



# SHC BENEFITS

PLAN YEAR 2026

# PRIME CARE

## HEALTH BENEFIT PLAN

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Unlimited doctor visits, hospital, surgery, maternity, labs, imaging, virtual care, and prescriptions benefits. Low monthly rates. Low out of pocket cost. Affordable Healthcare Access

# Be Smart about your healthcare benefits

SmartHealth Healthcare Benefit Plans give you the freedom to choose the healthcare benefits that best meet the needs for you and your family by providing cost effective reliable healthcare options with low monthly rates and out of pocket costs.

The Best Healthcare Plan  
is the plan that meets  
**the needs and budget**  
**for you and your family.**



# SHC PrimeCare Benefit Plans Comparison

	PrimeCare Basic	PrimeCare Plus	PrimeCare Premium
Virtual Primary Care / Urgent Care	✓	✓	✓
Virtual Behavioral Health/Therapy	✓	✓	✓
Prescriptions	✓	✓	✓
Labs Testing & Screenings	✓	✓	✓
Primary Care Office Visits	✓	✓	✓
Specialist Physician Office Visits	✓	✓	✓
Urgent Care Visits	✓	✓	✓
Annual Wellness & Preventive Care	✓	✓	✓
X-rays	✓	✓	✓
Emergency Room Visits		✓	✓
Hospitalization, ICU, Sub-acute ICU		✓	✓
Surgery (inpatient / outpatient) inclds surgeon, anesthesia & facility fees		✓	✓
Physical rehabilitation (inpatient/outpatient)		✓	✓
Catastrophic Illness and Disease		✓	✓
Advanced Diagnostic Imaging		✓	✓
Maternity inclds physician visits, delivery, hospital stay, NICU, Sub-acute NICU		✓	✓
Final Expense Benefits		✓	✓
Dental & Vision			✓
Extended Care Medical Expense Bridge			✓

# Outpatient Benefits

Outpatient benefits for primary care physician, specialist physician, urgent care, labs, x-rays, prescriptions, plus annual wellness and preventive care are provided utilizing the Claritev network of doctors, medical facilities, and hospitals - formerly PHCS Multiplan.

This extensive network of healthcare providers gives you and your family nationwide access to more than 1.2 million healthcare providers; 87,000 medical facilities; 4800 hospitals; and more than 60,000 participating pharmacy locations.



**Unlimited Outpatient Physician Visits with low copays and no balance billing or deductibles**

When you need to see a doctor, we've got you covered. \$15 copay for Primary Care and Specialist physician visits. \$50 copay for urgent care visits.

<https://providersearch.multipan.com/>  
click PHCS Specific Services & search



**Get the medication you need when you need them with no monthly or annual limits; and no deductibles**

With over 60,000 participating pharmacy locations nationwide; you have direct access to our extensive formulary 6000+ prescription medication with low copays starting at \$15 and all preventive care Rx at \$0 cost.

<https://smarthealthcompany.com/nsite/purerxlookup.html>

**Save valuable time and money with unlimited virtual urgent care for everyday minor illnesses or injuries**

24/7 virtual urgent care provides you with access to licensed physicians that can treat minor illness and minor injury medical issues, and even prescribe medication when medically necessary without the hassles and wait time of an in-office doctor visit. Virtual Urgent Care is always 100% free and is included with your plan.





# Outpatient Schedule of Benefits

## MEDICAL BENEFITS<sup>1</sup>

	Description
Preventive & Wellness Care	Covered 100%. (See preventive care benefit schedule)
Primary Care / Specialist Physician Visit	\$15 Copay. No Deductible. Unlimited use.
Urgent Care Visit	\$50 Copay. No Deductible. Unlimited use.
Laboratory Services / X-rays	\$50 Copay. No Deductible. Unlimited use.
Prescription Drugs <sup>2</sup>	Tier 1: \$15 copay   Tier 2: \$30 copay Tier 3: \$50 copay   Tier 4: \$75 copay Unlimited use. No Deductible.

