European Central Bank

Staff Rules

Annex IV
Long-term care insurance

1 January 2018

European Central Bank – Long-term care insurance

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Section I – Definitions

Article 1: Definitions

For the purposes of this Annex, the following definitions apply.

(a) "administrator" means an external service provider selected in accordance with the procedures laid down by the European Central Bank's (ECB) procurement framework and entrusted with the administration of the long-term care insurance in accordance with these Rules;

(b) "applicant" means any of the persons listed in paragraph 1 of Appendix 1, who has filed the form for applying for long-term care benefits in accordance with the procedure set out in Appendix 1;

(c) "application" means an application for long-term care benefits filed in accordance with the procedure set out in Appendix 1;

(d) "assessment form" means a form for assessing the degree of reliance on long-term care;

(e) "beneficiary" means an insured person entitled to receive payment of long-term care benefits under the long-term care insurance in accordance with a decision of the Director General Human Resources or any persons appointed by them;

(f) "dependent child" has the same meaning as provided in Article 16 of the Conditions of Employment and Article 3.6.1 of the Staff Rules;

(g) "insurance cover" means cover provided under the long-term care insurance;

(h) "insured dependant" means a spouse, recognised partner or child who is insured in accordance with Article 4 of this Annex;

(i) "insured member" means a person who is insured in accordance with Article 3 of this Annex;

(j) "insured person" means an insured member or an insured dependant as specified respectively in Articles 3 and 4, who is covered by the long-term care insurance;

(k) "long-term care insurance" means insurance cover against the risk of long-term loss of autonomy;

(l) "long-term loss of autonomy" means the loss by an insured person of the ability to take care of themselves independently, measured in relation to their capability of performing everyday activities of a physical and cognitive nature with a view to assessing the degree of reliance on long-term care as further specified in Appendix 2 to this Annex, and which loss of autonomy is expected to last for a period of at least six months;

(m) "long-term care benefits" means financial support of a fixed monthly amount determined in accordance with the beneficiary's degree of reliance on long-term care as established in accordance with these Rules;

(n) "Medical Officer of the administrator" means a person who graduated from a medical school listed in the Word Health Organisation's Directory of Medical Schools and who is licensed to practise medicine in the relevant country, appointed by the administrator to give expert advice on medical questions arising in relation to the long-term care insurance.

(o) "Medical Officer of the risk carrier" means a person who graduated from a medical school listed in the Word Health Organisation's Directory of Medical Schools and who is licensed to practise

medicine in the relevant country, appointed by the risk carrier to give expert advice on medical questions arising in relation to the long-term care insurance;

(p) "pre-existing condition" means a situation in which a person experiences long-term loss of autonomy or has an elevated risk of experiencing long-term loss of autonomy as a result of: (i) personal risk factors, or (ii) medical condition(s) that required medical treatment during the five-year period preceding the most recent medical examination carried out in accordance with these Rules;

(q) "risk carrier" means an external service provider, selected in accordance with the procedures laid down by the ECB's procurement framework, with whom the ECB has signed a separate agreement limiting the ECB's financial risks in respect of the long-term care insurance;

(r) "spouse or recognised partner" means the spouse or recognised partner of an insured member, or the former spouse or former recognised partner of an insured member in respect of whom the latter is under an obligation to provide long-term care insurance by virtue of the terms of a divorce or legal separation agreement. Such legal obligation must have arisen during the insured member's employment with the ECB.

Section II – Insured persons

Article 2: Membership administration

1. The ECB shall report in writing to the administrator relevant data relating to insured persons, and any changes relating thereto, at a minimum once a month.

   Such data may include the following:

   (a) a unique identifier per insured person;

   (b) name(s) of the insured person/s;

   (c) their gender;

   (d) their date of birth;

   (e) start and end dates of insurance cover;

   (f) start and end dates of any suspension from insurance cover;

   (g) the nature of the employment relationship of the respective insured member;

   (h) the relationship of the insured person to the respective insured member;

   (i) the place of employment of the respective insured member;

   (j) the date of death.

2. The ECB shall retain the right to rectify such reported data, including any retroactive changes in data regarding insured persons.

