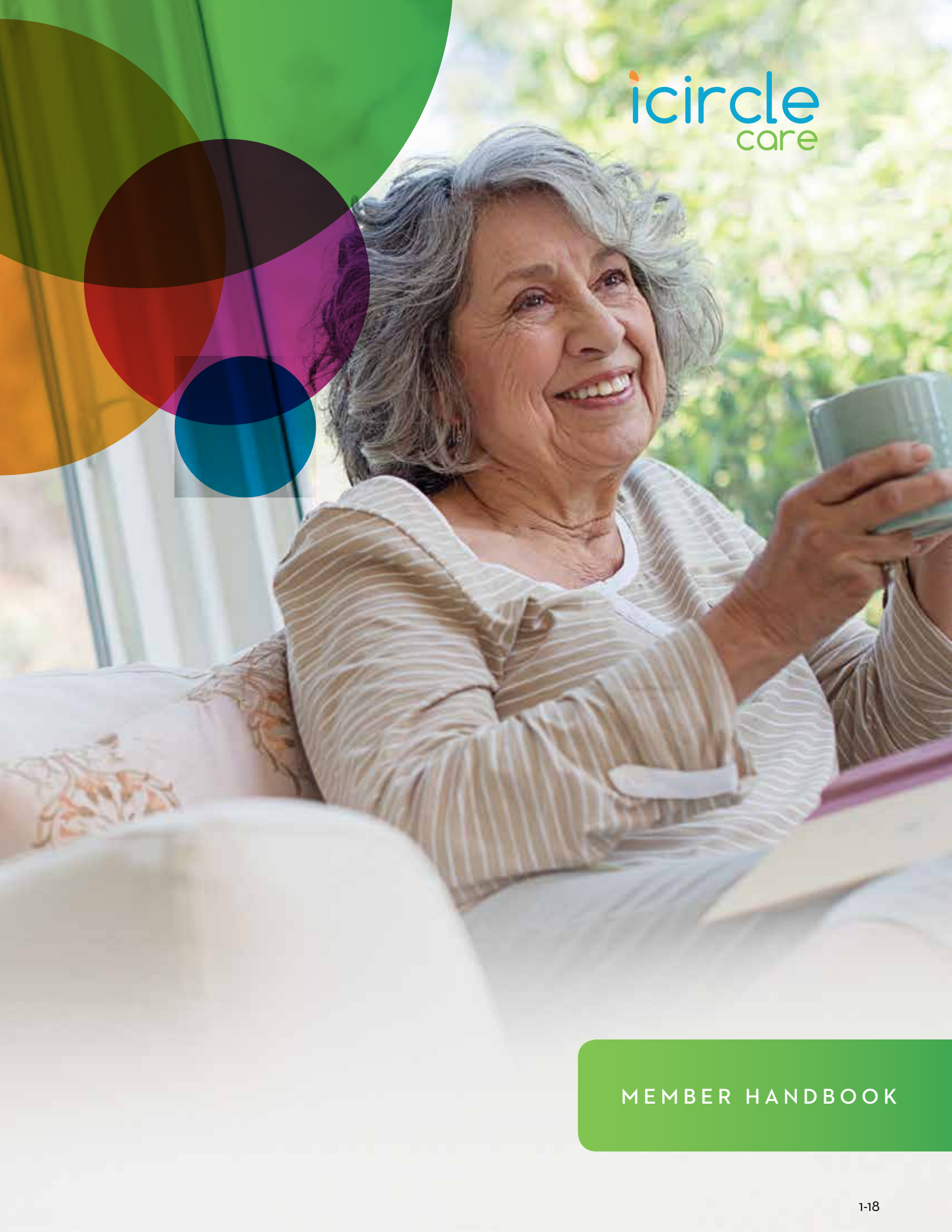
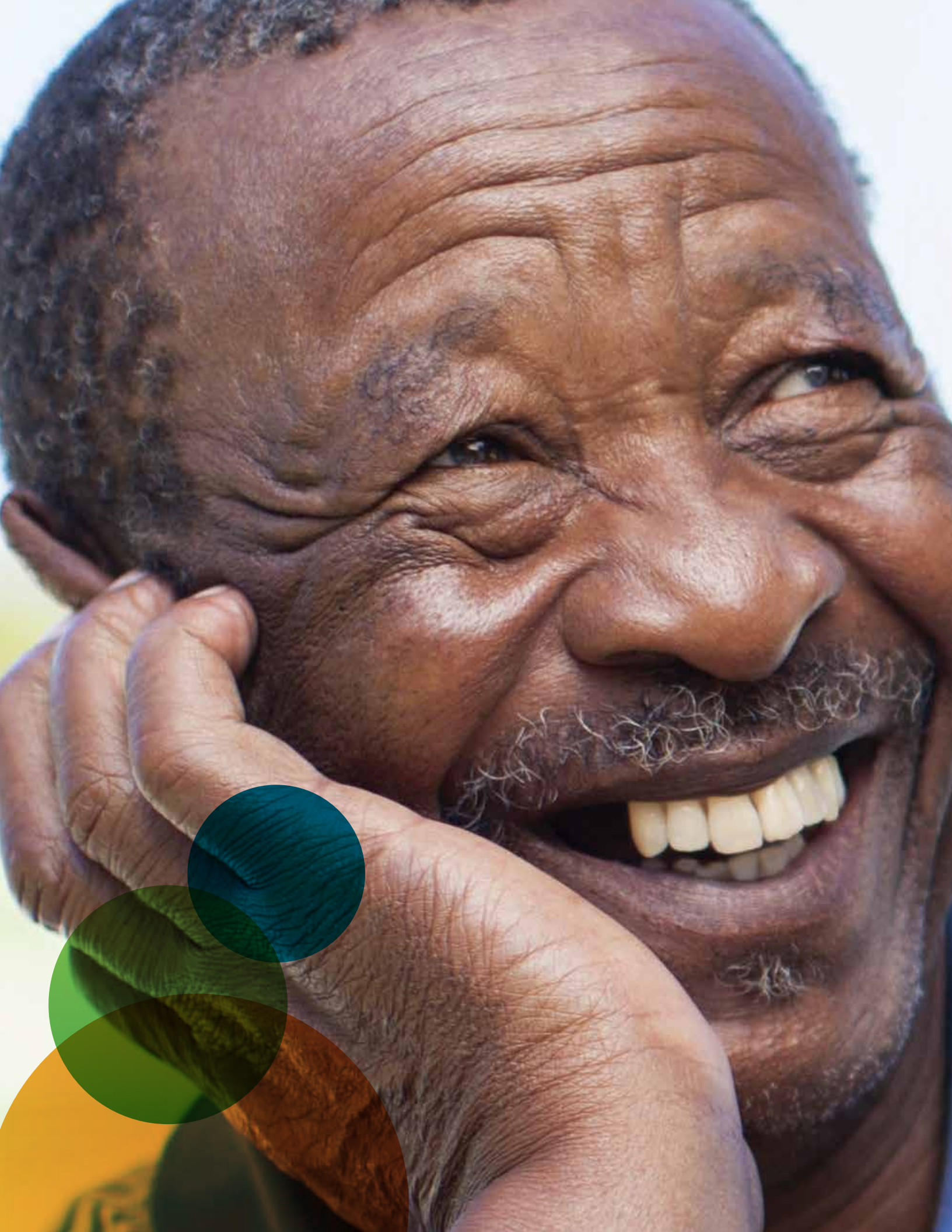

