Bowtie Pink VHIS Plan

Terms and Conditions

SUPPLEMENT NO. 1

This Supplement No. 1 (“this Supplement”) is a Supplement to Part 6 of the Terms and Conditions and the Benefit Schedule of this Certified Plan.

Unless otherwise defined in this Supplement, all capitalized terms used in this Supplement will have the meanings ascribed to them in the Terms and Conditions and this Supplement.

Contents

1. Limitations and claims provisions

(a) Territorial scope of cover

This Section 1(a) supplements Section 1(a) of Part 6 of these Terms and Benefits:

(i) Unless otherwise provided, all benefits described in these Terms and Benefits shall be applicable worldwide excluding the United States.

(ii) For any Eligible Expenses incurred inside the United States, the final amount payable under these Terms and Benefits shall be calculated according to the formula in Section 1(d)(iii) of this Supplement, and in so doing,

(aa) any benefits payable under Sections 3(a) to (k) of Part 6 of these Terms and Benefits shall be subject to the benefit limits as stated in the benefit schedule attached to the Standard Plan Terms and Benefits;

(bb) no benefit shall be payable under Section 3(l) of Part 6 of these Terms and Benefits, Sections 2 or 3 of this Supplement; and

(cc) the restrictions on the choice of ward class as stated in Section 1(c) of this Supplement shall not apply.

(iii) The restrictions described in (i) and (ii) above shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of these Terms and Benefits.

(b) Choice of healthcare services providers

This Section 1(b) supplements Section 1(c) of Part 6 of these Terms and Benefits:

(i) Unless otherwise provided, for any Eligible Expenses or other expenses charged by any Hospitals in mainland China in the event of Confinement, the following restrictions shall apply:

(aa) If such Hospital is neither a Designated nor a High-end Hospital at the time when Eligible Expenses or other expenses are incurred, then the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 1(d)(iii) of this Supplement, and in so doing:

I. any benefits payable under Sections 3(a) to (k) of Part 6 of these Terms

and Benefits shall be subject to the benefit limits as stated in the benefit schedule attached to the Standard Plan Terms and Benefits;

II. no benefit shall be payable under Section 3(I) of Part 6 of these Terms and Benefits, Sections 2 or 3 of this Supplement; and

III. the restrictions on the choice of ward class as stated in Section 1(c) of this Supplement shall not apply.

(bb) If such Hospital is a High-end Hospital at the time when Eligible Expenses or other expenses are incurred, then the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 1(d)(ii) of this Supplement. Any benefits described in these Terms and Benefits shall be subject to an adjustment factor of fifty percent (50%) and the ward class adjustment factor (if applicable) as stated in Section 1(c) of this Supplement according to the formula as stated in Section 1(d)(ii) of this Supplement.

(cc) If such Hospital is a Designated Hospital at the time when Eligible Expenses or other expenses are incurred, then the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 1(d)(ii) of this Supplement. Any benefits described in these Terms and Benefits shall be subject to the ward class adjustment factor (if applicable) as stated in Section 1(c) of this Supplement according to the formula as stated in Section 1(d)(ii) of this Supplement.

(ii) For the purpose of these Terms and Benefits, a “High-end Hospital” means a Hospital listed and specified as a “High-end Hospital” in the list titled "List of Designated Hospitals in Mainland China" published in the Company's website (www.bowtie.com.hk) and a “Designated Hospital” means a Hospital listed in the list but not a High-end Hospital. The list is subject to change by the Company from time to time at the Company's sole discretion without notice. Any change to the list shall be deemed as effective on the date of publication on the Company's website.

(iii) The restrictions described in (i) above shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of these Terms and Benefits.

(c) Choice of ward class

This Section 1(c) supplements Section 1(d) of Part 6 of these Terms and Benefits in situations other than the Standard Plan Limits Applicable Situation as specified in Section 1(d)(i):

(i) Unless otherwise provided, all benefits described in these Terms and Benefits are subject to the restriction in the choice of ward class as stated in the Benefit Schedule.