Article 3: Insured members

1. The following persons shall be insured on a compulsory basis:

   (i) members of staff with an employment contract appointing them for a definite or an indefinite period to a position within the ECB and who are insured under the ECB health insurance, unless they opted out of the long-term care insurance within a month of its introduction;

   (ii) former members of staff whose employment contract with the ECB ended after the introduction of the long-term care insurance on 1 January 2018, and who are insured under the ECB health insurance pursuant to Articles 36 or 36a of the Conditions of Employment or to Article 5.4 of Annex V to the Staff Rules;

   (iii) former members of staff who are insured under the ECB health insurance pursuant to Article 37a of the Conditions of Employment, unless they opted out of the long-term care insurance within a month of its introduction.

2. The following persons shall be insured on a voluntary basis:

   (i) former members of staff whose employment contract with the ECB ended after the introduction of the long-term care insurance on 1 January 2018, for as long as they opt for a voluntary continuation of their cover under the ECB health insurance;

   (ii) provided they are not themselves already insured as an insured member in accordance with paragraph 1, the spouse, recognised partner or dependent child of an insured member referred to in Article 3(1) who, following the death of the latter, receives a spouse's pension or a children's pension in accordance with Article 38 of the Conditions of Employment, for as long as they are insured under the ECB health insurance.

3. Insured members shall benefit from primary cover under the long-term care insurance subject to payment of the regular contributions in accordance with Article 8.

Article 4: Insured dependants

Spouses or recognised partners, and children may be insured on a voluntary basis at the request of an insured member as referred to in Article 3(1), provided that they are not themselves an insured member in accordance with Article 3, and that they fulfil the conditions laid down in Articles 5 and 6 respectively.

Article 5: Conditions of insurance cover for spouses or recognised partners

1. *Eligibility*

   Upon application by an insured member, spouses or recognised partners shall be eligible for long-term care insurance provided that:

   (i) they are insured under the ECB health insurance; and

   (ii) they undergo a medical examination that certifies on the basis of criteria defined by the administrator that there are no pre-existing conditions. Such prior medical examination shall be carried out in accordance with the procedure specified by the administrator:

   - at the time of the initial request for insurance cover; or
   - following any period of cessation of insurance cover of more than one year.

2. *Primary cover*

   Spouses or recognised partners shall benefit from primary cover provided that:

   (i) they benefit from primary cover under the ECB health insurance; and

   (ii) the insured member pays a special contribution, where required, as further specified in Article 9.

3. *Top-up cover*

   Spouses or recognised partners shall benefit from top-up cover provided that:

   (i) they benefit from top-up cover under the ECB health insurance; and

   (ii) the insured member pays a special contribution, where required, as further specified in Article 9.

Article 6: Conditions of insurance cover for children

1. Upon application by an insured member, dependent children shall be eligible for long-term care insurance provided that:

   (i) they are insured under the ECB health insurance; and

   (ii) they successfully undergo a medical examination that certifies on the basis of criteria defined by the administrator that they have no pre-existing conditions. Such prior medical examination shall be carried out in accordance with the procedure specified by the administrator:

   - at the time of the initial request for insurance cover; or
   - following any period of cessation of insurance cover of more than one year.

   Such prior medical examination shall not be required for newly born children of insured members, who shall be insured as of their birth.

2. Notwithstanding paragraph 1, children of staff members may continue to be insured under these Rules beyond the date on which they cease to qualify as dependent children, until they reach the age of 30, upon application by an insured member and provided that the insured member concerned pays a special contribution as further specified in Article 9.

Section III - Contributions

Article 7: Costs of the long-term care insurance

1. The costs of the long-term care insurance comprise the total amount required to fund: (i) the payment of long-term care benefits, (ii) the fees of the administrator, and (iii) the fees of the risk carrier.

2. On the basis of the costs of the long-term care insurance, the Director General Human Resources or any persons appointed by them establishes a uniform premium rate, which is used for the calculation of the full contribution in respect of each insured person liable to pay regular contributions or special contributions as further specified under Articles 8 and 9.

The aforementioned full contribution is derived by multiplying the contribution basis determined on the basis of Article 12 of Annex III to the Staff Rules, subject to adjustments in line with Article 3(5)(b) of Annex III to the Staff Rules as appropriate, by the uniform premium rate.