icircle
care
MEMBER HANDBOOK



CONTENTS

Welcome to iCircle Care

Thank you for choosing iCircle Care for your Medicaid Managed Long-Term Care (MLTC) plan.

We provide our members with high-quality health and social services that are culturally appropriate, community integrated and tailored to their individual needs, ensuring a positive impact on their personal health, lifestyle and independence.

iCircle Care is committed to helping those who are chronically ill or have a disability find and receive the best long-term care and treatment for their situation. As a locally based organization, we understand the special health needs of our community. We don't have to answer to a large, distant corporation.

As a nonprofit, iCircle Care's first priority will always be to fulfill our mission of serving and enriching the lives of our members. As part of that mission, we treat all members with respect and compassion. Always.


Hometown care.
Centered on you.

USING THIS HANDBOOK

This handbook is a valuable resource you can use to obtain information about the iCircle Care plan. It explains Managed Long-Term Care (MLTC); the procedures for enrollment and disenrollment in the iCircle Care plan; how to file a complaint, grievance or appeal; the benefits you're entitled to; how to request a benefit; and other valuable information pertaining to your enrollment.

As an iCircle Care member, you will be able to keep your current primary care physician.

If you require additional information, please contact our Member Services Department by calling 1-844-MY-iCARE (694-2273) or dialing TTY: 711.

ABOUT iCIRCLE CARE

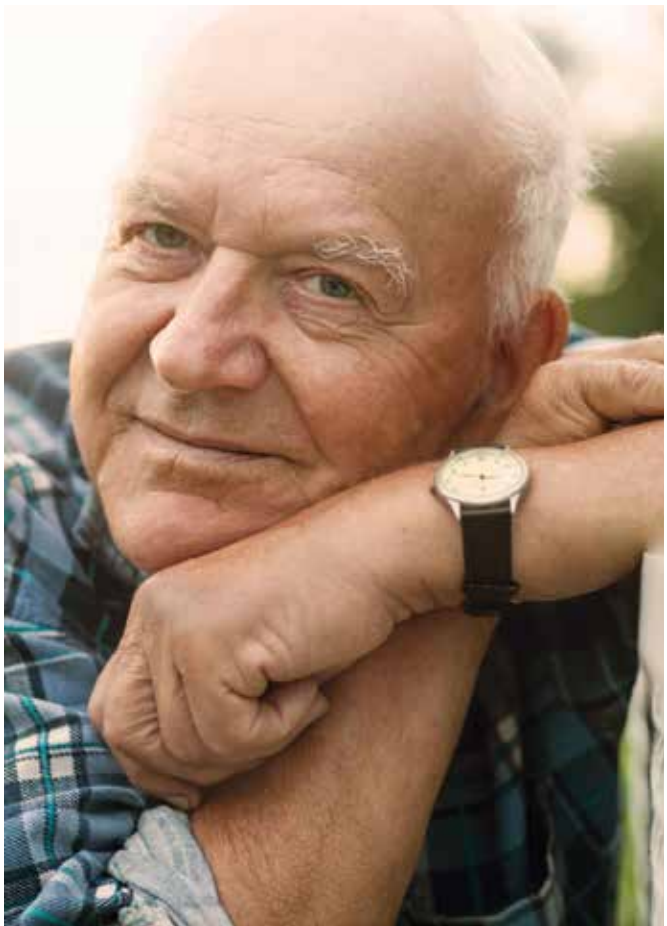
Licensed by the New York State Department of Health, iCircle Care is an MLTC plan formed by a collaboration of leading community-based providers who believed the region deserved a higher level of individual choice and personalized care. Through a distinctly compassionate and friendly approach to service and care, iCircle Care empowers individuals residing in Upstate New York who are 18 years of age or older and require long-term care supports and services to live independently in their homes as productive members of their communities.

Through periodic mailings or website postings, iCircle will keep you informed about important health education issues, such as immunizations, injury prevention, falls prevention, physical fitness and nutrition.

iCircle Care is dedicated to addressing your needs and questions in a timely and appropriate manner. Our knowledgeable Care Management Team will work closely with you and your circle of support to ensure that we are meeting your needs.

WHAT IS MLTC?

The goal of MLTC is to enable individuals with chronic illnesses and/or disabilities to safely reside in their appropriate setting by reimbursing for the care and support needed to perform day-to-day activities that they are unable to perform without assistance.



