Level 2 - 2024 POINTS APPEAL FORM
For members enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Plan Options
Note: Not applicable to dependent children or members enrolled in Kaiser Permanente or Medicare Advantage Plan Options

You may file a Level 2 Points Appeals through the process outlined below:

If you receive notice that your Level 1 appeal is denied, you will be able to appeal this decision by submitting a Level 2 appeal with additional evidence of completion of the 2024 Well-Being Activities. Your Level 2 appeal must be postmarked within 15 calendar days following the date of the 2024 Level 1 – appeal decision.

Section I. Points Appeals: You and your covered spouse may appeal the total points applied if the points are less than you believe should have been awarded to you or your covered spouse. Appeals may be filed beginning February 15, 2024 and must be received by 5:00 p.m. ET on January 31, 2025.

Please provide supporting documentation that you completed the requirements. For example, provide one of the following for inclusion with your appeal:

- A copy of the completed 2024 Physician Screening Form and confirmation that it was sent to Sharecare by the December 2, 2024 deadline (if applicable).
- A copy of the Know Your Numbers Form as confirmation of onsite screening participation upon completion at an SHBP-sponsored onsite screening event.
- Print screen or take a snapshot of the incentive status when activities through the Sharecare App or online

You must complete all applicable sections on the Points Appeal Form, including any additional facts or material that are pertinent to the case. Generally, a decision is reached within **30 calendar days** of receipt unless additional information is needed. Appeals will be investigated by Sharecare. Sharecare will provide written notification of whether the appeal was granted or denied.

Section II.

Last Name _____ **First Name** _____

Address: _____ **Member ID:** (Found on your medical ID card) _____

City _____ **State** _____ **Zip Code:** _____

Email Address _____ **Phone Number** (xxx-xxx-xxxx) ( ) - _____ **Date of Birth** (MM/DD/YYYY) ___/___/___

Section III. Reason for Appeal (please give detailed explanation for review)

For the Health Action(s) identified below, enter the date in which each applicable Action was completed and submit proof that it was sent to Sharecare

COMPLETED HEALTH ACTIONS		
1	RealAge Test	
2	Biometric Screening	
3	Coaching Session	
4	Online Challenge	
5	Mini Program	
6	Preventive Screening	

SECTION IV. If the 2024 Wellness Requirement was not met, due to circumstances beyond your control or for medical reasons, type or legibly print the reason in the space provided below. Please attach documentation from your physician stating why you cannot participate. (Limit description to visible area below)

SECTION V.

- All appeals must be submitted on this form.
- There are several ways to file your appeal:
  - **Email:** You may email your appeal to us at BeWellSHBP@appeal.sharecare.com
  - **Fax:** Appeals can be faxed to us at (1-615-261-1418)
  - **Mail:** Send appeals through the mail to:

    Sharecare

    Attention: State Health Benefit Plan Appeal

    255 East Paces Ferry Rd NE, Suite 700

    Atlanta, GA 30305

AUTHORIZATION

I hereby certify that the above information and any supporting document(s) are true and correct.

FAILURE TO PROVIDE SUPPORTING DOCUMENTATION AS DESCRIBED IN SECTION I ABOVE WILL RESULT IN DENIAL OF MY APPEAL.

Signature	Date