TARIFF INSURANCE CONDITIONS
OF THE LONG TERM CARE INSURANCE PLAN : DKV HOME CARE

EDITION 09/2008/ Plan 497 (ex 494)

The Tariff Insurance Conditions (T.I.C.) are formulated in implementation of the General Insurance Conditions (G.I.C)

1. Insurance Plan (= G.I.C. 5)

1.1. The purpose of the insurance plan care insurance is to pay a monthly remittance in the case of serious need for care by the insured person.
1.2. Serious need for care is defined as long-lasting and seriously reduced ability to care for oneself on the part of the insured person, who needs non-medical home care or residential care.
1.3. Residential care is defined as non-medical care provided by an effective stay either in a recognized rest home or in a recognized rest and nursing home or in a recognized psychiatric care home.
1.4. Home care is defined as non-medical care with the exception of residential care.
1.5. The long term care insurance plan also has the objective of granting supplementary guarantees that provide specific services according to the conditions and criteria as noted in article 3 of these T.I.C.

2. Insurance Case (= G.I.C. 6)

2.1. The insurance case is formed by long-lasting and seriously diminished ability to care for oneself on the part of the insured person
2.2. The insurance case starts with the application by the insured person, confirmed by evidence of the assessment of diminished ability to take care of oneself as defined under point 2.3 to 2.6, and ends from the time that the diminished ability to take care of oneself no longer reaches the required level of seriousness.
2.3. The determination of the seriousness of the diminished capacity for self-care that makes home care necessary will be evaluated by the insurer on the basis of attestations or by an assessor of care authorized by the insurer.
2.3.1. The insured person supplies the evidence of the determination of long-lasting and seriously diminished capacity for self-care at home in one of the following forms of attestation:
2.3.1.1. attestation of minimum of 3 months on the basis of the Katz scale for home care (at least score B);
2.3.1.2. attestation of minimum of 6 months on the basis of the BEL scale of a service for home care (at least score 35);
2.3.1.3. attestation on the basis of the medical-social scale for contributions for integration and contribution help for old people (at least 15 points);
2.3.1.4. attestation on the basis of the evaluation scale for contributions in a care institution (at least score C);
2.3.1.5. attestation of supplementary child allowance with a disability of at least 66% and with at least 7 points on the scale of ability to live independently;
2.3.1.6. attestation of supplementary child allowance on the basis of the medico-social scale composed of columns P1, P2 and P3 (at least 18 points);
2.3.1.7. any other attestation than those summarized above that indicates an equivalent level of diminished capacity for self-care, if this scale is imposed by the insurer.
2.3.2 The insured person who does not have one of the attestations as summarized in art. 2.3.1, supplies evidence of determination of long-lasting and seriously diminished capacity for self-care at home:
2.3.2.1. through a care assessor authorized by the insurer;
2.3.2.2. on the basis of the BEL scale or a scale that determines an identical level of diminished capacity, if this is imposed by the insurer;
2.3.2.3. for children this determination is done from the age of 5 years and up to18 years on the basis of the adapted BEL scale (minimum 10 points under the heading 'physical activities of daily life').
2.4. the determination of the seriousness of diminished capacity for self-care that makes residential care necessary is made by the insurer only on the basis of attestations.
2.4.1. The insured person procures the evidence of the determination of serious need for care in a residential home on the basis of one of the following forms of attestation:
2.4.1.1. attestation on the basis of the evaluation scale for contributions in a nursing home (at least score A);
2.4.1.2. any other attestation than those summarized above that indicates an equivalent level of diminished capacity for self-care, if this scale is imposed by the insurer.
2.5. The following is reimbursed in the context of an insurance case:
2.5.1. the long-lasting and seriously diminished capacity for self-care determined with the help of an official attestation that fulfils the criteria 2.3 or 2.4 of these T.I.C.;
2.5.2. delivered by a care provider who is legally authorized to make this determination. If there is no legal authorization, the insurer may authorize the care provider.
2.6. The insurer reserves the right to determine the reality, the duration and the seriousness of the diminished capacity for self-care and to check this by a person appointed by him, according to the criteria mentioned in articles 2.3 up to and including 2.5 of these T.I.C.
2.7. On any modification of the form of care the insured person retains the right to the insurance guarantee (by modification is understood a transition from home care to residential care and vice versa):
2.7.1. on condition that the insured person fulfils the condition defined for the new form of care. These criteria are described in art. 2.3 up to and including 2.5 of these T.I.C In this case the insured person has the right to the monthly allowance for the new form of care from the first day of the month that follows the communication of the modification to the insurer;
2.7.2. the modification in form of care is sent to the insurer in writing, at the latest at the end of the month following the month in which the modification in the form of care is made. In the case of late notification the insurer reserves the right to pay the monthly allowance for the new form of care only in the month following the month in which he received the notification.
2.8. the insurer guarantees the payment of the monthly allowance insured in the policy according to the following conditions:.
2.8.1. after the written or electronic communication of the application for care to the insurer at the earliest at the beginning of residential or home care;
2.8.2. after the receipt of the evidence of long-lasting and seriously diminished capacity for self-care; this evidence must be delivered at the latest at the end of the third month following the month of the request and to be accepted by the insurer. If the evidence is not received or is received too late, the insurance guarantee is not acquired and a new application must be filed to the insurer;
2.8.3. by making a payment at the earliest from the fourth month that follows the month in which the application is made;
2.8.4. with retrospective effect to the first of the month that follows on the month of the application, inasmuch as there is still a current insurance case at the time of the first payment;
2.8.5. per lapsed month;
2.8.6. for the period of serious need for care determined by the attestation.
2.9. The insured monthly reimbursement is supplemented with an additional reimbursement according to the following conditions and criteria:
2.9.1. from the 75th birthday of the insured person;
2.9.2. on effective residence and for the duration of the residence either in a recognized rest home or in a recognized rest and nursing home or in a recognized psychiatric institution;
2.9.3. on the basis of the official daily price for the institution for the relief of the elderly, as determined by the Federal Public Service for the Economy, SMC and self-employed (Price service) of Belgium;
2.9.4. according to the insured monthly reimbursement:
2.9.4.1. to the maximum of the average official price for all institutions, if the official monthly reimbursement amounts to at least € 1 000 (09.2008 = index 100);
2.9.4.2. to the maximum of the official price of the institution in which the insured person is effectively resident, if the insured monthly reimbursement is at least € 2 000 (09.2008 = index 100). When the official price exceeds this insured monthly reimbursement by more than 20%, the prior agreement of the insurer is necessary.
2.9.5. to a maximum of the officially invoiced price. The official invoices must be submitted within 30 days of issue at the registered business address of the insurer. If the invoices are issued in a foreign language and a translation is necessary to investigate the right to reimbursement, then the insurer can suspend the right to the insurance guarantee until they are in the possession of translated and acceptable invoices
2.9.6. per expired month.
2.10. The premium and the insured monthly reimbursement can, on the annual expiry date, be indexed according to the following stipulations:
2.10.1. taking into account at the maximum the positive percentage of the the official prices fluctuation mentioned in art. 2.9 of these T.I.C;
2.10.2. on the basis of the premium and the insured monthly allowance valid before the indexation
2.10.3. according to the age reached by the insured person at the moment of the indexation.
2.11. The insurance case is also formed by the necessity for non-medical home care for the benefit of the insured person according to the criteria and conditions applicable in the supplementary guarantee as mentioned in articles 3.1 and 3.2 of these T.I.C.