ENROLLING IN iCIRCLE CARE

Enrollment Criteria

To be eligible to enroll in iCircle Care, you must:

- Be 18 years of age or older
- Reside in one of the following counties:
  - Broome, Cayuga, Chautauqua, Chemung, Chenango, Cortland, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming or Yates
- Be determined by your local Department of Social Services or entity designated by the New York State Department of Health to be eligible for Medicaid
- New York Medicaid Choice (Maximus) serves as the NYS entity that provides independent and conflict-free evaluation, education and enrollment services for new applicants in need of Community-Based Long-Term Care Services (CBLTCS)
- Be determined eligible for MLTC based on assessment conducted by an entity designated by the New York State Department of Health, using an eligibility tool designated by the department
- Be capable at time of enrollment of staying in your home without jeopardy to your health and safety, based upon criteria provided by the Department of Health
- Require at least one of the following CBLTCS for more than 120 days from the effective date of enrollment:
  - Nursing Services in the Home
  - Therapies in the Home
  - Home Health Aide Services
  - Personal Care Services in the Home
  - Adult Day Health Care
  - Private Duty Nursing
  - Consumer-Directed Personal Assistance Services

Enrollment Process

If you are interested in enrolling in iCircle Care:

Call 1-844-iCircle (424-7253) or dialing TTY: 711 to speak with an Enrollment Coordinator (EC).

The EC will:

- Provide an overview of iCircle Care
- Review the eligibility requirements (to determine whether you meet the basic eligibility criteria, such as age and county of residence)
- Ask whether you are a current recipient of Medicaid; if you're not currently receiving Medicaid benefits, the EC will arrange for a Medicaid Enrollment Specialist to help you complete a Medicaid application
- Assist in determining if you will need a conflict-free evaluation done by a registered nurse representing NYS Medicaid. New York Medicaid Choice (Maximus) serves as the NYS entity that provides independent and conflict-free evaluation, education and enrollment services for new applicants in need of CBLTCS.

If you decide to continue the enrollment process, an in-person visit with an assessment nurse will be scheduled within 30 days of initial referral. The assessment nurse will conduct a comprehensive evaluation of your health and safety, as well as your environmental surroundings.

If you are deemed eligible for iCircle Care, the in-person evaluation information will be used to generate your Person Centered Plan of Care.

Your finalized Person Centered Plan of Care will be provided to you within 5 business days from the completion of the assessments.

During your in-person visit, the assessment nurse will:

- Review the Member Handbook, Provider Directory and Medicaid Managed Long-Term Care Guide with you
- Answer any questions you or your family member, caregiver or other support person may have
- Discuss and review the Person Centered Plan of Care that's being recommended, based upon the completed assessments
- Explain what to expect by enrolling in iCircle Care and your rights and responsibilities as a member
- Explain what benefits are covered and how you access services
- Explain how care will be coordinated

If you decide to enroll in iCircle Care, you will:

- Need to complete the enrollment agreement and associated paperwork
- Be informed of when you can expect your enrollment to start if it is approved by New York State or its designated entity.

iCircle Care does not discriminate based on health status, need or cost of covered services. The final decision on your application will be made by New York State or its designated entity.

Choosing iCircle Care as your MLTC plan is voluntary on your part. At any time during the process of your inquiry about enrollment in iCircle Care, and even after you complete the application process, you can change your mind and withdraw your application by noon on the 20th day of the month prior to effective date of enrollment by indicating this orally or in writing. If you enroll in iCircle Care, but at a later time change your mind, you can request disenrollment from the plan.

Remember, you can keep your current primary care physician if you become an iCircle Care member.

Managing Your Care

The most important benefit you will receive by enrolling in iCircle Care is Care Management. In general, Care Management is a process that identifies, coordinates and helps you obtain medical, social, educational, psychosocial, financial and other necessary services.

Every member of iCircle Care is assigned a Care Manager and any other specialists required to help meet your needs. iCircle Care Managers are registered nurses and/or social workers.

Following your enrollment in iCircle Care, your Care Manager, in consultation with your primary care physician, where applicable, will create a plan of care that is customized to meet your unique needs. Your Care Manager will continuously monitor your Person Centered Plan of Care and work with your primary care physician to adjust it as necessary.

Your iCircle Care Benefits

Enrolling in iCircle Care will not reduce the benefits you receive through Medicaid, Medicare and/or private insurance. Benefits under your health insurances will be coordinated.

Denial of Enrollment

You can be denied enrollment into iCircle Care for one or more of the following reasons:

- You are not at least 18 years old
- You are not Medicaid eligible
- You are not eligible for nursing home level of care
- You are not capable of returning to or remaining in your home and community without jeopardy to your health and safety at the time of enrollment
- You do not require community-based long-term services for more than 120 days
- You have been previously involuntarily disenrolled from iCircle Care, as determined on a case-by-case basis

iCircle Care offers a wide range of home, community and facility-based long-term care and health-related services. Your provider must get authorization from iCircle Care for services. These services will be authorized by iCircle Care as long as they are medically necessary. Medical necessity means covered services that are necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person's capacity for normal activity or threaten some significant handicap.

BENEFIT	DESCRIPTION
Adult Day Healthcare	Adult day healthcare is care and services provided in a residential healthcare facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult Day Healthcare includes the following: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities (which are a planned program of diverse, meaningful activities), dental, pharmaceutical and other ancillary services.
Audiology/Hearing Aids	Audiology services include audiometric examination or testing, hearing-aid evaluation, conformity evaluation, and hearing-aid prescription or recommendations, if indicated. Hearing-aid services include selecting, fitting and dispensing of hearing aids, hearing-aid checks following dispensing and hearing-aid repairs. Products include hearing aids, earmolds, batteries, special fittings and replacement parts.
Care Management	Care management is a process that helps you access necessary covered services as identified in your care plan. Care management services include referral, assistance with or coordination of services to help you obtain needed medical, social, educational, psychological, financial and other services in support of the care plan even if those services are not covered by iCircle Care.
Consumer-Directed Personal Assistance Services (CDPAS)	As part of your Medicaid MLTC services, you may be eligible to self-direct your own care. CDPAS is a specialized personal care program that empowers self-directing seniors, people with disabilities or their designated representatives to recruit, hire, train, supervise and terminate their choice of personal assistant home care worker. iCircle Care has contracted fiscal intermediary companies that provide the necessary supports to administer the program, such as facilitate paperwork, payroll, benefits and administration. If you are interested or want to learn more, speak with your Care Management team.