(ii) If the Insured Person is Confined in a room of class higher than the restricted ward class specified in the Benefit Schedule for any Medical Services, benefits payable under these Terms and Benefits in relation to such days of Confinement shall be subject to the adjustment as follows:

For Bowtie Pink VHIS Plan (Semi-Private Room):

Ward class of Insured Person's Confinement	**Applicable adjustment factor**
Standard Private Room	50%
Above Standard Private Room	25%

For Bowtie Pink VHIS Plan (Private Room):

Ward class of Insured Person's Confinement	**Applicable adjustment factor**
Above Standard Private Room	50%

(iii) The adjustment factor referred to in (ii) above is not applicable when the Policy Holder can provide evidence issued by the Hospital at which the Insured Person has been Confined proving that the Insured Person has been Confined in a ward class higher than the restricted ward class specified in the Benefit Schedule as a result of unavailability of accommodation at the restricted ward class due to ward or room shortage for Emergency Treatment, isolation reasons requiring Confinement in the

higher ward class, or for any other reason not involving the Policy Holder's and/or the Insured Person's personal preference.

(iv) The restrictions described in (i) and (ii) above shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of the Terms and Benefits.

(d) Overall benefit limit and benefit payable

(i) For the purpose of this Section 1, a "Standard Plan Limits Applicable Situation" shall mean a situation where Sections 1(a)(ii) or 1(b)(i)(aa) above is applicable.

(ii) Except in any Standard Plan Limits Applicable Situations, for any Eligible Expenses and other expenses, the benefit payable under these Terms and Benefits shall be determined using the following formula:

Benefit payable *equals*	1. Amount of Eligible Expenses or other expenses payable according to these Terms and Benefits, after applying exclusion and before applying the benefit limits 2. *multiplied by* adjustment factors (if applicable) (see Sections 1(b)(i)(bb), 1(b)(i)(cc) and 1(c)(ii) of this Supplement) 3. *subject to* remaining balance of the benefit limits as stated in the Benefit Schedule (i.e. the benefit limits as stated in the Benefit Schedule, less the benefit amount(s) previously paid during the same Policy Year) 4. *less* any remaining balance of Deductible (if applicable)

(iii) In Standard Plan Limits Applicable Situations, for any Eligible Expenses, the benefit payable in accordance with these Terms and Benefits shall be determined using the following formula:

Benefit payable *equals*	1. Amount of Eligible Expenses payable according to Sections 3(a) to (l) of Part 6 of the Standard Plan Terms

	and Benefits, after applying exclusion and before applying the benefit limits of the Standard Plan Terms and Benefits 2. *subject to* remaining balance of the benefit limits as stated in the benefit schedule of the Standard Plan Terms and Benefits (i.e. the benefit limits as stated in the benefit schedule attached to the Standard Plan Terms and Benefits, less the benefit amount(s) previously paid under Standard Plan Limits Applicable Situations during the same Policy Year) 3. *less* any remaining balance of Deductible (if applicable)

(iv) For Eligible Expenses and other expenses incurred in the second and third Policy Year arising from unknown Pre-existing Condition(s), the Company shall use such amount immediately before deducting the remaining balance of Deductible as shown in (ii) and (iii) above to apply the reimbursement percentage specified in Section 4 of Part 6 of these Terms and Benefits. The Company shall then apply the remaining balance of the Deductible in the relevant Policy Year (if applicable).

(v) If there are any Eligible Expenses or other expenses payable under these Terms and Benefits that have been reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of these Terms and Benefits, the remaining balance of Deductible in the relevant Policy Year, if applicable, shall be reduced by such reimbursed amount.

(vi) All benefits payable in accordance with these Terms and Benefits (including the Standard Plan Terms and Benefits, if applicable), except otherwise specified, shall be subject to the application of any applicable remaining balance of Deductible, and such benefits payable before the application of any applicable remaining balance of Deductible shall be counted towards the corresponding benefit limit, Annual Benefit Limit of the relevant Policy Year and the Lifetime Benefit Limit as specified in the Benefit Schedule.

(vii) If the benefits payable according to the formula in Section 1(d)(ii) is lower than the benefits payable according to the formula in Section 1(d)(iii), the Company shall pay the latter.

