. For the insured with health insurance premiums partially paid by the state budget as defined in Clauses 3 and 4, Article 4 of this Decree:

a/ Monthly health insurance premiums payable by the insured and partially paid by the state budget shall be determined by multiplying the health insurance premium rate by the base salary at the time of premium payment;

b/ When the State adjusts the health insurance premium rate and base salary, the insured and state budget are neither required to pay additional premiums nor entitled to refund of the difference arising from the adjustment for the remaining period during which the insured have paid health insurance premiums.

3. For the insured paying household-based health insurance premiums as defined in Article 5 of this Decree:

a/ Their monthly health insurance premiums shall be determined by multiplying the health insurance premium rate by the base salary at the time of premium payment;

b/ When the State adjusts the health insurance premium rate and base salary, the insured are neither required to pay additional premiums or nor entitled to refund of the difference arising from the adjustment for the remaining period during which they have paid health insurance premiums.

4. For the insured who start to pay health insurance premiums on a date within a month, their health insurance premiums shall be determined by month counting from such date.

Chapter III

HEALTH INSURANCE CARDS

Article 11. Making of a list of certain categories of the insured eligible for grant of health insurance cards

1. Employers shall make a list of the insured defined in Article 1 of this Decree.

2. Education institutions and vocational education institutions shall make a list of the insured under their management as prescribed in Clause 15, Article 3, and Clause 3, Article 4, of this Decree.

3. Units of the Ministry of National Defense and Ministry of Public Security shall make a list of the insured under their management as prescribed in Clause 1, Article 1, Clause 13, Article 3, and Clause 3, Article 6, of this Decree and as instructed by the Ministry of National Defense or Ministry of Public Security.

4. For a person who has donated his/her body organ under law, the social insurance agency shall issue a health insurance card based on the hospital discharge paper issued by the health establishment where he/she donated the body organ.

5. Commune-level People's Committees shall make a list of the insured defined in Article 2; Clauses 1 thru 12, and 16 and 17, Article 3; Clauses 1, 2 and 4, Article 4; and Article 5, of this Decree.

6. Lists of the insured shall be made according to Forms No. 2 and No. 3 in the Appendix to this Decree.

Article 12. Health insurance cards

A health insurance card shall be issued by the social insurance agency to an insured and must contain the following information:

1. The insured's full name, gender, birthdate, and address of place of residence or workplace.

2. Level of health insurance benefit prescribed in Article 14 of this Decree.

3. Effective date of the card.

4. Registered place of health insurance-covered initial medical care.

5. Period of 5 or more consecutive years of health insurance premium payment, for the insured having to jointly pay medical care costs. The consecutive period of health insurance premium payment includes the successive periods written in the card with intervals (if any) not exceeding 3 months each.

For a person appointed by his/her agency to work or study or accompany his/her spouse in an overseas Vietnamese mission or his/her accompanying natural child or lawfully adopted child younger than 18 years old, the period of overseas stay shall be considered a period of health insurance premium payment.

For a guest worker, the period during which he/she paid health insurance premiums before he/she went to work abroad shall be considered a period of health insurance premium payment if he/she resumes paying health insurance premiums within 30 days from the date of returning to the country.

For an employee awaiting the completion of procedures for receiving unemployment allowance under the Law on Employment, the previous period of health insurance premium payment shall be considered a period of health insurance premium payment.

For the persons defined at Point a, Clause 3, Article 12 of the Law on Health Insurance who retired, were demobilized, changed or quitted their jobs, if they have not paid health insurance premiums for the period of study or working in the People's Army or People's Public Security force or a cipher organization, such period shall be considered a successive period of health insurance premium payment.

6. A photo of the insured (except under-6 children), if the insured has neither photo-stuck personal identification paper issued by a competent agency or organization nor written certification given by the commune-level Public Security agency or another paper certified by the education institution or vocational education institution managing the insured or another lawful personal identification paper.

Article 13. Validity period of health insurance cards

1. For the persons defined in Clause 6, Article 2, their health insurance cards will be valid from the first month when they receive unemployment allowance as written in the competent state agency's decision permitting them to receive unemployment allowance.

2. For the persons defined in Clause 7, Article 3 of this Decree:

a/ For a child born before September 30, his/her health insurance card will be valid through September 30 of the year when he/she reaches full 72 months of age;

b/ For a child born after September 30, his/her health insurance card will be valid through the last day of the month when he/she reaches full 72 months old.

3. For the persons defined in Clause 8, Article 3 of this Decree, their health insurance cards will be valid from the date they are entitled to receive social allowance stated in the decision issued by the district-level People's Committee.

4. For the persons defined in Clause 9, Article 3, and those defined in Clause 1, Article 4, of this Decree with health insurance premiums wholly paid by the state budget, their health insurance cards will be valid from the date written in the competent state agency's decision approving the list of eligible persons.

5. For the persons defined in Clause 10, Article 3 of this Decree, their health insurance cards will be valid from the date written in the competent state agency's decision approving the list of eligible persons.

6. For the persons defined in Clause 14, Article 3 of this Decree, their health insurance cards will be valid immediately after they donate their body organs.

7. For the persons defined in Clause 3, Article 4 of this Decree:

a/ Health insurance cards shall be issued on an annual basis to pupils of general education institutions, specifically as follows:

- For grade-1 pupils, their health insurance cards will be valid from October 1 of the first year of the primary education level;

- For grade-12 pupils, their health insurance cards will be valid through September 30 of the year of the twelfth grade.

b/ Health insurance cards shall be issued on an annual basis to students of higher education institutions and vocational education institutions, specifically as follows:

- For students of the first year of a training program, their health insurance cards will be valid from the first date of their school attendance, unless their grade-12 pupil cards remain valid;

- For students of the last year of a training program, their health insurance cards will be valid through the last day of the month when the program finishes.

8. For other persons, their health insurance cards will be valid from the date they start to pay health insurance premiums. For the persons defined in Clause 4, Article 4, and Articles 5 and 6, of this Decree who participate in health insurance for the first time or pay health insurance premiums inconsecutively for 3 months or more in a fiscal year, their

health insurance cards may be used for 12 months from their effective date as prescribed at Point c, Clause 3, Article 16 of the Law on Health Insurance.

9. The validity period of health insurance cards prescribed in this Article corresponds to the paid health insurance premium under regulations, except cards of under-6 children.

