SDC WELLCARE CONSORTIUM · 2027 SERVICE GUIDE

One platform connecting community health and care

SDC WellCare Integrated Services — One participant record · 10 services



A service guide for staff at public health centers · Dementia Relief Centers · local integrated community care · local clinics · care facilities

Lead SDC WellCare Co., Ltd.
Partners BAMBOL Inc. · Wellune Inc. · GTAcom Inc. · Eight Studio Inc. · Team Elysium Inc.

October 2026
Prices: proposed 2027 list prices (KRW), excl. VAT

ABOUT SDC WELLCARE

Who to check on first, right now — shown on a single screen

SDC WellCare is an integrated platform that gathers checkup, measurement, vital sign, gait, posture, check-in call, cognitive and daily-living signals into **a single record for each consenting participant**, assesses them against the same baseline, and gives staff priorities along with the reasons behind them. Start with only the services you need and add more to the same platform, one at a time.

Measure · collect	Checkup history · YOCHECK urine chemistry · certified BP monitors & meters · VitalRing · Wellune radar · MEDISTEP · Bodydot · AI check-in calls
Analyze	Longitudinal analysis engine · KidneyWatch AI · WellCare AI (vital signs) · voice cognitive signals · CareOps personal-baseline assessment
Operate	Weekly priority list · 3 alert pathways · staged data-gap response · 3-tap field-app notes · task queue
Link	PHCs · local clinics · Dementia Relief Centers · home-based medical care centers · integrated support meetings · caregivers — referrals and replies tracked
Report	Personal result sheets · monthly & quarterly agency reports · draft year-end performance reports · regional population analysis

One participant record

Within the scope of consent, checkup, measurement, sensor and call records are linked in time order for one person

10 services

Same screen · same baseline

Agency platform charged once

Lead company: SDC WellCare Co., Ltd.

30 sites
AI vital sign management pilot at long-term care facilities

232 people
Adult day care clients observed for 971 consecutive days

184,736 records
Cumulative vital sign data

186 people
YOCHECK field validation, Yuseong-gu, Daejeon (2025)

1. **SDC WellCare Integrated Management System**
   CareOps assessment & operations engine — personal baselines, 3 alert pathways, data-gap response, 3-tap field app
2. **WellCare AI**
   Vital sign trend analysis — pilot at 30 long-term care facilities, validation at a 180-bed nursing home, validation at care facilities in Japan
3. **KidneyWatch AI · Longitudinal Analysis Engine**
   Longitudinal kidney/metabolic risk and suggested retest intervals; patent filed for disease prediction from longitudinal checkup data
4. **YOCHECK YC-11**
   11-parameter urine chemistry analyzer, MFDS Class II IVD medical device — product approval and GMP certification acquired by transfer (Aug 2026)

Operating principles applied to every service

People make the decisions
The system presents priorities and the reasons behind them; staff and clinicians decide on contact, visits and medical referral.

We do not diagnose
Results from wellness devices and voice analysis are reference information for health management; medical-threshold alerts are issued only from MFDS-approved medical device readings.

Emergencies go through 119
The system never reports automatically; emergencies are directed to caregivers, staff and 119 (Korea's emergency number).

We never ask for name lists
Participation is by self-application and item-by-item consent only; agency screens show only participants who have consented.

Operated in Korea
Domestic cloud; identifiers stored separately from analytics data; access logs retained.

CONSORTIUM

Integrated Service Providers

Five companies specializing in measurement, sensors, voice, gait and posture deliver their capabilities as one service on the SDC WellCare platform.



Single point of contact
SDC WellCare Co., Ltd., the lead company, handles contracts, billing and the help desk.

One record
Within the scope of consent, each partner's measurements flow into the same participant record in SDC WellCare.

Data minimization
No raw voice, video or radar signals are received — only analysis results and indicators are linked.

Accountability for supply quality
SLAs for device uptime and valid-data rate are tied to supplier payments.

SDC WellCare Co., Ltd.

Lead · Integrated platform · Measurement · Lead for all services · S1·S2·S3·S5·S8

SDC WellCare Integrated Management System (CareOps), WellCare AI (vital sign trends), KidneyWatch AI, YOCHECK YC-11 (MFDS Class II IVD medical device)

BAMBOL Inc.

Voice-based cognition · S6 · S4

Memory Detective — observes cognitive-change signals in everyday phone-call speech (technology transferred from ETRI)

Wellune Inc.

Contactless sensor · S7 · S4

60 GHz radar — monitors presence, bed exit, movement, breathing and sleep without a camera

GTAcom Inc.

Wearable sensor · S7 · S4

VitalRing smart ring — heart rate, SpO_2, sleep, activity, gesture SOS; field-proven in local-government care programs

Eight Studio Inc.

Gait analysis · S9

MEDISTEP — markerless gait analysis with an iPad camera; designated a PPS Innovative Prototype Product (Oct 2025)

Team Elysium Inc.

Posture & musculoskeletal analysis · S10

Bodydot — contactless 3D-camera posture and body-alignment analysis; designated an MSIT Innovative Product (Jan 2026)

10 Services · Contents

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SERVICE 01 · SCREENING & PREDICTION

Longitudinal Health Checkup Analysis Report

WellCare Health Trajectory Report

Disease-risk analysis and health status report based on longitudinal analysis of health checkup data

Not a single-year snapshot— a 10-year trajectory

Links up to 10 years of the National Health Screening results people already receive to analyze "where their health is heading," and sets out whom the public health center (PHC) should manage first, and through which program.

Provided by SDC WellCare · **Key customers** PHC health promotion teams · Healthy Living Support Centers

Why it matters now

75.6%
General health screening participation rate (2024)

69.8%
Screened adults with 1+ metabolic syndrome risk factor

40%+
Kidney-related abnormal findings, 186 people in the Yuseong-gu validation

Many people are screened, but results are read only as a "single-year snapshot" and rarely lead to follow-up care. PHCs run mobile healthcare and AI·IoT programs for older adults, yet lack an evidence-based tool for deciding whom to assign first, and to which program.

How it works — From 10 years of checkups to PHC program assignment

STEP 1
Consent & collection
Import checkup history or photograph results (OCR)

STEP 2
Longitudinal analysis
Annual slope & variability when ranges are crossed

STEP 3
Report & counseling
8-page plain-language report
10-minute standard session

STEP 4
Program assignment
Metabolic syndrome · mobile health
home visits · clinic referral

STEP 5
6-month re-assessment
Re-measurement · change report
year-end results report

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not a service that displays checkup results, but one that uses them to drive PHC programs**

Target outcomes — proposed 2027 pilot KPIs

80%↑
Result counseling completion

70%↑
High-risk linkage to programs or care

40%↑
1+ risk factor improved at 6 months

2 days
Report generation (business days)

Voice from the field — 58-year-old self-employed man
Now Rated "Normal B" for six years — unaware that his glucose, triglycerides and eGFR worsen a little every year
After Sees the rate of change on a slope chart; receives three action goals and guidance to a PHC program

Key differentiators

1 Longitudinal trajectory analysis

Looks at the "speed of change" through year-by-year slope, variability and the point at which reference ranges are crossed — not a cross-sectional risk score.

