

A photograph of a middle-aged couple hiking on a grassy hill. The man, on the right, has grey hair and a beard, is wearing a dark blue jacket and a large backpack, and is smiling broadly. The woman, on the left, has blonde hair and is wearing a red jacket and a backpack; she is also smiling and has her hand on the man's chest. The background shows a vast landscape with rolling hills and a small town in the distance under a cloudy sky. The entire image is framed by a thick orange border.

Lateral

Welcome to Your Health Plan.

Here’s What You Can Look Forward To.

The Lateral Health Plan is designed to help fit and active over 60s stay healthy and keep moving. It combines insurance cover with a range of preventative services. It’s designed to complement the NHS, offering private healthcare access where it’s most helpful, while facilitating your NHS care in other areas.

The Lateral Health Plan’s preventative ‘stay-healthy’ services help you proactively manage your health and wellbeing and stay active. These include an annual health check and other digital health services that support your overall health and wellbeing including physiotherapy and a virtual GP.

When you have a new health issue, our nurse-led navigation service offers personalised support to help you understand your diagnosis and explore treatment pathways. Call the helpline and we will guide you through your NHS and private options, helping you to make informed choices and avoid delays.

If you need treatment for something on our list of named surgical procedures, you will be able to access private consultations, private diagnostic tests and care in a private hospital.



How to start a claim:

All claims are managed via our nurse-led navigation service.

 **0203 432 2401**
 **claims@lateral.uk**

Our lines are open **Monday - Friday 08:00 to 20:00, Saturday 09:00 to 15:00.**



How to contact us:

If you need to speak to one of the Lateral support team for any reason.

 **0203 826 8898**
 **support@lateral.uk**

Our offices are open **Monday - Friday, 09:00 to 17:30** (excluding bank holidays).



How to book my health check:

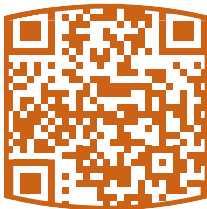
Book online via your Lateral portal

lateral.uk



How to access my portal:

Visit **lateral.uk**



Scan the QR code.

What’s In This Policy Document

Lateral Health Plan Overview	01
Who Is Covered by This Policy	02
Important Information About Your Policy	04
Premium	04
Your Renewal and Auto-Renewal	04
Period Of Insurance	04
Cancellations	05
Pre-Existing Conditions And Their Symptoms	06
Chronic Conditions	08
Cancer	10
Making a Claim	12
Why Our Process Is Different	12
What Information Do I Need to Provide When I Make a Claim?	13
Pre-Authorisations	13
How to Access Healthcare with Lateral	14
A Guide to What’s Covered	16
Summary Of Benefits	16
Section 1: Healthcare Navigation	19
Section 2: Private Consultations and Diagnostic Tests	20
Section 3: Surgery in a Private Hospital	22
Section 4: Physiotherapy	30
Section 5: Annual Health Check	32
Section 6: Virtual GP	34
Section 7: Virtual Lifestyle & Dietitian Support	34
Section 8: Virtual Cancer Support	36
Exclusions (What’s Not Covered)	38
Conditions of Cover	42
Other Policy Terms	43
How to Make a Complaint	44

Lateral Health Plan Overview



The Lateral Health Plan is a collection of health services and insurance cover designed to support individuals aged 60+ to maintain good health and an active lifestyle.

It is designed to complement the NHS, offering private healthcare access where it is most helpful, while facilitating NHS care in other areas.

The Health Plan contains preventative health benefits including an annual health check and digital health services that support overall health and wellbeing.

When new health issues arise, policyholders are provided access to a care navigation service that can optimise medical treatment through the use of both NHS and private services.

If private care is required, policyholders can access consultations, diagnostic tests and elect to have a list of named surgical procedures in a private hospital.



Please remember that this Policy is not intended to cover all eventualities and is designed to complement rather than replace all the services provided by the National Health Service (NHS)

Who Is Covered by This Policy



To be covered by this Policy, you must:

- ✓ Live in the **United Kingdom (UK)**, and be legally allowed to live and work there
- ✓ Have been registered with a **doctor** in the **UK** for at least the **last 2 years**

We do not provide cover if you, at the outset of this Policy:

- ✗ Have a **BMI** below 18 or above 30
- ✗ Have **diabetes** (type 1 or type 2) that is not well controlled, where your most recent HbA1c result is 53.1 mmol/mol or above
- ✗ Are an active **smoker**. This includes having used cigarettes, cigars, a pipe, or nicotine products (including e-cigarettes, patches, gum, or vaping devices) in the last 12 months.
- ✗ Have been diagnosed with or treated for a **heart attack**, angina, or other serious heart condition requiring hospitalisation, surgery, or ongoing medication in the past 3 years
- ✗ Have been diagnosed with or received treatment for **cancer** in the past 5 years, except for non-melanoma skin cancers (e.g. basal cell carcinoma) that were fully removed and pre-cancerous cervical changes treated locally with no further follow-up required
- ✗ Have experienced **organ failure** (e.g. kidney, liver, or heart) or undergone an organ transplant
- ✗ Cannot **walk** 1 kilometre or 0.6 miles unaided

We will not renew your Policy if you, at the time of renewal:

- ✗ Have a **BMI** below 18 or above 30
- ✗ Have **diabetes** (type 1 or type 2) that is not well controlled, where your most recent HbA1c result is 53.1 mmol/mol or above
- ✗ Are an active **smoker**. This includes having used cigarettes, cigars, a pipe, or nicotine products (including e-cigarettes, patches, gum, or vaping devices) in the last 12 months.



It is important that you provide full and accurate information to us at the time you purchase and renew your Policy, and when you make any changes. This includes, but is not limited to, disclosing any of the matters above.

If you do not provide full and accurate information then we may be forced to void your insurance policy in full (in other words, treat it as though it never existed), and we may also need to retain premiums that you have already paid.

Important Information About Your Policy

This section includes important details about your Policy and the rules for pre-existing and chronic conditions.

Premium

The premium is the amount you pay us so we can provide you with this insurance.

We will collect premiums monthly in advance. It is important you keep up to date with your payments. We will not pay claims if you have any unpaid premiums.

 **Important**

If you miss a payment, you will have 30 days to pay and stay covered. If it still goes unpaid, we will cancel your Policy from the date the unpaid premium was due. You will not be able to request any care or treatment during any period of unpaid premiums.

Your Renewal and Auto-Renewal

If we offer you renewal terms, we will automatically renew your Policy so you do not lose any cover. We will write to you at least 3 weeks before your Policy is due to renew to let you know when it will renew, the price and terms for the next 12 months.

When your Policy renews, the annual benefit limits and excess also reset.

 **Important**

There will be things that can affect the price you pay when you renew. This can include your age, increased medical cost inflation and previous claims history. If you do not want to continue your cover with us when we write to you regarding renewal, please let us know.

Period of Insurance

Your Lateral Health Plan is an annual policy. The start date and renewal date are shown on your Policy schedule.

Your Policy continues as long as you pay your premium each month. If you fail to pay your premium within 30 days of its due date, your Policy will be cancelled and cover will end on the date the unpaid premium was due.

Cancellations

 By ‘claim’ here, we mean either using your Health Check, receiving any private treatment or using the nurse-led navigation service for an eligible and approved condition.