Chapter IV

HEALTH INSURANCE BENEFIT LEVELS AND PROCEDURES FOR HEALTH INSURANCE-COVERED MEDICAL CARE

Article 14. Health insurance benefit levels for the persons defined in Clauses 1 and 7, Article 22 of the Law on Health Insurance

1. An insured who uses medical care services under Articles 26, 27 and 28 of the Law on Health Insurance or Clauses 4 and 5, Article 22 of the Law Amending and Supplementing a Number of Articles of the Law on Health Insurance will have medical care costs covered by the health insurance fund within the scope of benefits at the following levels:

a/ 100% of the costs, for the persons defined in Clauses 3, 4, 8, 9, 11 and 17, Article 3 of this Decree;

b/ 100% of the costs without applying the restrictions on payment rates for drugs, chemicals, medical supplies and technical services as prescribed by the Minister of Health to:

- Revolutionary activists before January 1, 1945;

- Revolutionary activists between January 1, 1945, and the August 1945 Uprising date;

- Vietnamese heroic mothers;

- War invalids, persons entitled to policies like war invalids, grade-B war invalids, and diseased soldiers suffering a working capacity decrease of 81% or more;

- War invalids, persons entitled to policies like war invalids, grade-B war invalids, and diseased soldiers receiving treatment of recurring injuries or diseases;

- Persons participating in resistance wars and infected with agent orange who suffer a working capacity decrease of 81% or more;

- Under-6 children.

c/ 100% of the costs, if they receive medical care at commune-level health establishments;

d/ 100% of the costs, in case the cost per medical care is lower than 15% of the base salary level;

dd/ 100% of the costs, when patients have paid health insurance premiums for at least 5 consecutive years and jointly paid medical care costs in the year higher than the 6 months' base salary, unless they receive medical care at a health establishment of an improper level;

d/ 95% of the costs, for the persons defined in Clause 1, Article 2, Clause 12, Article 3, and Clauses 1 and 2, Article 4, of this Decree;

dd/ 80% of the costs, for other persons;

h/ The health insurance fund shall cover medical care costs within the scope and at the levels specified at Points a, b, dd, e and g, Clause 1 of this Article for patients who receive diagnosis and treatment prescriptions from superior-level health establishments and are transferred to commune-level health establishments for management, monitoring and drug dispensing under the Minister of Health's regulations.

2. For a person who falls into different categories of the insured, the highest level of benefits prescribed in Clause 1 of this Article shall be applied to him/her.

3. In case a health insurance card holder goes to a health establishment of an improper level for medical care, then he/she is transferred by this establishment to another health establishment of a proper level, the health insurance fund shall pay medical care costs at the level prescribed in Clause 3, Article 22 of the Law on Health Insurance, except the following cases: emergency aid; while receiving inpatient treatment at a health establishment, he/she is detected to suffer another disease which falls beyond the professional capacity of such establishment; or his/her disease develops beyond the establishment's professional capacity.

4. An insured who registers to take initial medical care at an adjacent commune-level health station of an adjacent province will have 100% of medical care costs covered by the health insurance fund within the scope and at the levels specified in Clause 1 of this Article when he/she takes medical care at such health station.

5. In case of change of the level of health insurance benefit, the new level of benefit shall be applied from the date the new health insurance card becomes valid.

Article 15. Procedures for health insurance-covered medical care

1. To receive medical care, an insured shall produce his/her photo-stuck health insurance card; if the card has no photo, he/she shall also produce a photo-stuck personal identification paper issued by a competent agency or organization or a written certification given by the commune-level Public Security agency or another paper certified by the education institution that manages the insured; or other lawful personal identification papers.

2. For an under-6 child taking medical care, only his/her health insurance card is required. If the child has not been granted a health insurance card, a copy of his/her birth certificate is required; if the child needs immediate treatment after the birth when no birth certificate is issued yet, the head of the health establishment and the child's parent or guardian shall sign his/her medical records for certification as the basis for payment of medical care costs under Clause 1, Article 27 of this Decree and take responsibility for such certification.

3. Pending the re-grant or renewal of his/her health insurance card, to receive medical care, an insured shall produce the paper of appointment for re-grant or renewal of the card issued by the social insurance agency or its authorized organization or person according to Form No. 4 in the Appendix to this Decree, and his/her personal identification paper.

4. To receive medical care, an insured who has donated his/her body organ shall produce the papers mentioned in Clause 1 or 3 of this Article. If he/she needs immediate treatment after the donation, the head of the health establishment where his/her body organ has been taken and the patient or his/her relative shall sign his/her medical records for certification as the basis for payment of medical care costs under Clause 2, Article 27 of this Decree and take responsibility for such certification.

5. In case of treatment-line transfer, an insured shall produce a treatment-line transfer dossier issued by the health establishment, and a treatment-line transfer paper made according to Form No. 6 in the Appendix to this Decree. If this paper is valid through December 31 but the treatment has not yet finished by that date, it may be used till the end of the treatment.

To take re-examination according to treatment requirements, the insured shall produce a paper of appointment of the re-examination date issued by the health establishment according to Form No. 5 in the Appendix to this Decree.

6. In case of emergency aid, an insured may take medical care at any health establishment and shall produce the papers specified in Clause 1, 2 or 3 of this Article before being discharged therefrom. Upon

the end of the emergency period, if the insured is transferred to another department or division within that health establishment for further supervision and treatment or transferred to another health establishment, he/she shall be considered as receiving medical care at a health establishment of a proper level.

A health establishment that has no health insurance-covered medical care contract shall provide its discharged patients with valid papers and documents related to medical care costs for them to directly carry out payment procedures with the social insurance agency under Articles 28, 29 and 30 of this Decree.

7. An insured who is on a business trip, does a mobile job, attends a training course or temporarily resides in a new place may take initial medical care at a health establishment of the same or equivalent level with the registered health establishment for initial medical care written in his/her health insurance card and shall produce the papers specified in Clause 1, 2 or 3 of this Article and one of the following papers (the original or a copy): official letter sending him/her on a business trip; decision sending him/her to a training course; pupil or student card; temporary residence registration paper; or school transfer paper.

8. A health establishment or the social insurance agency may not impose any health insurance-covered medical care procedures other than those specified in this Article. If it needs copies of health insurance cards or medical care-related papers of patients to serve management work, it shall photocopy them by itself and may not request patients to do so or to pay photocopying costs.

Chapter V

HEALTH INSURANCE-COVERED MEDICAL CARE CONTRACTS

Article 16. Dossiers for signing health insurance-covered medical care contracts

1. For the first-time signing of a medical care contract, a dossier must comprise:

a/ A written request for signing a contract, made by the health establishment;

b/ A copy of the health establishment’s medical care license granted by a competent state agency;

c/ A copy of the hospital ranking decision (if any) issued by a competent authority, bearing the seal of the health establishment, or of the decision determining the professional-technical line of the health

establishment issued by a competent authority, for non-public health establishments;

d/ A list of medical technical services and list of drugs, chemicals and medical supplies approved by a competent authority (a hard copy or soft copy).

2. In case a health establishment is approved by a competent agency to add a function or tasks and expand the scope of professional operations or is promoted to a higher rank, it shall notify such to the social insurance agency for addition to the health insurance-covered medical care contract. Within 10 working days after receiving the written approval, the social insurance agency shall complete the signing of an additional contract annex or a new contract.