## VIRTUAL HEALTH BENEFITS<sup>3</sup>

	Description
24/7 Virtual Urgent Care	Covered 100%. No fees. Unlimited use.
Virtual Behavioral Health	\$50 fee for 1st three visits. \$85 thereafter. Unlimited use.

(1) The EliteCare plan excludes out of network services and covers only the services listed above and on the preventive care benefit schedule.

(2) Prescription drug benefits are subject to the formulary drug list. To review the formulary visit [www.sbmaBenefits.com/pure-standard](http://www.sbmaBenefits.com/pure-standard) Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.

(3) Recuro Health's Virtual Care program includes unlimited 24/7 access to virtual urgent care with board-certified doctors via phone, video, or messaging and connects members with a Psychiatrist or Licensed Counselor through secure and private online video or phone sessions at \$50 each (first 3 visits - \$85 after).

# Preventive Care Benefit Schedule

Network: Multiplan PHCS, in-network only benefits

Annual Wellness Exam

- Max. benefit: 1 exam per year per insured - History, Wellness Exam, Measurements (height, weight, body mass index)
- Age and biological gender specific preventive care services, as detailed below
- Preventive care services not listed are not covered

## ADULTS 18+

- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood Pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over living in a community setting
- Hepatitis B screening for people at high risk
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizations for adults – doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Shingles, and Tetanus
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 years at high risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults with symptoms at high risk

## WOMEN 18+

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk (counseling only; not testing)
- Breast cancer mammography screenings: every 2 years for women over 50 and older or as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast Cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Cervical Cancer screening: Pap test (also called a Pap smear) for women 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes

## WOMEN 18+

- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Expanded tobacco intervention and counseling for all pregnant tobacco users
- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for women
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women

## CHILDREN 0-17

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents beginning at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV negative adolescents at high risk for getting HIV through sex or injection drug use
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Immunizations for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Chickenpox (Varicella); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenzae type B; Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Mumps; Pneumococcal, Rubella; and Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children
- Well-baby and well-child visits



## Prescription Benefit

### Effortless Prescription Fulfillment:

Experience a seamless prescription fulfillment process through PureRx. Access your medications with ease at our extensive network of 60,000+ retail pharmacies nationwide. We are committed to providing affordable and convenient medication fulfillment to support your overall well-being.

**Prescription Lookup:** <https://smarthealthcompany.com/nsite/purerxlookup.html>



### Personalized Support for Your Prescription Journey

Our dedicated team of experts is here to cater to your unique prescription needs. From understanding your prescription benefits to optimizing your medication regimen, we strive to provide a seamless and positive Rx management experience. With PureRx, you can be confident that your health and well-being are our top priorities.



# Comprehensive Care

SHC PrimeCare utilizes a health sharing plan to facilitate comprehensive care needs such hospital stays, surgery, catastrophic illnesses, emergency room visits, and maternity. Comprehensive care benefits are not insured benefits.

**An exceptionally better option to the high cost of traditional plans and support your healthy living**

## Lower monthly costs

SHC PrimeCare Plus & Premium plans are up to 30%+ lower in monthly costs vs tradition HDHP plan options found on the healthcare marketplace.

## Lower Out of Pocket

When comprehensive care needs occur, SHC PrimeCare Plus & Premium plans provide out of pocket costs (member responsible amount) as low as \$1500, \$3000, or \$6000 based on your plan choice.

## What is a Health Share

It is a community where members agree to share medical expenses through voluntary giving following the terms set forth in the Member Guidelines.

There are no religious affiliations requirements and member from all walks of life can choose to participate in the plan, so long as they agree to the Membership Guidelines.

## How Does Sharing Work

Once you're a member, sharing works in 3 simple steps:

1. Submit your sharing request
2. At your appointment, present as a self-pay patient
3. Share with the community - eligible medical expenses will be shared amongst the community. We will work directly with you to coordinate provider payments.



# Comprehensive Care

If you're under the age of 65 and tired of the high costs of traditional HDHP healthcare plans, SHC PrimeCare Plus & Premium plans provide a comprehensive healthcare solution that can help you optimize your health, lower healthcare costs, and provide a community of support when the unexpected happens.