BENEFIT	DESCRIPTION
Dentistry	Dentistry includes, but is not limited to preventative, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability. Please contact Healthplex at 1-888-468-5175, toll-free Monday-Friday from 8:00 a.m. to 6:00 p.m. For TTY/TDD, call 1-800-662-1200.
Durable Medical Equipment (DME) Prosthetics and Orthotics	DME includes: • Prosthetics, and orthotics and orthopedic footwear • Enteral and parenteral formula • Hearing-aid batteries DME includes devices and equipment, other than for a prosthetic-or orthopedic-specific medical condition, that have the following characteristics: • Can withstand repeated use for a protracted period of time • Are primarily and customarily used for medical purposes • Are generally not useful in the absence of an illness or injury • Are not usually fitted, designed or fashioned for a particular individual's use Where equipment is intended for use by only one member, it may be either custom made or customized. Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances or devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value. Prosthetic appliances and devices are appliances and devices, which replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. *Continued on next page.*

BENEFIT	DESCRIPTION
Durable Medical Equipment (DME) Prosthetics and Orthotics, *continued*	Medicaid coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube; 2) individuals with rare inborn metabolic disorders; 3) children up to age 21 who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein.
Home Care	Home care includes the following preventive, therapeutic, rehabilitative, health guidance and/or supportive services: nursing, home health aide, medical social, telehealth, physical therapy, occupational therapy and speech pathology.
Home Health Aide	A home health aide is a person who carries out healthcare tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to assist with healthcare needs in your home.
Home-Delivered or Congregate Meals	Meals provided in support of your plan of care.
Non-Emergency Transportation	Transportation by ambulance, ambullette, taxi, livery service or public transportation at the appropriate level for your condition to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or Medicare. iCircle Care uses only approved Medicaid ambulette vendors to provide transportation services to members. Please contact the Member Services team 3 days prior to your scheduled service date for your transportation needs.
Nursing Home Care (Residential Healthcare Facility)	Nursing home care is care provided to you by a licensed facility.

BENEFIT	DESCRIPTION
Nursing Services	Nursing services include intermittent, part-time and continuous nursing services provided in accordance with an ordering physician's treatment plan as outlined in the physician's recommendation. Nursing services will be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to you and instructions to your family or caretaker in the procedures necessary for your treatment or maintenance.
Nutrition	The assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for your physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within your home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, and provision of in-service education to health agency staff, as well as consultation on specific dietary problems and nutrition teaching to you and your family. Nutrition services must be provided by a qualified nutritionist.
Optometry/Eyeglasses	Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the enrollee's condition. Examinations that include refraction are limited to every 2 years unless otherwise justified as medically necessary.
Personal Care	Personal care means some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks.

BENEFIT	DESCRIPTION
Personal Emergency Response System (PERS)	PERS is an electronic device that enables certain high-risk members to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist that employ different signaling devices. Such systems are usually connected to your phone and signal a response center once a help button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.
Physical, Occupational, Speech and Other Therapies (Provided in a Setting Other Than Your Home)	Physical therapy services are rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level. Occupational therapy services are rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level. Speech therapy services are rehabilitation services provided by a licensed and registered speech-language pathologist for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level. Limitations: Limited to 20 visits of each therapy type per calendar year, except for those under 21 and the developmentally disabled. The MLTC plan may authorize additional visits.
Podiatry	Podiatry means services by a podiatrist that include routine foot care if a physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and as an integral part of medical care, such as the diagnosis and treatment of diabetes, ulcers and infections. Limitations: Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care, such as cleaning or soaking feet, are not covered in the absence of a pathological condition.
Private Duty Nursing	Continuous and skilled nursing care provided in your home or, under certain conditions, a hospital or nursing home, by a properly licensed registered professional or licensed practical nurse.

BENEFIT	DESCRIPTION
Respiratory Therapy	Respiratory therapy means the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures, including the application of medical gases, humidity and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. Respiratory therapy services must be provided by a qualified respiratory therapist.
Social and Environmental Supports	Services and items that support your medical needs and are included in your plan of care. These services and items include maintenance tasks, homemaker/chore services, housing improvement and respite care.
Social Day Care	A structured program that provides functionally impaired individuals with socialization, supervision and monitoring, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include, and are not limited to, maintenance and enhancement of daily living skills, personal care maintenance, transportation, caregiver assistance, and case coordination and assistance.
Telehealth	Telehealth-delivered services use electronic information and communication technologies to deliver healthcare services by telehealth providers. These services include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an enrollee. Telehealth providers can include, but are not limited to, physicians, physician's assistants, dentists, nurse practitioners, registered professional nurses, podiatrists, optometrists, psychologists, social workers, speech-language pathologists, audiologists, certified diabetes educators, hospitals, home care agencies or hospice.

Services Not Covered

The following are examples of services that are not covered by iCircle Care:

- Physician services
- Emergency transportation
- Inpatient hospital services
- Outpatient hospital services
- Laboratory services
- Radiology and radioisotope services
- Rural health clinic services
- Chronic renal dialysis
- Mental health services
- Alcohol and substance abuse services
- Office for People With Developmental Disabilities (OPWDD) services
- Family planning services
- Prescription and non-prescription drugs

If you have a question about whether a service is covered by iCircle Care, please contact our Member Services Department by calling 1-844-MY-iCARE (694-2273) or dialing TTY: 711.

Identification Card (ID)

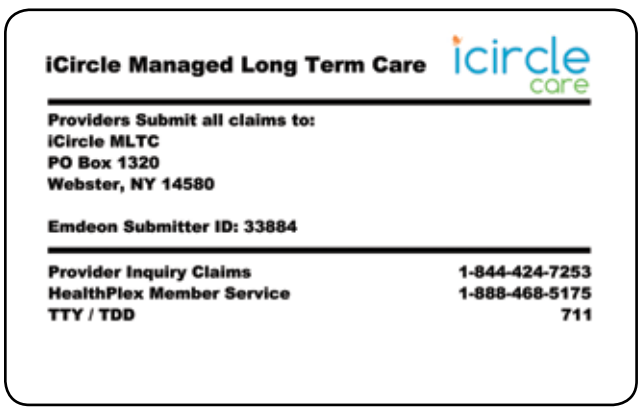
Every member of iCircle Care will receive an ID card, which you should carry with you at all times. You will use your member ID card to access the services covered by iCircle Care and to prove that you are a member of iCircle Care.

