

EXHIBIT 1



2018 Major Medical Expense Policy



Ambetter.SuperiorHealthPlan.com

Notice: Premium may be increased upon the renewal date.

CELTIC INSURANCE COMPANY FOR AMBETTER FROM SUPERIOR HEALTHPLAN

Major Medical Expense Policy

THIS MAJOR MEDICAL EXPENSE POLICY (CONTRACT) IS ISSUED TO YOU, WHO HAVE ENROLLED IN

CELTIC INSURANCE COMPANY FOR AMBETTER FROM SUPERIOR HEALTHPLAN

HEALTH BENEFIT PLAN. YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS CONTRACT. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR COVERED HEALTH SERVICES AND BENEFITS.

Celtic Insurance Company
77 West Wacker Drive, Suite 1200
Chicago, IL 60601
877-687-1196

IMPORTANT NOTICES:

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Ambetter from Superior HealthPlan's toll-free telephone number for information or to make a complaint at:

1-877-687-1196

You may also write to us at:

5900 E. Ben White Blvd.
Austin, Texas 78741

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

YOU may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Ambetter from Superior HealthPlan's para obtener información o para presentar una queja al:

1-877-687-1196

Usted también puede escribir a Superior:

5900 E. Ben White Blvd.
Austin, Texas 78741

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Celtic Insurance Company
Major Medical Expense Policy

In this Major Medical Expense Policy (*contract*), the terms “*you*”, “*your*” or “*yours*” will refer to the *enrollee* named on the *Schedule of Benefits*. The terms “*we*,” “*our*,” or “*us*” will refer to Celtic Insurance Company or Ambetter from Superior Health Plan.

AGREEMENT AND CONSIDERATION

In consideration of *your* application and the timely payment of the premium *we* will provide benefits to *you*, the *enrollee*, for covered *Healthcare Services* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

Pages 5-81 Omitted

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application is the entire contract between *you* and *us*. No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver

If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions

No misrepresentation of fact made regarding an *enrollee* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by an *enrollee*;
2. A copy of the application, and any amendments, has been furnished to the *enrollee(s)* or to the *enrollee's* personal representative; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *enrollee*. An *enrollee's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information

During the first two years an *enrollee* is covered under the *contract*, if an *enrollee* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *enrollee* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *enrollee* pay back to *us* all benefits that *we* provided or paid during the time the *enrollee* was covered under the *contract*.

Conformity with State Laws

Any part of this *contract* in conflict with the laws of Texas on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of Texas state law.

Conditions Prior To Legal Action

Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *contract*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;

2. Refer to the specific *contract* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.

Time Limit on Certain Defenses:

(a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy.



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Superior HealthPlan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Superior HealthPlan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Superior HealthPlan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Superior HealthPlan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) 로 전화하십시오.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Superior HealthPlan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Urdu:	اگر Ambetter from Superior HealthPlan کے بارے میں آپ، یا جن کی آپ مدد کر رہے ہیں ان کے سوالات ہوں تو، آپ کو بلا معاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-877-687-1196، (Relay Texas/TTY 1-800-735-2989) پر کال کریں۔
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from Superior HealthPlan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalín, tumawag sa 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Superior HealthPlan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Superior HealthPlan के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) पर कॉल करें।
Persian:	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Superior HealthPlan دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) تماس بگیرید.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Superior HealthPlan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Superior HealthPlan વિશે કોઈ પણ હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) ઉપર કોલ કરો.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Superior HealthPlan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Japanese:	Ambetter from Superior HealthPlan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) までお電話ください。
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Superior HealthPlan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນ ຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໃບທາງ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

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Statement of Non-Discrimination

Ambetter from Superior HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Superior HealthPlan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Superior HealthPlan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If *you* need these services, contact Ambetter from Superior HealthPlan at 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

If *you* believe that Ambetter from Superior HealthPlan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a grievance with: Superior HealthPlan Appeal Department, 5900 E. Ben White Blvd, Austin, TX 78741, 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989), Fax 1-866-683-5369. *You* can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, Ambetter from Superior HealthPlan is available to help *you*. *You* can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Declaración de no discriminación

Ambetter de Superior HealthPlan cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter de Superior HealthPlan no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Superior HealthPlan:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
 - Intérpretes calificados de lenguaje por señas
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de Superior HealthPlan a 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

Si considera que Ambetter de Superior HealthPlan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Superior HealthPlan Appeal Department, 5900 E. Ben White Blvd, Austin, TX 78741, 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989), Fax 1-866-683-5369. Usted puede presentar una queja en persona, por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Superior HealthPlan está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.