## What Is the Member Responsible Amount

The Member Responsible Amount, or MRA, is the amount a member will pay per Sharing Request, similar to a deductible on an insured medical plan, before the community shares in medical expenses.

There are 3 MRA options available \$1500, \$3000, and \$6000. The lower the MRA, the higher the monthly cost will be on the plan.

The MRA can occur 2 times within a 12 month period. If a 3rd event occurs within the same 12 period, there is no additional out of pocket expense to the member for shareable medical needs. The MRA is per plan, not per plan member.

Once the MRA is met for the specific medical need, the plan will provide the balance of the medical expense at 100% for all shareable medical needs.



Dan and his wife have an SHC PrimeCare Plus Plan. The plan has an active date of January 1, 2026. On June 3rd, Dan has an accident and dislocates his shoulder. Dan's out of pocket cost or MRA for the ER visit, imaging, and follow up doctor visits is \$3000.

On October 15th, Dan's wife is diagnosed with an appendicitis and needs surgery. Dan's MRA for the surgery, hospital stay, and follow doctor visits is \$3000.

On March 20th of the following year, Dan has to have his tonsils removed. There is no out of pocket cost (MRA) for this procedure, since it occurred within the 12 month period of Dan's first MRA on June 3, 2026.

## MRA Reduction Program

This program recognizes that healthcare costs can vary widely across providers and that members often have more influence over them than they realize. When members take extra steps to plan ahead or work directly with the negotiation team, we may authorize a reduction of the MRA.

### How Members Can Reduce Their MRA

Members may qualify for a MRA reduction when they take one or more of the following actions:

- The most impactful step a member can take is to work with the Negotiation Team.
- Our team is highly experienced in working directly with hospitals and surgical facilities to help members qualify for self-pay or direct-pay discounts.
- Choosing to work with or switch to a fair cost provider identified by EverTrust.
- Traveling to receive care from a provider that offers high-quality services at significantly lower prices.
- Working with a EverTrust legal representative to negotiate or lower existing medical bills.

# Comprehensive Care

The following Summary of Benefits only provides a brief summary of highlighted features and benefits. Only the actual plan benefit provisions or policy will control benefit availability and any limitations or exclusions including those for pre-existing conditions. All benefits listed in the Comprehensive Care Summary of Benefits are assumed to be an approved Sharing Request. See Member Guidelines for specific details. All Sharing Requests are subject to Community approval.

## COMPREHENSIVE CARE OVERVIEW SUMMARY

MEDICAL SHARE PLAN REQUIREMENT & MRA *	Description
Network for comprehensive care	No network requirement.
Annual / Lifetime benefit max	No annual or lifetime benefit max
Member Responsible Amount (out of pocket cost)	\$1500, \$3000, or \$6000 for 1st two medical sharing needs per plan within a 12month period; after \$0.
Tobacco / Nicotine use Applies to any person enrolled in the comprehensive care plan who has use products containing nicotine 12 months prior to their plan active date.	\$100/month additional surcharge
MEDICAL SHARE PLAN BENEFITS *	Description
Emergency Room Visits	100% shareable after MRA met.
Hospitalization, ICU, Sub-acute ICU	100% shareable after MRA met.
Surgery (inpatient / outpatient) includes surgeon, anesthesia and facility fees	100% shareable after MRA met.
Physician & specialist visits (inpatient/outpatient)	100% shareable after MRA met.
Physical rehabilitation (inpatient/outpatient)	100% shareable after MRA met.
Catastrophic Illness and Disease (diagnosis / treatment)	100% shareable after MRA met.
Advanced Diagnostic Imaging & Labs includes lab tests, X-ray, MRI, CT, PET, EEG, gastroenterology	100% shareable after MRA met.
Maternity includes prenatal physician & OBGYN visits; birth (at home, birth center,hospital); surgery; hospital stay (mother & child); and emergency room with admission. 30 Day waiting period for all maternity benefits • NICU - For NICU admission, the time limit for sharing is 35 days after birth. • Congenital Disorders - For children born from an eligible Maternity Sharing Request, sharing is limited to \$125,000 for medical bills related to congenital conditions after the initial hospital discharge.	100% shareable after MRA met.
End of Life Assistance Shareable for all services required at time of death for a participating active member.- paid one time per decedent	Primary or Spouse \$10,000 Child \$5,000

\* Please refer to Membership Guidelines regarding all medical sharing guidelines, limitations, an exclusions.