3. The uniform premium rate is adjusted regularly as required to take account of changes to the costs of the long-term care insurance.

4. When regular contributions or special contributions as further specified under Articles 8 and 9 must be paid by a person in receipt of an ECB salary or pension, they are deducted directly from such a salary or pension.

Article 8: Regular contributions

In accordance with Article 33a(d) of the Conditions of Employment, insured members shall pay one third of the full contribution, except in the cases listed in Article 13.1 (a) to (e) of Annex III to the Staff Rules where regular contributions are paid in accordance with those provisions.

Article 9: Special contributions

1. Monthly special contributions due in accordance with Articles 5 and 6 of these Rules shall be paid as specified in Article 13.1 (f) to (i) of Annex III to the Staff Rules.

2. Where applicable, the penalty provided for in Article 4(3) of Annex III to the Staff Rules is payable in relation to the long-term care insurance under the same conditions as for the ECB health insurance.

Section IV– Long-term care benefits

Article 10: Entitlement to long-term care benefits

1. Without prejudice to the following paragraphs, insured persons shall be entitled to receive payment of long-term care benefits provided that:
   (i) their long-term loss of autonomy is established in accordance with the procedure set out in Appendix 1 and as further specified by the administrator; and
   (ii) a waiting period of one year with insurance cover has expired.
2. Notwithstanding paragraph 1, insured children shall not be entitled to receive payment of long-term care benefits before they have reached the age of three.
3. In the event of a cessation of the insurance cover of one year or less, the waiting period provided for in paragraph 1(ii) shall be suspended. In the event of a cessation of insurance cover of more than one year, the waiting period shall commence anew at the end of the cessation period. This notwithstanding, temporary opt-out periods during periods of part-time work, parental leave or unpaid leave of a member of staff shall not affect the entitlement to long-term care benefits of an insured person if the waiting period provided for in paragraph 1(ii) had already expired prior to such periods of part-time work, parental leave or unpaid leave.
4. In exceptional circumstances, the Chief Service Officer, on behalf of the Executive Board, may authorise the payment of long-term care benefits before the waiting period provided for in paragraph 1(ii) has expired.

5. There shall be no entitlement to long-term care benefits where the long-term loss of autonomy is due to any of the following causes:
   (i) a civil or foreign war, an uprising, a scuffle, terrorist acts in which the insured participated actively;
   (ii) the transmutation of the atomic nucleus.
6. The procedure to be followed in order to apply for long-term care benefits is set out in Appendix 1.
7. The entitlement to long-term care benefits shall not be affected by changes to the insurance cover of the beneficiary after the date on which the complete application was filed in accordance with paragraph 8 of Appendix 1.
8. On a proposal from the administrator, the Director General Human Resources or any persons appointed by them shall decide on the entitlement to long-term care benefits, specifying the level of benefits. The decision shall identify the degree of reliance on long-term care of the beneficiary.

Article 11: Criteria for assessing the degree of reliance on long-term care

The degree of reliance on long-term care shall be assessed in accordance with the procedure specified by the administrator and on the basis of the criteria set out in Appendix 2.

Article 12: Level of benefits

1. Depending on the degree of reliance on long-term care identified on the basis of the criteria set out in Appendix 2, the fixed monthly amount paid to beneficiaries insured under primary cover in accordance with Articles 3 and 5, shall correspond to the following percentages of the basic monthly salary for step 1 in the ECB's salary band A, adjusted every year in line with the general salary adjustments made in accordance with the Conditions of Employment:
   - Level I 50%;
   - Level II 75%;
   - Level III 100%.
2. For beneficiaries insured as children in accordance with Article 6, the fixed monthly amount paid is determined as follows:
   (i) Provided that reliance on long-term care is established as provided for in Appendix 2, the fixed monthly amount paid to beneficiaries between three and six years of age shall be two thirds of the Level I benefits referred to in paragraph 1.
   (ii) Depending on the degree of reliance on long-term care identified on the basis of the criteria set out in Appendix 2, the fixed monthly amount paid to beneficiaries of six years of age and above shall be two thirds of the benefits referred to in paragraph 1.
3. Depending on the degree of reliance on long-term care identified on the basis of the criteria set out in Appendix 2, the fixed monthly amount paid to beneficiaries insured under top-up cover in accordance with Article 5 shall be two thirds of the benefits referred to in paragraph 1.
4. The level of benefits shall be determined in accordance with the insurance cover of the insured person concerned applicable on the date the complete application was filed in accordance with

paragraph 8 of Appendix 1. It shall only be reviewed in accordance with changes in the degree of reliance on long-term care.