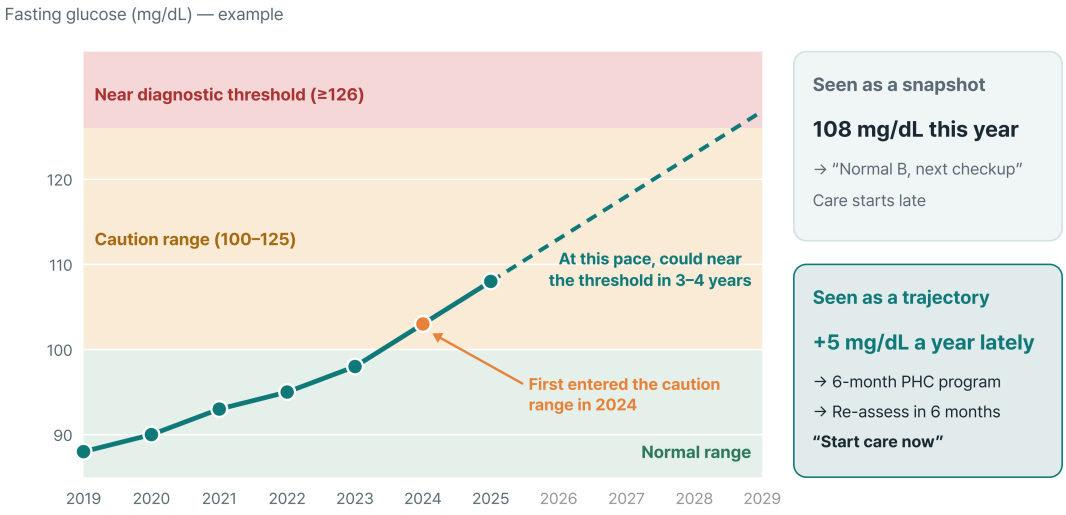
2 Kidney axis built in

KidneyWatch AI combines eGFR decline rate, urine protein and YOCHECK urine chemistry to show kidney–metabolic trajectories.

3 Assignment & re-assessment

Does not stop at the report: continues through program assignment, referral to medical institutions and 6-month re-assessment.

Trajectories change the picture



Even within the same "Normal B," seeing how fast values rise each year brings the start of care forward (illustrative chart).

Key features

- **M1** **Data collection** — MyData linkage, OCR of result sheets, PHC measurements, automatic YOCHECK intake
- **M2** **Data cleansing** — Unit harmonization (LOINC), correction for assay changes, check for 3+ years of data
- **M3** **Longitudinal analysis engine** — Composite scores in 5 domains (cardio-cerebrovascular, glucose, kidney, liver, metabolic syndrome)
- **M4** **Personal report** — Year-by-year charts, 3 action goals, guidance to PHC programs and medical institutions
- **M5** **PHC dashboard** — Risk-trajectory distribution, recommended participants by program, counseling & referral log, re-assessment schedule
- **M6** **Regional population analysis** — Risk by sub-district, age and sex; before/after comparison; draft results report

Linked services

- **S2** Adds urine chemistry readings to the kidney trajectory
- **S3·S5** Report shared on clinic referral of high-risk patients (with consent)
- **S6** Physical-risk summary for Dementia Relief Center participants

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Agency platform	per site/yr	**KRW 3,600,000**
Personal health status report	per person, once	**KRW 18,000**
6-month re-assessment report	per person, once	**KRW 8,000**
Regional population analysis report	per report	**KRW 4,000,000**
Report printing & mailing	per person	**KRW 2,500**

Small, 100 people
KRW 6.2M
KRW 62,000/person

Standard, 300 people
KRW 10.5M
Approx. KRW 4.83M on pilot terms

Large, 1,000 people
KRW 23.6M
KRW 23,600/person

Clinic counseling KRW 99,000/mo (50 reports) · corporate employees KRW 25,000/person · individual report KRW 9,900 · family KRW 29,000/yr

Labeling & operating rules Resident reports show no diagnoses or probabilities (%) — only 4 levels (Maintain · Watch · Manage · Consultation advised) · Where results differ from NHIS predictions, the reason (longitudinal change, additional measurements) is stated alongside · The clinician-facing kidney retest-interval feature will operate only after an MFDS inquiry on medical-device status

SERVICE 02 · MEASUREMENT & CHRONIC DISEASE
YOCHECK Chronic Disease Management

WellCare YOCHECK Care

Management service using the YOCHECK urine chemistry analyzer for participants in PHC chronic disease programs

One cup of urine fills the two-year gap between checkups

People registered for hypertension or diabetes and older adults test 11 parameters from one urine sample, at a community hub or at home, on a regular schedule — and only repeated abnormalities are referred to a neighborhood clinic for confirmatory testing.

Provided by SDC WellCare · **Key customers** PHC chronic disease & home-visit health programs · Healthy Living Support Centers · senior community centers

Why it matters now

6.3 %
Adult chronic kidney disease prevalence (25.9% at age 70+)

2.7 %
Fully normal results, 186 people in the Yuseong-gu validation

28.38 M KRW
Annual medical cost per dialysis patient (2021)

Urine testing in the National Health Screening focuses on urine protein and usually takes place once every two years. The device kits for PHC AI·IoT programs (watch, BP monitor, glucometer) also leave out urine testing, so kidney and metabolic changes are detected late.

How it works — From measurement to confirmatory testing

STEP 1
Regular testing
Hub 2×/month · home 1×/week
11 parameters via Bluetooth

STEP 2
Reading & QC
QC and strip lot check
re-test requests

STEP 3
KidneyWatch
Repeat patterns + eGFR
BP & glucose → 4 grades

STEP 4
3 alert pathways
Same-day check · worsening & retest
device management

STEP 5
Clinic confirmation
Only repeated abnormalities referred
reply logged

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not a service that sells test strips, but one that carries chronic disease care from one urine sample all the way to medical follow-up**

Target outcomes — proposed 2027 pilot KPIs

85% ↑
Hub testing adherence

60% ↑
Repeat abnormals referred for confirmation

50% ↑
Replies from medical institutions

98% ↑
QC pass rate

Voice from the field — 74-year-old with diabetes who visits a senior community center
Now Ten years on diabetes medication; last national screening two years ago — does not remember the urine protein result
After Tests twice a month at the senior center, gets a plain-language result card, and is guided to confirmatory testing at his regular clinic if results repeat

Key differentiators

1 Built on an approved device

Clinical alerts are issued only from readings of YOCHECK YC-11, an MFDS Class II IVD device.

2 Risk-based retest intervals

KidneyWatch AI lengthens intervals for stable participants and moves high-risk ones to home testing, cutting testing costs by 18–37% (internal simulation).

3 Only repeated abnormalities referred

A single positive triggers a re-test; only repeated results are referred for confirmation at CDM-program or primary care clinics, reducing anxiety and over-referral.

Two operating models

Hub-based testing

Where
PHC · Healthy Living Center · senior center

How often
2×/month (24 strips/yr)

Who
Mobile registrants · senior-center users

Device
1 hub analyzer per 50 people

KRW 60,000/person/yr

KidneyWatch
4 AI grades

Repeat abnormal · high risk → home

Stable 6 months → hub, less often

Testing cost cut 18–37%
(internal simulation)

Home-based testing

Where
Participant's home (1 analyzer each)

How often
Weekly (52 strips/yr)

Who
Home-visit · limited mobility · high risk

Condition
After confirming home-use approval

KRW 140,000/person/yr

Participants move between the hub-based and home-based models according to their grade, adjusting testing frequency and cost.

Key features

M1 **Enrollment & consent** — Self-application, item-by-item consent, eligibility check, operating-model assignment

M2 **Measurement** — 11 parameters; hub tablet and home app (large text, voice); 72-hour offline mode

M3 **Reading & QC** — Validates lot, expiry date, QC and testing interval; requests re-tests

M4 **KidneyWatch AI** — Combines repeated urine chemistry + checkup eGFR + BP and glucose; 4 grades

M5 **CareOps alerts** — 3 alert pathways, staff assignment, 3-tap action log, referral letters

M6 **Dashboard & reporting** — Adherence by hub, grade distribution, referrals & replies, draft year-end results

Linked services

- **S1** Urine chemistry added to checkup trajectories (kidney & metabolic plus)
- **S3·S5** Testing history sent to clinic screens (with consent)
- **S4** Weekly urine chemistry with the same device
- **S6** Test-day reminders, check-in calls for missed tests

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Agency platform	per site/yr	**KRW 3,600,000**
Hub-based testing	per person/yr	**KRW 60,000**
Home-based testing	per person/yr	**KRW 140,000**
Analyzer purchase / strip	per unit / strip	**KRW 390,000 / 600**
Rental for clinics & LTC facilities	per month	**KRW 25,000 + 500/strip**

Hub-based, 200 people
KRW 15.6M
KRW 8.4M on pilot terms

Home-based, 100 people
KRW 17.6M
KRW 9.8M on pilot terms

Mixed, 400 people
KRW 35.6M
Hub 300 + home 100

Home B2C KRW 199,000/yr (analyzer + 52 strips + app; launch in 2028 after confirming the approved scope)

Labeling & operating rules Result cards use two phrases only — "We'll check again next time" / "We recommend a check at a medical institution" — no diagnostic language · Quantitative confirmatory tests (ACR, eGFR, etc.) are decided by physicians · Home testing is offered only after confirming the approved scope (self-testing); otherwise replaced by testing during home visits

SERVICE 03 · CLINIC SUPPORT
Primary Care Chronic Disease Management Support System

WellCare Clinic Care

Support system for primary care clinics delivering chronic disease management services

Not a system that records the CDM program, but one that gets it done

Brings in-clinic urine chemistry, remote home BP and glucose monitoring, AI task prioritization and a performance dashboard together on one screen, so neighborhood clinics can complete every Chronic Disease Management (CDM) program task even without a care coordinator.