Article 17. Contents of, and conditions for health establishments to sign, health insurance-covered medical care contracts

1. A health insurance-covered medical care contract shall be made according to Form No. 7 in the Appendix to this Decree. Depending on the conditions of a health establishment, the social insurance agency and this establishment shall reach agreement on adding certain contents to the contract provided that such contents do not contravene the law on health insurance.

2. Conditions for a health establishment to sign a health insurance-covered medical care contract:

a/ Fully satisfying the conditions for providing medical care services under the regulations on medical care and possessing a licensed to provide medical care services granted by a competent agency;

b/ Supplying drugs, chemicals and medical supplies within the scope of its professional operations.

Article 18. Signing of health insurance-covered medical care contracts

1. For the first-time signing of a medical care contract:

a/ A health establishment shall send 1 dossier set prescribed in Article 16 of this Decree to the social insurance agency;

b/ Within 30 days after receiving a complete and valid dossier (as shown in the incoming mail's stamp), the social insurance agency shall check it and sign a health insurance-covered medical care contract. If refusing to sign a contract, this agency shall issue a written reply stating the reason.

2. Validity period of a health insurance-covered medical care contract

a/ The validity period of a contract is from January 1 through December 31 of a year and must not exceed 36 months;

b/ The validity period of a contract signed for the first time shall be counted from the date of its signing through December 31 of the year when the contract expires and must not exceed 36 months;

c/ In case of signing annual health insurance-covered medical care contracts, the health establishment and social insurance agency shall complete the signing of a contract for the subsequent year before December 31 of the current year.

At least 10 days before their contract expires, if the health establishment and social insurance agency agree to extend the contract by signing a contract annex, such contract annex is legally valid, unless otherwise agreed upon.

3. For medical care costs for the insured who take medical care before January 1 but are discharged from hospital on or after January 1:

a/ In case a health establishment signs a new health insurance-covered medical care contract, such medical care costs shall be included in medical care costs of the subsequent year;

b/ In case a health establishment does not sign a new health insurance-covered medical care contract, such medical care costs shall be included in medical care costs of the current year.

4. A health insurance-covered medical care contract must state the method of payment of health insurance-covered medical care costs which is suitable to the conditions of the health establishment.

5. The parties shall guarantee the interests of patients possessing health insurance cards under the law on health insurance and ensure non-interruption of the provision of medical care services for such patients.

Article 19. Contracts on health insurance-covered medical care at commune-level health stations, public maternity hospitals, regional general clinics, or health establishments of agencies, units or schools

1. For commune-level health stations, public maternity hospitals and regional general clinics:

a/ The social insurance agency shall sign a contract with a district-level health center or hospital or another health establishment approved by the provincial-level Department of Health to provide medical care at commune-level health stations, public maternity hospitals and regional general clinics for the insured;

b/ The health establishment signing a health insurance-covered medical care contract prescribed at Point a of this Clause shall supply

drugs, chemicals and medical supplies to commune-level health stations, public maternity hospitals and regional general clinics and pay expenses for hospital bed use (if any) and medical technical services provided within its scope of professional operations and, at the same time, monitor, supervise and sum up the expenses for carrying out payment procedures with the social insurance agency.

2. For health establishments of agencies, units and schools (except agencies, units and schools having medical care costs included in initial health care expenses under Clause 1, Article 34 of this Decree), the social insurance agency shall sign health insurance-covered medical care contracts directly with such agencies, units and schools.

Article 20. Rights and responsibilities of social insurance agencies in performing health insurance-covered medical care contracts

1. Rights of social insurance agencies:

a/ To implement Article 40 of the Law on Health Insurance;

b/ To request health establishments to transfer e-data serving assessment work and payment of health insurance-covered medical care costs under the Minister of Health's regulations.

2. Responsibilities of social insurance agencies:

a/ To implement Article 41 of the Law on Health Insurance;

b/ Within the first 10 days of the first month of the contract performance period and at the beginning of every quarter, to provide health establishments with a hardcopy or softcopy of the list of health insurance card holders who have registered to receive initial medical care bearing the signature and seal of a competent person, made according to Form No. 8 in the Appendix to this Decree;

c/ To comply with the Minister of Health's regulations on medical care and management of medical records;

d/ To coordinate with health establishments in receiving and checking health insurance-covered medical care procedures; to revoke or temporarily seize health insurance cards and handle violations according to their competence; to assist health establishments in applying information technology to assessment work and payment of health insurance-covered medical care costs;

dd/ To protect the interests of the insured; to settle petitions, complaints and denunciations about health insurance regimes according to their competence;

e/ To improve the assessment system and maintain the receipt of and response to health insurance-covered medical care e-data and

assessment results for health establishments under the Minister of Health's regulations.

Article 21. Rights and responsibilities of health establishments in performing health insurance-covered medical care contracts

1. Rights of health establishments: To comply with Article 42 of the Law on Health Insurance.

2. Responsibilities of health establishments:

a/ To comply with Article 43 of the Law on Health Insurance;

b/ To supply drugs, chemicals, medical supplies and technical services according to their technical professional line under the Minister of Health's regulations;

c/ To send e-data serving management of health insurance-covered medical care right after completing a medical examination or an outpatient treatment period or an inpatient treatment period for a patient under the Minister of Health's regulations;

d/ To send e-data on health insurance-covered medical care costs requested for payment within 7 working days from the date of completing medical care for a patient under the Minister of Health's regulations.

Article 22. Modification of contracts

1. In the course of performing a health insurance-covered medical care contract, if either party wishes to modify the contract, it shall notify in writing the other party of the contents that need to be modified at least 30 days in advance.

2. In case both parties can reach agreement on the modification of a health insurance-covered medical care contract, such modification shall be made by signing a contract annex or a new contract.

3. In case both parties cannot reach agreement on the modification of a contract, they shall continue to perform the old contract.

Article 23. Cases of termination of contracts

1. A health establishment terminates operation, is dissolved, goes bankrupt, or has its operation license revoked.

2. Both parties agree to terminate a health insurance-covered medical care contract in accordance with law.

3. In the course of performing a health insurance-covered medical care contract, if the social insurance agency or an agency, unit, organization or individual detects that a health establishment breaches

the contract, it/he/she shall notify the breach to the provincial-level Department of Health, for health establishments managed by provincial-level Departments of Health, or to the Ministry of Health, for those managed by the Ministry of Health, or to the concerned ministry's or sector's health management agency, for health establishments managed by ministries or sectors (below referred to as managing agency).

Within 5 working days after receiving the notice, the managing agency shall send a written request to the health establishment for the latter to explain in writing the breach.

After receiving the request, the health establishment shall send a written explanation enclosed with supporting documents (if any) to the managing agency.

