

PREVENTIVE CARE CHALLENGE

From **January 1 - November 30**, complete at least three preventive care activities, these include:

ACTIVITY TYPE	ACTIVITY DESCRIPTION	SUPPORTING DOCUMENTATION EXAMPLES
Healthcare Preventive Screening	Healthcare preventive screenings include annual physicals, mammograms, prostate and colorectal screenings, biometric screenings and mental health consultations.	☆ Copy of an Explanation of Benefits (EOB) ☆ Invoice from the provider's office
Health Management Program Enrollment*	Participation in any of GPC's Health Management Programs, including Livongo Hypertension, Livongo Diabetes Management, Hinge Health Exercise Therapy, Omada Diabetes Prevention and Transcarent Surgery Care.	☆ Confirmation email from the Health Management Program
Rx Savings Solutions Enrollment*	Enrollment in GPC's prescription drug savings program.	☆ Screenshot or email from Rx Savings Solutions confirming account activation
Dental Preventive Visit	Preventive dental care includes routine exams, cleanings and x-rays.	☆ Copy of an Explanation of Benefits (EOB) ☆ Invoice from the provider's office
Vision Preventive Visit	A comprehensive eye exam performed by an optometrist or ophthalmologist.	☆ Copy of an Explanation of Benefits (EOB) ☆ Invoice from the provider's office

**You must be enrolled in a GPC Medical Plan option.*

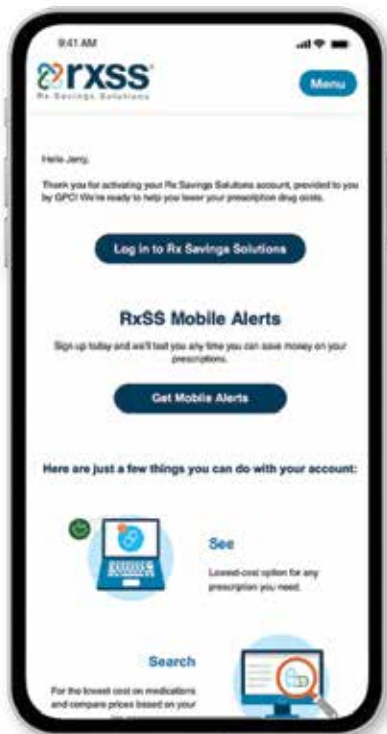


Preventive care activities completed between October 1, 2025 and November 30, 2026, will be eligible for the Preventive Care Challenge.



Remove or black out all financial details and personal health information before submitting.

Supporting Documentation Examples



Screenshot or email confirming account activation.

The invoice is from Smith Dental. It includes the following information:

- Invoice #:** [Redacted]
- Invoice Date:** January 17, 2024
- Doctor Information:**
 - Doctor: Dr. Laverly Smith
 - Specialty: General Dentistry
 - License Number: 01234567
- Patient Information:**
 - Joseph Doe
 - 408 Rough Road Avenue, Liberty Valley, CA 95210
 - (222) 555-7777
 - jdoe@sample.com

PROCEDURE CODE [2]	DESCRIPTION	TOOTH	FEE
D0120	Routine Dental Exam		\$
D0274	Bitewing X-rays (4 films)		\$
D0330	Panoramic X-ray		\$
D1100	Prophylaxis (cleaning)		\$
D2950	Composite Filling, 1 surface	14	\$
D4341	Periodontal Scaling & Root		\$
D1206	Topical Fluoride Treatment		\$
D7940	Extraction, erupted tooth	32	\$
D0820	Intraoral Periapical X-ray	21	\$
D2740	Crown - porcelain/ceramic	18	\$

Payment Information: Please make checks payable to "Smith Clinic" and mail to the address above. For electronic transfers, use the following details:

SubTotal	Tax	Tax Amount	Total Amount
\$	8.50%	\$	\$

Bank: [Redacted]
Account Name: [Redacted]
Account Number: [Redacted]
Routing Number: [Redacted]

Total Amount: \$ [Redacted]

Thank you for choosing Smith Clinic for your dental care. For any inquiries, please contact us at (222) 555-7777 or info@smithclinic.com.

Invoice from the provider's office with personal health information redacted.

The EOB statement includes the following information:

- Service Center:** Address, City, State, ZIP Code, Phone: 1-800-888-8888
- Have more questions about your claim?** Visit (name of member website) for all your claim and benefit information.
- Date:** [Redacted]
- Member/Patient Information:**
 - Member/Patient: John Johnson
 - Member ID: 123456789
 - Group Name: ABC Company
 - Group #: [Redacted]

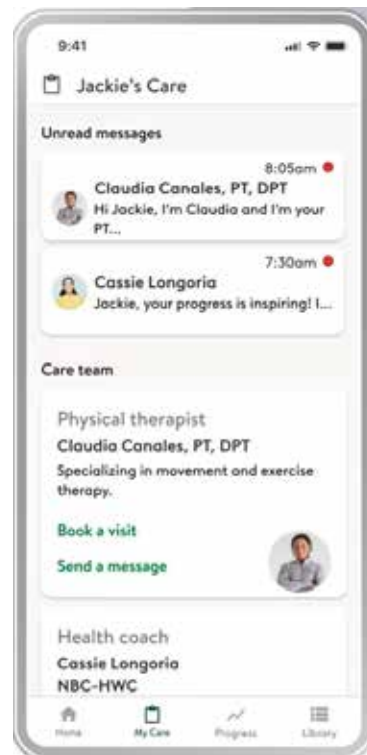
Explanation of Benefits Statement
This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary
Detailed claim information is located on following page(s)

Dollar Amount	Description
\$220.00	Amount Billed The amount your provider charged for services provided to you.
\$32.25	Plan Discounts Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
\$40.00	Year Plan Paid The money your health benefit plan paid.
\$116.75	Total Amount You Owe the Provider(s) The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non-covered charges. This amount does not include any payments made to the subscriber. If a payment was made directly to the subscriber, your/our subscriber is responsible for paying the physician, facility or other health care professional. <small>*When coordination of benefits applies, this amount will include payments made to the subscriber.</small>

Use this EOB statement as a reference or retain as needed. Page 1 of 4

Explanation of Benefits (EOB) with personal health information redacted.



Screenshot demonstrating that you have registered or logged into a Health Management Program.