DEPARTMENT OF
HUMAN RESOURCES
THE CITY OF ALBANY, NEW YORK

ALBANY
NEW YORK | EST. 1686

Kathy M. Sheehan
Mayor

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Albany City Hall
24 Eagle Street
Room 301

(p) 518-434-5049
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November 1, 2025

Dear City of Albany Employees:

Open Enrollment for Medical, Dental and Vision benefits and Medical and Dependent Care Flexible Spending Accounts (FSA) for the 2026 plan year begins on November 1 and runs through November 30, 2025.

This is the only time to change or update your healthcare benefits unless you experience a mid-year Qualifying Life Event (QLE). Common QLE's include birth or adoption of a child, loss of coverage, marriage, divorce, domestic partnership, dissolution of domestic partnership, and over age dependents. Proper supporting documentation must be submitted to the Office of Human Resources within 30 days of a QLE.

Open Enrollment benefit changes are made through the City of Albany's eSuite HR Portal at https://selfservice.albanyny.gov/. The eSuite HR Portal must be accessed from a City of Albany computer - It does not work on personal computers or phones. Plan summaries and rates are on the HR Open Enrollment website (albanyny.gov/2344/Open-Enrollment-2026), the eSuite HR Portal, and in the Office of Human Resources.

All employees must sign into eSuite to confirm emergency contact information and submit deduction elections for 2026 Flexible Spending Accounts if you choose to enroll. FSAs are an optional benefit, but must be opted into annually and require an enrollment form.

Also, during Open Enrollment you may review or make changes to your health benefits including:

- Enrolling for the first time
- Re-enrolling after previously dropping coverage
- Adding, removing, or changing coverage or provider
- Adding or removing qualified dependents
- Declining benefit coverage

Employees are not required to make changes to medical, dental, or vision benefits. If no changes are made, current medical, dental and/or vision plan elections will roll into 2026.

When using the eSuite HR Portal, if you have forgotten your username or password:

- Go to https://selfservice.albanyny.gov on a city computer
- Click "eSuite HR Portal"
- Click "Login to My Account"
- Go to "Forgot Username?" or "Forgot password?"
- Click "Retrieve Username" of "Reset Password"
- Follow the prompts
- Still having issues? Call the IT Help Desk at (518) 434-5016.

Beyond enrollment:

- Office of Human Resources After Hours – Wednesdays, 5-7 p.m. (November 5, 12, 19).
- 4th Annual City of Albany Live Long, Be #AlbanyStrong Staff Health & Wellness Fair
    - Thursday, November 13, from 10 a.m.- 4 p.m. at Washington Park Lakehouse (Stoplight at the intersection of New Scotland Ave. and Madison Ave.)
    - Multiple raffles, DJ, photo booth, ample parking, yoga session, Honest Weight Food Co-op, Albany Massage, and more!
- See Open Enrollment calendar to find out about other health and wellness activities happening in November!

If you have additional questions about benefits:

- Go to https://albanyny.gov/2344/Open-Enrollment-2025
- Email hr@albanyny.gov
- Call (518) 434-5049
- Visit the HR staff in City Hall Room 301.
- If you have trouble logging in, call the IT Help Desk at (518) 434-5016.

Health Insurance Buyout

Eligible employees with documentation of qualifying alternate health insurance coverage may opt out of City health insurance and receive a buyout. Employees are reimbursed at two designated times per year.

To receive the health insurance buyout for the 2026 plan year, complete and submit the Declination of Group Health Insurance Coverage Form (enclosed) and proof of insurance documentation to the Office of Human Resources by May 1, 2026 to receive the first of two buyout payments in June 2026. Submissions are accepted until November 1, 2026 for single payment in December 2026. See declination form for more details. If an employee opts into City health insurance mid-year or if they leave employment, they must reimburse the City a pro-rated amount.

Flexible Spending Account (FSA)

All employees must opt in if they wish to participate in the City's Flexible Spending Account (FSA) program every year. Selections do not roll over. An FSA is a tax-free account that reimburses medical or dependent care expenses. Employees choose the amount of a paycheck to set aside with pre-tax dollars. This lowers taxable income, so employees also pay less in taxes.

Dependent Care FSA – Contributing can save an estimated 30% or more on dependent care. Dependent funds can be used for work-related babysitting, childcare center costs, elder care, after school programs, summer camps, preschool tuition, and more.

Medical FSA – Medical FSA funds can be used for the employee, a spouse, or eligible dependents. Medical funds can cover co-pays, deductibles, or over-the-counter medications.

FSAs are use-it or lose-it accounts. Funds do not roll over.

How to Enroll – Log in to the City of Albany HR eSuite Portal (on a city computer) **and return the enclosed form by November 30, 2025**. See enrollment form for additional details.

