CRC BENEFITS | THRIVE Workplace Benefits
Dedicated to Development and Success

NEW YORK

Regulatory Compliance and Resources by State

STATE CONTINUATION OF COVERAGE

Article 32 of the New York Insurance Regulation requires employers with less than 20 employees to offer 18 months of continuation coverage. Notice of continuation rights must be sent by employer with five days following the date of termination.

PAID FAMILY LEAVE

PFL provides more than just a monetary benefit — it provides job security for employees out on paid leave, similar to unpaid leave under FMLA, but regardless of the size of the employer.

- Paid leave can be taken in full-day increments and — unlike NY Disability Benefit Law (DBL) — in intermittent intervals, such as every other Monday. You cannot use PFL in hourly or partial day increments.
- There is no waiting period.
- 30 days advanced employer notice is required for foreseeable leave. If this is not possible due to the circumstances (such as an accident or heart attack), then the notification needs to be given as soon as practicable (possible).
- If a qualifying event stretches over more than 52 consecutive weeks, a new request must be submitted before the next 52-week period begins.
- If the gap between leave dates is more than three months, a new claim package will need to be completed and submitted to your insurance carrier.
- The benefit amount that is in effect at the time the leave began applies to the full duration of the paid leave for that event, even if a new calendar year with increased benefit levels falls within that period.
- An employee can't take DBL and PFL at the same time, i.e., receive benefits for both concurrently. They have to be taken in sequence, and if the employee qualifies for both, the combined duration may not exceed 26 weeks in a consecutive 52-week period.
- An employer cannot require employees to exhaust their accumulated PTO before letting them go out on paid family leave (unless it's an approved FMLA leave).

STATE EMPLOYER REPORTING

Paid Sick Leave

Employees will receive an amount of sick leave depending on the size of their employer:

- Employers with 100 or more employees must provide up to 56 hours of paid sick leave per calendar year.
- Employers with 5 to 99 employees must provide up to 40 hours of paid sick leave per calendar year.
- Employers with 4 or fewer employees and net income of greater than $1 million in the previous tax year are required to provide up to 40 hours of paid sick leave per calendar year.
- Employers with 4 or fewer employees and net income is $1 million or less in the previous tax year are required to provide up to 40 hours of unpaid sick leave per calendar year.

70825-1145
25-2262

- All private-sector employees in New York State are covered, regardless of industry, occupation, part-time status, and overtime exempt status.
- Federal, state, and local government employees are NOT covered, but employees of charter schools, private schools, and not-for-profit corporations are covered.

After January 1, 2021, employees may use accrued leave following a verbal or written request to their employer for the following reasons impacting the employee or a member of their family for whom they are providing care or assistance with care:

Sick Leave:

- For mental or physical illness, injury, or health condition, regardless of whether it has been diagnosed or requires medical care at the time of the request for leave*; or
- For the diagnosis, care, or treatment of a mental or physical illness, injury or health condition; or need for medical diagnosis or preventive care.

*This includes using leave for the recovery of any side effects of the COVID-19 vaccination.

MANDATORY 401K REQUIREMENTS

Which employers does this apply to?

This Secure Choice Savings plan applies to for-profit and non-profit employers in New York state that meet the following requirements:

- The employer had at all times during the previous calendar year at least ten employees in the state,
- The employer has been in business for at least two years, and
- The employer does not offer a qualified retirement plan such as a 401(k) or 403(b).

All three of these requirements have to be met in order for an employer's participation in the program to be mandatory. This means if an employer had less than 10 employees at any point during the previous year, participation in the program isn't compelled. Likewise, if an employer has been in business for more than two years and has at least ten employees, participation isn't required if the employer already offers a qualified retirement plan to its employees. A "qualified retirement plan" most often comes in the form of a 401(k) or 403(b), but the definition includes other types of retirement plans too.

The legislation contains a provision prohibiting an employer from terminating the employer sponsored retirement plan for purposes of participating in the Secure Choice Savings plan. A participating employer's duties under the program are designed to be purely administrative. As such, participating employers must:

- Set up a payroll deposit retirement savings arrangement,
- Automatically enroll each employee who does not opt out of the program,
- Withhold and remit employee contributions to the program

SURPRISE BILLING

Surprise bills happen when an out-of-network provider treats you at an in-network hospital or ambulatory surgical center OR you are referred by an in-network doctor to an out-of-network provider. (In-network means in your health plan's network.) You only have to pay your in-network cost-sharing for a surprise bill.

It's a Surprise Bill at an In-Network Hospital or Ambulatory Surgical Center if an Out-of-Network Provider Treats You and:

- An in-network provider was not available; OR
- An out-of-network provider provided services without your knowledge; OR
- Unforeseen medical services were provided when you received health care services.

It is NOT a surprise bill if you chose to receive services from an out-of-network provider instead of from an available in-network provider before you got to the hospital or ambulatory surgical center.

Beginning January 1, 2022, the following services will usually be a surprise bill when provided by an out-of-network provider in a hospital or ambulatory surgical center: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

If your healthcare services were before January 1, 2022, you are only protected from a surprise bill if you were treated by an out-of-network physician (and not other healthcare providers) at an in-network hospital or ambulatory surgical center.

It's a Surprise Bill When Your In-Network Doctor Refers You to an Out-of-Network Provider if:

- You did not sign a written consent that you knew the services were out-of-network and would not be covered by your health plan; AND
- During a visit with your participating doctor, a non-participating provider treats you; OR
- Your in-network doctor takes a specimen from you in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; OR
- For any other healthcare services when referrals are required under your plan.

If You Get a Surprise Bill because an Out-of-Network Provider Treats You at an In-Network Hospital or Ambulatory Surgical Center OR Your Doctor Refers You to an Out-of-Network Provider:

- You only have to pay your in-network cost-sharing.

If an out-of-network provider bills you for any amount over your in-network cost-sharing (copayment, coinsurance, or deductible), this is called balance billing.

If your doctor referred you to an out-of-network provider, you MUST send a Surprise Bill Certification Form to your health plan and your provider to make sure that they know you received a Surprise Bill and that you must be protected from balance billing.

If an out-of-network provider treats you at an in-network hospital or ambulatory surgical facility, you MUST send a Surprise Bill Certification Form to your health plan and your provider if you received the healthcare services before January 1, 2022 to make sure that they know you received a Surprise Bill and that you must be protected from balance billing. The form is not required for services provided after January 1, 2022 at an in-network hospital or ambulatory surgical facility, but it is recommended. You may also file a complaint with DFS.

RESOURCES

https://www.dfs.ny.gov/