If you have not made a claim:

Within the cooling-off period:
If you request to cancel your annual Lateral Health Plan within 14 days of the start date as listed on your schedule (cooling-off period), you will receive a full refund of your premium.

After the cooling-off period:
If you pay monthly, your cover will end at the conclusion of your current billing cycle. No refunds will be issued.
If you paid annually upfront, you will be entitled to a pro-rated refund for the period of cover between the date you requested cancellation and the policy expiry date.

If you have made a claim:

No refunds will be issued, regardless of the time of cancellation if you have made a claim. You will need to pay any outstanding premium balance for your annual policy by the end of the original policy period. If you do not, we will be entitled to recover from you any claims we may have already paid during the policy year.

Pre-Existing Conditions and Their Symptoms



When we say ‘pre-existing medical condition’, we mean a symptom, condition or disability that you knew about when you bought this insurance.

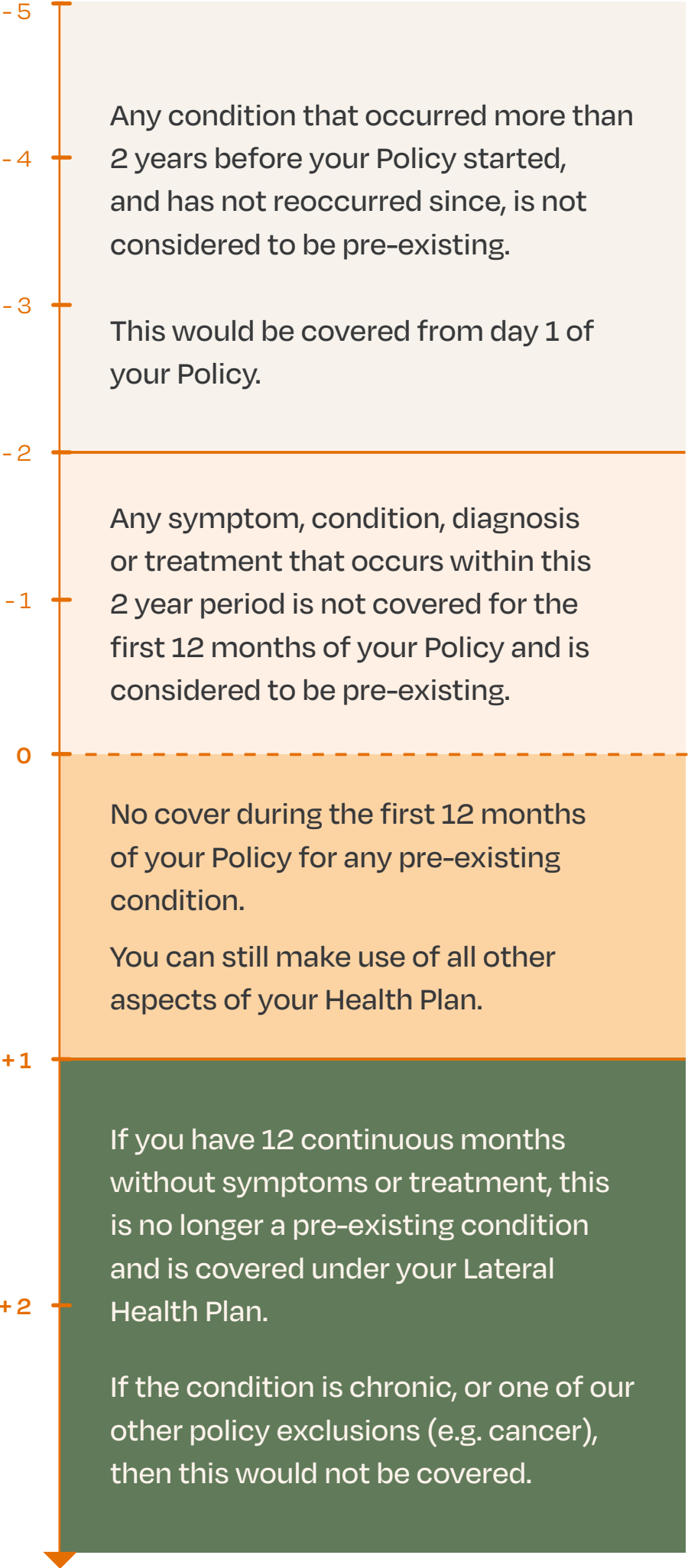
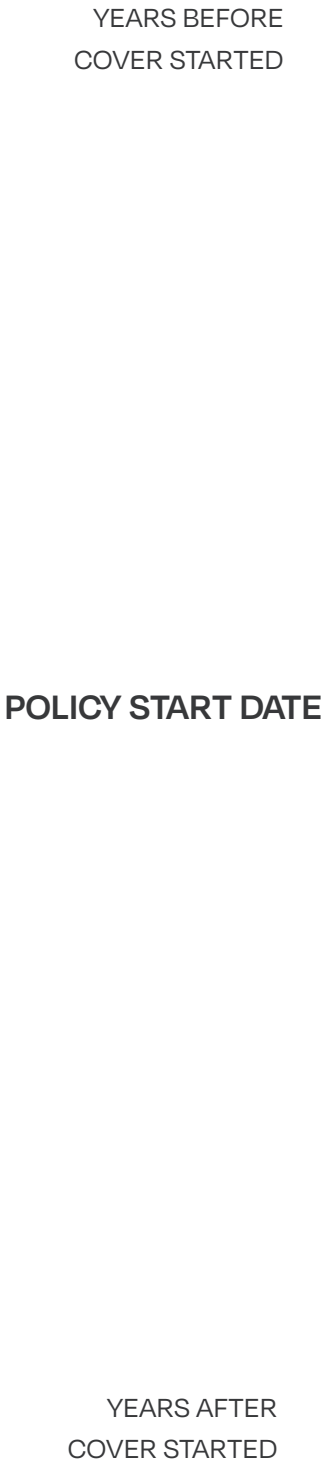
At the outset of your Policy, we do not cover any pre-existing conditions that you were aware of during the two-year period preceding the start date of your current continuous period of cover (cover start date).

Once you have been symptom-free and have not consulted a doctor, taken medication, or sought treatment for that condition for 12 consecutive months from your cover start date, we will then be able to include cover for the original condition.

Any older condition that occurred prior to, and did not reoccur within, the 2 years before your Policy start date, is NOT considered a pre-existing condition.

You should not put off treatment or avoid seeking advice in order to try to comply with our cover requirements, as it would not impact our assessment of pre-existing conditions.

If you are in any doubt about this section, please get in touch with the Lateral support team before purchasing.



Chronic Conditions



How do we define a chronic condition?

We define a chronic condition as a disease, illness or injury that has one or more of the following characteristics:

- Needs ongoing or long-term monitoring through consultations, check-ups or tests
- Needs ongoing or long-term control or relief of symptoms
- Requires rehabilitation or training to cope with it
- Continues indefinitely
- Has no known cure



This Policy is designed to cover the costs of treatment for acute conditions, i.e. medical problems that respond quickly to treatment.

We pay for:

- ✓ Treatment of an acute condition
- ✓ Initial investigations to establish a diagnosis of a new condition
- ✓ Treatment of acute flare-ups or complications, in order to bring the condition back under control

Your Policy will cover you for limited stages of treatment of a chronic condition:

- Initial investigations to establish a diagnosis
- Treatment of acute flare-ups or complications, in order to bring the condition back under control

We will also pay for the first eligible surgical treatment relating to a chronic condition, provided:

- The diagnosis is made at least six months after your Policy start date, and
- No other exclusion applies



What if my condition is chronic and gets worse?

