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Costo de Su Cobertura en 2025

Sus deducciones mensuales de nómina para sus beneficios se muestran en las tablas a continuación:

Nivel de Beneficios Mensual	Cobertura Médica: MEC Basic
	Usted paga:
Empleado Solo	$75.00
Empleado Solo	$165.75
Empleado y Hijo(s)	$150.75
Familia	$239.25

Medical: MEC Plus

Tasa de Pago - Rango Inferior	*Tasa de Pago - Rango Mayor*	*MEC PLUS Empleado Solo*	*MEC PLUS Empleado y Cónyuge*	*MEC PLUS Empleado y Hijo(s)*	*MEC PLUS Familia*
$ 7.25	*$ 7.99*	$84.82	$281.30	$271.13	$816.50
$ 8.00	*$ 8.99*	$93.60	$290.08	$279.91	$825.28
$ 9.00	*$ 9.99*	$105.30	$301.78	$291.61	$836.98
$ 10.00	*$ 10.99*	$117.00	$313.48	$303.31	$848.68
$ 11.00	*$ 11.99*	$128.70	$325.18	$315.01	$860.38
$ 12.00	*$ 12.99*	$140.40	$336.88	$326.71	$872.08
$ 13.00	*$ 13.99*	$152.10	$348.58	$338.41	$883.78
$ 14.00	*$ 14.99*	$163.80	$360.28	$350.11	$895.48
$ 15.00	*$ 15.99*	$175.50	$371.98	$361.81	$907.18
$ 16.00	*$ 16.99*	$187.20	$383.68	$373.51	$918.88
$ 17.00	*$ 17.99*	$198.90	$395.38	$385.21	$930.58
$ 18.00	*$ 18.99*	$210.60	$407.08	$396.91	$942.28
$ 19.00	*$ 19.99*	$222.30	$418.78	$408.61	$953.98
$ 20.00	*$ 20.99*	$234.00	$430.48	$420.31	$965.68
$ 21.00	*$ 21.99*	$245.70	$442.18	$432.01	$977.38
$ 22.00	*$ 22.99*	$257.40	$453.88	$443.71	$989.08
$ 23.00	*$ 23.99*	$269.10	$465.58	$455.41	$1,000.78
$ 24.00	*$ 24.99*	$280.80	$477.28	$467.11	$1,012.48
$ 25.00	*$ 25.99*	$292.50	$488.98	$478.81	$1,024.18
$ 26.00	*$ 26.99*	$304.20	$500.68	$490.51	$1,035.88
$ 27.00	*$ 27.99*	$315.90	$512.38	$502.21	$1,047.58
$ 28.00	*$ 28.99*	$327.60	$524.08	$513.91	$1,059.28
$ 29.00	*$ 29.99*	$338.73	$535.21	$525.04	$1,070.41
$ 30.00	*+*	$338.73	$535.21	$525.04	$1,070.41

Cobertura Médica: MVP

Tasa de Pago - Rango Inferior	*Tasa de Pago - Rango Mayor*	*MVP Empleado Solo*	*MVP Empleado y Cónyuge*	*MVP Empleado y Hijo(s)*	*MVP Familia*
$ 7.25	*$ 7.99*	**$84.82**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 8.00	*$ 8.99*	**$93.60**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 9.00	*$ 9.99*	**$105.30**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 10.00	*$ 10.99*	**$117.00**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 11.00	*$ 11.99*	**$128.70**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 12.00	*$ 12.99*	**$140.40**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 13.00	*$ 13.99*	**$152.10**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 14.00	*$ 14.99*	**$163.80**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 15.00	*$ 15.99*	**$175.50**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 16.00	*$ 16.99*	**$187.20**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 17.00	*$ 17.99*	**$198.90**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 18.00	*$ 18.99*	**$210.60**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 19.00	*$ 19.99*	**$222.30**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 20.00	*$ 20.99*	**$234.00**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 21.00	*$ 21.99*	**$245.70**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 22.00	*$ 22.99*	**$257.40**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 23.00	*$ 23.99*	**$269.10**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 24.00	*$ 24.99*	**$280.80**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 25.00	*$ 25.99*	**$292.50**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 26.00	*$ 26.99*	**$304.20**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 27.00	*$ 27.99*	**$315.90**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 28.00	*$ 28.99*	**$327.60**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 29.00	*$ 29.99*	**$339.30**	**$1,256.19**	**$1,232.32**	**$2,512.37**
$ 30.00	*+*	**$351.00**	**$1,256.19**	**$1,232.32**	**$2,512.37**