Provided by SDC WellCare · **Key customers** Clinics in (or joining) the Chronic Disease Management Program · PHC-supported model

Why it matters now

5 %
CDM program enrollment vs. eligible patients

960 clinics
Applied but running no patient management (Jul 2025)

0.5 ×
Hospitalization of CDM participants (vs. non-participants)

The CDM program has become a permanent national program, yet enrolled patients are only about 5% of those eligible, and about 960 clinics have applied without running it. The bottleneck is people — few clinics have a care coordinator, so physicians and nurses handle the work between appointments.

How it works — Follows the CDM program's one-year cycle

STEP 1
Enrollment & consent
Tablet or text link
program overlap check

STEP 2
Assessment & plan
Measurements
auto-filled
draft care plan

STEP 3
Education & counseling
10 sessions/yr tracked
3-tap notes

STEP 4
Check-up & evaluation
2 per cycle
missed-item warnings

STEP 5
Patient follow-up
Home readings reviewed
no-show recall

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING For clinics that use WellCheck for submissions, we add measurement, reading and task handling; for clinics with nothing, we start alongside them from day one

Target outcomes — proposed 2027 pilot KPIs

+20%
Enrolled patients in 12 months

85% ↑
Check-up & evaluation completion

50% ↑
No-shows recalled within 30 days

30% ↓
Coordinator task time

Voice from the field — Clinic nurse (doubling as care coordinator)
Now CDM calls and education on top of reception, injections and tests — deciding every day whom to contact first
After AI-prioritized contact list (with reasons), automatic text reminders, 3-tap counseling notes

Key differentiators

1 Kidney & urine chemistry axis

In-clinic YOCHECK 11-parameter testing + KidneyWatch AI kidney/metabolic risk with suggested retest intervals.

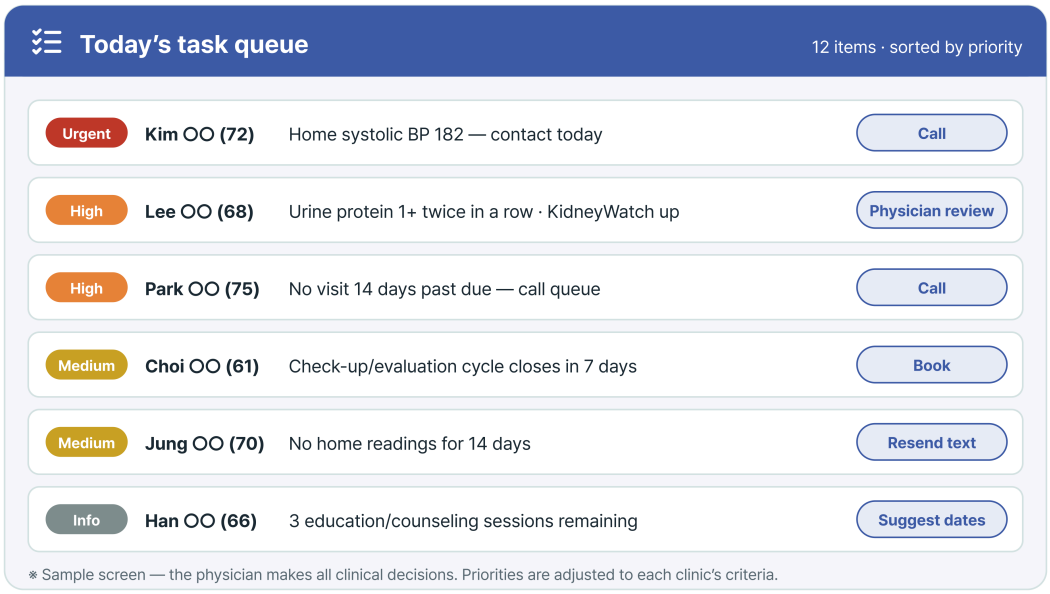
2 Remote reading from approved devices

Clinical alerts only from certified BP monitors, glucometers and YOCHECK, flagged against each patient's baseline.

3 Coordinator task queue

Scores abnormal readings, missed uploads, no-shows and upcoming check-ups to sort today's tasks with reasons.

Today's task queue



Scores measurement, visit and cycle data to show nurses what to handle first, with reasons (sample screen).

Key features

- **M1** **Enrollment & consent** — E-consent; CDM / innovation-pilot overlap check
- **M2** **Care plan templates** — Hypertension, diabetes, combined and kidney (4 types); suggested targets
- **M3** **Education, counseling & scheduling** — Session materials, sessions remaining, missed check-up warnings
- **M4** **Reminders & no-shows** — Text at 7 days → call queue at 14 → physician review at 30
- **M5** **YOCHECK · KidneyWatch** — 7-second reading (manufacturer spec), kidney retest interval (Pro)
- **M6** **Performance dashboard** — Enrollment, control rates, return visits, education completion, workload

Linked services

- **S2** Shares home-testing devices, strips and app
- **S5** Same engine; per-patient program flag blocks double enrollment
- **S1** Checkup report as enrollment reference
- **S4·S7** Shares home-care measurement summaries (with consent)

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Basic (300 patients)	per clinic/mo	**KRW 150,000**
Pro	per clinic/mo	**KRW 290,000**
Additional patients	per 100/mo	**KRW 30,000**
PHC-supported model	per clinic/yr	**KRW 1,200,000**
Urine chemistry strip	per strip	**KRW 500**

Small, 150 patients, Basic
KRW 1.8M/yr
15% of CDM program fees

Mid-size, 300 patients, Pro
KRW 4.08M/yr
Strips included

PHC-supported, 10 clinics
KRW 15.6M
KRW 8.4M on pilot terms

ROI: Basic costs 11.3% of the approx. KRW 16M/yr in CDM program fees for a 200-patient clinic — recovered with 23 new enrollees

Labeling & operating rules HIRA submissions stay on existing channels (e.g., WellCheck) — we integrate and complement rather than compete · The EMR holds the original medical record; the system keeps care-management records and measurements · KidneyWatch features are limited to clinician decision support, subject to MFDS inquiry

SERVICE 04 · CARE & INTEGRATION

Integrated Physical & Cognitive Care for Lonely-Death Prevention and Senior Care

WellCare HomeCare 360

Integrated physical and cognitive health management service specialized for lonely-death prevention and senior care

Visit order once set by intuition, now set by data

Evaluates four data streams — measurement, wearable, installed sensor and voice — against one personal baseline, and tells in-home life support workers, social workers and visiting nurses "whom to check on first this week."

Provided by SDC WellCare · BAMBOL · Wellune · GTAcom · **Key customers** Local integrated care · Customized Care Services for Older Adults · lonely-death prevention · PHCs

Why it matters now

3,924 people
Lonely deaths in 2024 (+7.2% year on year)

15 people
Older adults per in-home life support worker (staffing frozen)

1.525 M
Estimated people at risk of lonely death

Customized Care Services for Older Adults now cover 576,000 people, while the number of in-home life support workers has been frozen. Emergency safety devices catch "events" such as fire, calls for help or no detected activity, but not the early signs of declining health — and visit order is set by habit.