We will pay for short-term treatment of acute exacerbations or complications (flare-ups) in order to bring the condition back to its controlled state.

However, there are certain conditions that are likely to require ongoing treatment, recur or have frequent flare-ups, such as Crohn's disease (inflammatory bowel disease). Because of the ongoing and unpredictable nature of these conditions we will write to tell you when the benefit for that condition will stop.



It is not intended to cover long-term, ongoing, or recurrent care of chronic conditions.

We do not pay for:

- ✗ Ongoing, recurrent, or long-term treatment of any chronic condition
- ✗ Monitoring of a medical condition (e.g. routine check-ups or tests)
- ✗ Routine follow-up consultations
- ✗ Frequent flare-ups of a chronic condition over a short period of time

We will not pay for subsequent complications, deterioration, or treatment directly linked back to the chronic condition after that point.

If a condition has failed to improve following treatment we may then consider it to be a **chronic condition that is not eligible for cover**. This could include having more than one joint replacement revision. Should this happen we will let you know.

Cancer



This Policy does not cover private cancer treatment. If you need treatment for cancer, you will receive your care through the NHS.

NHS cancer care offers world-class treatment and access to nationally recognised clinical pathways, including rapid referral routes and access to specialist centres of excellence.

Cancer treatment is usually complex, multi-step and requires close coordination between a wide range of specialists such as surgeons, oncologists, radiologists, pathologists and specialist nurses. The NHS delivers this at scale, through dedicated cancer centres that bring all these services together under one roof.

While your cancer treatment will be delivered by the NHS and is not covered by this Policy, we have partnered with Reframe who provide wrap-around guidance and support to help you navigate your cancer diagnosis, treatment and recovery.

We've partnered with Reframe Cancer to give you access to their expert-led support when you need it.

➔ Please see "Section 8: Access to Virtual Cancer Support" section for more details.

Reframe provide expert cancer navigation and support across all cancer types, at every stage of the cancer pathway - from diagnosis through treatment, recovery and beyond.

Diagnostic tests related to cancer are not covered when cancer is the most probable diagnosis (such as biopsy of solid lesions, except endoscopy-related biopsies). Procedures primarily intended to confirm a cancer diagnosis are also excluded from coverage. Such investigations should be pursued through NHS services.

However, we will cover diagnostic tests (see Section 2: Private consultations and diagnostic tests) where cancer is one of the possible diagnoses (such as radiological imaging or endoscopy).

Specifically, we do not pay for:

- ✗ Private surgery, radiotherapy, chemotherapy, or cancer drug treatments
- ✗ Private inpatient or outpatient care related to cancer
- ✗ Private diagnosis, staging or monitoring of cancer (including scans and tests done privately for this purpose)
- ✗ Private palliative care for cancer
- ✗ Private follow-up appointments or aftercare relating to cancer treatment



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Making a Claim

We know that navigating healthcare can feel complicated. That's why we've designed a process that doesn't start with paperwork or authorisation codes, but with a conversation.

With Lateral, your first call is always to a nurse who can guide you through your options and help you feel confident about your next steps.

If, for whatever reason, you require someone else to manage claims on your behalf, please contact the Lateral support team where we will be able to assist in setting up an authorised representative.

Why Our Process Is Different

With many insurers, making a claim is a transactional step where you phone up, get a code, and are left to make arrangements yourself.

At Lateral, claims are about **helping you get the right care at the right time**, not just about paying bills.

We have designed our claims process to:

- ✓ Put your long-term health outcomes first
- ✓ Give you a single, trusted point of contact
- ✓ Balance NHS strengths with private options to get you the best of both worlds
- ✓ Ensure you are never left alone to navigate complex systems

Your claims experience with us should leave you feeling supported, respected, and cared for - not just covered.

What Information Do I Need to Provide When I Make a Claim?

When you call us, we will explain if your treatment is covered. Our claims team will need some medical details to ensure that your claim meets the policy conditions. Occasionally to confirm cover we might need access to your medical records.

For example, we may need more detailed information in any of the following ways:

- We may need to write to your GP or your consultant to send us more details about your medical condition. The charges for this are covered by your Policy up to the amount of £50 for the medical report(s) per claim.
- If we have any questions regarding the diagnosis, we may have to ask a specialist to advise us on the medical facts. We may also ask you to give us consent to access your medical records.

Please note that if you are not willing to give us any information that we ask for, or you do not consent to our accessing your medical records, then we may not be able to assess your claim and may not be able to pay it.

Pre-Authorisations

If you want to make a claim, you must get a pre-authorisation code to make sure your claim is valid. You will not be able to get a pre-authorisation code once a treatment, appointment, investigation or procedure has taken place. Once you have a pre-authorisation code you can go ahead and get the care you need. If you book a pre-authorised treatment yourself, you must tell us about your claim within 3 months of the treatment taking place. If you wait longer than this, we may not be able to cover the cost.



We can only pay for treatment that:

- Took place while your Policy was active, or
- Was authorised by us during that period.

If your cover has already ended, we cannot authorise new treatments - even if the condition began while you were insured.

How to Access Healthcare with Lateral

01 Call Our Nurse Navigation Service

Whenever you need help, guidance or are considering whether private care might be right – *please call our nurse-led navigation service.*

- You will speak directly to a qualified nurse, not a call centre or administrator.
- The nurse will listen carefully, understand your medical situation and personal circumstances, and review any referral notes from your GP.
- They will explain, in clear language, what your Policy covers and how this sits alongside your NHS care.

This first step is designed to make you feel supported and informed from the outset.

 If you intend to claim for any private consultations, diagnostics or surgeries, you will need a referral from your GP first. You may want to do this before calling our nurse navigation service to speed up your experience.

 Our Nurse Helpline is available **Monday - Friday**
08:00 to 20:00, Saturday 09:00 to 15:00

 **0203 432 2401**
 **claims@lateral.uk**

02 Exploring Your Options

Your nurse will help you weigh up both NHS and private pathways:

 **NHS care.**
You will be supported to make the most of the NHS options available, including the “Right to Choose,” which can give faster access to appointments, sometimes in local private hospitals at no cost to you.

 **Private care.**
Where private treatment is determined as the way forward, the nurse will explain what is covered under your Plan. For example, specialist consultations, diagnostic scans, or certain surgical procedures. Where appropriate, the nurses can suggest consultants who also work in the NHS which may be important for ensuring continuity of care.

The focus is on finding the best outcome for your long-term health, not simply the fastest appointment. Our nurses will support you to make the best choices for long-term sustainable health management. This is especially important for conditions that may become chronic with age.

You remain in control at every stage. We provide guidance and support, but all decisions about your care are yours to make.

03 Arranging and Authorising Your Claim

If private care is the right choice, our nurses and specialist claims team will help set everything up.

- We will arrange the appointment on your behalf and confirm what we will cover under your Plan.
- We will explain any limits, excesses, or shortfalls in advance, so there are no surprises.

This is different from most insurers. You do not have to chase authorisation codes or navigate multiple phone calls, we will do the heavy lifting for you.

 Please do not book or pay for medical appointments before speaking to our nurses. This Policy does not cover unauthorised claims and we will not fund claims unless they are pre-approved by us.