Cobertura Médica: Mayor Compra Medica

Tasa de Pago - Rango Inferior	*Tasa de Pago - Rango Mayor*	*Empleado Solo*	*Empleado y Cónyuge*	*Empleado y Hijo(s)*	*Familia*
$ 7.25	*$ 7.99*	**$195.67**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 8.00	*$ 8.99*	**$204.45**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 9.00	*$ 9.99*	**$216.15**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 10.00	*$ 10.99*	**$227.85**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 11.00	*$ 11.99*	**$239.55**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 12.00	*$ 12.99*	**$251.25**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 13.00	*$ 13.99*	**$262.95**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 14.00	*$ 14.99*	**$274.65**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 15.00	*$ 15.99*	**$286.35**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 16.00	*$ 16.99*	**$298.05**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 17.00	*$ 17.99*	**$309.75**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 18.00	*$ 18.99*	**$321.45**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 19.00	*$ 19.99*	**$333.15**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 20.00	*$ 20.99*	**$344.85**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 21.00	*$ 21.99*	**$356.55**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 22.00	*$ 22.99*	**$368.25**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 23.00	*$ 23.99*	**$379.95**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 24.00	*$ 24.99*	**$391.65**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 25.00	*$ 25.99*	**$403.35**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 26.00	*$ 26.99*	**$415.05**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 27.00	*$ 27.99*	**$426.75**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 28.00	*$ 28.99*	**$438.45**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 29.00	*$ 29.99*	**$450.15**	**$1,431.34**	**$1,404.14**	**$2,862.66**
$ 30.00	*+*	**$461.85**	**$1,431.34**	**$1,404.14**	**$2,862.66**

Nivel de Beneficios Mensual	**Plan Médico de Imdemnización:**		
	Opción 1	**Opción 2**	**Opción 3**
Empleado Solo	$103.66	$147.96	$214.49
Empleado y Cónyuge	$242.05	$349.46	$510.50
Empleado y Hijo(s)	$170.52	$243.67	$354.99
Familia	$272.62	$392.45	$573.46

Nivel de Beneficios Mensual	**Cobertura Voluntaria Dental PPO (bajo/alto)** *Usted paga:*	**Cobertura Voluntaria deVisión** *Usted paga:*
Empleado Solo	$23.38 / $33.35	$4.69
Empleado y Cónyuge	$45.45 / $66.00	$9.37
Empleado yHijo(s)	$46.93 / $87.18	$10.90
Familia	$66.94 / $119.84	$17.41

Nivel de Beneficios Mensual	**Seguro Voluntario de Descapacidad a Corto Plazo** *Usted paga:*
Employee Only	$17.00
Empleado Solo	----------
Empleado y Cónyuge	----------
Empleado yHijo(s)	----------
Familia	

Nivel de Beneficios Mensual	**Seguro Voluntario Temporal de Vida y AD&D**
Empleado Solo	$4.60
Empleado y 1 dependiente	$5.51
Empleado y 2 o más dependientes	$5.51

Nivel de Beneficios Mensual	**Seguro contra Enfermedades Graves** (Empleado+Cónyuge/Familia) *Usted paga:*	
	EE Only	*EE+ Dependentes*
18-24	$1.80	$3.15
25-29	$2.20	$3.85
30-34	$3.30	$5.78
35-39	$5.50	$9.63
40-44	$8.80	$15.40
45-49	$13.20	$23.10
50-54	$19.80	$34.65
55+	$26.40	$46.20

Nivel de Beneficios Mensual	**Seguro Voluntario de Accidente** *Usted paga:*
Empleado Solo	$12.18
Empleado y Cónyuge	$21.02
Empleado yHijo(s)	$22.10
Familia	$30.94