How it works — Four data streams, one assessment

STEP 1
Measurement
BP & urine chemistry weekly
ECG monthly

STEP 2
Wearable & installed
VitalRing / radar assigned by track

STEP 3
Voice
Weekly AI check-in call cognitive-change signals

STEP 4
CareOps assessment
Personal baseline physical–cognitive fusion

STEP 5
Priorities & action
3 alert pathways weekly visit list

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not a program that hands out devices, but an operating service that helps a small workforce reach the most at-risk older adults first**

Target outcomes — proposed 2027 pilot KPIs

85% ↑
Data collection rate

≤4/mo
False alerts per household

95% ↑
Visits within 48 h of a gap

14 days+
Early detection of worsening (research)

Voice from the field — In-home life support worker (50s, 15 clients)
Now Weekly visits and check-in calls — "whom to see first today" is a hunch; an hour a day on records
After Weekly priority list (one-line reason), measurement kit, 3-tap notes and voice work log

Key differentiators

1 One assessment across 4 streams

Combines measurement, wearable, installed sensor and voice into one personal baseline to track physical decline and cognitive change together.

2 Track assignment & gap response

Basic·R·N·RN track assignment and staged data-gap response (6 h → 24 h → 48 h → 4 weeks) keep the program actually running.

3 Tasks for each staff role

Splits alerts into 3 pathways — emergency, predicted worsening and device management — delivered as tasks to life support workers, social workers and visiting nurses.

A data gap is itself a check-in signal

Staged response to data gaps

0 h	6 h	24 h	48 h	4 weeks
Data break	**Automatic check-in**	**Phone check**	**Visit & inspection**	**Track switch**
Not worn · not charged · disconnected	Text + AI check-in call (S6)	Assigned life support worker · caregiver	Visit & replace, no exceptions	Wear rate <70% → radar

3 alert pathways — delivered as tasks for each staff member

Emergency

SOS · no return after leaving bed
prolonged inactivity · BP danger

Caregiver & staff alerted together
→ 119 guidance (no auto-report)

Predicted worsening

Cumulative deviation from
4-stream personal baseline
voice cognitive-change signals

Top of weekly priorities
→ visit · nursing · center

Device management

Not worn · low battery
offline · missed readings

Staged gap response
→ SDC field support

As in the Hwaseong City case, a break in data is itself treated as a risk signal. Visits within 48 hours are made without exception.

Key features

- **M1** **Measurement stream** — Home BP monitor and YOCHECK weekly; 6-lead ECG monthly
- **M2** **Wearable stream (R)** — VitalRing heart rate, SpO_2, skin temperature, HRV, sleep, steps; gesture SOS
- **M3** **Installed stream (N)** — Wellune 60 GHz radar, no camera, aggregated indicators only
- **M4** **Voice stream** — Cognitive-change signals from weekly check-in call speech (reference)
- **M5** **CareOps assessment** — 4-stream baselines, deviation scores, physical–cognitive fusion, gap detection
- **M6** **Priorities & field app** — Weekly list, 3-tap notes, 72-hour offline mode, voice log

Linked services

- **S2** Home urine chemistry included — no separate charge
- **S6** AI check-in & voice cognition included — no separate charge
- **S7** Used as the ring/radar sensing layer
- **S8** Vital sign AI included — no separate charge

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Basic (measurement · check-in · assessment)	per person/mo	**KRW 25,000**
Wearable (R)	per person/mo	**KRW 50,000**
Installed (N)	per person/mo	**KRW 49,000**
Combined (RN)	per person/mo	**KRW 72,000**
Radar installation & retrieval	one-time	**KRW 50,000**

Basic, 100 people
KRW 33.6M
KRW 336,000/person/yr

Mixed, 100 people
KRW 55.69M
Basic 40 · R 25 · N 25 · RN 10

Integrated care, 300 mixed
KRW 159.87M
About 50% of the KRW 1.06M/person benchmark

Family plan (B2C) KRW 39,000/mo — Basic + family app (weekly summary, emergency-pathway alerts)

Labeling & operating rules Ring, radar and voice values serve only as deviation-from-baseline signals; clinical alerts use approved medical device values only · No risk grades or diagnoses on older adults' screens; people make the final decision · Emergencies go through 119 — no automatic reporting by the system

SERVICE 05 · CLINIC SUPPORT

Primary Care Physician (Primary Care Innovation) Pilot Task Support

WellCare Primary Care Workstation

Task-support management system for clinics participating in the Korean primary care physician pilot program

The primary care clinic's second nurse

A task-support SaaS that helps clinics and hub agencies in the Community Primary Care Innovation Pilot handle enrollment, risk-group management, health management plans, multidisciplinary team tasks, care linkage and performance indicators on one screen.

Provided by SDC WellCare · **Key customers** 120 clinics in the Primary Care Innovation Pilot · 8 hub support agencies

Why it matters now

120 clinics
Pilot clinics (20 solo + 100 collaborative) + 8 hubs

1,000 patients
Enrollment cap per clinic (age 50+)

1.5 %
Subscription vs. max. annual revenue of a 1,000-patient clinic

In the pilot that began on September 29, 2026, clinics must enroll up to 1,000 patients and deliver comprehensive assessment, planning, ongoing care, home visits and care linkage. Yet the program notice sets no required information system, so clinics divide the work using Excel and messaging apps.

How it works — Pilot program workflow

STEP 1
Enrollment & consent
1,000-patient cap count
CDM overlap · app sign-up

STEP 2
Comprehensive assessment
Checkup summary attached
HCC tier support

STEP 3
Health management plan
Drafted by nurse
confirmed by physician

STEP 4
Ongoing care
Contact tasks by tier
remote monitoring

STEP 5
Linkage & performance
Visit & care referral replies
indicator dashboard

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Treatment stays in the EMR; enrollment, planning, team tasks, care linkage and performance reporting happen in the Workstation**

Target outcomes — proposed 2027 pilot KPIs

90%
Health plans established (2027)

90% ↑
Task-queue deadlines met

70% ↑
Referral replies confirmed

50% ↓
Time to prepare performance data

Voice from the field — Dedicated nurse at a solo-model clinic
Now Manages 600 patients in Excel and searches by hand every day for those with no plan or missing uploads
After Role-based task queue, plan templates, 3-tap notes, progress on performance indicators

Key differentiators

1 Workflow fitted to the program

Automatically checks the enrollment cap, CDM overlap, My Health Record app sign-up and the 4 HCC tiers as business rules.

2 Multidisciplinary team queue

Tasks and delays by role — physician, dedicated nurse, other staff — plus after-hours/holiday counseling logs (evidence for bonus points).

3 From referral to reply

Tracks remote readings from approved devices and replies to referrals to PHCs, integrated care and Dementia Relief Centers (S4·S6·S7).

Care intensity by risk tier (defaults)

	Contact frequency (default)	Remote monitoring	Linkage priority
Tier 1 Prevention	Remote quarterly + in-person yearly	Optional	**PHC health promotion (S1 report)**
Tier 2 General	Remote monthly + in-person half-yearly	BP (if applicable)	**Education & counseling, PHC programs**
Tier 3 Intensive	Remote 2×/month + in-person quarterly	BP · YOCHECK weekly	**Intensive counseling, specialist referral**
Tier 4 Specialized	Home visits & home-based care, weekly check	BP · YOCHECK + ring · radar	**Home-based care center · integrated care · Dementia Relief Center**

Official tiers are NHIS calculations · system-estimated tiers are shown for internal management only

Official tiers follow NHIS calculations; contact frequencies are task-management defaults that each clinic can adjust.

