Exhibit 1					
Memorial Hermann Health Plan					
2023 Medicare Advantage Bids					
Plan Design Summary					
	H7115-001-000	**H7115-003-000**	**H7115-004-000**	**H7115-005-000**	**H7115-005-000**
	HMO	**HMO**	**HMO**	**DSNP**	**MA Only**
Member Premium	$0	$25	$0	$27.00	$0
Part C					
Maximum Out-of-Pocket (MOOP) - In Network	$3,400	$3,400	$3,400	$8,300	$3,400
Deductible	$0	$0	$0	Standard Medicare	$0
Part B Buydown	$0	$0	$0	$0	$125
1a - Inpatient Hospital - Acute	$350 / IP-Admit	$350 / IP-Admit	$350 / IP-Admit	Standard Medicare	$500 / IP-Admit
4a - Emergency Care / Post Stabilization Care	$125	$125	$125	Standard Medicare	$125
4b - Urgently Needed Care / Urgent Care Centers	$25	$25	$25	Standard Medicare	$25
7a - Primary Care	$0	$0	$0	Standard Medicare	$0
7d - Physician Specialist Services	$25	$20	$25	Standard Medicare	$30
8a - Outpatient Diagnostic Procedures/Tests	$25	$25	$25	Standard Medicare	$25
8a - Outpatient Diagnostic Lab Services	$0	$0	$0	Standard Medicare	$0
8b - Outpatient Diagnostic Radiological Services	$150	$150	$150	Standard Medicare	$150
8b - Outpatient Therapeutic Radiological Services	$25	$25	$25	Standard Medicare	$25
8b - Outpatient X-Ray Services	$0	$0	$0	Standard Medicare	$0
9d - Outpatient Blood Services	$0	$0	$0	Standard Medicare	$0
10b - Transportation (Non-Medicare Covered)	Covered (10 trips)	Covered (15 trips)	Covered (10 trips)	Covered (58 trips)	Covered (10 trips)
13b - OTC Items and Services (Non-Medicare Covered)	$25 per Quarter	$40 per Quarter	$25 per Quarter	$75 per Quarter	$25 per Quarter
13c - Meal Benefit (Non-Medicare Covered)	Covered	Covered	Covered	Covered	Covered
16a - Preventive Dental (Non-Medicare Covered)	Covered - $2,000 Limit	Covered - $2,500 limit	Covered - $2,500 limit	Covered - $2,500 limit	Covered - $1,000 limit
16b - Comprehensive Dental (Non-Medicare Covered)	Covered - $2,000 Limit	Covered - $2,500 limit	Covered - $2,500 limit	Covered - $2,500 limit	Covered - $1,000 limit
Initial Coverage Limit (ICL)	$4,660	$4,660	$4,660	$4,660	N/A
Annual Deductible	$0	$0	$0	$505	
Retail Pharmacy Copay (Preferred Network)					
Tier 1 - Preferred Generic	$0	$0	$0	25%	
Tier 2 - Non-Preferred Generic	$5	$5	$5	25%	
Tier 3 - Preferred Brand	$39	$39	$39	25%	
Tier 4 - Non-Preferred Brand	$92	$92	$92	25%	
Tier 5 - Specialty	33%	33%	33%	25%	
Tier 6 - Select Care	$0	$0	$0	25%	
Coverage in Gap	Tier 6	Tier 6	Tier 6	Defined Standard	
Retail Pharmacy Copay (Non-Preferred Network)					
Tier 1 - Preferred Generic	$10	$10	$10	25%	
Tier 2 - Non-Preferred Generic	$18	$18	$18	25%	
Tier 3 - Preferred Brand	$47	$47	$47	25%	
Tier 4 - Non-Preferred Brand	$100	$100	$100	25%	
Tier 5 - Specialty	33%	33%	33%	25%	
Tier 6 - Select Care	$8	$8	$8	25%	
Coverage in Gap	Tier 6	Tier 6	Tier 6	Defined Standard	
Mail Copay (90-Day)					
Tier 1 - Preferred Generic	$0	$0	$0	25%	
Tier 2 - Non-Preferred Generic	$10	$10	$10	25%	
Tier 3 - Preferred Brand	$78	$78	$78	25%	
Tier 4 - Non-Preferred Brand	$184	$184	$184	25%	
Tier 5 - Specialty	33%	33%	33%	25%	
Tier 6 - Select Care	$0	$0	$0	25%	
Coverage in Gap	Tier 6	Tier 6	Tier 6	Defined Standard	