04 Ongoing Support

You will have an assigned nurse throughout your care journey. They can:

- Check in on how your appointments went;
- Help chase results or reports if there are delays;
- Offer further guidance if your situation changes or new decisions are needed.

Our goal is for you to feel supported until your health issue is resolved or you have a clear healthcare management plan in place.

A Guide to What's Covered

This section explains the scope of your cover and what you can claim for. The list of exclusions (What Is Not Covered) can be found in full on pages 40-43.

Health Insurance and Lateral's Nurse-led Navigation

	Plan Benefits	Description	Annual Plan Limits And Restrictions
Section 1	Healthcare Navigation	Lateral's nurse-led navigation service, designed to help you make informed decisions and get the most from your healthcare options.	Fair use policy applies
Section 2	Private Consultations and Diagnostic Tests	Private consultations and diagnostic tests provided they are approved and arranged by our nurses	Up to £2,000 per year £100 excess for the first claim during the policy year
Section 3	Surgery in a Private Hospital	Hospital charges and specialists' fees directly related to eligible surgical procedures, which are medically necessary to treat acute conditions, in a hospital facility.	Only named surgery codes covered up to a maximum contribution per code Minor procedures: up to £5,000 per year Major procedures: up to £50,000 per year

Stay-Healthy Benefits

	Plan Benefits	Description	Annual Plan Limits And Restrictions
Section 4	Physiotherapy	Access to virtual and in-person physiotherapy services	Virtual access: Up to 6 sessions per year In person access: Up to 6 sessions per year
Section 5	Annual Health Check	Fully funded annual health check	1 health check per policy year
Section 6	Virtual GP Service	Telephone or video consultations with a UK-based GP	Fair use policy applies
Section 7	Virtual Dietitian Service	Telephone or video consultations with a UK-based dietitian	Up to 3 sessions per year
Section 8	Virtual Cancer Support Service	Wrap-around support alongside your NHS treatment, providing guidance, emotional support and personalised care to help you navigate your cancer journey.	On referral by Lateral



Please remember that this Policy is not intended to cover all eventualities and is designed to complement rather than replace all the services provided by the National Health Service (NHS)



Section 1

Healthcare Navigation

This Policy provides access to a nurse-led navigation service, designed to help you make informed decisions and get the most from your healthcare options.

Run by qualified case-management nurses, the service offers personalised support to help you understand your diagnosis and explore treatment pathways.

They will work with you to identify the most appropriate care pathway and, where appropriate, support you to access faster treatment using the NHS e-referral service. This may include arranging appointments in local private hospitals where care is funded by the NHS.

The service does not provide medical advice or make treatment decisions, but your dedicated nurse can guide you through the system, explain what to expect, help reduce delays, and support you emotionally and practically throughout your care journey.

This service is designed to wrap around your NHS and private care - helping you get timely access, understand your choices, and feel supported throughout your health journey. Our nurses provide guidance and support, but all decisions about your care are yours to make.



You must have already seen your doctor before using this service. This can be your local NHS GP, a HealthHero GP or any other privately registered UK GP. Our nurses will ask to see your doctor's referral note, which must be dated after your Policy start date.

While care can be delivered through the NHS, there are times when the use of private consultants can help speed up diagnosis, clarify treatment options, or provide additional reassurance — particularly where timely access to specialist input can make a meaningful difference.

You are covered for the cost of private consultations and diagnostic tests up to the amount shown in this section, provided they are recommended and arranged by our specialist claim handlers.

Before accessing this cover:

- 1. **You must have consulted a doctor first.**
We will need your doctor’s referral note, dated after the policy start date shown on your schedule.
- 2. **You will then need to speak to our specialist claims team.**
Our specialist claims team are here to support you. They are here to help you understand your options and make it easier to access all levels of care.

We pay for:

- ✓ **Specialist consultations**
- ✓ **Consultant referred tests and diagnostic scans**, including blood tests and scans such as MRIs, CT, PET, ECGs, X-rays and ultrasounds

Up to a limit of £2,000 limit per policy year

 **Endoscopic procedures** - if referred, these are included too, subject to the list of procedures and limits in “Section 3: Surgery in a Private Hospital”.

We do not pay for:

- ✗ **Cancer**
 - ✗ Consultations or treatment related to cancer
 - ✗ Biopsies to investigate potential cancer
 - ✗ Diagnostic procedures primarily intended to confirm a cancer diagnosis
- ✗ **Complementary therapies.** Treatment provided by complementary or alternative medicine practitioners (including, but not limited to, acupuncture, chiropractic, osteopathy, homeopathy, naturopathy, Chinese medicine, Ayurveda, herbalism, or reflexology), whether or not the practitioner is registered
- ✗ **Mental health.** Treatment, consultations, therapy, or counselling relating to mental health conditions
- ✗ **Drugs or medicines** prescribed for use outside hospital
- ✗ **Dressings or medical appliances**, including hearing aids
- ✗ **£100 excess** for the first claim during the policy year

For older adults, complex conditions such as major surgeries and emergencies are often best managed by the NHS, which is highly experienced and equipped for such care.

This Policy focuses on covering common later-life procedures that deliver significant quality-of-life benefits and can be safely performed in private hospitals.

This Policy covers you for the hospital charges and specialists’ fees directly related to eligible surgical procedures, which are medically necessary to treat acute conditions, in a hospital facility.

! It does not include emergency surgical procedures and procedures related to cancer.

Summary of Surgical Benefits

	Description	Plan Limits And Restrictions
Minor procedures	Specified list of minor procedures and diagnostic endoscopic procedures	Annual cap per policy year of £5,000
Major procedures	Specified list of major procedures, focused on elective, quality of life enhancing procedures that are safe to perform in a private setting	Annual cap per policy year of £50,000 Fully covered within Lateral Hospital network, defined contribution per procedure code. Annual policy limits still apply.

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What is the Lateral Hospital Network?

The Lateral Hospital Network is a group of private hospitals and healthcare providers with whom we have agreed treatment arrangements.

The hospitals included in the Lateral Hospital Network may change from time to time. For the most up-to-date list, please visit [lateral.uk](#) or speak to our claims team.

i

Benefits for surgery under your Plan may be different when you are not using our medical network, so it is important that you bear this in mind when choosing where to have your treatment.

If you use this Policy outside of the Lateral Hospital Network for private treatment, please be aware that the amount we pay out may not cover the full cost of the surgery. If it does not, you will have to fund the difference yourself.

Within the Lateral Hospital Network we pay for:

- ✓ **Hospital charges** including hospital standard accommodation and meals, theatre fees, nursing care, operation and inpatient drugs, consumable equipment, surgical dressings, and NHS equivalent prostheses. Standard pre-anaesthesia tests (ECG, chest X-ray and coagulation analysis)
- ✓ **Specialist fees** charged by the surgeon and his team to perform the eligible surgical intervention and the fee for one consultation with the treating surgeon before the intervention and one post-operative consultation and histology/pathology test, where authorised
- ✓ **Anaesthetist fees** for standard pre-operative consultation and intervention during the surgical procedure
- ✓ **Drugs, dressings and medical devices used while you are an inpatient or day-patient**, where these are required as part of your covered treatment
- ✓ **Post-operative physiotherapy** will be covered if prescribed by the treating physician up to the agreed number of sessions per procedure. This will be agreed at the point of our authorisation.
- ✓ **Procedure complications.** Costs to treat complications directly related to the surgical intervention will only be covered until you are clinically stable to be transferred to an NHS hospital for further treatment if required. Section limits of the Policy still apply.