(e) Reducing Deductible

(i) The Policy Holder can exercise a one-off right to reduce the Deductible, without re-underwriting and without providing further evidence of insurability of the Insured Person once the conditions set out in items (aa), (bb) and (cc) below are satisfied, subject to the Deductible options available at that time:

(aa) Where the Insured Person's Age on the Policy Issuance Date is zero (0) to fifty-five (55), the Policy Holder makes the request to exercise such right not less than thirty (30) days prior to the Renewal Date on or immediately following the date that the Insured Person attains the Age of sixty-five (65);

(bb) Where the Insured Person's Age on the Policy Issuance Date is fifty-six (56) to seventy-five (75), the Policy Holder makes the request to exercise such right not less than thirty (30) days prior to the tenth (10^{th}) Renewal Date; and

(cc) Where the Insured Person's Age on the Policy Issuance Date is seventy-six (76) to eighty (80), the Policy Holder makes the request to exercise such right not less than thirty (30) days prior to the Renewal Date on or immediately following the date that the Insured Person attains the Age of eight-five (85).

(ii) The right described in (i) above can only be exercised one (1) time during the lifetime of the Insured Person.

(iii) For the avoidance of doubt, (i) and (ii) above do not affect the Policy Holder's rights to make the requests set out in items (aa) and (bb) below:

(aa) On any Renewal Date, the Policy Holder has the right to request the Company to increase the Deductible without re-underwriting and without providing further evidence of insurability of the Insured Person, subject to the Deductible options available at that time; and

(bb) On any Renewal Date, the Policy Holder has the right to request the Company to reduce the Deductible with re-underwriting, subject to the Company's sole

discretion to approve or reject any such requests according to the Company's prevailing underwriting practices.

(iv) For Eligible Expenses and other expenses incurred on or after a Renewal Date when an increase or decrease of Deductible becomes effective, the benefit payable shall be subject to the relevant increased or decreased Deductible.

2. Enhanced benefits covered

(a) Accident Emergency outpatient treatments

Eligibility

(i) This benefit shall be payable for the Eligible Expenses charged on Emergency outpatient treatments, once the conditions set out in items (aa), (bb) and (cc) below are satisfied:

(aa) the Insured Person sustains an Injury resulting in an Emergency;

(bb) the Insured Person receives Medical Services as a Day Patient within twenty-four (24) hours of the relevant Accident in an outpatient unit or emergency room of a Hospital; and

(cc) the Medical Services referred to in item (bb) above are directly related to and as a result of the Injury referred to in item (aa) above.

Benefit payment

(ii) This benefit shall cover the following charges incurred by the Insured Person, subject to the limit as stated in the Benefit Schedule:

(aa) consultation fee of a Registered Medical Practitioner;

(bb) western medication prescribed by a Registered Medical Practitioner and consumed during outpatient treatment and post treatment up to the ensuing four (4) weeks;

(cc) laboratory examination and reports;

(dd) diagnostic imaging services, including ultrasound and X-ray, and their interpretation; and

(ee) other medical related fee covering the costs of dressing and intravenous ("IV") infusions, including IV fluids.

Benefit payment order

(iii) Where Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Conditions, such Eligible Expenses shall be payable in the following order:

(aa) this Section 2(a);

(bb) Section 3 of Part 6 of the Terms and Conditions.

For the avoidance of doubt, Eligible Expenses for Prescribed Diagnostic Imaging Tests shall only be payable under Section 3(i) of Part 6 of the Terms and Conditions and will not be payable under this benefit.

(b) Outpatient kidney dialysis

Eligibility and benefit payment

(i) This benefit shall be payable for the Eligible Expenses charged on haemodialysis or peritoneal dialysis, once the conditions set out in items (aa) and (bb) below are satisfied:

(aa) the Insured Person receives haemodialysis or peritoneal dialysis as a Day Patient; and

(bb) as evidenced in writing, a Registered Medical Practitioner has exercised his prudent professional judgment, recommends the haemodialysis or peritoneal dialysis referred to in item (aa) above.

Benefit payment order

(ii) Where Eligible Expenses under this benefit are also covered under Section 3(k) of Part 6 of the Terms and Conditions, such Eligible Expenses shall be payable in the following order:

(aa) this Section 2(b);

(bb) Section 3(k) of Part 6 of the Terms and Conditions.