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3. Supplementary Guarantees (= G.I.C. 6)

3.1. The insurer puts the following supplementary services at the disposal of the insured person:

3.1.1. a service 'care management'; this is accessible to the insured person in case of need for home care after a one night stay in a hospital recognized by the insurer. This service gives advice and organizes none-resident care according to the provisions and applicable conditions recorded in the agreement between this service and the insurer;

3.1.2. a service 'care in kind'; this is accessible to the insured person in the case of the need for care after a one night stay in a hospital recognized by the insurer. This offers non-medical 'care in kind' at the residence of the insured person in Belgium. In the case of residence in another country of the European Union this service is offered after prior agreement by the insurer. The conditions for this service are:

3.1.2.1. the application for home care is filed to the insurer within at most 72 hours after discharge from the hospital;

3.1.2.2. the number of hours is determined on the basis of the total insured monthly allowance;

3.1.2.3. as far as a contract has been closed between the service and the insurer and according to the stipulations that are applicable and in operation;

3.1.3. a service 'palliative care'; this is available for insured persons who have a right to a contractual intervention provided by Royal Decree 2/12/1999 for palliative home care. This service organizes 'care in kind':

3.1.3.1. from the date of the reception of evidence of the effective payment of the previously mentioned contractual palliative care;

3.1.3.2. for the number of hours determined by the total insured monthly allowance;

3.1.3.3. as far as as an agreement has been made between the service and the insurer and according to the stipulations that are applicable and valid;

3.1.3.4. for a period of 3 months, extendable one time.