Outside of the Lateral Hospital Network we pay for:

- ✓ If you choose to receive treatment outside of our recognised hospital network, we will pay up to our agreed maximum contribution per procedure.



You will be responsible for paying any difference directly to the hospital or consultant.

Please be aware that procedures undertaken outside of the Lateral Hospital Network may not have the equivalent inclusions. This will be clearly explained to you by our specialist claim handlers.

We do not pay for:

- ✗ **Take-home drugs or medicines prescribed on discharge**
- ✗ **Long-term or repeat prescriptions**
- ✗ **Dressings, supports, braces, crutches, orthotics or prosthetics for use outside hospital**
- ✗ **Medical devices or appliances for ongoing management of a condition** (e.g. hearing aids, CPAP machines, insulin pumps, oxygen equipment, catheters or stoma supplies)
- ✗ **Travel costs to or from a hospital**
- ✗ **Personal items such as telephone calls, newspapers, alcoholic refreshments, cosmetics or personal laundry service**
- ✗ **Residential stay in a hospital arranged wholly or partly for domestic reasons, or which is not directly related to the treatment of a medical condition**

Surgeries & Procedures Covered by Lateral

How to understand these tables

- 1. The surgical procedures covered by your Policy are listed below with the corresponding CCSD code.
- 2. These are first categorised by either Major procedures (up to £50,000) or Minor procedures (up to £5,000)
- 3. Then split into main issues or body parts (Category)
- 4. Where relevant, sub categories of different procedures or specific body parts are listed (Subcategory)
- 5. The CCSD codes then detail the specific treatments, surgeries or treatments.

Minor Procedure List - up to £5,000 per policy year

Category	Subcategory	CCSD Code
Abscess and Haematoma	Incisions and drainage	D0410, S4720, S4740
Endoscopy	Bronchoscopy	E5100, E5180
	Capsule endoscopy	G8080, G8081, G8086, G8087
	Cystoscopy	M3820, M3900, M4210, M4230, M4320, M4400, M4420, M4480, M4510, M4514, M4712, M4714, M5600, M5820, M7700, M7920
	ERCP	J3800, J3801, J3900, J4300, J4301
	Colonoscopy and Sigmoidoscopy	H2001, H2002, H2350, H2380, H2502, H2503, H2510
	Nasopharyngeal endoscopy	E1780, E2400, E2500, E2501
	Oesophago-gastro-duodenoscopy	G4410, G4430, G4520, G6500, G8082, G8083, G8084, G8085
Eyelid surgery	Correction of ectropion/entropion	C1512, C1513, C1522
	Eyelid lesion removal and local reconstruction	C1110, C1210, C1230
	Ptosis correction	C1810, C1812
Haemorrhoids procedure		H5100, H5101, H5230, H5240
Joint injection/aspiration		W9030, W9035, W9040, W9045, W9111, W9112, W9170, W9240, W9282
Skin lesion removal		E0910, F0200, S0632, S0633, S0642, S0643, S0651, S0652, S0654, S0655, S0820, S1110
Spinal injection		A5200, A5210, A5211, A5220, A5743, A5744, A5745, A5753, A5754, A5755, A5756, A5763, A5764, A5765, A5766, A5773, A5774, A5775

i What are CCSD codes?

CCSD (Clinical Coding & Schedule Development code) is a standard alphanumeric code used in the UK private healthcare sector to describe medical procedures and diagnostics. These codes are most relevant and useful to any clinical practitioner reviewing what is available under this Policy.

The maximum amount that we will pay if accessed outside of the Lateral Hospital Network can be confirmed by calling our claims team. To learn more about our covered procedure list and the current Lateral Hospital Network, please see the Lateral website.

Before accessing this cover:

- 1. **You must have consulted a doctor first.**
We will need your doctor's referral note, dated after the policy start date shown on your schedule.
- 2. **You will then need to speak to our specialist claims team.**
Our specialist claims team are here to support you. They are here to help you understand your options and make it easier to access all levels of care.

Section 3

Major Procedure List - up to £50,000 per policy year

Category	Subcategory	CCSD Code
Abdominal wall hernia repair		T1900, T1910, T2000, T2002, T2008, T2010, T2012, T2014, T2017, T2020, T2021, T2022, T2023, T2024, T2100, T2102, T2110, T2112, T2200, T2300, T2400, T2740
Bunion correction surgery		W0321, W0322, W0323, W0324, W7900, W7910, W7921, W7922, W7980
Cataract surgery		C7100, C7110, C7122, C7123, C7124, C7180, C7190
Dupuytren's fasciectomy		T5202, T5203, T5210, T5222, T5223, T5410
Enlarged prostate surgery		M6100, M6530, M6532, M6533, M6620, M7080
Gallbladder surgery		J1800, J1830, J1880
Ganglion cyst or bursa surgery		T5900, T6000, T6220
Gynaecological procedures	Hysterectomy	Q0740, Q0750, Q0751, Q0790, Q0800, Q0830, Q0890
	Hysteroscopy	Q1702, Q1703, Q1800, Q1802
	Laparoscopy	Q3800, Q3900
	Myomectomy	Q0920
	Oophorectomy (laparoscopic or open)	Q2081, Q2230, Q2231, Q2232, Q2233
	Procedure on cervix	P2730, Q0220, Q0230, Q0330
	Repair of prolapse of womb or vagina	P2210, P2230, P2310, P2340, P2380, P2390, P2450
	Repair of vaginal fistula	P2510, P2520, P2530
	Surgery for stress incontinence in women	M5100, M5220, M5300
	Vulval procedure	P0310, P0320, P0600, P0610
Hydrocele Repair		N1100, N1101
Joint repair surgery	Arthroscopic joint procedure	W7400, W7430, W7482, W7483, W7484, W7485, W7500, W7530, W8200, W8300, W8600, W8602, W8620, W8645, W8646, W8650, W8680, W8800, W8820, W8830, W8840, W8880
	Hip replacement	W3712, W3713, W3717, W3732, W3733
	Knee joint repair	W5810, W7410, W7480, W7490, W7580, W7583, W7730, W8230, W8280, W8400, W8500, W8520, W8580
	Knee replacement (partial or total)	W4200, W4210, W4212, W4280, W5200, W5201, W5210, W5800
	Shoulder arthroscopy and repair	T7910, T7915, T7916, W7718, W7719, W7872, W8110, W8193, W8194
	Shoulder joint repair	W8603
	Shoulder replacement (partial or total)	W4900, W4930, W5000, W5030
	Shoulder soft tissue surgery	T7917, T7981, T7982, T7990, W7713, W7780, W7810
Kidney stone procedure		M0910, M0940, M1400, M2310, M2730, M3110, M3111, M4410
Nasal/Sinus Surgery	Removal of adenoids	E2010
	Surgery on sinuses	E1220, E1240, E1260, E1310, E1330, E1350, E1360, E1370, E1380, E1410, E1432, E1480, E1500, E1742
	Surgery to correct impaired nasal airflow including removal of nasal polyps	E0310, E0340, E0360, E0412, E0420, E0440, E0810, E0820, E0850
Nerve decompression or repair	Carpal tunnel release	A6510, A6530, A6570, A6580
	Cubital tunnel release	A6710, A6711, A6740
	Other nerve release/repair	A6400, A6600, A6700, A6810, A6900
Rectal prolapse surgery		H3380, H3500, H4200
Tendon surgery	Tendon Release or Lengthening	T6910, T6914, T6980, T6982, T7050, T7231, T7232, W7880, W7881
	Tendon Repair and Reconstruction	T6710, T6750, T6752, T6762, T6763, T6770, T6780, T6782, T6800, T6810, T6820, T6822, T6830, T6832
	Tendon Transfers and Grafts	T6402, T6410, T6450, T6460, T6461, T6462, T6580
	Tenosynovectomy	T7010, T7110
Thyroidectomy and Parathyroidectomy	Parathyroidectomy	B1450, B1680
	Thyroidectomy	B0812, B0820, B0830, B0860
Varicose Veins procedure		L8510, L8512, L8513, L8514, L8515, L8520, L8540, L8541, L8542, L8543, L8620, L8621, L8700, L8750, L8751, L8780, L8880, L9000