# Comprehensive Care

SHC PrimeCare utilizes a health sharing plan to facilitate comprehensive care needs such hospital stays, surgery, catastrophic illnesses, emergency room visits, and maternity. Comprehensive care benefits are not insured benefits.

## Initial 90-Day Ineligibility / Waiting Period for Certain Conditions \*

The following conditions and any related treatment are not eligible for sharing if signs, symptoms, diagnosis, or treatment occur within the first 90 days of membership:

- Gallbladder-related care – including gallstones, gallbladder removal, or related complications
- Kidney stones – including diagnostic imaging, treatment, or removal procedures
- Cancer – any form of diagnosis, staging, or active treatment
- Tumor- benign or malignant

## Treated As Pre-existing For Sharing Requests \*

The following conditions and treatments are eligible after the initial pre-existing waiting period.

- Arthritis
- Basal & Squamous Cell Cancer
- Cataracts
- Celiac Disease
- Chronic Fatigue
- Chronic Pain
- Diagnostic Colonoscopy
- Ear Tubes
- GERD/Acid Reflux
- Hashimoto's
- Hormone and Hormone Therapy
- Injections & Regenerative procedures from non-acute injury
- Irritable Bowel Syndrome
- Long-Covid
- Lyme Disease
- Mold Toxicity
- Preventive Mastectomy
- Osteoporosis
- Sleep Apnea
- Treatment For Non-Seasonal Allergies
- Varicose Veins

## NON-SHAREABLE MEDICAL EXPENSES \*

The following treatments and procedures are not eligible for medical sharing under this plan:

- Abortion
- Adult Immunizations
- Alcohol and Drug abuse treatment
- Birth Control
- Breast Implant Removal
- Dental
- Diabetic Medication & Supplies
- Elective Procedures
- IVF & Fertility
- Hearing Aids
- Infertility
- Light Therapies
- Organ Donation
- Prophylactics
- Seasonal Allergies
- Sleep Studies
- Surrogacy
- TMJ Therapeutics
- Transportation to Appointment
- Vision

\* Please refer to Membership Guidelines regarding all medical sharing guidelines, limitations, and exclusions.

# Comprehensive Care

## MEDICAL CONDITIONS EXISTING PRIOR TO MEMBERSHIP

Members have a waiting period for medical conditions that existed before the membership start date. A pre-existing medical condition limitation is applied based on the first date of active membership. Any illness or injury for which a person has had any of the following occur:

- Been examined
- Taken medication
- Had symptoms
- Received medical treatment

Within 24 months prior to the effective date of the membership is considered pre-existing.

### Pre-existing for Cancer

Any testing, preventive treatments, prophylactics, or medications that were taken by the Member 36 months prior to the start date of a previously diagnosed cancer will result in a recurrence or related recurrence of that type of cancer being considered a pre-existing condition.

### Exceptions That Are Not Considered Pre-existing

High blood pressure, high cholesterol, hyperthyroidism, hypothyroidism, and type 2 diabetes will not be considered pre-existing conditions if it's controlled, and the member has not been hospitalized for the condition 12 months before enrollment.

### Pre-Existing Condition Phase-in Period

Pre-existing conditions have a phase-in period wherein sharing is limited. Members have a one-year waiting period from the initial enrollment date before pre-existing conditions are eligible. After the first year, pre-existing Sharing Requests are eligible with a sharing limit that increases each membership year.

#### Eligible amounts for pre-existing conditions:

- Year One: \$5,000 maximum per Sharing Request
- Year Two: \$30,000 maximum per Sharing Request
- Year Three: \$60,000 maximum per Sharing Request
- Year Four: \$150,000 maximum per Sharing Request
- Year Five: The sharing maximum is removed for all pre-existing conditions.