Once you receive your ID card, you should confirm that all of the information it contains is correct. In the event that the information is incorrect, you did not receive your ID card or your ID card is lost, you should contact our Member Services Department by calling 1-844-MY-iCARE (694-2273) or dialing TTY: 711.

If you are covered by Medicare and/or have private insurance, you will continue to have coverage through those programs and should carry all of your ID cards, including your Medicaid Benefit card.

In the event of an emergency, you are not required to present your iCircle Care ID card to obtain emergency care and you should call 911 or go to the nearest emergency room immediately.

Below is a sample ID card, which shows what your card will look like.



Our mission at iCircle Care is to give each member the best customized plan of treatment and care for his or her unique situation. That means putting you at the center of everything we do. We can't imagine doing it any other way.

ACCESSING YOUR iCIRCLE CARE BENEFITS

iCircle Care Network

You are required to obtain all services covered by iCircle Care from a provider within iCircle Care's provider network. A copy of the Provider Directory should have been provided to you at your enrollment. If you need a copy of iCircle Care's Provider Directory, would like an additional copy or need assistance selecting a provider from the network, please contact the Member Services Department by calling 1-844-MY-iCARE (694-2273) or dialing TTY: 711. You can also view and download a comprehensive listing of all providers online at icirclecarecny.org.

If you are veteran, spouse of a veteran or Gold Star parent enrollee in need of long-term placement, iCircle will notify you about the availability, or lack thereof, of a veteran's home in our network.

Emergency Care

Prior authorization is not needed for emergency care. You should tell your doctor and your iCircle Care Manager as soon as possible after you receive emergency care so he/she can update your medical record and arrange for any post-emergency follow-up care.

Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that would lead you to believe that the condition, sickness or injury is of such a nature that failure to obtain immediate medical care could a) place the health of the person affected with such condition in serious jeopardy or, in the case of behavioral condition, place the health of such person or others in serious jeopardy, b) cause serious impairment to such person's bodily functions, c) cause serious dysfunction of any bodily organ or part of such person, or d) cause serious disfigurement of such person.

Examples of emergencies include:

- A heart attack or severe chest pain
- Trouble breathing
- Bleeding that won't stop
- A bad burn
- Broken bones
- Convulsions
- When you feel like you might hurt yourself or others
- Loss of consciousness
- If you are pregnant and have pain, bleeding, fever or vomiting

Examples of non-emergencies are colds, sore throat, upset stomach, minor cuts and bruises, or strained muscles.

If You Are Hospitalized

If you are hospitalized, a family member, friend or representative should contact iCircle Care within 24 hours of admission. Your Care Manager can reschedule any planned services you might miss during that time or start to make any needed changes to your care plan. If you are in the hospital, please ask your primary care physician or hospital discharge planner to contact iCircle Care. We will work with them to plan for your care upon discharge from the hospital.

Care Outside the Service Area

If you are planning to be out of the service area for an extended period of time, please contact your Care Manager as soon as possible so that any necessary supplies or other services may be arranged for you. Please inform your Care Manager at least one week in advance to assist you.

Note that you may be disenrolled if you leave the service area for more than 30 consecutive days. If you have an emergency (see the Emergency Care section of this handbook), go to the nearest emergency room or call 911. Emergency coverage is part of your primary medical coverage, e.g., Medicaid or Medicare.

TRANSITIONAL CARE

New iCircle Care members may continue an ongoing course of treatment for a transitional period of up to 90 calendar days from the enrollment effective date with a non-network healthcare provider, provided that such provider (a) accepts payment at an agreed-upon rate with iCircle Care, (b) adheres to iCircle Care's requirements for quality assurance and other policies and procedures, and (c) provides necessary medical information to iCircle Care about the care being rendered.

In addition, iCircle Care members may continue an ongoing course of treatment for a transitional period of up to 90 calendar days should your participating provider leave the provider network, provided that such provider (a) accept payment at an agreed-upon rate with the plan, (b) adhere to the plan requirements for quality assurance and other policies and procedures, and (c) provide necessary medical information about the care being rendered.

If you are transitioning from fee-for-service Medicaid to MLTC, you must continue to receive services under your pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the plan, whichever is later. iCircle will issue a notice of action for any restriction, reduction, suspension or termination of authorized services. If you disagree with the plan's determination, you have the right to a fair hearing and external appeal and to have authorized services continue when requesting a fair hearing.

SERVICE AUTHORIZATIONS AND ACTION REQUIREMENTS

Service Authorization

Your Care Manager will work with you, your family and your healthcare provider(s) to determine the services you need. Your Care Manager will then authorize the services and make the referral(s) to iCircle Care's participating provider network. Services that you are authorized to receive from iCircle Care's provider network will be listed in your Person Centered Plan of Care and provided to you at no cost. If you receive a bill for a service in this situation, you should contact Member Services at 1-844-MY-iCARE (694-2273) or dialing TTY: 711. You may be responsible for paying for services that are not covered or authorized by iCircle Care or are received from a provider that is not in iCircle Care's provider network.

If at any time you feel you need a certain covered service, you or your provider on your behalf may request authorization for the service by making a verbal or written request to your Care Manager calling 1-844-MY-iCARE (694-2273) or dialing TTY: 711. or sending the written request to 860 Hard Road, Webster, NY 14580.

When you ask for approval of a treatment or service, it is called a **service authorization request.** To get a service authorization request, you or your doctor may call iCircle Care. Services will be authorized for a certain amount and for a specific period of time. This is called the authorization period.

To obtain a service authorization, you should have your provider submit a service authorization request to 860 Hard Road, Webster, NY 14580, 1-844-MY-iCARE (694-2273) or dialing TTY: 711.