After receiving the written explanation, the managing agency shall coordinate with the same-level social insurance agency in conducting verification and making a conclusion on the breach. Such conclusion must state whether the health establishment commits the breach, and remedies (if any).

4. In the course of performing a health insurance-covered medical care contract, if an agency, unit, organization or individual detects that the social insurance agency breaches the contract, it/he/she shall notify the breach to the managing agency.

Within 5 working days after receiving the notice, the managing agency shall send a written request to the social insurance agency for the latter to explain in writing the breach.

After receiving the request, the social insurance agency shall send a written explanation enclosed with supporting documents (if any) to the managing agency.

After receiving the written explanation, the managing agency shall coordinate with the same-level social insurance agency (or with the superior social insurance agency if the same-level social insurance agency is involved in the breach) in conducting verification and making a conclusion on the breach. Such conclusion must state whether the social insurance agency commits the breach, and remedies (if any).

Chapter VI

PAYMENT OF MEDICAL CARE COSTS BETWEEN SOCIAL INSURANCE AGENCIES AND HEALTH ESTABLISHMENTS

Article 24. Fee-for-service payment

1. Fee-for-service payment means a method of payment of medical care costs based on medical care service fees set by competent authorities and costs of medicines, chemicals, medical supplies, blood and blood preparations not yet included in fees for services used for patients at health establishments.

2. The fee-for- service payment method shall be applied to pay health insurance-covered medical care costs, except costs of medical services paid by other methods.

3. Payment principles:

a/ Health insurance-covered medical care service fees are uniformly applicable to hospitals of the same rank nationwide;

b/ Costs of medicines, chemicals and medical supplies not yet included in medical care service fees shall be paid at their purchase prices in accordance with the bidding law;

c/ Costs of blood and blood preparations shall be paid under the guidance of the Minister of Health.

4. The total amount of health insurance-covered medical care costs to be annually paid to a health establishment shall be calculated according to the following formula:

$$T = [T_{n-1} \times k]_{\text{medicines, chemicals}} + [T_{n-1} \times k]_{\text{medical supplies}} + [T_{n-1}]_{\text{blood, blood preparations}} + [T_{n-1}]_{\text{medical care services}} + C_n$$

In which:

a/ T means the total amount of health insurance-covered medical care costs to be paid to the health establishment, which is the total of inpatient medical care costs and outpatient medical care costs;

b/ T_{n-1} means health insurance-covered medical care costs of the preceding year at the health establishment the finalization of which has been appraised by the social insurance agency;

c/ k means the adjusting coefficient for the fluctuation of prices of medicines, chemicals and medical supplies at the health establishment each item of which is not yet included in service fees, excluding costs already included in C_n.

d/ C_n means a cost amount increased or reduced in the year at the health establishment for the following reasons: application of new technical services; addition of new medicines, chemicals or medical supplies; application of new medical care service fees; new prices of blood and blood preparations; adjustment of the hospital rank; change of

health insurance card holders; change in the scope of operation of the health establishment under a competent authority's decision (if any); change in the morbidity pattern; and number of patients using medical care services. This cost amount shall be accounted as an actual cost for the calculation of total amount of health insurance-covered medical care costs to be paid to the health establishment.

5. The health insurance fund shall pay medical care costs according to appraised annual cost finalization reports of the health establishment which must not exceed the total amount of health insurance-covered medical care costs determined under Clause 4 of this Article.

6. Annually, based on the price index of each medicine, chemical or medical supplies item announced by the General Statistics Office of Vietnam, the Ministry of Health shall announce coefficient k after reaching agreement with the Ministry of Finance.

Article 25. Capitation payment

1. Capitation payment is applicable to health establishments providing health insurance-covered outpatient medical care services.

2. Capitation payment covers costs of insured services to be provided to and costs to be paid for health insurance card holders having registered for initial medical care at health establishments and those having registered for initial medical care at other health establishments and using medical care services at such establishments.

3. Diseases, groups of diseases, medical care services and service costs not covered by the capitation payment shall be prescribed by the Minister of Health.

4. The capitation fund to be annually assigned to a health establishment providing health insurance-covered medical care services must be within the capitation fund assigned to the province and the national capitation fund.

5. Handling of difference of the capitation fund assigned to a health establishment

a/ In case the capitation fund has a surplus balance in a year (the assigned capitation fund is larger than medical care costs), the health establishment shall account such surplus balance as a non-business revenue for use as a basis for determining the capitation fund for the next year. In case the health establishment is assigned to enter into contracts to provide initial medical care at facilities including commune health stations, it shall transfer part of the surplus balance to such health stations;

b/ In case the capitation fund has a deficit in a year (the assigned capitation fund is smaller than medical care costs), the health establishment shall offset the deficit with its own revenues under regulations.

6. In case total costs to be covered by the national capitation fund in the year of assignment are larger than the total national capitation fund already assigned, the Vietnam Social Security shall sum up and report the deficit to its Governing Body for approval and reporting to the Ministry of Finance and Ministry of Health. The Ministry of Health shall assume the prime responsibility for, and coordinate with the Ministry of Finance in, considering, summing up and reporting the fund deficit to the Prime Minister for decision.

7. The Minister of Health shall prescribe the scope, schedule and techniques of determining the capitation fund and capitation payment mechanism mentioned in this Article.

Article 26. Payment of patient transportation costs

1. The insured specified in Clauses 3, 4, 7, 8, 9 and 11, Article 3 of this Decree who are in emergency cases or under inpatient treatment shall be subject to technical treatment-line transfer from district-level health establishments to higher-level health establishments, including:

a/ From the district level to the provincial level;

b/ From the district level to the central level.

2. Levels of transportation costs to be paid:

a/ In case of using a vehicle of a health establishment which orders treatment-line transfer, the health insurance fund shall pay the two-way transportation cost to such health establishment at the level of 0.2 liter of petrol per km calculated according to the actual distance between the two health establishments and petrol price at the time of patient transfer. If more than one patient are transported on the same vehicle, the payment level is the same as that for the transportation of one patient. The patient-receiving health establishment shall give a certification signature on the vehicle scheduling slip of the patient-transferring health establishment. In case of patient transportation beyond the working hours, the signature of the patient-receiving doctor is required;

b/ In case of not using a vehicle of a health establishment, the health insurance fund shall pay the one-way transport cost (from the patient-transferring establishment to the patient-receiving establishment) for the patient at the level of 0.2 liter of petrol per km calculated according to the actual distance between the two health establishments and petrol price at the time of patient transfer. The health establishment which

orders treatment-line transfer shall pay this cost directly to the patient before the transfer, then get it paid by the social insurance agency.

Article 27. Payment of medical care costs in some cases

1. Payment of medical care costs for under-6 children who have no health insurance cards: A health establishment shall sum up a list of under-6 children and health insurance-covered medical care costs of services within the scope and at the level of benefits, then send it to the social insurance agency for payment under regulations.