(c) Post-Confinement/Day Case Procedure daily home nursing

Eligibility

(i) This benefit shall be payable for the Eligible Expenses charged by the nursing service provider(s) on the daily nursing services provided to the Insured Person pursuant to (ii) below, once the conditions set out in items (aa) to (ee) below are satisfied:

(aa) the Insured Person has been discharged from Confinement or Day Case Procedure, provided that:

I. the room and board benefit is payable under Section 3(a) of Part 6 of the Terms and Conditions for such Confinement;

II. the intensive care benefit is payable under Section 3(e) of Part 6 of the Terms and Conditions for such Confinement; or

III. the Surgeon's fee benefit is payable under Section 3(f) of Part 6 of the Terms and Conditions for such Confinement or Day Case Procedure;

(bb) the daily nursing services are provided by Qualified Nurse to the Insured Person and not to anyone else;

(cc) the daily nursing services are provided within the period as stated in the Benefit Schedule;

(dd) as evidenced in writing, a Registered Medical Practitioner has exercised his prudent professional judgment, recommends the daily nursing services, and is of the view that the daily nursing services are directly related to and as a result of the same cause (including any and all complications therefrom) of the

Confinement or Day Case Procedure referred to in item (aa) above and is independent of any other cause; and

(ee) a written authorization by the Company is obtained prior to the provision of the daily nursing services.

Benefit payment

(ii) This benefit shall cover the Eligible Expenses charged by the nursing service provider(s) on the daily nursing services provided to the Insured Person, and:

(aa) In the event that more than one (1) Qualified Nurse provides nursing services during the same time slot to the Insured Person, the one (1) Qualified Nurse with the highest Eligible Expenses shall be payable. There is no limitation on the number of time slots in which nursing services are provided.

(bb) On a particular day, regardless of:

I. whether the nursing services are provided for all or part of the day; and

II. the number of time slots in which nursing services are provided,

that day shall be counted as one (1) day for the purpose of calculating the benefit limit.

(cc) This benefit is subject to the limit as stated in the Benefit Schedule.

(d) Rehabilitative care

Eligibility and benefit payment

(i) This benefit shall be payable for the Eligible Expenses and other expenses charged on rehabilitative care, once the conditions set out in items (aa) to (ee) below are satisfied, subject to the limit as stated in the Benefit Schedule:

(aa) the Insured Person has been discharged from Confinement;

(bb) the Insured Person has Stayed in a Rehabilitation Centre after the discharge from the Confinement referred to in item (aa) above;

(cc) the Stay referred to in item (bb) above is within the period as stated in the Benefit Schedule;

(dd) as evidenced in writing, a Registered Medical Practitioner has exercised his prudent professional judgment, recommends the Stay referred to in item (bb) above, and is of the view that the Stay referred to in item (bb) above is directly related to and as a result of the same cause (including any and all complications therefrom) of the Confinement referred to in item (aa) above and is independent of any other cause; and

(ee) a written authorization by the Company is obtained prior to the provision of the rehabilitation care.

Benefit payment order

(ii) Where Eligible Expenses under this benefit are also covered under Section 3(k) of Part 6 of the Terms and Conditions, such Eligible Expenses shall be payable in the following order:

(aa) this Section 2(d);

(bb) Section 3(k) of Part 6 of the Terms and Conditions.

(e) Hospital companion bed

Eligibility and benefit payment

(i) This benefit shall be payable for the expenses charged for the use of one (1) extra bed by one (1) person who accompanies the Insured Person in the same ward class during the Insured Person's Confinement, once the conditions set out in items (aa) and (bb) below are satisfied:

(aa) the Insured Person has been Confined; and

(bb) the room and board benefit is payable under Section 3(a) of Part 6 of the Terms and Conditions for the Confinement referred to in item (aa) above.

(f) Hospice and palliative care benefit

Eligibility

(i) This benefit shall be payable pursuant to (ii) below, once the conditions set out in items (aa) to (dd) below are satisfied:

(aa) the Insured Person has been conclusively and unequivocally diagnosed with a Terminal Illness;

(bb) the Insured Person has been discharged from Confinement for a Disability relating directly to the Terminal Illness referred to in item (aa) above;

(cc) the Insured Person has been admitted to a hospice or palliative care facility within the period as stated in the Benefit Schedule; and

(dd) as evidenced in writing, a Registered Medical Practitioner has exercised his prudent professional judgment, recommends the admission to the hospice or palliative care facility referred to in item (cc) above, and is of the view that the conditions set out in items (aa), (bb) and (cc) above are satisfied.