Article 13: Regular review of entitlement to benefits

1. The initial assessment of the degree of reliance on long-term care shall be reviewed regularly, at least once a year, or at shorter intervals as considered necessary by the administrator in view of the circumstances.
2. The Medical Officer of the administrator shall have the right, whenever he considers it appropriate:
   (i) to seek clarification regarding or verify the condition and level of care required by any beneficiary;
   (ii) to be given and to use specialist medical documents, results and reports; and
   (iii) to require an appointment for a visit and/or medical examination of a beneficiary.
3. The administrator shall request the applicant to report on the state of health of the beneficiary and on the circumstances affecting their living conditions in accordance with the procedure specified by the administrator. The applicant shall duly cooperate with the Administrator and provide all relevant information, including where relevant evidence proving that the beneficiary is still alive, such as documents issued by public authorities, the medical doctor of the beneficiary, the administration of the institutional care establishment or from private or public health insurance companies.
4. Where a new assessment concludes that there are changes in the degree of reliance on long-term care of the beneficiary, the administrator shall communicate to the ECB its opinion indicating the proposed new level of benefits, if any, to be granted. Where the opinion concludes on a lower care level, the applicant shall be given the opportunity to comment on the assessment within a deadline set by the administrator.
5. On a proposal from the administrator, the Director General Human Resources or any persons appointed by them shall decide on the entitlement to long-term care benefits from the date on which evidence of changes in the degree of reliance on long-term care were submitted, specifying the new level of benefits. The decision shall identify the degree of reliance on long-term care of the beneficiary.

Article 14: Payment and duration of benefits

1. Without prejudice to Article 10, the long-term care benefits shall be payable from the date on which the complete application is filed in accordance with paragraph 8 of Appendix 1. They shall be payable until death or recovery, subject to adjustments in accordance with the decisions taken by the Director General Human Resources or any persons appointed by them as provided for in Article 13(5).
2. The payment of long-term care benefits referred to under paragraph 1 shall only be made once a deferment period of three months following the filing date of the complete application has expired, provided the insured person to whom the application relates is still alive at the end of the deferment period.

3. The payment of long-term care benefits shall only be made to the beneficiary or to their legal representative.
4. The payment of long-term care benefits shall not be affected by entitlements to other benefits of the same nature provided by other sources.

Article 15: Suspension of benefits

1. Benefits shall be suspended in the event of non-compliance with a request to undergo a medical examination or with an obligation to disclose requested documents for the purpose of reviewing the entitlements to long-term care benefits. Where non-compliance is not attributable to the applicant, reinstatement of benefits shall be granted with retroactive effect on compliance with the requests of the administrator. In other cases, reinstatement of benefits shall be granted upon compliance with the requests of the administrator.
2. On a proposal from the administrator, the Director General Human Resources or any persons appointed by them shall decide on the suspension of long-term care benefits.

Section VI – General provisions

Article 16: Internal appeals procedure

1. Decisions taken by the ECB in relation to long-term care insurance shall be subject to the internal appeals procedures laid down in Articles 41 to 43 of the Conditions of Employment. Appeals may be initiated by the member of staff, the former member of staff or those entitled under them.
2. Where an appeal involves a dispute of a medical nature, the procedure set out under Article 17 for the referrals of disputes of a medical nature shall apply. This procedure shall suspend the timeframe for delivering a decision under the administrative review procedure. Once the referral procedure set out under Article 17 has been exhausted, medical findings or conclusions shall be regarded as definitive and the internal appeal procedure shall be considered exhausted if there are no other points of dispute in the appeal.