Prior Authorization Review

A prior authorization review is a request by you or your provider on your behalf for coverage of a **new service** (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period before such service is provided to you.

Concurrent Review and Discharge Planning Requests

A concurrent review is a request by you or your provider on your behalf for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid-covered home healthcare services following an inpatient admission.

Review Process

Any of the authorization requests specified above will be considered by a standard or expedited review process. A decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action. These decisions will be made by a qualified healthcare professional. If iCircle Care decides that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a healthcare professional who typically provides the care requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical-necessity determinations.

After iCircle Care receives the request, the plan will review it under a standard or expedited process. You must receive an expedited review if we or your doctor indicate that a delay would seriously jeopardize you life, health, or ability to attain, maintain or regain maximum function. If your request for an expedited review is denied, the plan will inform you and the request will be handled under the standard review process. In all cases, it will be reviewed as fast as your medical condition requires it to be, but no later than mentioned below. iCircle Care will tell you and your provider both by phone and in writing whether your request is approved or denied. You will also be informed of the reason for the decision. You will be informed what options you have for appeals or fair hearings if you don't agree with our decision.

Timeframes for Service Authorization Determination and Notification

- Standard review: Notify you within 3 business days of receipt of necessary information, but no more than 14 days from receipt of request for services.
- Expedited review: 3 business days after receipt of the service authorization request.

Timeframes for Concurrent Review Requests

- Standard review: One business day after receipt of necessary information, but no more than 14 days from receipt of the service authorization request.
- Expedited review: One business day after receipt of necessary information, but no more than 3 business days of receipt from the service authorization request.

In the case of a request for Medicaid-covered home healthcare services following an inpatient admission: 1 business day after receipt of necessary information, except when the day subsequent to the request for services falls on a weekend or holiday, 72 hours after receipt of necessary information, but in any event, no more than 3 business days from receipt of the request for services.

If the plan needs more information to make either a standard or expedited decision about your service request, the timeframes on the previous page can be extended up to 14 calendar days. The plan will:

- Write and inform you what information is needed. If the request is an expedited review, the plan will call you immediately and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as it can when the plan receives the necessary information, but no later than 14 calendar days from the end of the original timeframe.

You, your provider or someone you trust may also ask iCircle Care to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling your assigned Care Manager. You or someone you trust can also file a complaint with iCircle Care if you do not agree with the plan's decision to take more time to review the request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health MLTC by calling 1-866-712-7197. If you are not satisfied with iCircle Care's answer, you have the right to file an action appeal with the plan.

Timeframes for Notice of Other Actions

In most cases, if the plan makes a decision to reduce, suspend or terminate a service it has already approved and which you are now receiving within an authorization period, the plan must inform you at least 10 calendar days before it changes the service.

If iCircle Care is reviewing care that has been given in the past, the plan will make a decision about paying for it within 30 calendar days of receiving necessary information for the retrospective review. If the plan denies payment for a service, the plan will send a notice to you the day payment is denied. You will not have to pay for any care you received that was covered by the MLTC plan or by Medicaid, even if the plan later denies coverage.

GRIEVANCES AND APPEALS

iCircle Care will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have. There will be no change in your services or the way you are treated by iCircle Care staff or a healthcare provider because of a grievance you file or an appeal. Further, we will not act in any manner so as to restrict your right to a fair hearing or influence your decision to pursue a fair hearing. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative, friend or provider) to act for you.

To file a grievance or to appeal a plan action, please call 1-855-775-3778 (TTY: 711) or write to 860 Hard Road, Webster, NY 14580. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services.

The Grievance Process

You may file a grievance with us orally or in writing. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of 2 timeframes:

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours from receipt of necessary information.

2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased by up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

Appealing a Grievance

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision. Once we receive your appeal, we will send you a written acknowledgment telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including healthcare professionals who were not involved in the initial decision for grievances involving clinical matters.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process.

For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When iCircle Care denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions." An action is subject to appeal. (See How Do I File an Appeal of an Action? on Page 21 for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take
- Cite the reasons for the action, including the clinical rationale, if any
- Describe your right to file an appeal with us (including whether you may also have a right to the state's external appeal process)
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal

The notice will also tell you about your right to a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing
- It will say that you do not have to file an appeal before asking for a Fair Hearing
- It will explain how to ask for a Fair Hearing
- If we are reducing, suspending or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later

Filing an Appeal of an Action

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 business days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

Contacting My Plan to File an Appeal

We can be reached by calling 1-855-775-3778 or dialing TTY: 711 or writing to 860 Hard Road, Webster, NY 14580. The person who receives your appeal will record it and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

Requesting Continuation of Services

For some actions, you may request to continue service during the appeal process. If you are appealing a restriction, reduction, suspension or termination of services, you must request a Fair Hearing to continue to receive these services while your appeal is decided. We must continue your service if you ask for a Fair Hearing no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the action, whichever is later.

Although you may request a continuation of services, if the Fair Hearing is not decided in your favor, we may require you to pay for these services if they were provided only because you

asked to continue to receive them while your case was being reviewed.

Deciding an Appeal of an Action

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased by up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review, you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about your appeal decision, identifying the decision and the date it was reached.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

Expedited Appeal Process

In some cases, you may request an expedited appeal. If you or your provider feel that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review. We will respond to you with our decision within 2 business days after we receive all necessary information. The time for issuing our decision will not be more than 3 business days after we receive your appeal. (The review period can be increased by up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

Note: You must request a Fair Hearing within 60 calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your behalf.

State Fair Hearings

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a plan appeal and a Fair Hearing at the same time, or you can wait until the plan decided your appeal and then ask for a Fair Hearing. In either case, the same 60-calendar-day deadline applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing an internal and external appeal will not guarantee that your services will continue.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal, the original authorization period for your services ends, or the state Fair Hearing officer issues a hearing decision that is not in your favor, whichever occurs first.

If the state Fair Hearing officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing officer.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear that you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. In all cases, you must make your request within 10 days of the date on the notice or by the intended effective date of our action (whichever is later).