As we grow older, maintaining mobility, strength and balance becomes increasingly important to our overall health and independence. Everyday aches, joint pain or stiffness can begin to affect how we move.

Physiotherapy plays a vital role in helping individuals stay active, recover from injury, and manage age-related conditions such as arthritis, back pain or reduced flexibility. Early intervention can make a significant difference - helping you stay confident on your feet, continue the activities you enjoy, and reduce the risk of falls or long-term pain.

Physiotherapists can help with:

- ✓ Musculoskeletal conditions, including joint, back and soft tissue issues
- ✓ Rehabilitation following illness, injury or surgery
- ✓ Posture, flexibility and movement problems
- ✓ Pelvic floor issues, balance issues, respiratory issues and other covered acute conditions where physiotherapy is recommended by a consultant

This Policy includes access to HealthHero’s Digital Physiotherapy Service, designed to support recovery from injury, pain or reduced mobility. You will have an initial virtual assessment with a qualified physiotherapist, followed by a personalised digital treatment plan.

Suitability for virtual treatment is assessed on a case-by-case basis. Support may include up to six video sessions, a guided home exercise programme, pain tracking, and onward referral to your GP if further investigations are needed. Use of the digital physiotherapy service does not count towards your in-person physiotherapy session limit.

If required, your Policy also includes up to six in-person physiotherapy sessions when recommended by a GP, consultant or specialist in connection with a condition covered by your Policy. These will be delivered by our approved supplier list.

Benefit		Access	Plan Limits
Digital Physiotherapy Service	Rapid virtual physiotherapy appointments, usually available within 24-48 hours, via secure video call on your phone, tablet or computer.	Self-refer and access via the Lateral Members portal	Up to six sessions per policy year
	Access to our approved digital physiotherapy service, which provides tailored exercise plans, progress tracking, and remote support.	Use of this service does not count towards your outpatient physiotherapy session limit.	
		This service can also be used to manage chronic conditions.	

In-person Physiotherapy Sessions	In-person physiotherapy sessions or hands-on physical treatment for new and acute conditions.	GP or specialist referral required before access	Up to six sessions per policy year
			In-person sessions cannot be used for chronic condition management.

We do not pay for:

- ✗ Ongoing or maintenance in-person physiotherapy for chronic conditions
- ✗ Self-referred physiotherapy unless carried out through our virtual service
- ✗ Alternative or complementary therapies (e.g. chiropractic, osteopathy, acupuncture).
- ✗ In-person physiotherapy delivered outside of our approved supplier list, which has not been pre-authorised by us

If further diagnostics or specialist referrals are advised, please speak to our specialist claims team. They are here to help you understand your options and make it easier to access all levels of care.

We’ve partnered with Bluecrest Wellness to deliver our Annual Health Check, designed to help you stay on top of your health and spot potential risks early.

Each year, you will be entitled to one fully-funded health assessment, specifically designed to support individuals aged 60+. This is more than just a check-up, it is a comprehensive review of your health, delivered in a convenient and professional setting.

This assessment will help identify early signs of conditions such as heart disease, diabetes, kidney diseases, and more, supporting you to stay healthier for longer.

Through Bluecrest, you will benefit from:

- A choice of hundreds of clinic locations nationwide, making it easy to attend your appointment close to home or work.
- A tailored health check that will include tests and measurements such as:
 - Blood pressure, pulse and BMI checks
 - Cholesterol and diabetes checks
 - Liver and kidney function tests
 - Vitamin and mineral profiles, including Vitamin D
 - Heart rhythm screening (ECG)
 - Inflammation markers linked to heart disease and other conditions

A personalised, easy-to-understand digital health report, explaining your results in clear language and helping you take action if anything needs attention.

If your Health Check results suggest further medical investigations, please consult with your NHS GP or our Virtual GP service (see Section 6) and speak to our claims team for support in navigating your Lateral Health Plan and options.

If your Health Check unveils something you were not aware of before taking out the Policy and impacts your eligibility for this Policy, you will be able to remain under cover for the duration of the policy term. You will still be able to access Lateral services (e.g. virtual dietitian) to help support your health. At the point of renewal, if you can demonstrate more recent results that mean you now meet the eligibility criteria for the policy, you will be able to renew.

Important to Know

- 01

Only one health check per person is funded each policy year.

During your health check, you may be offered the option to add-on further tests to your health check package. These are not covered by this Policy and you will be responsible for paying for any extra tests yourself.

Only the Lateral Health Check provided by Bluecrest is covered under this Plan. We will not pay for any other health checks.
- 02

If your health check report clearly demonstrates that your health status did not meet our eligibility criteria questions that you answered when purchasing your Lateral Health Plan, we will void your Policy in full (in other words, treat it as though it never existed). We may also be entitled to retain any premiums you have paid and cover for any ongoing claims will end with immediate effect.
- 03

It is a condition of policy renewal that you complete and share the results of your annual health check with us each policy year. This helps us tailor our products and services to best meet your health needs and achieve our goal of supporting you to stay healthy and active for longer.

 - Throughout your Policy year, we will send you regular reminders and prompts to book.
 - Ahead of renewal, we will contact you regarding your renewal with a final deadline to attend your Health Check.
 - **If you have not completed your Health Check**, we will not be able to offer you a renewal quote and your Policy will lapse at the end of your current policy year.

We reserve the right to substitute service providers at any time, where necessary to maintain service quality or ensure the overall effectiveness of the policy.

We’ve partnered with HealthHero to provide access to a 24/7 virtual GP service.

HealthHero provides private GP services designed to help you get medical advice and treatment quickly, without waiting for a routine NHS GP appointment. This service offers convenient, confidential access to experienced GPs — anytime, from anywhere — helping you get the care you need without waiting for a routine NHS appointment.

HealthHero GPs can provide:

- ✓ Medical advice, reassurance and diagnoses where appropriate
- ✓ Private prescriptions, available for home delivery or local pharmacy collection
- ✓ Open referral letters

Appointments can be booked by phone or video, including same-day appointments where available.

This service provides private video GP consultations only. It does not include:

- ✗ Face-to-face consultation or examination
- ✗ Private referrals or the costs of private specialist consultations or treatments that may follow
- ✗ Private prescriptions costs (the cost of medication itself).
- ✗ Routine or repeat prescriptions for chronic conditions
- ✗ Emergency medical treatment.