- Log in to HR eSuite portal
- Go to "Benefit Enrollment"
- Go to "Open Enrollment"
- Go to "FSA Medical" or "FSA Dependent Care"
- Unclick the "opt out" field at the bottom
- Input the amount you wish to contribute to the FSA account(s)

Other Reminders

Dependents 19-26 years old

An employee may enroll a qualified dependent(s) during Open Enrollment or within 30 days of loss of other health insurance. Dependents aged 19-26, even if eligible for health insurance coverage through an employer, are eligible for coverage under City insurance.

Student dependents, 19-25 years old

Student dependent(s) may remain on dental and/or vision insurance. A student verification form must be submitted to the Office of Human Resources each semester (January and September) and the dependent must be a full-time college student. If proper documentation isn't filed each semester, the dependent will be removed from dental and/or vision insurance. If a dependent loses full-time status the employee must contact the Office of Human Resources to receive appropriate Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance coverage options.

Optional Benefits

Capital Employee Assistance Program (EAP)

The Capital Employee Assistance Program provides free support to employees and family members including counseling, advice, and assistance managing life events. For more information go to capitaleap.org or (518) 465-3813.

NYS Deferred Compensation

This voluntary retirement savings plan helps public employees through a convenient payroll deduction and a wide array of investment options. The Plan also provides education and investment guidance. For more information go to nysdcp.com/rsc-web-preauth/index.html or contact Michael Kochan at (518) 986-3342.

New York's 529 College Savings Program

This state-sponsored college saving program helps employees save for college tuition, certain room-and-board expenses, books, supplies, and other qualified higher-education expenses through a convenient payroll deduction. There are also NYS tax advantages by enrolling in the program. For more information go to nysaves.org.

Sincerely,

The Office of Human Resources

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your child(ren) are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, New York may have a premium assistance program that can help pay for coverage, using funds from Medicaid or CHIP programs.

If you or your child(ren) are NOT eligible for Medicaid or CHIP, you are not eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace at healthcare.gov.

If you or your dependent(s) are already enrolled in Medicaid or CHIP, contact New York State Medicaid or CHIP office to find out if premium assistance is available at https://health.ny.gov/health_care/medicaid/ or call 1-800-541-2831.

If you or your dependent(s) are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact New York State Medicaid or CHIP office, call 1-877-KIDS NOW or go to insurekidsnow.gov.

If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, you can enroll if you aren't already. This is called "special enrollment", and you must request coverage within 60 days of being deemed eligible for premium assistance. If you have questions, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

ARE YOU READY FOR GREAT BENEFITS?

2026 BENEFIT RATES

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What you pay weekly:

Medical

	Non-Union		Union*		Blue Collar Union		Fire Union	
	Anthem Blue Cross	CDPHP	Anthem Blue Cross	CDPHP	Anthem Blue Cross	CDPHP	Anthem Blue Cross	CDPHP
Individual	**$25.55**	**$28.41**	**$28.09**	**$28.97**	**$28.09**	**$28.97**	**$28.09**	**$28.97**
Family	**$148.59**	**$165.30**	**$163.18**	**$168.68**	**$163.18**	**$168.68**	**$65.27**	**$67.47**

Dental

	Non-Union	Union*	Blue Collar Union		Fire Union
	Delta Dental PPO	Delta Dental PPO	Delta Dental PPO	Delta Dental HMO	Delta Dental PPO
Individual	**$0.90**	**$0.90**	**$4.40**	**$2.44** Plus One **$7.08**	**$0.90**
Family	**$5.20**	**$5.20**	**$16.26**	**$12.70**	**$5.20**

Vision

	Non-Union	Union*	Blue Collar Union	Fire Union
	Davis Vision	Davis Vision	Davis Vision	Davis Vision
Individual	**$0.11**	**$0.11**	**$0.11**	**$0.11**
Family	**$0.72**	**$0.72**	**$0.72**	**$0.72**

Union* Includes: Communications, Police Civilian, Sworn Police, Sgt/Lt, Operating Engineers, Teamsters

NOTE: THERE ARE 52 PAY PERIODS IN 2026

ARE YOU READY For Great Benefits?

SAVE THE DATE

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4th Annual

Live Long, Be #AlbanyStrong Staff Health & Wellness Fair

Thursday, November 13th

10am - 4pm

Washington Park Lakehouse- 35 Willett St, Albany, NY 12203 (entrance at intersection of Madison Ave and New Scotland Ave)

WHAT'S IN STORE:

- City employees get: **FREE t-shirt**, **raffle tickets** and **lunch gift card while supplies last.**
- Mat **yoga session**, **Albany massage booth** and **photobooth.**
- **Raffle prizes** galore.
- Free samples, gift cards and swag.
- Benefits information from our city representatives.
- **Open enrollment:** get your questions ready!