Benefit payment

(ii) This benefit shall be payable for the following Eligible Expenses and other expenses charged by the hospice or palliative care facility on the accommodation, care and nursing services provided by the facility to the Insured Person, subject to the limit as stated in the Benefit Schedule:

(aa) accommodation and meals;
(bb) nursing care provided by Qualified Nurse(s);
(cc) western medication prescribed by a Registered Medical Practitioner and consumed during the stay; and
(dd) physical and psychological support care.

3. Other benefits covered

(a) Day Case Procedure cash benefit

Eligibility

(i) This benefit shall be payable to the Policy Holder once the conditions set out in items (aa) and (bb) below are satisfied:

(aa) the Insured Person undergoes any surgical procedure as a Day Case Procedure; and

(bb) the Surgeon's fee benefit is payable for the procedure referred to in item (aa) above under Section 3(f) of Part 6 of the Terms and Conditions.

Benefit payment

(ii) The Company shall pay this benefit in the amount as stated in the Benefit Schedule.

(iii) For the avoidance of doubt, the payment under this benefit shall not affect and/or replace any benefits payable under the Surgeon's fee, the Anaesthetist's fee and the operating theatre charges benefits under Sections 3(f), (g) and (h) respectively of Part 6 of the Terms and Conditions.

(iv) This benefit is not subject to any Annual Benefit Limit, Lifetime Benefit Limit, Deductible or adjustment factor.

(b) Special bonus

Eligibility

(i) This benefit shall be payable to the Policy Holder once the conditions set out in items (aa) and (bb) below are satisfied:

(aa) the Insured Person has been Confined or has undergone any surgical procedure as a Day Case Procedure; and

(bb) the Insured Person is covered by any other individual or group hospital indemnity insurance plans offered by other insurance company(ies), and partial or full reimbursement has been paid by such other insurance company(ies) for Eligible Expenses or other expenses payable under Part 6 of these Terms and Benefits or Section 2 of this Supplement.

Benefit payment

(ii) This benefit shall be payable in the amount as stated in the Benefit Schedule for each day of the Confinement or Day Case Procedure referred to in item (i)(aa) above.

(iii) Regardless of the number of Day Case Procedures the Insured has undergone on a particular day, that day shall be counted as one (1) day for the purpose of calculating the benefit limit.

(iv) This benefit is not subject to any Annual Benefit Limit, Lifetime Benefit Limit,

Deductible or adjustment factor.

(c) Medical negligence benefit

Eligibility

(i) The Company shall pay this benefit to the Policy Holder once the conditions set out in items (aa), (bb) and (cc) below are satisfied:

(aa) the Insured Person dies as a direct result of any negligence of a Registered Medical Practitioner or Qualified Nurse in the course of any Medical Services received in a Hospital and independent of any other cause;

(bb) the death referred to in item (aa) above occurs within thirty (30) days after the occurrence of the incident constituting the negligence referred to in item (aa) above as recorded by the relevant government authority under the laws of the territory in which the incident is occurred; and

(cc) the negligence referred to in item (aa) above has been confirmed by a relevant government authority under the laws of the territory in which the incident is occurred.

Benefit payment

(ii) The Company shall pay this benefit in a lump sum in the amount as stated in the Benefit Schedule once all the conditions set out in (i) above are satisfied. For the avoidance of doubt, this benefit is payable to the Policy Holder or the Policy Holder's estate (if applicable).

(iii) The benefit is not subject to any Annual Benefit Limit, Lifetime Benefit Limit, Deductible or adjustment factor.