3.2. The insured person is completely free to choose whether he makes use of the services offered in art. 3.1.1 up to and including 3.1.3 of these T.I.C. Once the insured person has given his agreement, the execution of the service falls completely under the responsibility of the service provider.

The insurer, irrespective of the grounds, origins or consequences, bears no responsibility whatsoever for shortcoming, error, failure to perform or mistake by the service provider. The insured person or his legal representative has no rights at all of redress against the insurer for claims of damage for any possible damage or detriment suffered.

4. Qualifying period (= G.I.C. 10)

4.1. There is no qualifying period: neither for illness nor for accident.

4.2. For newborns the guarantee is acquired from birth if the child is insured within 60 days following the month of the birth, in the same plan and for the same monthly allowance as one of the insured parents and in as much as this parent has been insured for at least 9 months at the time of the birth.

5. Deferred Period (= G.I.C. 11)

There is no deferred period.

6. Insurability (= G.I.C. 14 and 15)

Are insurable:

6.1. persons who are healthy when the insurance is taken out.

6.2. persons who, when the insurance is taken out, have an entrance age that allows the calculation of the premium according to an anticipated and prevailing age;

6.3. persons who have residence or whose fixed and normal residence is in Belgium;

6.4. persons who have residence or whose fixed and normal residence is in another country of the European after prior agreement of the insurer.

7. Excluded risks (= G.I.C. 22)

There is no right to benefits during a period of forced internment or of collocation of the insured person unless this measure is exclusively a necessary consequence of the long-lasting and seriously diminished capacity for self-care.

8. Territoriality of the insurance guarantee(= G.I.C. 23)

The guarantee is valid:

8.1. in Belgium;

8.2. in another country of the European Union after prior agreement of the insurer.

9. Information to the insurer (= G.I.C. 33 and 34)

The policyholder and the insured person are obliged to:

9.1. inform the insurer about the determination of a severe need for care or of any changes in this within 30 days after the beginning of it;

9.2. to account for the progress and the level of the severe need for care every 6 months unless the insurer provides for other notice and in the case of the appointment of a doctor or of a different care assessor

9.3. to inform the insurer within 30 days of the occurrence of:

9.3.1. the removal of the residence or the fixed normal residence to another country than Belgium;

9.3.2. the new transfer of the residence or the fixed normal residence either to Belgium or to some other country of the European Union.

10. Premium (= G.I.C.35)

The policyholder owes, with respect to children who during the period of the care insurance plan leave the age group 0 to 19, the premium for the age of 20 years from the annual expiry date that follows their 19th birthday.

11. Application to increase the monthly allowance (= G.I.C. 16 and 21)

11.1. For every application for raising the insured monthly allowance on the request of the policyholder the prior agreement of the insurer is required. The insurer can make this application subject to specific subscription and acceptance conditions.

11.2. The increase in the insured monthly allowance is possible up to and including the age of 69 years.

11.3. An increase in the insured monthly allowance is not possible for current cases.

11.4. The premium associated with the supplementary monthly allowance is calculated according to the age of the insured person. This is also applicable to the supplementary guarantees that are defined in article 3 of these T.I.C.

12. Suspension of the insurance guarantee (= G.I.C. 24)

12.1. The right to the insurance guarantee is suspended from the beginning and for the duration of the transfer of the residence or of the fixed normal residence of the insured person outside the European Union

12.2. The policyholder continues to owe payment of the premium during the suspension of the insurance guarantee.

12.3. The insured person or his legal representative should inform the insurer from the moment that the insurance conditions stated in article 6.3 or 6.4 of these T.I.C. are again fulfilled and requests the insurer again to be covered by the insurance guarantee.

12.4. The date on which the right to the insurance guarantee is again granted is confirmed by the issue of an addendum to the insurance contract.

12.5. The insurance case that begins during the period of suspension of the insurance guarantee gives the right to performance by the insurer at the earliest from the date on which the insured person again meets the insurance conditions defined in article 6.3 or 6.4 of these T.I.C.

12.6. In the case that the policyholder or the insured person does not accept the suspension of the insurance guarantee as it is provided for in article 12.1. of these T.I.C., the policyholder can agree, with the agreement of the insurer, that the insurance plan and guarantee end on a date agreed between the policyholder and the insurer.