Article 17: Referrals to a single medical arbitrator for disputes of a medical nature

1. The Director General Human Resources or their Deputy shall refer disputes of a medical nature to a single medical arbitrator at the administrative review stage.
2. Disputes of a medical nature shall include the assessment of the long-term loss of autonomy and in particular of the degree of reliance on long-term care.
3. The single medical arbitrator shall be chosen by agreement between the Medical Officer of the administrator and the doctor nominated by the applicant. The single medical arbitrator shall possess the relevant medical expertise required to produce an expert opinion related to the medical dispute, and shall independently review all relevant documentation. The individual concerned shall not have been consulted on medical issues by the applicant, the insured person on whose behalf the application was made, their relatives, including their spouse, partner, children, parents or those related to them living in the same household, during the preceding three years. Failure to reach an agreement on the appointment of a single medical arbitrator within a period of

one month will result in the designation by the Medical Officer of the risk carrier of a doctor as single medical arbitrator.

4. The single medical arbitrator shall provide their opinion to the applicant and the administrator within 40 working days. The opinion of the single medical arbitrator shall be binding. The administrator shall communicate this opinion within two weeks from the day of receipt to the Director General Human Resources or any persons appointed by them with a proposal confirming or amending the challenged decision.

5. The single medical arbitrator shall be subject to the obligation of professional secrecy pursuant to Article 8(3) of Directive 95/46/EC of the European Parliament and of the Council[1] or Article 9(2)(h) of Regulation (EU) 2016/679 of the European Parliament and of the Council[2], whichever may be applicable at the relevant time.

6. Costs incurred for the settlement procedure by the single medical arbitrator shall be borne in full by the applicant if the initial assessment of the degree of reliance on long-term care carried out by the administrator is confirmed. If the initial assessment is amended, all costs shall be borne by the administrator.

Article 18: Jurisdiction

Pursuant to Article 42 of the Conditions of Employment, after all available internal appeals procedures as referred to in Article 16 have been exhausted, the Court of Justice of the European Union shall have jurisdiction.

Article 19: Recovery of unwarranted payments

1. Acting on behalf of the ECB, the administrator shall endeavour to recover from the insured member or beneficiary, or the legal representative to whom the payment was made, any sums that have been
   (a) overpaid,
   (b) unduly paid, or
   (c) paid as a result of fraud, misrepresentation or omission of facts.

2. The recovery by the administrator of sums overpaid or unduly paid must be initiated no later than five years from the date on which the sum was unduly paid. The recovery of sums paid as a result of fraud, misrepresentation or omission of facts must be initiated no later than ten years from the date on which the sum was paid.

3. Where the administrator fails to recover the sums referred to in paragraph 1 within six months from the first recovery attempt, the ECB shall recover these sums in accordance with Article 21a the Conditions of Employment.

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1 Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data (OJ L 281, 23.11.1995, p. 31).

2 Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (OJ L 119, 4.5.2016, p. 1).

Article 20: Set-off

The administrator shall be entitled to set off against any long-term care benefits due to a beneficiary, any sum overpaid, unduly paid or paid as a result of fraud, misrepresentation or omission of facts.

Article 21: Fraud

1. Article 26 of Annex III to the Staff Rules shall be applicable in relation to sanctionable irregularities or of breaches of professional obligations in relation to the long-term care insurance.
2. Where the ECB or the administrator has knowledge or a well-founded suspicion that long-term care benefits are being fraudulently claimed, the payment of long-term care benefits may be suspended. In a case of suspension, a review of entitlements to the long-term care benefits in accordance with Article 13 shall be initiated without undue delay and on a proposal from the administrator, the Director General Human Resources or any persons appointed by them shall decide on the reinstatement of benefits within two months from the date of the suspension. In case of non-compliance with a request to undergo a medical examination or with an obligation to disclose requested documents for the purpose of the review, the beneficiary of long-term care benefits shall automatically cease to be entitled to such benefits.