You can file for a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online request form: errswebnet.otda.ny.gov/errswebnet/erequestform.aspx
- Mail a printable request form:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, NY 12201-2023
- Fax a Printable Request Form: 518-473-6735
- Request by Telephone:
  Standard Fair Hearing Line: 1-800-342-3334
  Emergency Fair Hearing Line: 1-800-205-0110
- Request in Person:
  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, NY 11201
  Albany
  40 North Pearl Street, 15th Floor
  Albany, NY 12243

For more information on how to request a Fair Hearing, please visit otda.ny.gov/hearings/request

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal, along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within 4 months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within 2 business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

DISENROLLMENT FROM iCIRCLE CARE

Voluntary Disenrollment

You may disenroll from iCircle Care at any time, for any reason. To initiate your disenrollment, you must notify iCircle Care by calling the Member Services Department at 1-844-MY-iCARE (694-2273) or dialing TTY: 711 or sending written notice to 860 Hard Road, Webster, NY 14580.

If you notify iCircle Care by telephone, you will receive a written notice confirming your intent to disenroll. If you have not provided your reason for wanting to disenroll, iCircle Care will contact you to obtain the reason why you want to disenroll, but you are not required to provide it if you do not want to.

iCircle Care will then send you a disenrollment request form, which you will be asked to sign and return. The disenrollment request form will provide you with the effective date of your disenrollment. iCircle Care will forward your disenrollment request to the appropriate New York State agency. Please note, your disenrollment will not be delayed while we obtain your signature.

iCircle Care will consider you to have initiated your disenrollment if you join and/or receive services from another Medicaid MLTC plan, another type of managed care plan or a waiver program.

If you reside in a county where enrollment in an MLTC plan is mandatory and choose to voluntarily disenroll but do not choose to enroll into another MLTC plan, another type of managed care plan or a waiver program, you may no longer be able to receive community-based services, such as personal care.

Involuntary Disenrollment

Involuntary disenrollment occurs when you are disenrolled from iCircle Care without providing your consent.

iCircle Care must involuntarily disenroll you if you:

- No longer reside in one of the following counties:
  - Broome, Cayuga, Chemung, Chenango, Cortland, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming or Yates
- Have been absent from iCircle Care's service area for more than 30 consecutive days
- Enter an Office of Mental Health (OMH), OPWDD or Office of Alcohol and Substance Abuse (OASAS) residential program for 45 consecutive days or longer
- Clinically require nursing home care but are not eligible for such care under the Medicaid Program's institutional rules
- Need only Social Day Care service
- Are no longer eligible to receive Medicaid benefits
- Become incarcerated
- Are not eligible for MLTC because you are assessed as no longer demonstrating a functional or clinical need for community-based long-term care services or, for non-dual-eligible enrollees, no longer meet the nursing home level of care as determined using the assessment tool prescribed by the New York State Department of Health; iCircle Care will provide the local DSS or Maximus with the results of its assessment and recommendations regarding disenrollment within 5 business days of such determination

iCircle Care may involuntarily disenroll you if:

- You, a member of your family or other person in your home engages in conduct or behavior that seriously impairs the ability of iCircle Care to furnish services to you or another iCircle Care member
- Fail to pay your balance due within 30 days of the payment becoming due, provided that iCircle Care makes a reasonable effort to collect such amount, including a written demand for payment and advising you of your potential disenrollment
- Knowingly fail to complete and submit any necessary consent or release that is requested by iCircle Care
- Provide iCircle Care with false information, deceive iCircle Care or engage in fraudulent conduct with respect to any substantive aspect of your membership in iCircle Care

MEMBER RIGHTS AND RESPONSIBILITIES

Rights

As a member of iCircle Care, your rights include:

- The Right to receive medically necessary care
- The Right to timely access to care and services
- The Right to privacy about your medical record and when you get treatment
- The Right to get information on available treatment options and alternatives presented in a manner and language you understand
- The Right to get information in a language you understand; you can get oral translation services free of charge
- The Right to get information necessary to give informed consent before the start of treatment
- The Right to be treated with respect and dignity
- The Right to get a copy of your medical records and ask that the records be amended or corrected
- The Right to take part in decisions about your healthcare, including the right to refuse treatment
- The Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- The right to be free from any form of discrimination on the basis of race/ethnicity, color, national origin, gender, disability, political beliefs, religion, sexual orientation, age, medical condition (including physical and mental illness), claims experience, receipt of healthcare, medical history, genetic information, or evidence of insurability or disability

- The Right to be told where, when and how to get the services you need from your Medicaid plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network
- The Right to complain to the New York State Department of Health or your local Department of Social Services
- The Right to use the New York State Fair Hearing system and/or a New York State external appeal, where appropriate
- The Right to appoint someone to speak for you about your care and treatment
- The Right to seek assistance from the Participant Ombudsman Program (see Page 29)
- The Right to file a complaint with the New York State Department of Health:
  By phone at 1-866-712-7197
  By mail at
  NYS Department of Health
  Bureau of Managed Long-Term Care
  Room 1911
  Corning Tower
  Empire State Plaza
  Albany, NY 12237

Responsibilities

As a member of iCircle Care, your responsibilities include:

- Receiving all covered services through iCircle Care from a provider in iCircle Care's provider network
- Obtaining all required referrals and authorizations prior to receiving covered services
- Informing iCircle Care about your needs and concerns
- Notifying iCircle Care when you go away or are out of town
- Making all required payments to iCircle Care

SPEND DOWN

Spend down applies to individuals who have incomes higher than the Medicaid income level and allows those individuals to qualify for MLTC by requiring they make a spend down payment. Individuals who are subject to spend down will be notified by their local Department of Social Services that they are subject to spend down, as well as the amount of the spend down payment they are required to make.

If you are subject to spend down, iCircle Care will make reasonable efforts to contact you about obtaining your spend down payment. If you fail to make this payment or arrangements for the payment that are satisfactory to iCircle Care within 30 days of the payment becoming due, you may be disenrolled from iCircle Care without your consent. (See Involuntary Disenrollment on Page 24.)