The social insurance agency shall base itself on the health establishment's list of children having received medical care to check and verify the grant of health insurance cards to these children, and pay medical care costs. For children having no health insurance cards, it shall grant health insurance cards to them under regulations.

2. Payment of medical care costs for persons who have donated their body organs and need medical treatment right after the donation but have no health insurance cards: After taking body organs, a health establishment shall sum up a list of body organ donors and medical care costs within the scope and at the level of benefits, then send it to the social insurance agency for payment under regulations.

The social insurance agency shall base itself on the health establishment's list of body organ donors having received medical care after the donation and medical care costs to pay medical care costs and grant health insurance cards to these persons.

3. Payment of medical care costs for a patient who has paid health insurance premiums for at least 5 consecutive years and has jointly paid medical care costs in the year with an amount larger than 6 months' base salary as specified at Point dd, Clause 1, Article 14 of this Decree:

a/ In case the patient has jointly paid medical care costs for one or more than one time of medical care at the same health establishment which exceed 6 months' base salary, the health establishment may not collect the excessive amount. The health establishment shall issue receipts for the amount equal to 6 months' base salary for use as a basis for the patient to request the social insurance agency to certify that he/she is exempt from jointly paying medical care costs for the year;

b/ In case the patient has jointly paid medical care costs at different health establishments or at the same health establishment with an accumulated amount in a fiscal year exceeding 6 months' base salary, he/she may bring payment receipts to the social insurance agency that has granted his/her health insurance card to get the excessive amount

paid and receive a written certification of exemption from joint payment of medical care costs for the year;

c/ In case the patient has jointly paid medical care costs with an amount exceeding 6 months' base salary calculated from January 1 of a year, the health insurance fund shall pay 100% of medical care costs within the scope of benefits arising from the date by which he/she has paid health insurance premiums for full 5 consecutive years through December 31 of that year.

4. In case of treatment-line transfer for a patient requiring an accompanying medical worker and involving the use of medicines and medical supplies to meet professional requirements during the transportation, costs of medicines and medical supplies shall be included in treatment costs of the health establishment which orders the treatment-line transfer.

5. In case a patient's health becomes stable after the inpatient treatment but he/she still needs to take medicines after being discharged from a health establishment as prescribed by such health establishment under regulations of the Minister of Health, the health insurance fund shall pay medicine costs within the scope and at the level of benefits as prescribed. The health establishment shall include these medicine costs in the patient's medical care costs before he/she is discharged from the health establishment.

6. In case a health establishment cannot perform para-clinical tests, diagnostic imaging or functional probing, and has to transfer a patient or swab sample to another health establishment providing insurance-covered health care services or to an establishment approved by a competent authority to be qualified for providing such services, the health insurance fund shall pay the service fee within the scope and at the level of benefits as prescribed to the health establishment from which the patient or swab sample is transferred. The health establishment transferring the patient or swab sample shall pay the service fee to the health establishment or unit performing the service, then include it in medical care costs of the patient for getting it paid by the social insurance agency.

The Minister of Health shall prescribe principles and promulgate the list of para-clinical tests, diagnostic imaging and functional probing permitted to be transferred to health establishments or service-performing units.

7. Payment of medical care costs for technical services performed by employees of a health establishment transferring techniques under a program on treatment-line direction or a scheme on raising of

professional capability of the health establishment being the transferee or a technique transfer contract under regulations of the Minister of Health:

a/ In case technical services have been approved by a competent authority for the health establishment being the transferee, the health insurance fund shall pay costs thereof at approved service fee rates;

b/ In case technical services have not yet been approved by a competent authority for the health establishment being the transferee, this establishment shall notify such in writing to the social insurance agency for entering into health insurance-covered medical care contracts for technical services performed under a program, scheme or contract to serve as a basis for cost payment, and at the same time submit to a competent authority for approval the list of techniques for use as a basis for implementation when receiving such medical techniques;

c/ The health insurance fund shall pay costs of medicines, chemicals and medical supplies at purchase prices paid by the health establishment under the bidding law.

8. Payment of medical care costs in case a health establishment applies a new technique or method approved by a competent authority while regulations on medical service fee rates are not yet issued, the health establishment shall formulate and submit to a competent authority for approval technical service fee rates for use as a basis for payment. The health establishment shall notify in writing the social insurance agency of the application of the new technique or method.

9. In case a health insurance card holder is under inpatient treatment at a health establishment but his/her health insurance card has expired, he/she may get medical care costs paid by the health insurance fund within the scope and at the level of benefits until he/she is discharged but for no more than 15 days from the date of expiration of the card. The health establishment shall notify the expiration of the health insurance card to the patient and social insurance agency that has entered into the health insurance-covered medical care contract with the establishment so that the patient can continue paying health insurance premiums and the social insurance agency can grant or extend the health insurance card to the patient during the period of inpatient treatment.

10. Payment of medical care costs to a health establishment that provides health insurance-covered medical care services on weekends and public holidays:

a/ A health insurance card holder coming to receive medical care may get medical care costs paid by the health insurance fund within the scope of and at the level of health insurance benefits as prescribed;

b/ The health establishment shall ensure manpower and professional conditions, publicize costs payable by patients beyond the scope and exceeding the level of health insurance benefits as prescribed, and notify such in advance to patients; and notify such costs in writing to the social insurance agency for addition in medical care contracts for use as a basis for cost payment before carrying out medical care activities on weekends and public holidays.

Chapter VII

DIRECT PAYMENT OF MEDICAL CARE COSTS BETWEEN SOCIAL INSURANCE AGENCIES AND THE INSURED

Article 28. A dossier of request for direct payment

1. Copies of the following papers (enclosed with originals for comparison):

a/ Health insurance card and personal identity card as specified in Clause 1, Article 15 of this Decree;

b/ Discharge paper and medical care card or book, of the medical care period with costs requested to be paid.

2. Payment receipts and related documents.

Article 29. Submission of dossiers and approval of direct payment

1. A patient or his/her relative or lawful representative as prescribed by law shall submit a dossier prescribed in Article 28 of this Decree directly to a district-level social insurance agency of the locality where he/she resides.

2. A district-level social insurance agency shall:

a/ Receive the patient's payment request dossier and make a dossier receipt. In case the dossier is incomplete, to guide the dossier supplementation;

b/ Within 40 days after receiving a complete payment request dossier, complete the health insurance assessment and pay medical care costs to the patient or his/her relative or lawful representative. In case of refusal to pay costs, it shall reply in writing, clearly stating the reason.