Article 22: Subrogation of rights

1. Where the long-term loss of autonomy of a beneficiary is caused by a third party, the payment of long-term care benefits under these Rules shall not be affected provided that, prior to such payment, the beneficiary subrogates to the ECB in writing their right of recourse against the liable third party within the limits of the amounts of benefits payable under the long-term care insurance.
2. The right to compensation in respect of purely personal damage, such as non-material injury, damages for pain and suffering or compensation for disfigurement and loss of amenity over and above the payment of long-term care benefits granted under these Rules, shall not be subrogated to the ECB.
3. For the purpose of the realisation of the rights stemming from this subrogation, the beneficiary shall disclose the relevant information to the ECB or to the administrator and cooperate to the extent necessary so that rights stemming from the subrogation may be enforced either by the ECB or by the administrator, on the ECB’s behalf.
4. Insured persons are not considered as third parties amongst themselves.

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Section VII – Appendices

Appendix 1: Procedure to be followed in order to claim long-term care benefits

1. The following shall be entitled to file an application:
   (i) an insured member on their own behalf and/or on behalf of their insured dependants, as well as an insured member's legal representative acting on behalf of the insured member;
   (ii) an insured dependant on their own behalf, as well as an insured dependant's legal representative acting on behalf of the insured dependant.
2. The application shall be made using the prescribed form and shall be dated and signed by one of the persons referred to in paragraph 1. The person signing the application shall at all times be responsible for any statements made therein.
3. The application, accompanied by all prescribed documents, shall be sent directly to the administrator, which shall inform the ECB thereof.
4. An assessment form shall be forwarded to the applicant by the administrator.
5. The assessment form shall be completed, dated and signed by the insured person's personal doctor, who shall indicate, by placing a tick in the appropriate box, the extent to which the patient is able to perform the activities in question without the assistance of a third person.
6. The assessment form shall be returned to the Medical Officer of the administrator accompanied by all the relevant medical information, documents, results and reports concerning the physical or mental examinations of the insured person and indicating clearly the diagnosis and state of health of that person.
7. An applicant shall be entitled, if that person so wishes, to send the application accompanied by the assessment form and the relevant medical reports to the Medical Officer of the administrator directly.
8. The application shall only be considered complete when the application form, the assessment form and all the relevant medical documents and reports referred to in the assessment form have been filed.
9. The Medical Officer of the administrator, in assessing the forms and reports, shall have the right, whenever he considers it appropriate, to seek clarification of or verify the condition and level of care required by the insured person on whose behalf the application is being made, to check whether the forms have been correctly filled in, to ask for and make use of specialist medical documents, results and reports, and to require an appointment for a visit and/or medical examination of the insured person at their place of residence or elsewhere.
10. The rights described in paragraph 9 shall always be exercised in cases where the application is signed personally by an insured dependant or an insured dependant's legal representative.
11. When the administrator has all the necessary information, it shall examine whether the criteria corresponding to the level of long-term loss of autonomy are satisfied, and shall communicate to the ECB its opinion indicating the proposed level of benefits, if any, to be granted.

12. Decisions regarding entitlement to long-term care benefits shall be made by the Director General Human Resources or any persons appointed by them, on a proposal from the administrator. The decision shall identify the degree of reliance on long-term care of the beneficiary and be communicated to the applicant together with the administrator's opinion.
13. Where an application is rejected, a new application shall not be made before the expiration of a period of three months following rejection of the previous application. The new application shall include documents providing evidence of any new aspects relating to a deterioration of the insured person's state of health.

Appendix 2: Criteria for measuring the degree of reliance on long-term care

1. **For adult persons and children aged above age 16,** the measurement of the degree of reliance on long-term care shall be performed on the basis of the below criteria.

   Care level 1

   The insured person requires help in connection with at least **three out of the seven** abilities/capacities mentioned in categories 1 and 2, and:

   - in category 1, at least c or d is required (and "mobility" must relate to "transferring");
   - in category 2, at least b or c is required;
   - a minimum number of 24 points must be allocated for categories 1, 2 and 3 together.

   Care level 2

   The insured person requires help in connection with at least **four out of the seven** abilities/capacities mentioned in categories 1 and 2, and:

   - in category 1, at least c or d is required (and "mobility" must relate to "transferring");
   - in category 2, at least b or c is required;
   - a minimum number of 48 points must be allocated for categories 1, 2 and 3 together.