# Comprehensive Care

## Real Stories of Members Helping Members

### Emergency Room Visit and Gallbladder Removal\*

A member received care through Doylestown Health after an emergency room visit that led to a gallbladder removal. The total billed amount for hospital services was \$63,375. By approaching the hospital as a self pay patient and coordinating payment directly, the billed amount was adjusted to a discounted and shared amount of \$25,590.

Additional related costs included: Ultrasound: \$160 | Surgeon: \$3,420

Member responsibility amount: \$1,500

The total shared amount for this event came to \$29,170, representing a substantial savings compared to traditional billed rates. This example shows how members can take control of their medical expenses by requesting self-pay pricing, obtaining clear estimates, and taking advantage of direct payment opportunities with support from the comprehensive team.

#### EXPLANATION OF SHARING SUMMARY 09/05/25

Event Description ER Visit Gallbladder Removal - Itemized Bills

Provider Name	Bill Line Item	Billed Amount	Patient Expense Applied to MRA	Discount	EverTrust Community
Doylestown Health	ER Visit	\$63,375.81	\$1,500.00	\$37,785.81	\$25,590.00
Doylestown Radiology Associates	Ultrasound	\$160.00	\$0.00	\$0.00	\$160.00
Doylestown Health Physician	Physician's Bill	\$3,420.00	\$0.00	\$0.00	\$3,420.00

Member Responsible Amount (MRA) \$1,500.00  
 Total Reimbursements \$0.00  
 Total Sharing Contributions Paid for Sharing Request \$29,170.00

### Emergency Room Visit for Esophageal Tear\*

A member received care through Intermountain Health for an emergency esophageal tear. The hospital billed \$201,271 for the stay and related services. After self-pay adjustments, the total was reduced to \$33,469.

Additional related costs included: Anesthesia: billed \$5,247, adjusted to \$3,413 | Additional services: total shared amount \$40,932  
 Member responsibility amount: \$3,000

This case demonstrates how powerful the combination of direct pay status, prompt payment, and transparency can be in reducing costs. Members gain peace of mind knowing that their medical bills are reviewed carefully and shared responsibly.

#### EXPLANATION OF SHARING SUMMARY 10/10/2025

Event Description ER Visit /Esophageal Tear - Itemized Bills

Provider Name	Bill Line Item	Billed Amount	Patient Expense Applied to MRA	Discount	EverTrust Community
Utah Emergency Physicians	Physician	\$3,912.00	\$0.00	\$0.00	\$3,912.00
Gold Cross Ambulance	Ambulance	\$2,234.20	\$1,787.36	\$446.84	\$0.00
Utah Pathology	Tissue Exam	\$138.00	\$0.00	\$0.00	\$138.00
Mountain West Anesthesia	Anesthesia	\$5,247.00	\$767.34	\$1,066.13	\$3,413.53
Intermountain Health	Hospital Services	\$201,271.72	\$445.30	\$166,530.74	\$33,469.26

Member Responsible Amount (MRA) \$3,000.00  
 Total Reimbursements \$0.00  
 Total Sharing Contributions Paid for Sharing Request \$40,932.79

\* This Explanation of Sharing Summary is provided for informational purposes only and reflects the outcome of these specific medical sharing instances only. There is no guarantee, inferred or implied, that any medical sharing event will result in similar results.

# Comprehensive Care

## Submitting A Sharing Request

Submitting a Sharing Request at EverTrust isn't just about paying a bill. It's an advocacy-driven process designed to help you use the self-pay system effectively, reduce medical costs, and get the most value from your membership. Traditional insurance focuses on claims processing that benefits large companies. At ShareWELL, our focus is on helping you and the entire community alleviate the burden of medical bills through smarter, member-centered solutions.



Review the Member Guidelines for eligibility. These explain which medical needs are eligible and which may not qualify. Reviewing first avoids delays.



Sharing begins only after expenses exceed your MRA. Be sure the medical event will surpass this amount before submitting.



Be sure to collect, organize, and submit documents such as itemized bills with self-pay discounts and medical records from your visit.



## “ A Smarter Way to Manage Healthcare

### ► Advocacy On Your Behalf

Every Sharing Request is different. Providers, hospitals, and bills all require different strategies. The EverTrust team evaluates your situation and applies the right tools to secure the best outcome for you as a self-pay patient.