Article 30. Direct payment levels

1. In case a patient comes to receive medical care at a district- or equivalent-level health establishment without any health insurance-covered medical care contract (except case of emergency), he/she may get payment at the following level:

a/ In case of outpatient medical care, payment shall be made according to actual costs within the scope and at the level of health insurance benefits as prescribed which must not exceed 15% of the base salary at the time of medical care;

b/ In case of inpatient medical care, payment shall be made according to actual costs within the scope and at the level of health insurance benefits as prescribed which must not exceed 50% of the base salary at the time of discharge.

2. In case a patient comes to receive inpatient medical care at a provincial- or equivalent-level health establishment without any health insurance-covered medical care contract (except case of emergency), payment shall be made according to actual costs within the scope and at the level of health insurance benefits as prescribed which must not exceed the base salary at the time of discharge.

3. In case a patient comes to receive inpatient medical care at a central- or equivalent-level health establishment without any health insurance-covered medical care contract (except case of emergency), payment shall be made according to actual costs within the scope and at the level of health insurance benefits as prescribed which must not exceed 250% of the base salary at the time of discharge.

4. In case a patient comes to receive medical care at a health establishment where he/she has registered for initial medical care not in accordance with Clause 1, Article 28 of the Law on Health Insurance, payment shall be made by the health insurance fund according to actual costs within the scope and at the level of health insurance benefits as prescribed which must not exceed 15% of the base salary at the time of medical care in case of outpatient medical care or must not exceed 50% of the base salary at the time of discharge in case of inpatient medical care.

Chapter VIII

MANAGEMENT AND USE OF THE HEALTH INSURANCE FUND

Article 31. Distribution and use of the health insurance fund

The total health insurance premiums paid under Article 7 of this Decree shall be distributed and used as follows:

1. 90% shall be used for medical care (below referred to as the medical care fund) for the following purposes:

a/ Payment of costs within the scope of benefits of the insured under Articles 14, 26, 27 and 30 of this Decree;

b/ Retention at education institutions or vocational education institutions, agencies, organizations and enterprises that fully satisfy the conditions prescribed in Clause 1, Article 34 of this Decree.

2. 10% shall be set aside as a contingency fund and to cover expenses for the management of the health insurance fund as follows:

a/ Total expenses for the management of the health insurance fund must not exceed 5% of the total health insurance premiums paid. Specific annual amounts of expenses for the management of the health insurance fund and specific expenses must comply with the regulations of the Prime Minister;

b/ The amount to be set aside as a contingency fund means the remainder after covering expenses for the management of the health insurance fund mentioned at Point a of this Clause and must be at least equal to 5% of the total health insurance premiums paid.

Article 32. Expenses for the management of the health insurance fund

1. Expenses for the management of the health insurance fund include:

a/ Expenses for apparatus operations of social insurance agencies at all levels;

b/ Expenses for the tasks of propagation and dissemination of policies and laws; development and management of the insured; professional training and refresher courses; reform of procedures; collection of premiums; inspection and examination, and other tasks as prescribed by the law on health insurance;

c/ Expenses for the application of information technology and for development investment.

2. Specific expenses mentioned in Clause 1 of this Article must comply with the regulations of the Prime Minister.

Article 33. Expenses for medical care in the primary healthcare work

1. Amount to be retained at an education institution or a vocational education institution includes:

a/ 5% of the collected health insurance premiums calculated on the total number of under-6 children or pupils or students enrolled in the institution according to the following formula:

To be-retained amount = 5% x ($N_{\text{number of people}}$ x $M_{\text{health insurance}}$ x $L_{\text{base salary}}$ x Th)

In which:

- $N_{number\ of\ people}$: Total number of under-6 children; pupils or students enrolled in the institution and covered by health insurance.

- $M_{health\ insurance}$: Health insurance premium level applicable to under-6 children or pupils or students specified in Clause 1, Article 7 of this Decree.

- $L_{base\ salary}$: Base salary at the time of health insurance premium payment.

- Th: Number of months of health insurance premium payment.

Once every 3, 6 or 12 months, the social insurance agency shall transfer the amount prescribed at this Point to the education institution or vocational education institution, and include it in the finalization of the health insurance-covered medical care fund.

b/ 1% of the health insurance premiums monthly paid for employees of the education institution or vocational education institution, and the social insurance agency shall pay this amount right after receiving health insurance premiums from the institution.

2. The amount to be retained at an agency, organization or enterprise that fully satisfies the conditions prescribed in Clause 1, Article 34 of this Decree is equal to 1% of health insurance premiums monthly paid for employees of the agency, organization or enterprise. The social insurance agency shall pay this amount right after receiving health insurance premiums from the agency, organization or enterprise.

3. Amount to be retained for persons working on board an offshore fishing ship:

a/ It is equal to 10% of the collected health premiums calculated on the number of people working on board the ship and covered by health insurance for purchase of a medicine cabinet, medicines and medical supplies for first aid and primary treatment according to the following formula:

To be-retained amount = 10% x ($N_{number\ of\ people}$ x $M_{health\ insurance}$ x $L_{base\ salary}$ x Th)

In which:

- $N_{number\ of\ people}$: Total number of the insured working on board the ship.

- $M_{health\ insurance}$: Health insurance premium level applicable to the first person in a household as prescribed at Point e, Clause 1, Article 7 of this Decree.

- $L_{\text{base salary}}$: Base salary at the time of health insurance premium payment.

- Th: Number of months of health insurance premium payment.

b/ Chairpersons of provincial-level People's Committees shall organize the purchase and supply of medicine cabinets, medicines and medical supplies to offshore fishing ship owners. Social insurance agencies shall transfer the amount specified at Point a of this Clause to agencies and organizations assigned by chairpersons of provincial-level People's Committees to purchase medicine cabinets, medicines and medical supplies, and include the transferred amount in the finalization of the medical care fund.

4. Based on the practical needs and capability to balance the health insurance fund, the Minister of Health shall adjust the amount to be transferred to cover medical care costs in the primary healthcare work.

Article 34. Payment conditions, specific expenses, payment and finalization of expenses for medical care in the primary healthcare work

1. An education institution, a vocational education institution, an agency, organization or enterprise specified at Point b, Clause 1, Article 31 of this Decree (except those that have entered into health insurance-covered medical care contracts under Article 19 of this Decree) may receive funds from the health insurance fund to cover expenses for medical care in the primary healthcare work if fully satisfying the following conditions:

a/ Having at least one person qualified for medical care practice under the regulations on medical care and working on a part-time or full-time basis in the primary healthcare work;

b/ Having a separate medical room or working office for first aid or primary treatment of persons managed by the institution, agency, organization or enterprise who suffer injuries caused by accidents or suffer common diseases during the period of studying or working at the institution, agency, organization or enterprise.

2. Specific expenses:

a/ Expenses for purchase of medicines and medical supplies for first aid or primary treatment of children, pupils, students or persons managed by the agency, organization or enterprise who suffer injuries caused by accidents or suffer common diseases during the period of studying or working at the institution, agency, organization or enterprise;

b/ Expenses for purchase or repair of common medical equipment for primary healthcare and file cabinets for management of medical records at the institution, agency, organization or enterprise;

c/ Expenses for purchase of stationeries for medical care in the primary healthcare work.