If further diagnostics or specialist referrals are advised, please speak to our claims team for support in navigating your care plan and options.

We reserve the right to substitute service providers at any time, where necessary to maintain service quality or ensure the overall effectiveness of the Policy.

We’ve partnered with HealthHero to provide access to registered dietitians through HealthHero’s virtual dietitian service.

Following an initial assessment, you will receive tailored dietary and lifestyle advice, designed to support your long-term health, up to a total of 3 follow-up sessions.

This service can help with:

- ✓ Weight management and healthy eating
- ✓ Digestive conditions (e.g. IBS, coeliac, GORD)
- ✓ Metabolic and hormonal health (e.g. diabetes, PCOS)
- ✓ Food intolerances, allergies and skin-related nutrition concerns
- ✓ Bone health, men’s and women’s health, and general wellbeing
- ✓ The service includes one assessment and up to three follow-up sessions, with additional digital resources and dietary tools available to support your goals

We reserve the right to amend, withdraw or substitute service providers or specific benefits at any time, where necessary to maintain service quality or ensure the overall effectiveness of the Policy.

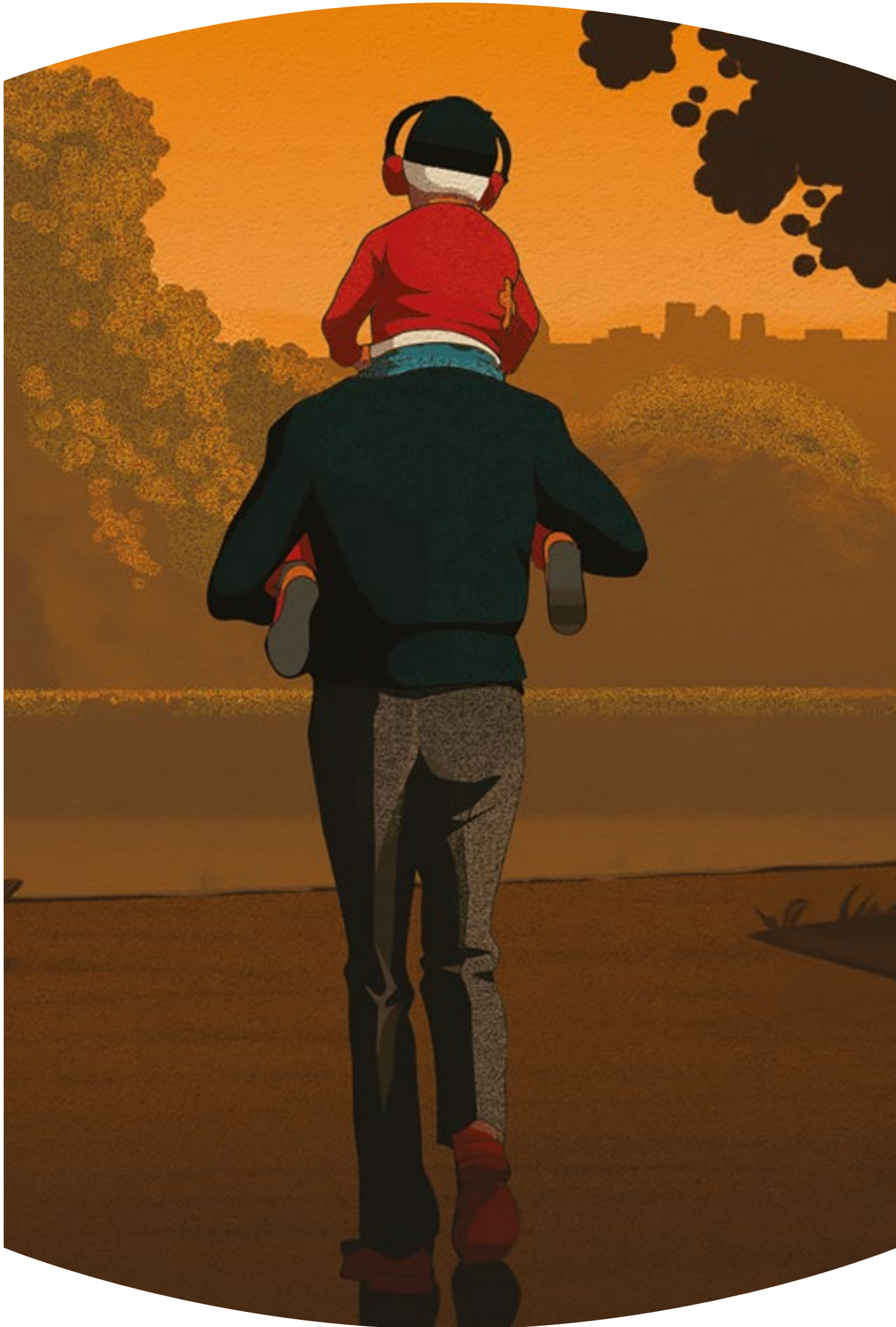
We've partnered with Reframe Cancer to give you access to their expert-led support when you need it.

Reframe provide expert cancer navigation and support across all cancer types, at every stage of the cancer pathway - from diagnosis through treatment, recovery and beyond.

Through Reframe, you'll have:

- ✓ Access to an experienced cancer nurse for support if you are worried about symptoms, facing a diagnosis, undergoing treatment or adjusting to life after cancer
- ✓ A growing library of expert-created resources, including videos, webinars and articles to support education, wellbeing and recovery

We reserve the right to substitute service providers at any time, where necessary to maintain service quality or ensure the overall effectiveness of the Policy.



Exclusions (What Is Not Covered)

This section explains the circumstances which are not covered by your Lateral Health Plan.

General Medical Exclusions

- ✗ **Accidents and emergencies requiring immediate surgery.** We will not pay for treatment in the accident and emergency department or for admissions resulting from such visits. We will, however, pay for eligible surgical treatment if the condition can be stabilised and further management deferred as a planned procedure, provided no other limiting policy conditions apply to any such claim.
- ✗ **Cancer.** We do not fund tests or treatment for cancer, carcinoma in situ, low malignant potential and pre-malignant conditions and any other directly related conditions.
- ✗ **Organ transplant.** We will not pay for any condition requiring organ transplant such as heart, lung, kidney, cornea, or bone marrow. These require a multidisciplinary approach and should be best undertaken within the NHS.
- ✗ **Dialysis.** We will not pay for kidney dialysis (haemodialysis) for a chronic condition. We will pay for haemodialysis for an acute complication following a surgical procedure authorised under this scheme, undertaken as an inpatient, for a short time. We will not pay for peritoneal dialysis for a chronic condition.
- ✗ **Mental health** and behavioural disorders
- ✗ **Speech or language therapy (SLT)**
- ✗ **Sleep disorders**, other than Obstructive Sleep Apnoea (OSA)
- ✗ **Cosmetic** procedures or surgeries
- ✗ Investigation or treatment for **allergies and intolerances**
- ✗ **Obesity**, weight loss drug treatments or other bariatric care
- ✗ **HIV/AIDS.** We will not pay for any condition arising as a result of AIDS or HIV exposure.
- ✗ **Fertility, infertility, contraception and gender reassignment.** We will not fund any treatment to investigate or manage fertility/infertility, procedures done for contraceptive purposes or gender reassignment surgery.
- ✗ **Other specialist fees and expenses related to co-morbidities** or complications that may require additional medical services provided by different medical specialities