   Care level 3

   The insured person requires help in connection with at least **five out of the seven** abilities/capacities mentioned in categories 1 and 2, and:

   - in category 1, at least c or d is required (and "mobility" must relate to "transferring");
   - in category 2, at least b or c is required;
   - a minimum number of 60 points must be allocated for categories 1, 2 and 3 together.

2. **For assigning children aged six years up to and including age 16** to the care levels of additional support, a comparison must be made to the needs of a healthy child of the same age.

   Care level I

   The additional time required for the extra care needs must exceed at least 1.5 hours per day compared to the care needs of a healthy child at the same age. The rationale for the additional care must be related to activities regarding the basic everyday activities mentioned in category 1. The person requiring the care must need help at least once a day for two of the basic everyday activities mentioned in category 1.

   Care level II

   The additional time required for the extra care needs must exceed at least three hours per day compared to the care needs of a healthy child at the same age. The rationale for the additional care must be related to activities regarding the basic everyday activities mentioned in category 1. The person requiring the care must need help at least three times a day at different times for the basic everyday activities mentioned in category 1.

Care level III

The additional time required for the extra care needs must exceed at least five hours per day compared to the care needs of a healthy child at the same age. The caregiver must be directly reachable at all times ("round the clock care"). Children in care level 3 must require round-the-clock help every day in relation to the basic everyday activities mentioned in category 1.

3. **For children aged between three and six years**, the reliance on long-term care shall be established provided that the existence of an additional care need significantly exceeding the normal parental care of children at that age and resulting from a medical condition is established.

4. **Abilities and capacities** referred to under paragraphs 1 and 2 are defined as follows:

Category 1: the ability to perform basic everyday activities

This category comprises five (5) activities, defined as follows:

- **mobility**: the ability to transfer between bed and chair, move inside and outside the home, moving in and out of a chair, including the use of a walking stick, frame or another support;
- **dressing**: the ability to put on and remove clothing;
- **washing**: the ability to maintain a satisfactory level of personal hygiene in accordance with customary standards, including showering, bathing, brushing teeth, combing hair;
- **feeding**: the ability to take and eat food and drink, that was prepared beforehand and put at one's disposal;
- **continence**: ability to control bowel movement and bladder function and to ensure hygienic urinary and faecal secretions, taking into account the availability of sanitary protection or surgical devices.

Per activity, points are allocated by the Medical Officer of the administrator for the purpose of estimating the non-medical assistance, help and/or care that is needed:

a. performed without help;

b. able to perform but has to be encouraged;

c. in some degree physically unable to perform;

d. completely unable to perform without help.

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Points		a.	b.	c.	d.
Mobility	Mobility total*	0	2	4	8
	Ability to transfer between bed and chair				
	Ability to move in and out of a chair				
	Ability to move inside the house				
	Ability to move outside the house				
Dressing		0	1	2	4
Washing		0	3	6	12
Feeding		0	3	9	16
Continence	Continence total*	0	2	4	9
	Urinary continence				
	Faecal continence				

* Mobility/Continence: the exact amount of points allocated is assessed by the Medical Officer of the administrator based on the abilities in each subcategory and can be higher/lower than the average value.

Category 2: cognitive capacities

This category comprises two activities, defined as follows:

- **the ability to conduct one's daily life without the need for supervision:** being aware of dangers or possible dangers that could threaten one's personal integrity;
- **the capacity to communicate:** with or without the use of physical aids.

Per activity, points are allocated by the Medical Officer of the administrator for the purpose of estimating the non-medical assistance, help and/or care that is needed:

a. performed without help;

b. requires supervision from a third person up to three times a day;

c. requires supervision from a third person more than three times a day;

Points	a.	b.	c.
Ability to conduct one's daily life without the need for supervision	0	6	12
Capacity to communicate	0	6	12

Category 3 : the ability to perform basic housekeeping activities

This category comprises four activities:

- **preparing meals;**
- **cleaning the home;**
- **washing and ironing clothes;**
- **shopping for basic items and necessities.**

For each activity, the Medical Officer of the administrator evaluates whether these activities can be performed without any help from a third person.

a. performed without help;

b. unable to perform without help.

Points	a.	b.
Preparing meals	0	6
Cleaning the home	0	6
Washing and ironing clothes	0	6
Shopping for basic items and necessities	0	4