### ► Negotiation and Fair Pricing

Unlike traditional plans that lock you into network rates, EverTrust negotiates directly with providers—sometimes through legal specialists—to secure fair and transparent pricing. In many cases, self-pay rates are lower than those insurance companies negotiate.

### ► Prompt Pay Discounts

Paying quickly often means paying less. EverTrust helps members arrange prepayment for scheduled procedures or prompt payment for emergency bills. This benefits both you and your provider by reducing costs and avoiding collection delays.

### ► UA Reduction Opportunity

Most hospitals are nonprofits and are required to offer financial self-pay programs, even to higher-income patients. These programs can be confusing to navigate on your own. EverTrust advocates for you, helping you access available assistance and maximize savings. By applying and working with the EverTrust team, you can qualify for the MRA reduction program and lower your out-of-pocket responsibility.

# Dental+Vision Plan

The Dental+Vision Insurance Plan is a direct reimbursement combination plan that pays for covered dental and vision services direct to you. See any dental or vision provider that you prefer and tell them you are a “cash pay” customer, then submit your bill and receipt through the online claims link and get reimbursed based on the procedure cost reimbursement schedule.

## No Waiting Period

use your benefits starting day 1

## No Network Requirement

choose any dental or vision provider for covered services

## Direct Reimbursement

the plan pays you directly for all covered services received up to the maximum benefit amount.



### DENTAL+VISION PLAN SCHEDULE OF BENEFITS

NETWORK

No network requirement

#### MAXIMUM BENEFIT

Benefits for dental and vision are combined. Benefit is based on an aggregate total of accumulated expenses per covered person during the calendar year.

\$1000/ year/ insured

#### PROCEDURE REIMBURSEMENT COST SCHEDULE

Benefit reimbursement based upon total cost billed per visit	up to \$150.00	100%
	\$150.01-\$250.00	75%
	\$250.01-\$1800.00	50%
	\$1800.01+	0%

Waiting Period

N/A

### Covered Dental Procedures

#### Dental Class 1 - Preventive & Diagnostic Care.

Covered services: oral exams, routine cleanings, full mouth x-rays, bite-wing x-rays, panoramic x-rays, fluoride application, sealants, and histological examinations.

#### Dental Class 2 - Basic Restorative Care.

Covered services: fillings, periapical x-rays, anesthetics, space maintainers, emergency care to relieve pain, root canal therapy, endodontics, periodontal scaling, root planing, simple extractions, oral surgery except simple extractions, and surgical extraction of impacted teeth.

#### Dental Class 3 - Major Restorative Care.

Covered services: crowns, dentures, bridges, inlays, onlays, prosthesis over implant, repair to bridges / crowns / inlays, and denture adjustments and repairs.

### Covered Vision Procedures

**Vision Care Covered services:** routine examinations services, eye glass lenses (single, bifocal, trifocal), eye glass frames, contact lenses, lens sealants, and histological examinations.

# Extended Care Plan

PROTECT YOURSELF AND YOUR FAMILY FROM UNEXPECTED MEDICAL COSTS AND LOWER YOUR OUT OF POCKET EXPOSURE

Unexpected accidents, serious illnesses, and medical costs are an unfortunate reality we all have to face, but that doesn't mean that you can't be prepared. The ExtendedCare Plans through Mutual of Omaha provide a direct cash benefits paid to you in the event of covered hospitalization, surgery, accident injury, or critical illness events.

Cash indemnity benefits can be used to offset out of pocket expenses or personal expenses that often accompany these medical emergencies.