- ✗ Any **additional surgical procedures** performed during the authorised surgery that are not directly related to the primary procedure for which approval was granted
- ✗ **Costs of diagnostic tests other than standard pre-operative testing** (ECG, chest x-ray and blood testing) and related histology/pathology tests, where authorised
- ✗ **Treatment or admission where no approved procedure is planned.** We only authorise treatment or hospital admissions where a procedure approved under the scheme is being undertaken. *See below for further clarification.*
- ✗ **Surgical needs during surgery and admission due to underlying conditions known prior to surgery** or specific patient preferences, and that deviate from the usual needs of healthy people in this type of intervention. Among these are the need for evaluation and follow-up by other specialists after surgery and the use of special medications
- ✗ **Any excess** for the first claim in each policy year and any other expenses, whether medically necessary or not, beyond the policy limit
- ✗ **Treatment undertaken by non-specialists.** We will only fund treatment if undertaken by a medical specialist on the GMC specialist register and meets our quality standards.
- ✗ **Unauthorised claims.** We will not fund claims unless they are pre-approved by us.

Medications, Devices and Routine Care

- ✗ **Private prescriptions**
- ✗ **Outpatient drugs, dressings or medical appliances**
- ✗ **Crutches, medical devices and medical equipment**
- ✗ Any **home modifications**
- ✗ **Routine eye care.** We will not fund any visits to opticians, pay for glasses or contact lenses or for corrective laser eye surgery.
- ✗ **Dental treatment.** We will not pay for any dentist consultation, dental or oral test or treatment.
- ✗ **Visits to your GP.** We will not pay for any private GP visits outside of our virtual GP service.

Exclusions (What Is Not Covered)

Long-term Conditions That Require Ongoing Medical Management

- For more details see section on Chronic conditions
- ✗ **Chronic illnesses and their complications.** We will not fund treatment required due to the expected deterioration of chronic conditions or complications that are known to be associated with or arise from chronic conditions once the first eligible surgical treatment has been authorised, and no other limiting policy conditions apply.
 - ✗ **Congenital or genetic disorders.** We will not fund treatment for any condition that has been present since birth or is a result of known hereditary predisposition.

Pre-Existing Conditions

- For more details see section on Pre-Existing Conditions
- ✗ **Pre-existing medical conditions** i.e symptom, condition or disability that you knew about when you bought this insurance

Conditions That Can Be The Result of Your Choice of Lifestyle

- ✗ **Drug or substance abuse.** We will not pay for any condition which is arising from or as a result of harmful substance, alcohol, or drug consumption.
- ✗ **Professional and semi-professional sports.** We will not pay for treatment you need as a result of training for or taking part in any sport for which you are paid, compete for prize money, or receive a grant or sponsorship.
- ✗ **Self-inflicted injuries or harm.** We will not pay for any treatment required as a result of disregard for personal wellbeing, such as self-inflicted injuries, self-neglect, ignoring safety precautions or disregard for medical advice.

Other Treatments and Situations That Are Not Covered

- ✗ **Active war, terrorism and nuclear risks.** These are standard industry exclusions required by insurers.
- ✗ **Activities and expenses not directly related to your treatment,** such as any report writing or provision of certificates, telephone, TV, meals for guests
- ✗ **Any cancellation or non-attendance fees,** charges or penalties are not covered by this Policy. You will be required to pay these directly to the service provider.
- ✗ Any costs for **nursing homes or at home nursing**
- ✗ **Experimental or unproven treatment.** We will not fund any treatment that is not approved by the National Institute for Health and Care Excellence, NICE, or considered by it to be under evaluation.
- ✗ **Overseas treatment.** We will not pay for any treatment undertaken outside the United Kingdom unless agreed in advance.
- ✗ **Prevention, surveillance and genetic testing.** We will not pay for any preventative treatment - such as vaccinations or procedures for surveillance of clinical conditions and any type of genetic testing.

Conditions of Cover

In this section we set out a few conditions of cover that you must comply with for the duration of your Policy.

If you breach any of these conditions then we may do one or more of the following:

- refuse to pay any claims;
- recover from you any loss caused by the breach;
- refuse to renew your Policy;
- end your Policy and all cover immediately, and not return any of the premium(s) already paid to us.

Providing us with information

Whenever we ask you to give us information, you will make sure that all the information you give us is sufficiently true, accurate and complete for us to be able to consider your request or claim.

If we later discover that it is not, we can cancel your Policy or apply different terms of cover in line with the terms we would have applied if the information had been presented to us fairly.

Sanctions

We shall not provide any benefit under this Policy to the extent of providing cover, payment of any claim or the provision of any benefit where doing so would breach any sanction, prohibition or restriction imposed by law or regulation.

Other parties

This Policy is intended solely for your benefit. The benefit of this Policy cannot be transferred to any other person without our express consent.

If you attempt to transfer any policy benefit to another person, no clause or term of this Policy will be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999 or by any other person.

Other Policy Terms

Changes to your Policy:

Lateral

We can change all or any part of your Policy from any renewal date. We will give you at least 3 weeks notice of any changes to your Policy. Any changes to your Policy that apply from your renewal date will be made clear to you when we invite your Policy renewal.

You

If you wish to make any changes to your Policy then you can contact us on:
0203 826 8898.

Choice of language

We will use English for all information and communications about your Policy

Law and Jurisdiction

Unless you and we agree otherwise, your Policy will be governed by English Law and subject to the exclusive jurisdiction of the courts of England and Wales.

Making a claim in your name - subrogated rights

Lateral, or any person, insurer or company that we nominate, will be entitled to bring formal action in your name against any other parties in the event of a claim. This means that we will assume your legal right to recover any amount you might have been entitled to from that other party and which we have already paid for under this Policy.

For example, we may recover amounts from someone who caused injury or illness, or from another insurer, or a state healthcare provider.

You must provide us with all documents, including medical records, and any reasonable assistance we may need to exercise these subrogated rights.

How to Make a Complaint

We hope you are happy with your cover and the service you receive from us. But if you are unhappy about something, we would like to try to put things right. Please contact us using the details below, providing the policy or claim number.

 **Call Monday - Friday**
09:00 to 17:30

 **0203 826 8898**
 **complaints@lateral.uk**

If you are not happy with our response

If you are not happy with how your complaint was handled, or 8 weeks have passed since you raised it, you may be able to contact the Financial Ombudsman Service. Please be aware the Financial Ombudsman Service may not be able to consider your complaint if you have not given us the chance to resolve it first.

The Financial Ombudsman Service

The Financial Ombudsman Service is an independent complaints service that is free to use. You can find out more about them and how to complain at financial-ombudsman.org.uk. You can also contact them by:

Call 0800 023 4567
Email complaint.info@financial-ombudsman.org.uk
Post The Financial Ombudsman Service, Harbour Exchange Square, London E14 9SR

Please note that you will need to refer your complaint to the Financial Ombudsman Service within six months of receiving our final response.

Lateral is a trading style of Live Lateral Limited (FRN: 1043222). We are an Appointed Representative of Innovative Risk Labs Ltd, who are authorised and regulated by the Financial Conduct Authority under FRN: 609155. We are registered in England and Wales. Registered Company Number 16287723, Registered Office Address 71-75 Shelton Street, London, WC2H 9JQ.