ADVANCE DIRECTIVES

Advance directives are legal documents that allow you to make certain decisions about your medical care ahead of time in the event that you are not able to make them in the future. New York State recognizes the following 3 advance directives:

New York State Proxy

A New York State proxy allows you to appoint another person to make your healthcare decisions in the event that it is determined you are no longer able to.

Living Will

A living will allows you to write specific instructions regarding your medical treatment and care in the event that you are unable to make those decisions.

Do-Not-Resuscitate Order

A do-not-resuscitate order specifies whether you would like to be revived in the event that you stop breathing or your heart stops beating.

For more information regarding advance directives, please speak with your Care Manager.

MONEY FOLLOWS THE PERSON (MFP)/OPEN DOORS

This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP/Open Doors if they:

- Have lived in a nursing home for 3 months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called transition specialists and peers, who can meet with enrollees in the nursing home and talk with them about moving back to the community. Transition specialists and peers are different from Care Managers and discharge planners. They can help enrollees by:

- Giving them information about services and supports in the community
- Finding services offered in the community to help enrollees be independent
- Visiting or calling enrollees after they move to make sure they have what they need at home

For more information about MFP/Open Doors, or to set up a visit from a transition specialist or peer, please call the New York Association on Independent Living at 1-844-545-7108 or email mfp@health.ny.gov.

OMBUDSMAN

The Ombudsman Program advocates for long-term care recipients by investigating and resolving complaints made by or on behalf of recipients, promoting the development of recipient and family councils, and informing government agencies, providers and the general public about issues and concerns impacting long-term care recipients.

The Participant Ombudsman is an independent organization that provides free ombudsman services to long-term care recipients in the state of New York. These services include, but are not necessarily limited to:

- Providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information
- Compiling enrollee complaints and concerns about enrollment, access to services and other related matters
- Helping enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level, and assisting them through the process if needed/requested, including making requests of plans and providers for records
- Informing plans and providers about community-based resources and supports that can be linked with covered plan benefits

NEW YORK STATE OMBUDSMEN (BY COUNTY)

COUNTY	NAME	PHONE	EMAIL
Broome	Rebecca Bradley	607-722-1251	rbradley@actionforolderpersons.org
Cayuga	Dorothy Dunn	315-255-3447 ext. 320	ddunn@ariseinc.org
Chemung	Suzanne Motheral	607-274-5498	smotheral@tompkins-co.org
Chenango	Rebecca Bradley	607-722-1251	rbradley@actionforolderpersons.org
Cortland	Jeff Parker	315-671-5108	jparker@ariseinc.org
Genesee	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Livingston	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Madison	Krystal Wheatley	315-272-1872	kwheatley@rcil.com
Monroe	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Onondaga	Jeff Parker	315-671-5108	jparker@ariseinc.org
Ontario	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Orleans	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Oswego	Jeff Parker	315-671-5108	jparker@ariseinc.org
Otsego	Krystal Wheatley	315-272-1872	kwheatley@rcil.com
Schuyler	Suzanne Motheral	607-274-5498	smotheral@tompkins-co.org
Seneca	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Steuben	Taryn Roloson	607-962-8225 ext. 112	troloson@aimcil.com
Tioga	Rebecca Bradley	607-722-1251	rbradley@actionforolderpersons.org
Tompkins	Suzanne Motheral	607-274-5498	smotheral@tompkins-co.org
Wayne	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Wyoming	Alana Russell	585-287-6414	arussell@lifespan-roch.org
Yates	Alana Russell	585-287-6414	arussell@lifespan-roch.org

ADULT PROTECTIVE SERVICES BY COUNTY

COUNTY	PHONE NUMBER	AFTER HOURS
Broome	607-778-2635	911
Cayuga	315-253-1446	911
Chemung	607-737-5302	911
Chenango	607-337-1590	911
Cortland	607-753-5133	911
Genesee	585-344-2580	911
Livingston	585-243-7300	911
Madison	315-366-221	911
Monroe	585-753-6532	585-461-5698
Onondaga	315-435-2815	911
Ontario	585-396-4111	911
Orleans	585-589-7000	585-589-7000
Oswego	315-963-5339	911
Otsego	607-547-4355	911
Schuyler	607-535-8338	911
Seneca	315-539-1865	911
Steuben	607-664-2059	911
Tioga	607-687-8300	911
Tompkins	607-274-5323 or 607-274-5369	911
Wayne	315-946-4881	911
Wyoming	585-786-8900	911
Yates	315-536-5183	911

THANK YOU FOR CHOOSING iCIRCLE CARE

At iCircle Care, we pride ourselves on providing the best hometown care possible. Because we are made up of local providers who are knowledgeable about your community. We are friends, neighbors and family members striving to ensure you, the member, get exactly what you need, and our growing membership tells us that we are doing our job.

So from all of us at iCircle Care, thank you for choosing us. We will continue to do everything we can to make sure your needs are met. If you ever have a question, comment or concern, we're just a phone call away—you'll always be greeted by a live voice.

Enrollment/General Inquiry: 1-844-iCIRCLE (424-7253) TTY: 711
Member Care Assistance: 844-MY-iCARE (694-2273)
Grievance/Appeals: 1-855-775-3778
Fax: 1-888-519-2816
Email: info@icirclecarecny.org

COUNTIES WE SERVE:

Broome	Monroe	Steuben
Cayuga	Onondaga	Tioga
Chemung	Ontario	Tompkins
Chenango	Orleans	Wayne
Cortland	Oswego	Wyoming
Genesee	Otsego	Yates
Livingston	Schuyler	
Madison	Seneca	

icircle care

Please call us 24/7 with any questions regarding your coverage. You'll always be greeted by a live person.

General Inquiry/Enrollment: **1-844-iCIRCLE (424-7253)**
Member Assistance Line: **1-844-MY-iCARE (694-2273)**
Grievance/Appeals: **1-855-775-3778**
TTY/TDD: **711**
Email: **info@icirclecarecny.org**

iCircle Care • 860 Hard Road • Webster, NY 14580