Empire BlueCross An Anthem Company · CDPHP · Benetech benefits · payroll · hr · DELTA DENTAL · DavisVision · KevBank

NYSLRS · American Red Cross · New York State Deferred Compensation Plan A Plan for Your Future · Downtown Nutrition · Albany Massage · CVSHealth

BeAti Acupuncture and Physical Therapy · PEAK PERFORMANCE CHIROPRACTIC · CapitalEAP · CSEA EMPLOYEE BENEFIT FUND · Hinge Health · CANARX

Benetech
benefits • payroll • hr

One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE/EMPLOYER ELECTION FORM/COMPENSATION REDUCTION AGREEMENT * Required *

COMPANY/CLIENT NAME **CITY OF ALBANY**		
EMPLOYEE NAME *	DATE OF BIRTH* / /	DATE OF HIRE* / /
SOCIAL SECURITY NUMBER*	EMPLOYEE PHONE NUMBER* ☐ Mobile ☐ Home ☐ Work	
ADDRESS: STREET, CITY, STATE, ZIP * ☐ **New Address**		
EMPLOYEE EMAIL ADDRESS* **(REQUIRED)**		

ELECTION:

First payroll date _____ (REQUIRED Employer - Office Use Only)

ACCOUNT	MIN. ELECTION	MAX. ELECTION	ANNUAL ELECTION	NUMBER OF PAY PERIODS	DOLLARS WITHHELD/PAY PERIOD
Unreimbursed Medical Account		$3,400			
Dependent Care Account (Day Care Expenses for dependents up to Age 13)		$7,500 ($3,750 if married filing separately)			

FSA Direct Deposit: ☐ On File (FSA) ☐ New (attach ACH Authorization Form and copy of voided/canceled check)

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

DEPENDENT ENROLLMENT * – List **ALL eligible tax dependents** that can/will be eligible for reimbursements under **Medical and/or Dependent Care accounts**. Must be completed each year*

Dependent Name*	SSN *	Date of Birth *	Relationship *

PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION REGARDING FORFEITURES, ROLLOVERS, AND GRACE PERIOD EXTENSIONS, AS THEY MAY APPLY TO YOUR PLAN.

Plan Notes:

Benetech
benefits • payroll • hr

One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning _01_/_01_/_2026_, and ending _12_/_31_/_2026_. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
- My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
- My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy the provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
- **Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.**
- If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

PLEASE NOTE: The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to your Employer. Please keep a copy of this form for your records.

CHANGES/TERMINATIONS (Employer – Office Use Only)

Date of Event: ____/____/____
First paycheck date that change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
___ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment
___ Employment Termination

Employee Signature_____ Date_____

Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY (ALL FIELDS REQUIRED)

Highly Compensated ❑ Y ❑ N
Key Employee ❑ Y ❑ N
Officer ❑ Y ❑ N
Spouse or Dependent of Owner ❑ Y ❑ N
More than 5% Owner ❑ Y ❑ N
More than 1% owner with salary greater than $150,000 ❑ Y ❑ N

Kathy M. Sheehan
Mayor

Office of Human Resources
Tatiana Diaz, Director

Albany City Hall
24 Eagle Street, Rm 301
Albany, NY 12207
(p) 518-434-5049
(f) 518-434-5269

Declination of Health Insurance Coverage Form

Employee Full Name: (Please print)	City of Albany Department:

(a) I certify that I am eligible for the following City of Albany group health insurance coverage:

_____ Family Coverage _____ Individual Coverage

(b) I hereby decline the group health insurance that is offered through the City of Albany, for which I am eligible, for calendar year 2026.

(c) I understand that I must provide this completed form and proof of health insurance coverage [i.e., copy of health insurance card or insurance verification letter from employer or carrier [displaying my name as a subscriber or dependent] by May 1, 2026 in order to receive the first health insurance buyout payment in June. Note: If you do not submit the completed form and proof by May 1, you will receive the total buyout in December, provided you submitted form and proof by November 1.

(d) I understand that if I have a qualifying event and ask to be reinstated to health insurance coverage through the City of Albany, I must reimburse the City a pro-rated amount of any health insurance buyout I received before I may reenroll in City health insurance.

(e) I also understand that if I leave City employment before the end of the calendar year 2026, I must reimburse the City a pro-rated amount of any health insurance buyout I had already received. This amount will be withheld from my leave accruals buyout check. If my reimbursement exceeds my accrued benefit buyout, I will be billed for the balance.

(f) I understand and authorize the City of Albany to direct deposit the indicated amounts of the buyout to an account currently set up for depositing my wages.

All health insurance buyouts are paid in two installments: (1) in the paycheck following June 1, 2026 and (2) in the paycheck following December 1, 2026

- Individual buyouts are $1,500 for the full calendar year
- Family buyouts covered under alternative (non-City) plans are $5,000 for the full calendar year
- Family buyouts covered by City of Albany plans are $3,000 for the full calendar year (excluding PBA and APOU Non-sworn members)

_____ _____
Employee Signature Date

By initialing here _____, I am certifying that I have alternative (non-City) group health insurance and **I do not want to receive the health insurance buyout from the City of Albany.**

Provide your completed form and proof of insurance to: City of Albany Office of Human Resources, City Hall, Room 301, Albany, NY 12207 or HR@albanyny.gov.

Office of Human Resources Use Only

Employee ID: _____ Buyout Amount: $_____

_____ _____
Human Resources Office Approval Date

_____
Signature