3. Payment and finalization of expenses:

a/ A public education institution or vocational education institution shall account expenses for medical care in the primary healthcare work as expenses for the performance of medical care at the institution and make finalization of these expenses with the superior management agency under current regulations;

b/ A non-public education institution or vocational education institution shall account expenses for medical care in the primary healthcare work as its operation expenses and make finalization of these expenses them with the superior agency (if any);

c/ An enterprise or economic organization shall keep a separate account book to record the receipt and use of funds to cover medical care expenses, but may not include them in the finalization of its expenses;

d/ An agency or unit shall account expenses for medical care in the primary healthcare work as expenses for its performance of medical care and make finalization of these expenses with the superior management agency or unit (if any) or same-level finance agency under current regulations.

4. Education institutions or vocation education institutions, agencies, organizations and enterprises receiving funds for medical care in the primary healthcare work under this Decree shall use them for primary healthcare activities only, not for other purposes. Allocated funds that remain unused by the end of a year may be carried forward to the following year for further use without having to be finalized with social insurance agencies.

Article 35. Management and use of the contingency fund

1. Sources for setting aside the contingency fund:

a/ Amount to be annually set aside under Point b, Clause 2, Article 31 of this Decree and Point a, Clause 3, Article 35 of the Law on Health Insurance;

b/ Fines for late payment of or failure to pay health insurance premiums;

c/ Yields from investments from the health insurance fund;

d/ Interests on fines for late payment of or failure to pay health insurance premiums.

2. Use purposes of the contingency fund:

a/ Additionally covering expenses for health insurance-covered medical care for provinces and cities in case collected health insurance premiums for medical care specified in Clause 1, Article 31 of this Decree are smaller than expenses for medical care in a year. After appraising finalization of expenses, the Vietnam Social Security shall offset the whole deficit with the contingency fund;

b/ Refunding to the state budget the funds used for grant of health insurance cards to the insured who already hold health insurance cards.

3. In case the contingency fund is not enough to additionally cover medical care expenses for provinces and cities under Point a, Clause 2 of this Article, the Vietnam Social Security shall report to its Governing Body a plan to make up for the deficit before reporting such to the Ministry of Health and Ministry of Finance.

The Ministry of Health shall assume the prime responsibility for, and coordinate with the Ministry of Finance in, proposing to the Government measures to ensure sufficient and timely funds to cover expenses for health insurance-covered medical care under regulations.

Article 36. Making of financial plans and finalization

1. Annually, the Vietnam Social Security shall make financial plans on revenues and expenditures, expenses for the management and investments from temporarily idle amounts of the health insurance fund. The Ministry of Finance shall assume the prime responsibility for, and coordinate with the Ministry of Health in, examining and submitting such plans to the Prime Minister for assignment.

2. Before October 1 every year, the Vietnam Social Security shall sum up and make finalization reports of the health insurance fund of the preceding year under Article 32 of the Law on Health Insurance.

Chapter IX

APPLICATION OF INFORMATION TECHNOLOGY IN THE MANAGEMENT OF HEALTH INSURANCE-COVERED MEDICAL CARE

Article 37. Principles of application of information technology in health insurance-covered medical care

1. Complying with the regulations on application of information technology, health insurance-covered medical care, protection of state secrets and related secrets, e-transactions, archives, and information security.

2. Conforming with standards and technical regulations, ensuring compatibility, uninterruptedness, safety and convenience of e-transactions between health establishments and the Ministry of Health as well as social insurance agencies.

3. Ensuring confidentiality and privacy of data and information on medical care of the insured.

4. Ensuring technical infrastructure facilities, transmission lines, software and manpower to meet the needs for medical care management and assessment and payment of health insurance-covered medical care costs.

Article 38. Contents of, and funds for, the application of information technology in the management of health insurance-covered medical care

1. Contents of the application of information technology include:

a/ Application of information technology to serve the medical care of health establishments;

b/ Application of information technology to serve the management of the health insurance fund;

c/ Application of information technology to serve the state management of health insurance;

d/ Application of information technology to serve the management of health insurance-covered medical care.

2. Funds for the application of information technology in the management of health insurance-covered medical care must comply with the regulations on application of information technology.

Chapter X

IMPLEMENTATION PROVISIONS

Article 39. Transitional provisions

1. For the insured who are hospitalized for medical treatment before the effective date of this Decree but then discharged on or after the effective date of this Decree, the health insurance fund shall pay their medical care costs within the scope and at the level of benefits in

accordance with the Law on Health Insurance and Article 14 of this Decree.

2. Health insurance-covered medical care contracts entered into before the effective date of this Decree shall be performed through December 31, 2018.

3. Specific expenses to cover, management and finalization of, medical care costs in the initial healthcare work in 2018 in education institutions, vocational education institutions, agencies, organizations and enterprises which have been spent and carried out shall apply through December 31, 2018.

4. The finalization of the health insurance fund in 2017 and 2018 must comply with the Government's Decree No. 105/2014/ND-CP of November 15, 2014, detailing and guiding the implementation of a number of articles of the Law on Health Insurance and guiding documents.

5. Health establishments that fail to comply with Point c, Clause 2, Article 21 of this Decree shall fully submit e-data on health insurance-covered medical care to serve the management work no later than December 31, 2019.

Article 40. Reference provisions

In case the legal documents referred to in this Decree are replaced, amended or supplemented, the replacing, amending or supplementing legal documents shall prevail.

Article 41. Effect

1. This Decree takes effect on December 1, 2018.

2. The following documents shall cease to be effective on the effective date of this Decree:

a/ The Government's Decree No. 105/2014/ND-CP of November 15, 2014, detailing and guiding the implementation of a number of articles of the Law on Health Insurance; particularly, the provisions of Point b, Clause 1, Article 6, and Article 8 continue to be effective through December 31, 2018;

b/ Joint Circular No. 41/2014/TTLT-BYT-BTC of November 24, 2014, of the Ministry of Health and Ministry of Finance, guiding health insurance; particularly, the provisions of Article 11; Clause 2, Article 17, and Article 18 continue to be effective through December 31, 2018;

c/ Joint Circular No. 16/2015/TTLT-BYT-BTC of July 2, 2015, of the Ministry of Health and Ministry of Finance, amending Clause 5,

Article 13 of Joint Circular No. 41/2014/TTLT-BYT-BTC of November 24, 2014, guiding health insurance;

d/ Article 8 and Clause 2, Article 9 of Decree No. 151/2016/ND-CP of November 11, 2016, detailing and guiding the implementation of a number of articles of the Law on Professional Army Men and Defense Workers and Employees regarding the regimes and policies;

dd/ Clause 6, Article 11, and Point c, Clause 1 and Clause 2, Article 12 of the Ministry of Health's Circular No. 40/2015/TT-BYT of November 16, 2015, on the registration of health insurance-covered initial medical care and treatment-line transfer between health establishments covered by health insurance.