(d) Total and Permanent Incapacity income benefit

Definition of Total and Permanent Incapacity

(i) For the purpose of this Section 3(d), "Total and Permanent Incapacity" means the Insured Person's incapacity to perform any three (3) or more of the following activities of daily living for at least six (6) consecutive months –

(aa) transfer: getting in and out of a chair, bed or wheelchair on his own and without requiring the assistance of other person(s);

(bb) mobility: moving from room to room on level surfaces on his own and without requiring the assistance of other person(s);

(cc) toileting: voluntarily controlling bladder and bowel functions so as to maintain personal hygiene;

(dd) dressing: putting on and taking off all necessary clothing, correctional or protective braces, artificial limbs and other surgical appliances on his own and without requiring the assistance of other person(s);

(ee) bathing/washing: washing oneself in a bath or shower (including getting in or out of the bath or shower) or washing oneself by any other means on his own and without requiring the assistance of other person(s); or

(ff) eating: feeding oneself on food on his own and without requiring the assistance of other person(s),

and the Insured Person must be capable of performing the relevant activities of daily living immediately prior to the cause of the Confinement referred to in item (ii)(aa) below.

Eligibility

(ii) The Company shall pay this benefit to the Policy Holder once the conditions set out in items (aa) to (dd) below are satisfied:

(aa) the Insured Person has been Confined or discharged from Confinement, and did not suffer from Total and Permanent Incapacity thirty-six (36) months in the past from the first day of Confinement;

(bb) the Insured Person suffers from Total and Permanent Incapacity within eight (8) months after the first day of Confinement referred to in item (aa) above;

(cc) the Insured Person's Total and Permanent Incapacity is directly related to and as a result of the same cause (including any and all complications therefrom) of the Confinement referred to in item (aa) above and is independent of any other cause; and

(dd) as evidenced in writing, a Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that the conditions set out in items (aa), (bb) and (cc) above are satisfied.

Benefit payment

(iii) The Company shall make the first payment under this benefit once all the conditions set out in (ii) above are satisfied. For the avoidance of doubt, the earliest time the first payment will be made is after six (6) consecutive months of incapacity to perform the activities of daily living noted in (i) above.

(iv) The Company shall pay this benefit for the entire period stated in the Benefit Schedule. For the avoidance of doubt, even if the Insured Person dies within the period stated in the Benefit Schedule, payments under this benefit will still continue to be paid for that entire period to the Policy Holder or the Policy Holder's estate (if applicable).

(v) This benefit is not subject to any Annual Benefit Limit, Lifetime Benefit Limit, Deductible or adjustment factor.

4. Supplementary definitions

For the purpose of Sections 1 to 3 in this Supplement, words and expressions used shall have the following meanings -

"Above Standard Private Room"	shall mean a room in a Hospital with amenities or furnishings upgraded beyond a Standard Private Room.
"Qualified Nurse"	shall mean a nurse, (a) who is duly qualified and is registered with the Nursing Council of Hong Kong pursuant to the Nurses Registration Ordinance (Cap. 164 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as accepted by the Company); and (b) legally authorized for rendering nursing services in Hong Kong or the relevant jurisdiction outside Hong Kong where the

nursing services are provided to the Insured Person (as accepted by the Company),

but in no circumstance shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).

"Rehabilitation Centre"	shall mean an establishment other than a Hospital which - (a) is duly constituted and registered under the laws of the territory in which it is situated to provide institutional rehabilitation services, (b) is for providing physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, physical dysfunction or physical disability, and (c) is not primarily a place for alcoholics or drug addicts, a nature care clinic or a health hydro.
"Semi-Private Room"	shall mean a single or twin bedded room in a Hospital with a shared bathroom (or a similarly classed Hospital room).
"Standard Private Room"	shall mean a standard single bedded room in a Hospital with a private bathroom, but without any kitchen, dining room or sitting room (or a similarly classed Hospital room), other than a suite or VIP/deluxe room.
"Stay" or "Stayed"	shall mean either of the followings: (a) the admission of the Insured Person to a Rehabilitation Centre solely for the purpose of receiving Medical Services other than haemodialysis or peritoneal dialysis, where the period of stay in the Rehabilitation Centre is at least six (6) consecutive hours; (b) the admission of the Insured Person to a Rehabilitation Centre solely for the purpose of receiving Medically

	Necessary physiotherapy, occupational therapy or speech therapy provided by relevant registered practitioners, where the period of stay in the Rehabilitation Centre is at least one (1) consecutive hour.
“Terminal Illness”	shall mean an illness that is expected to result in the death of the Insured Person within twelve (12) months.