Key features

M1 **Enrollment & consent** — Cap count, CDM overlap, app sign-up check, withdrawal & transfer

M2 **HCC tier support** — Stores official NHIS tiers + internal estimated tiers for management

M3 **Plans & team queue** — Assessment & plan templates, tasks by role, 3-tap notes

M4 **Home visits & home-based care** — Visit scheduling, accompanying staff, monthly-limit warnings, referral to home-based medical care centers

M5 **Remote monitoring** — Certified BP monitors, YOCHECK, ring/radar (reference), missed-upload alerts

M6 **Performance & hub oversight** — Provisional performance-payment indicators, clinic comparison, draft agency reports

Linked services

- **S3** Same engine; dual-program clinics add S3 features at 10% off
- **S1** Checkup report as assessment input
- **S2** Shares YOCHECK readings and kits
- **S4·S6·S7** Community care referral → outcome summary returned

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Participating clinic license	per clinic/mo	**KRW 250,000**
Hub support agency license	per agency/mo	**KRW 800,000**
Remote monitoring kit	per person/mo	**KRW 5,000**
Additional user account	per account/yr	**KRW 300,000**
Referral intake desk	per agency	**No extra charge**

1 solo-model clinic
KRW 3M/yr
10% of operating support funds

1 hub + 12 clinics
KRW 45.6M/yr
KRW 31.92M on pilot terms

Clinic + remote kits for 100
KRW 9M/yr
4.5% of maximum revenue

ROI: maximum annual revenue for a 1,000-patient clinic is approx. KRW 198M — 2 more percentage points in performance payments covers the subscription

Labeling & operating rules Task support only — no diagnosis or prescribing; official tiers and fees follow NHIS calculations · Originals stay in the EMR; the system keeps task records and linked copies · Referrals send only the minimum information, after item-by-item consent

SERVICE 06 · CHECK-IN & COGNITION

AI Check-in Calls + Cognitive Screening Linkage

WellCare Care Call + Memory Detective

NAVER CLOVA-based replacement of check-in calls, check-in calls linked to professional counselors, and voice-analysis-based identification of people with suspected MCI, linked to PHCs and Dementia Relief Centers

Keep the check-in calls, add the link to the center

Keeps AI check-in calls once or twice a week while watching for memory-change signals in the person's voice, links to free screening at a Dementia Relief Center only when signals overlap, and has professional counselors take the crises the AI misses.

Provided by SDC WellCare × BAMBOL · **Key customers** Dementia Relief Centers · PHCs · Customized Care providers for older adults · local governments

Why it matters now

2.98 M
Estimated MCI among people 65+ (prevalence 28.42%)

186 K
People with an MCI diagnosis registered at Dementia Relief Centers

61.3 %
Centers short of required staff (157 of 256)

Each year 10–15% of people with MCI progress to dementia, yet only some are registered with a center. Centers are short-staffed, and AI check-in calls are already well established, so a "cheaper check-in call" alone is no reason to switch. What is needed is help finding whom to invite first, before the screening stage.

How it works — One call, used three ways

STEP 1
AI check-in call
1–2×/week, automatic daily-life & health items

STEP 2
Voice signals
Acoustic · linguistic · semantic vs. personal baseline

STEP 3
"Two or more" rule
Self & caregiver questionnaires + voice signals

STEP 4
Center linkage
Consent → CIST booking result category logged

STEP 5
Counselors
Callbacks for crisis & no answer high-risk calls 2×/month

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not replacing check-in calls, but making check-in calls lead into Dementia Relief Center work**

Target outcomes — proposed 2027 pilot KPIs

90% ↑
Routine call response rate

60% ↑
CIST uptake among those advised

95% ↑
Crisis responses handled on time

30% ↓
Time spent on check-in tasks

Voice from the field — Nurse team leader at a Dementia Relief Center (40s)
Now An average of 57 cases per case manager; mornings disappear into check-in calls to registrants
After AI handles routine calls; only check recommendations and crisis responses reach the screen — with CIST booking on the same screen

Key differentiators

1 Cognitive signals from the same call

BAMBOL's Memory Detective: after a 10-second voice profile, it observes everyday calls — no separate test required.

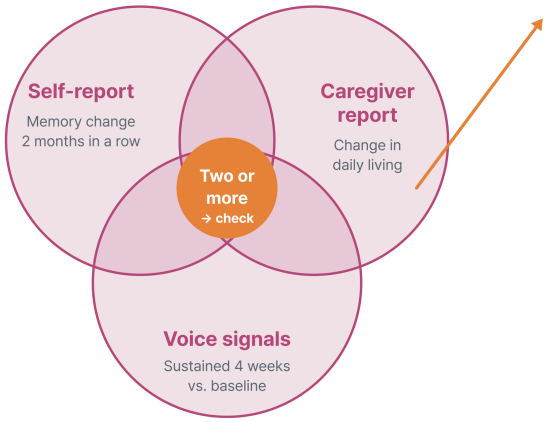
2 Check advised only when 2+ overlap

Links to CIST booking at a Dementia Relief Center only when two or more of self-report, caregiver report and voice signals overlap.

3 Professional counselor linkage

Counselors take the emotional and crisis signals the AI misses; high-risk participants get scheduled calls twice a month.

The "two or more" check-recommendation rule



Only one → keep observing, re-assess in 4 weeks
Already diagnosed/registered → "change note" only

1 Staff review — 3 business days
Overlapping signals · call records

2 Guidance & consent — 5 business days
Invitation to a free memory health check

3 CIST booking — Test within 2 weeks
At the center or via outreach screening

4 Linkage by result — Center criteria
Normal: re-observe in 6 months · diagnostic tests
cognitive classes · case management

Voice signals alone never decide. A check recommendation is not a conclusion but a list of "people for the center to check."

Key features

- **M1** **AI check-in calls** — 1–2×/week, follows up on previous conversations, 2 redials if unanswered
- **M2** **Voice cognitive signals** — 10-second profile; 4-week cycles: maintain · observe · check-recommended candidate
- **M3** **Questionnaires** — Self-reported memory change monthly; caregiver-reported daily-living change
- **M4** **Check recommendation & center linkage** — Staff review → consent → CIST booking → result category
- **M5** **Professional counselor center** — Crisis callbacks, scheduled calls, sample review of AI reports
- **M6** **Agency dashboard & family app** — Abnormal responses, check recommendations, counseling logs; weekly check-in summary

Linked services

- **S4** Cognitive stream of integrated care — no double charge
- **S7** AI check-in call when sensor data goes silent
- **S1** Physical-risk summary on counselor and center screens
- **S3·S5** Chronic disease information shared (with consent)

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
AI check-in call + voice cognitive signals	per person/mo	**KRW 4,500**
Professional counselor model	per person/mo	**KRW 15,000**
Dementia Relief Center screening linkage	per person/yr (add-on)	**KRW 30,000**
Switch from existing check-in service	per agency	**Free (year one)**
Family subscription (B2C)	per person/mo	**KRW 9,900**

Dementia Relief Center, 300
KRW 28.8M
AI + linkage; pilot KRW 17.64M

Senior care agency, 500
KRW 36.9M
AI 450 + counselor 50

Wonju pilot, 400
KRW 18.65M
Switch within the current KRW 20M budget

vs. Wonju "Every Care Call" (400 people, KRW 20M): AI 360 + counselor 40 on pilot terms KRW 18.648M

Labeling & operating rules No "dementia test," "diagnosis," scores or probabilities on participant/family screens — "memory health check recommended" · Performance figures appear only in agency proposals, with test conditions (KOLAS-tested accuracy 83.0%, MCI vs. normal) · Check-in calls continue even if voice-analysis consent is declined; emergencies directed to 119 (emergency) and 109 (suicide crisis line)

SERVICE 07 · SENSING & SAFETY
Radar & Smart Ring Sensing Care

WellCare Sensing Care Ring & Radar

SDC + Wellune integrated health management — specialized care for older adults living alone and health management tailored to each integrated-care participant type

The right sensor for each person, operations that never break

Assigns a smart ring to people who can manage on their own, camera-free radar to those who cannot wear a device, and both to those at highest risk — with a field team responsible for installation, charging and retrieval.