Article 42. Implementation guiding responsibilities

1. The Ministry of Health shall:

a/ Guide the implementation of articles and clauses assigned to it in this Decree;

b/ Assume the prime responsibility for, and coordinate with related ministries and agencies in, inspecting the implementation of the policies and laws on health insurance;

c/ Guide the appraisal of conditions for health establishments to sign health insurance-covered initial medical care contracts;

d/ Promulgate a set of codes of common-use lists for uniform application nationwide, including: medical technical services, modern medicines, traditional medicines, medical supplies, equipment, blood and blood preparations, traditional medicine-described diseases, disease diagnosis codes according to international classification of diseases (ICD), codes of health establishments, and sets of codes meeting the management requirements;

dd/ Direct health establishments to intensify the application of information technology in medical care; promptly, accurately and sufficiently update information on health insurance-covered medical care and transfer data to the Ministry of Health's system receiving health insurance-covered medical care data and the Vietnam Social Security's assessment information system for health insurance management and assessment and payment of health insurance-covered medical care costs;

e/ Specify activities involved in the application of information technology in health insurance-covered medical care;

g/ Prescribe the schedule for interconnection of data on test results, diagnostic imaging and information on the treatment of patients holding health insurance cards;

h/ Assume the prime responsibility for, coordinate with the Ministry of Finance and Vietnam Social Security in, formulating and sending extraordinary, periodical and annual reports on the implementation of the regimes and policies on health insurance, including the management and use of the health insurance fund, to the Government for submission to the National Assembly.

2. The Ministry of Finance shall:

a/ Balance and allocate central budget funds as support for localities that cannot themselves set aside their budgets to create sources for the implementation of health insurance policies in accordance with the law on the state budget;

b/ Annually or extraordinarily report on the management and use of the health insurance fund to the Government at the latter's request;

c/ Send annual reports on management and use of the health insurance fund to the Ministry of Health for summarization under Point h, Clause 1 of this Article;

3. The Ministry of National Defense and Ministry of Public Security shall guide health insurance for the subjects under their management as specified in Clause 1, Article 1; Clauses 13 and 15, Article 3; Clause 3, Article 4; and Article 6, of this Decree.

4. The Ministry of Labor, War Invalids and Social Affairs shall:

a/ Study and formulate the criteria for identifying agriculture, forestry, fishery and salt-making households with average living standards suitable to the socio-economic conditions in each period and submit them to the Prime Minister for promulgation;

b/ Guide the making of a list of subjects specified in Clauses 3 and 5; at Point a, Clause 9, and Clauses 11, 12, 16 and 17, Article 3; and in Clauses 1, 2 and 4, Article 4, of this Decree.

5. The Vietnam Social Security shall:

a/ Direct social insurance agencies at all levels to enter into contracts with eligible health establishments in accordance with this Decree;

b/ Direct provincial-level social insurance agencies to assume the prime responsibility for, and coordinate with provincial-level Health Departments and Finance Departments and health insurance-covered health establishments in their localities and adjacent localities and related agencies in, settling according to their competence, or proposing to competent authorities for consideration and prompt resolution, arising problems;

c/ Direct social insurance agencies at all levels in providing forms and guiding commune-level People's Committees in making a list of the insured paying health insurance premiums by household and managing such list;

d/ Improve the information technology system to receive, assess and promptly notify health establishments of, health insurance-covered medical care data; ensure the accuracy, safety and confidentiality of information and benefits of related parties;

dd/ Summarize, periodically, annually or extraordinarily report at the request of state management agencies on the implementation of health insurance regimes and policies and on revenues and expenditures, and management and use of the health insurance fund to the Ministry of Health and Ministry of Finance for summarization under this Decree;

e/ Define the competence of social insurance agencies to enter into health insurance-covered medical care contracts with health establishments in conformity with the functions, tasks, powers and organizational structure of the Vietnam Social Security;

g/ Social insurance agencies shall issue e-health insurance cards to the insured no later than January 1, 2020.

6. Provincial-level People's Committees shall propose provincial-level People's Councils to approve funds for payment of health insurance premiums for the insured whose health insurance premiums are wholly or partially covered by the state budget under current regulations.

Article 43. Implementation responsibility

Ministers, heads of ministerial-level agencies, heads of government-attached agencies and chairpersons of provincial-level People's Committees shall implement this Decree.-

On behalf of the Government
Prime Minister
NGUYEN XUAN PHUC

APPENDIX

(To the Government's Decree No. 146/2018/ND-CP of October 17, 2018)

Form No. 1	**List summarizing the number of the insured and health insurance premiums wholly or partially paid by the state budget**
Form No. 2	**The list of the health insured**
Form No. 3	**The list of members of households participating in health insurance**
Form No. 4	**Slip of dossier receipt and appointing result notification date for grant, re-grant and renewal of health insurance cards**
Form No. 5	**Patient re-examination paper**
Form No. 6	**Health Insurance-covered treatment-line transfer paper**
Form No. 7	**Health insurance-covered medical care contract**
Form No. 8	**List of the insured that register primary medical care**

Form No. 1

SOCIAL SECURITY OFFICE OF..... PROVINCE

THE SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

List summarizing the number of the insured and health insurance premiums wholly or partially paid by the state budget

In 20...

(Unit of calculation: credit; Vietnam dong)

No.	Categories of the insured with health insurance premiums wholly or partially paid by the state budget	Number of health insurance cards issued	Health insurance premiums calculated according to the prescribed rates	Health insurance premiums paid by the insured	Health insurance premiums wholly or partially paid by the state budget	Health insurance premiums already transferred by finance agency or labor agency	Health insurance premiums to be transferred by finance agency or labor agency
A	B	1	2	3	4=2-3	5	6=4-5
	Total number						
1	Under-6 children						

2	Members of poor households						
3	Members of households living in near poverty						
	-Persons with health insurance premiums wholly paid by the state budget						
	- Persons with health insurance premiums equal to …..% paid by the state budget						
4	Pupils and students						
5	Members of agriculture, forestry, fishery and salt-making households with an average living standard						
6	……..						

... day.... month....year 20...

LIST MAKER *(Signature and full name)*	**PERSON IN CHARGE OF ACCOUNTING** *(Signature and full name)*	**DIRECTOR** *(Signature, full name and seal)*

Note: In case a domestic or foreign organization or individual also pays health insurance premiums for the insured with health insurance premiums partially paid by the state budget, the amount paid by such organization or individual shall be written in column 3 “Health insurance premiums paid by the insured”.