## EXTENDED CARE PLAN SCHEDULE OF BENEFITS

Hospitalization Benefits	
Hospital Admission (limit 3 per year)	\$2,000 per admission
Hospital Stay (limit 30 days per year)	\$50/day
Outpatient Surgery (limit 1 per year)	\$75 physician office/\$250 hospital
Inpatient Surgery (limit 1 per year)	\$1,000
Accident Injury Benefits	
Urgent Care (limit 1 per year)	\$200
Diagnostic Testing (limit 1 per year)	\$200
Accident Hospital Confinement (up to 30 days per year)	\$200 per day
Intensive Care Unit Admission (limit 1 per year)	\$400
Emergency Room (limit 1 per year)	\$500
Outpatient Surgery (limit 1 per year)	\$500 - In a Physician's Office
Outpatient Surgery (limit 1 per year)	\$2,000 - In a Hospital or Freestanding Surgical Center
Inpatient Surgery (limit 1 per year)	\$2,000
Critical Illness Benefits	
Individual / Spouse / Child	\$10k / \$5k / \$2.5k
Heart Attack (Myocardial Infarction), Stroke, Major Organ Transplant, End-Stage Renal Failure & Invasive Cancer	100% of principle sum
Coronary Artery Bypass & Carcinoma in Situ	25% of principle sum
Health Screening (1 time per year)	\$50

### Direct Cash Paid To You For

- Hospital admission & confinement
- Accident injury benefits for urgent care & ER
- Inpatient & outpatient surgery benefits
- Critical illness benefits heart attack, stroke, and cancer



## **DISCLOSURE / DISCLAIMER NOTICES**

**The benefits and plans featured in this brochure are not major medical insurance and are not intended to replace any major medical policy in force or to be a substitute for any individual who requires the necessary coverage provided by a major medical insurance plan. No benefits or plans featured in this brochure are “qualified healthcare plans” as defined by the Affordable Care Act. All benefits featured in this brochure are voluntary. The plan benefits featured in this brochure may be comprised of both insured and non-insurance benefits and include limitations and exclusions specific to their respective underwriter and/or benefits provider. All benefits herein are subject to the terms, conditions, limitations, and exclusions as specified by the insurance underwriter or non-insurance benefit provider including but not limited to pre-existing conditions. Benefits may be subject to additional state regulations, limitations, and exclusions; or may not be available in some states. The unavailability of benefits due to state restrictions does not constitute a reduction in overall insurance premiums and fees due. The benefits and benefit providers contained herein may be subject to change without notice.**

**This brochure is a direct solicitation for healthcare benefit products and services offered through The SmartHealth Company, LLC, and its affiliates. There is no guarantee, either implied or inferred, that any benefits, products, or services featured in this brochure will meet all the healthcare needs of any enrollee without exception. It is solely the determination and decision of the enrollee as to the suitability of these benefit plans for their own personal health care needs and medical requirements.**

**This brochure only provides a brief description of the key features of benefits. Only the actual plan benefit provisions and/or policy will control benefit availability and any provider limitations or exclusions. Therefore, it is important that you review the provider plan benefit document and/or policy. It is recommended that you discuss any questions or concerns regarding any benefits with an authorized licensed health insurance agent prior to enrollment. You may request to review policies and plan benefit provisions by contacting The SmartHealth Company LLC or its authorized licensed insurance agent representative.**

The SmartHealth Company LLC; the licensed insurance agent; nor the SmartHealth affiliate partner presenting these healthcare benefit plans is an underwriter or direct benefits provider and does not pay claims. Neither does SmartHealth Company LLC; the licensed insurance agent; or the SmartHealth affiliate partner have any authority to adjudicate claims, in any manner, for any enrollee on behalf of any underwriter or non-insurance benefits provider.

Payment of the monthly insurance premiums and fees due are the sole responsibility of the enrollee. Collection and remittance of insurance premiums and fees; as well as any claims adjudication are administered by a third-party administrator designated by the underwriter or non-insurance benefits provider; or may be directly administered by the underwriter or non-insurance benefits provider.

# **DISCLOSURE / DISCLAIMER NOTICES**

## **BILLING**

**Billing is facilitated through First Continuity Management Group via the enrollment platform provided. The premiums and fees due for the benefit plan / service enrolled in will reflect the FIRST CONTINUITY name on your respective bank or financial institution monthly statement.**

All premiums and fees are billed monthly in advance of the next benefit / coverage period and payment in full is required. No partial payments will be accepted. All premiums and fees are recurring payments billed on the 20th of each month and is due by the 1st of each month. The primary account holder is solely responsible for any charges or fees incurred by their bank or financial institution related to benefits / coverage for which they are actively enrolled.