Provided by SDC WellCare · Wellune · GTAcom · **Key customers** Local integrated care & senior care · Emergency Safety Alert Service · LTC & residential facilities

Why it matters now

2.34 M households
Single-person households aged 65+ (calculated)

43.1 %
Landlords as first discoverers of lonely deaths (welfare workers 7.7%)

98 %
VitalRing measurement continuity (10,135 cumulative users)

Public devices catch “events” (fire, calls for help, no detected activity) but not “changes in condition” that worsen over several days. Wearables are useless once wearing or charging lapses, and older adults with dementia or who are bedridden cannot wear a ring. Trying to cover everyone with one device fails.

How it works — Operational responsibility from assignment to retrieval

STEP 1
Pre-assessment
30-minute visit
6-item checklist

STEP 2
Device assignment
Ring / radar / both
staff make the final call

STEP 3
Installation & training
Within 10 business days
charging & SOS practice

STEP 4
Continuous operation
3 alert pathways
gaps at 6–24–48 h

STEP 5
Reassign & retrieve
Switch if 4-week wear <70%
retrieval in 5 business days

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not the same device for everyone — we charge for person-by-person assignment and for operations that keep data flowing**

Target outcomes — proposed 2027 pilot KPIs

80% ↑
Valid ring-wear days

85% ↑
Valid-data rate

≤4/mo
False alerts per household

100%
Visits within 48 h of a gap

Voice from the field — 84-year-old man living alone, mild dementia
Now Takes off the ring and loses it, forgets to charge it; suspected night-time wandering
After Alerts for no return after leaving bed and prolonged inactivity, without wearing anything; monthly report on night sleep and breathing

Key differentiators

1 Assignment matrix by participant type

Recommended setup — ring / radar / both / 4–12 weeks after discharge / by integrated-care type — decided with a checklist.

2 Operational accountability

Data gap: AI check-in at 6 h, phone call at 24 h, visit at 48 h; switch to radar if the 4-week wear rate falls below 70%.

3 Linked to integrated assessment

Wellness values serve only as deviation-from-baseline signals; clinical alerts come only from approved medical device readings.

Assignment matrix by participant type

	Ring care	Radar care	Both	Why
Living alone, chronic illness, self-managing	●	○	○	Monitored when out; can press SOS
Dementia · cognitive decline	○	●	○	No wearing or charging; night bed exits
Bedridden · immobile	○	●	○	Bed-centered breathing & movement
Refuses or unsuited to wearables	○	●	○	Contactless
Highest risk (multimorbidity, ER history)	○	○	●	Covers gaps when out or not wearing
4–12 weeks after discharge	○	○	●	Both for 4 weeks → ring or radar
Middle-aged living alone, lonely-death risk	●	○	○	Active, so a wearable fits

6-item pre-assessment: cognition · willingness to wear · fingers & skin · daily charging · home Wi-Fi · bedroom layout

Assignment is recommended by a pre-assessment checklist and finalized by staff, and is reviewed every quarter.

Key features

M1 **Assignment & enrollment** — 6-item pre-assessment, matrix recommendation, staff confirmation

M2 **Ring care** — Heart rate, SpO_2, skin temperature, HRV, sleep, steps; gesture SOS

M3 **Radar care** — Presence, bed exit, movement, respiratory rate, sleep; no camera

M4 **Emergency pathway** — SOS → AI call to caregiver → 119 connection if pre-consented

M5 **Wear & device management** — Staged gap response, battery & connectivity, replacement & retrieval

M6 **Dashboard & integrated assessment** — Alerts, wear rate, device status; CareOps visit priorities

Linked services

- **S4** Sensing layer for wearable / installed / combined tracks (S4 rates apply)
- **S6** AI check-in call at a 6-hour gap (option, KRW 4,500)
- **S2·S8** Same personal ID as urine chemistry and BP readings
- **S3·S5** Activity & sleep summary sent to clinics (with consent)

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Ring care / radar care	per person/mo	**KRW 29,000 / 28,000**
Combined	per person/mo	**KRW 52,000**
CareOps integrated assessment	per person/mo	**+KRW 5,000**
Radar install & retrieval / LTE router	one-time / per month	**KRW 50,000 / 8,000**
Facility radar BIZ	per bed/mo	**KRW 25,000**

100 older adults living alone
KRW 49.18M
KRW 492,000/person/yr (incl. assessment)

Integrated care, 300 people
KRW 150.24M
Incl. 20 rotating post-discharge slots

LTC facility, 50 beds
KRW 17.5M
BIZ basic, year one

Family B2C: VitalRing purchase KRW 350,000 + caregiver app KRW 9,900/mo

Labeling & operating rules No "fall detection" claims — alerts read "no return after leaving bed" or "prolonged inactivity" · "Medical-grade accuracy" and "suspected arrhythmia" wording removed; ring and radar values are reference information for health management · No automatic 119 reporting by the system (the ring's 119 connection is a feature the user consents to in advance)

SERVICE 08 · MEDICAL CARE
WellCare AI Medical-Care Health Management

WellCare AI Vital Care

WellCare AI-based health management service for participants in PHC medical-care programs

Measurements you already take, turned into earlier visits

WellCare AI compares blood pressure, pulse, temperature, SpO_2, glucose and weight measured by visiting staff and at home against each person's usual state, and tells you whom to visit first this week and whom to refer to a medical institution.

Provided by SDC WellCare · **Key customers** PHC home-visit health, visiting nursing & integrated care · adult day care · small LTC facilities

Why it matters now

184,736 records
Vital signs observed: 232 day care clients, 971 days

422 centers
LTC home-based medical care centers (229 local governments)

30 sites
AI vital sign management pilot at LTC facilities

PHCs now carry the medical arm of integrated care, but vital signs taken by visiting staff are scattered across paper and Excel, so deterioration between visits is missed and visit order is set by habit. What is missing is not measurement but the step that turns readings into trends and priorities.

How it works — Readings from two routes, one personal trend

STEP 1
Data collection
Visit + home readings automatic Bluetooth intake

STEP 2
Quality check
Outlier flags measurement-gap detection

STEP 3
WellCare AI
vs. personal baseline direction · speed · co-change

STEP 4
Alerts & priorities
Observe · check needed medical referral advised

STEP 5
Linkage & reply
Home-based care centers & clinics referral/reply tracking

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not a service that asks for more measurement, but one that turns existing measurements into earlier visits**

Target outcomes — proposed 2027 pilot KPIs

80% ↑
Home measurement adherence

95% ↑
Checked within 24 h of an alert

≤2/mo
Unnecessary alerts per person

30% ↓
Visit documentation time

Voice from the field — 82-year-old with heart failure, 3 days after discharge
Now Lives alone; finds it hard to notice changes in weight or swelling on his own
After Three home devices + a scale; when weight or SpO_2 changes, the PHC and home-based medical care center are asked to check

Key differentiators

1 Personal-baseline trend analysis

Looks for "different from usual for this person" through direction, speed and simultaneous change across parameters — not a single cut-off.

2 Gaps are signals too

An operating flow that treats missed measurements and gaps as check signals (staged response at 24 · 48 · 72 h).

3 Referral and reply in one record

Links referrals and replies with post-discharge care, home-based medical care centers and primary care clinics in one record.

Flags "different from usual" first



When several parameters move outside the personal baseline (shaded) together, the person is raised to "check needed" (illustrative chart).

Key features

- **M1** **Data collection** — Automatic Bluetooth intake, manual app entry, 72-hour offline storage
- **M2** **Quality check** — Measurement errors & outliers; missed-measurement and gap detection
- **M3** **WellCare AI trends** — Personal baseline, direction and speed of deviation, multi-parameter co-change
- **M4** **Alerts & priorities** — 3-level alerts, weekly priority list, alert reasons shown
- **M5** **Field notes & linkage** — 3-tap notes, voice memos, referral to home-based care centers & clinics
- **M6** **Reports** — Monthly trend per participant (optional caregiver version), integrated support meeting materials

Linked services

- **S2** Adds YOCHECK urine chemistry (optional)
- **S4** Same baseline — S4 participants are not billed separately for S8
- **S5·S3** Summaries sent to primary care & chronic-care clinic screens
- **S6·S7** Check-in responses and ring/radar values as reference signals

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Visit-linked model	per person/mo	KRW 8,000
Home measurement model	per person/mo	KRW 15,000
Post-discharge intensive	per person/mo (max. 3 mo)	KRW 25,000
Measurement set for visiting staff	per set/mo	KRW 30,000
Facility model (adult day care)	per facility/mo	KRW 450,000

Visit-linked, 150 people
KRW 19.8M
Within single-quote sole-source range

PHC standard mix
KRW 31.8M
Visit 150 · home 50 · post-discharge 40

1 adult day care (30)
KRW 6.12M/yr
No agency platform needed

Family B2C: post-discharge family reassurance KRW 19,900/mo (3 home devices + family app) · accounts for home-based care centers & clinics free of charge

Labeling & operating rules Medical-threshold alerts link only to MFDS-certified device readings; wellness devices serve only as deviation-from-baseline signals · No risk scores or diagnoses on participant screens; emergency symptoms directed to 119 (no automatic reporting) · During the 2–4-week baseline period, only medical-threshold alerts operate

SERVICE 09 · FRAILTY & FALLS

MEDISTEP Gait, Frailty & Fall-Risk Management

WellCare Step Care

Frailty and fall-risk assessment and management service based on AI gait analysis

Walk 6 m for one minute — and frailty care begins

Walk 6 m in front of an iPad camera and MEDISTEP measures 40+ gait indicators within one minute; SDC WellCare then organizes each person's trend, risk stage, program assignment and change after 6 months.

Provided by SDC WellCare × Eight Studio · **Key customers** PHC frailty-prevention, fall-prevention & exercise classes · Healthy Living Support Centers · senior welfare centers

Why it matters now

1 min
40+ gait indicators measured with one iPad

300 M KRW
Hospital motion-capture system (company benchmark)

25.7 %
Goheung-gun AI·IoT program: pre-frail → healthy (2025)

"PHC frailty prevention" became a new service in 2026, but in the field frailty and fall risk still rely on questionnaires, stopwatches and tape measures, so records do not build up for each person. Precise gait analysis was available only in hospital motion-capture labs.

How it works — From a one-minute test to assignment and re-assessment

STEP 1
Questionnaire & consent
Recent falls · walking aids
separate filming consent

STEP 2
6 m walk
iPad camera, 1 minute
40+ indicators

STEP 3
Trend & stage
Reference values + personal trend
4 stages

STEP 4
Program assignment
Strength & fall-prevention classes
visit & rehab linkage

STEP 5
6-month re-assessment
Before/after comparison
results reporting

SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Gait measurement that does not stop at measuring — answering "who" and "how much better"**

Target outcomes — proposed 2027 pilot KPIs

95% ↑
First measurement completed

70% ↑
6-month re-assessment participation

80% ↑
"Manage" stage linked to programs

10 min
Per person (incl. guidance)

Voice from the field — PHC physical therapist for frailty prevention
Now 80 applicants for 30 exercise-class places — first-come, first-served leaves out at-risk older adults, and attendance is the only result
After Priority placement for the "Manage" stage; results reported with before/after tables from 6-month re-assessment

Key differentiators

1 Measurement you can carry

A 1-minute test, one iPad and on-device analysis support both fixed hubs and mobile rounds of senior community centers.

2 Trend · stage · assignment

SDC's operating layer turns readings into personal trends, 4 stages (Maintain · Watch · Manage · Consultation advised) and recommended programs.

3 6-month re-assessment

Reports the before/after results of frailty-prevention and exercise classes in numbers, as changes in walking.

Risk stages and program assignment (draft)

	Criteria (draft)	Result-sheet wording (e.g.)	Recommended program	Re-test
Maintain	Key indicators within reference; no change	"Keep walking as you do now"	Self-guided walking, daily activity	6 months
Watch	Some indicators borderline, lower than last time	"Try starting strength exercise"	Strength classes, AI·IoT senior program	6 months
Manage	Gait speed <1.0 m/s, several declines, recent fall	"Let's work on preventing falls"	Fall-prevention & exercise classes first, home-visit health	3–6 months
Consult	Rapid decline, repeated falls, pain or dizziness	"We recommend seeing a doctor"	Medical consultation, rehab linkage	Staff judgment

Assignment confirmed by PHC staff · medical judgment by medical institutions · result sheets lead with recommended activity and next test date, not stage names

A gait speed of 1.0 m/s is a "reference value" based on AWGS 2019 and does not determine sarcopenia. Cut-offs will be finalized with advice from partner clinicians.

Key features

- **M1** **Gait measurement** — 6 m walk, 40+ indicators within 1 minute (MEDISTEP)
- **M2** **Data linkage** — Only indicator values sent to SDC; video is not transferred
- **M3** **Brief questionnaire** — 3–5 items (recent falls, walking aids, etc.), 3-tap entry
- **M4** **Trend & risk stage** — Reference values + personal trend + questionnaire → 4 stages, reasons shown
- **M5** **Assignment & re-assessment** — Recommended programs, staff confirmation, 6-month re-assessment schedule
- **M6** **Result sheets & reports** — Plain-language result sheet, monthly & year-end reports, regional gait map

Linked services

- **S10** Same-day combined gait + posture test, KRW 50,000/person/yr
- **S7** Radar recommended for fall-risk older adults living alone
- **S8** Monitoring functional recovery after discharge
- **S6** Center linkage when gait and cognition change together (not for diagnosis)

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
MEDISTEP measurement hub license	per hub/yr	KRW 6,000,000
Additional mobile set	per set/yr	KRW 2,400,000
Frailty & fall management program	per person/yr	KRW 30,000
Regional gait & frailty map report	per report	KRW 3,000,000
Welfare center facility license	per month	KRW 500,000

PHC 1 hub + 300 people
KRW 18.6M
Within single-quote sole-source range

Hub 1 · mobile 2 · 600 · map
KRW 35.4M
Urban–rural rounds model

Welfare center license
KRW 6M/yr
KRW 4.2M on pilot terms

With an innovative-prototype pilot purchase, during the license-free period: 1 hub + 300 people KRW 12.6M (subject to supplier application and selection)

Labeling & operating rules No diagnostic or suspicion wording such as "sarcopenia," "Parkinson's" or "dementia," and no performance figures such as "95% accuracy" · SDC receives indicator values only, no video — filming consent is separate · Staff stand by during measurement; walking-aid users are measured with their aid

SERVICE 10 · EXERCISE & MSK

Bodydot Posture, Musculoskeletal & Exercise Prescription

WellCare Body Care

Personalized exercise-prescription health management service based on AI 3D posture and musculoskeletal analysis

Not the same exercise for everyone — exercise that fits your body

Stand in everyday clothes in front of a 3D camera for about 30 seconds to measure 40 items — posture, body imbalance, balance and mobility — without contact, followed by personalized exercise assignment → 6-month re-assessment → year-end results report.

Provided by SDC WellCare × Team Elysium · **Key customers** PHC health promotion & exercise classes · Healthy Living Support Centers · senior fitness centers

Why it matters now

30 sec
40 items measured contact-free in everyday clothes

240 PHCs
Running mobile healthcare (2025, 22,550 people)

23.9 %
Metabolic syndrome among national screening participants (2024)

PHCs keep expanding exercise programs — physical activity, obesity, mobile healthcare and frailty prevention — but with no tool to measure participants' posture, mobility and balance objectively, exercise is prescribed uniformly and results are reported only as satisfaction and attendance.

How it works — From a 30-second test to exercise for each person



SDC WellCare Integrated Management System — connected into one record for each consenting participant

POSITIONING **Not a service that opens another exercise class, but one that tailors existing exercise programs to each person and shows change in numbers**

Target outcomes — proposed 2027 pilot KPIs

95% ↑
First measurement completed

70% ↑
6-month re-assessment participation

0
Safety incidents during testing

7 min
Per-person flow (posture only)

Voice from the field — PHC exercise prescription specialist (30s)
Now 200 participants, the same exercises in every class, results reported as attendance
After Classes grouped by shoulder, lower-body and balance focus from a 30-second test; 6-month before/after comparison; draft year-end report

Key differentiators

1 30-second contact-free group testing

Everyday clothes, 30 seconds — one exercise class (20–30 people) measured in 1–2 hours.