If payment is not received by the 1<sup>st</sup> of the month, three re-billing attempts will be made to the payment method on file approximately on the 25<sup>th</sup> of the month prior to the next benefit / coverage period; end of the current month prior to the next benefit / coverage period; and finally on the 5<sup>th</sup> of the month during the next benefit / coverage period. Failure to remit full payment due will result in a lapse / termination of all enrolled benefits.

All billing related questions or concerns should be directed to The SmartHealth Company, LLC.

## **BENEFIT / COVERAGE LAPSE**

Benefits / coverage will be considered as “lapsed” when payment due for monthly premiums or fees have not been fully remitted by the 5<sup>th</sup> day of the month of the current coverage period. This means that access to benefits will be restricted until full payment is received. Payment for the lapsed benefit / coverage period must be made no later than the 15<sup>th</sup> of the current benefit / coverage period month in order to have benefits / coverage reinstated.

## **BENEFIT / COVERAGE TERMINATION**

Benefits / coverage will be considered as “terminated” based upon one of two of the following events:  
Failure to remit premiums and fees due. Failure to remit premiums and fees due in full by the 15<sup>th</sup> day of the current coverage period will result in a termination of all benefits / coverage.  
Receipt of written request of cancellation from the primary account holder.

Termination of benefits / coverage by either of the above methods will result in a six-month waiting before the primary account holder can re-enroll in any of the healthcare plans offered through SmartHealth Company.

## **CANCELLATIONS**

Members may cancel benefits / coverage at any time by submitting a written request for cancellation of benefits / coverage to [memberservices@smarthealthcompany.com](mailto:memberservices@smarthealthcompany.com)

Cancellation requests MUST INLCUDE the following:

Name of the primary account holder

Member ID number

Specific benefit / coverage name related to the cancellation

## **DISCLOSURE / DISCLAIMER NOTICES**

### **CANCELLATIONS – continued.**

Cancellation requests received by the 15<sup>th</sup> of the current month will result in termination of all specified benefits / coverage effective at the end of the current benefit / coverage period. Cancellation requests received after the 15<sup>th</sup> of the current month will result in termination of all specified benefits / coverage effective at the end of the next month's benefit / coverage period.

**EXAMPLE:**

Request for cancellation received on 3/15/2024 – termination date 3/31/2024

Request for cancellation received on 3/16/2024 – termination date 4/30/2024

If a cancellation request is received after the 15<sup>th</sup> day of the current benefits / coverage period, billing for the next benefits / coverage period will occur on the 20<sup>th</sup> of the current of the current month.

The primary account holder will be solely responsible for any and all medical / prescription claims or bills for any such services rendered after their termination date.

### **REFUNDS**

Refunds may be issued under the following:

Billing errors – members are entitled to a full refund for any billing errors.

Cancellation of coverage within 15 days of the initial effective date – members are entitled to a full refund if request for cancellation is received within 15 days of their initial effective date provide no claims have been received. An exception to this policy may be utilized for elderly members as defined by the regulations set forth in their respective state of residence. This exception does not negate the “no claims received” caveat.

Refunds are processed within 3 – 5 business days to allow sufficient time to verify that no claims have been received or are in process. Depending on your bank or financial institution it may take several business days for the refund to be reflected in your account.

### **ELIGIBILITY AND ENROLLMENT REQUIREMENTS**

- Enrollment is available for all primary and spouse dependents ages 18-64.
- Enrollment is available for all child dependents ages 0-25 – child coverage will be terminated at age 26.
- Date of Birth is required for all enrollees
- Biological gender is required for all enrollees
- A valid social security number or tax id number is required for all enrollees
- Enrollment is not permitted by any individual residing in any foreign country or US Territory
- Enrollee must reside in a valid US state with respect to the benefit enrolled.
  - No enrollment is available in the following US States: AK, HI, MA, NJ, NY, WA
- Electronic signature is required for all enrollments



# SHC BENEFITS

## PRIMECARE HEALTHCARE BENEFIT PLAN 2026

### Contact Us

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