2 Combined into one personal record

Combined with the checkup trajectory (S1), gait (S9) and chronic-disease measurements (S2·S8) in one person's record.

3 Follows the PHC program flow

Exercise assignment → 6-month re-assessment → year-end results report on "changes in posture and mobility."

Safety rules for measuring older adults

Before testing

- 5 screening questions (falls · dizziness · surgery · pain · condition)
- High-risk answer → basic test only
- Wheelchair · bedridden → refer to S8 · S7

Test space

- Non-slip mat, chair with backrest
- About 1.5 m from device; clear obstacles & cables
- Privacy screen

During testing

- 1 assistant within arm's reach
- Movements "only as far as you can"
- Stop at once if pain or dizziness

After testing

- Explain results while seated
- Advise medical check if pain persists
- Incidents recorded & shared within 24 h

Age 75+ · high risk · not wanted → skip movement items (basic test, mainly standing posture)

One assistant accompanies each person, movement items are done "only as far as you can," and high-risk respondents receive only the basic standing-posture test.

Key features

M1 **Enrollment & pre-check** — Item-by-item consent, suitability check, basic/full test choice

M2 **Bodydot measurement** — Front & side posture, imbalance, balance, squat, shoulder mobility, toe touch

M3 **Linkage & trends** — Only indicators and exercise guides synced to SDC; session records, before/after

M4 **Exercise program assignment** — Measurement + checkup & gait data (with consent) → class recommendation, staff confirmation

M5 **Result sheet & counseling** — Plain language, large print, home exercises, medical check advised where needed

M6 **Re-assessment & reports** — 6-month re-test reminders, change summary by class, year-end results report

Linked services

- **S9** Same-day frailty + MSK combined test (KRW 50,000/person/yr)
- **S1** Priority exercise prescription for obesity & metabolic risk groups
- **S2·S8** BP and other readings shown as exercise-intensity reference
- **S6** Participation reminders for those missing re-assessment

Proposed pricing · excl. VAT

Item	Unit	Price (proposed)
Bodydot measurement hub license	per hub/yr	**KRW 7,200,000**
MSK & exercise prescription program	per person/yr	**KRW 30,000**
Combined gait + posture (S9+S10)	per person/yr	**KRW 50,000**
Facility license	per month	**KRW 600,000**
Agency platform	per site/yr	**KRW 3,600,000**

PHC 1 hub + 300 people
KRW 19.8M
Within single-quote sole-source range

Welfare center facility license
KRW 7.2M/yr
KRW 5.04M on pilot terms

S9+S10 combined, 400
KRW 33.48M
1 hub each, 10% bundle applied

For clinical use at hospitals and clinics, Team Elysium's medical-institution product (iBalance) is offered separately

Labeling & operating rules No diagnostic wording such as "scoliosis," "forward head posture syndrome" or "herniated disc" — use "body imbalance / reduced mobility, care needed" · 97.0% accuracy and 12 published papers are presented only as company claims · 3D video and body images stay with Bodydot; SDC syncs indicator values only; image storage requires optional consent

Sample quotes are first-year · The agency platform (KRW 3.6M/yr) is charged once across all services

PACKAGES · PRICING · ONBOARDING

Start small, then add services to the same platform

Agency platform
KRW 3.6M per site per year — charged only once, however many services you adopt (5 admin accounts, dashboard, monthly report, training twice a year, help desk)

Bundle & multi-year discounts
10% for bundles of 2+ services; an additional 5% for 3-year contracts (excl. platform and installation fees)

2027 pilot agencies
Platform fee waived + 30% off usage fees (not combined with bundle/multi-year discounts); joint presentation of results required

No double billing
Service 4 participants are not billed separately for 2 (home testing), 6 (AI check-in), 7 (sensors) or 8 (vital sign AI) / 9+10 for the same person: KRW 50,000 per person/yr

Start small
100–300 people: approx. KRW 6.2M–19.8M in year one — can start with a single-quote sole-source contract (KRW 20M or less)

Recommended packages by customer — first-year quotes (proposed)

Customer	Recommended configuration	First-year quote
PHC health promotion team	S1 (300 people + re-assessment) + S2 hub-based (150 people)	**KRW 17.91M**
Dementia Relief Center	S6 (AI 200 + screening linkage 200) + S7 radar (10 people)	**KRW 22.24M**
Local integrated care · senior care	S4 (300 people, mixed) + S6 AI (700 people) + S1 regional population analysis	**KRW 182.39M**
PHC + local clinic linkage	S3 PHC-supported (10 clinics) + S2 hub-based (200 people) + S1 (300 people)	**KRW 31.41M**
PHC home-visit health · medical care	S8 (visits 150 · home 50 · post-discharge 40/yr) + S2 hub-based (100 people)	**KRW 34.38M**
PHC frailty & fall prevention	S9 + S10, 1 hub each + combined gait·posture testing for 400 people	**KRW 33.48M**
Adult day care · small LTC facilities	S8 facility model (30 people)	**KRW 6.12M/yr**
Agencies starting out	S1 (100) / S6 AI (100) / S8 visit-linked (150), each standalone	**KRW 6.2M / 9M / 19.8M**

Includes the agency platform (KRW 3.6M/yr, charged once) and the 10% bundle discount; radar installation/retrieval is not discounted · See the integrated price list for full pricing.

Onboarding steps

1. Consultation & demo
Review of your programs, sample report and screen demo, recommended services
1 week

2. Free trial
Small-scale trial of Service 1 or 6 (30–50 people)
4–8 weeks

3. Quote & contract
Custom quote, sample internal approval memo, data processing agreement
2–4 weeks

4. Kickoff & training
Agree on target groups and alert criteria; 2-hour staff training
2 weeks

5. Operation
Self-application & consent → measurement & analysis → priorities & referral → monthly report
Contract term

6. Results reporting
Quarterly reports, draft year-end performance report
Quarterly · yearly

2027 Pilot Partnership Offer

Recruiting additional pilot agencies beyond Wonju (MOLIT AI-specialized pilot city) and Yuseong-gu, Daejeon · March–December 2027 · Platform fee waived + 30% off usage fees · Joint presentation of results

How to procure

Up to KRW 20M: sole-source contract on a single quote · Above KRW 20M: two-quote sole-source, small-business special provision · Innovative Product and digital service (SaaS) contracts in progress

Operational support and service levels

Help desk
Weekdays 9:00–18:00 KST; first response within 4 business hours

Incident response
Notice issued and remediation started within 1 hour of detection

System availability
99.5% or higher monthly (scheduled maintenance announced 7 days ahead)

Device replacement
Shipped within 48 business hours after failure or loss (island areas excepted)

Personal data
Item-by-item consent; withdrawals processed within 7 days; agency notified within 72 hours of a breach

If levels are missed
5–10% reduction of the monthly fee (stated in the contract)

SDC WellCare

One platform · One participant record · 10 services

Contact SDC WellCare Co., Ltd., Business Planning Team · sdc@seouldaycare.com
www.sdcwellcare.com · www.kwellcareai.com

Lead: SDC WellCare Co., Ltd.
BAMBOL · Wellune · GTAcom
Eight Studio · Team Elysium

All prices are proposed 2027 list prices in Korean won (KRW), excl. VAT, to be finalized through pilot programs and procurement negotiations. VitalRing, Wellune radar (general model) and Memory Detective are wellness products that do not diagnose; results are reference information for health management. YOCHECK YC-11 is an MFDS Class II IVD medical device and is operated within the scope of its approval. MEDISTEP and Bodydot results describe functional changes and do not diagnose disease. Policy figures are based on public data from the Ministry of Health and Welfare, the Korea Health Promotion Institute and the National Health Insurance Service, and on press reports (2025–2026).