EXHIBIT X

Medicare Advantage Compliance Addendum

Centers for Medicare and Medicaid Services ("CMS") requires that specific terms and conditions be incorporated into the Contract between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108- 173, 117 Stat. 2066 ("MMA").

Except as provided herein, all other provisions of the contract between Health Plan of CareOregon, Inc., a wholly owned subsidiary of CareOregon, Inc. and/or CareOregon, Inc. not inconsistent herein shall remain in full force and effect. The terms of this Medicare Advantage Compliance Addendum shall supersede and replace any inconsistent provisions to such contract; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such contract.

NOW, THEREFORE, the parties agree as follows:

Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.
2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.
3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.
5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.
6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.
7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.
9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.
10. Related entity: any entity that is related to the MA organization by common ownership or

control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

<u>Required Provisions</u>:

First Tier or Downstream Entity ("FDR") agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Health Plan of CareOregon, Inc., a wholly owned subsidiary of CareOregon, Inc., (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. If applicable, for all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. If applicable, any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. FDR and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

7. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity [42 C.F.R. §§ 422.504(i)(4) and (5)]:

(i) The delegated activities and reporting responsibilities must be specified in detail in the base agreement/contract.
(ii) CMS and the CareOregon reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the CareOregon determine that such parties have not performed satisfactorily.
(iii) CareOregon will monitor the performance of the parties on an ongoing basis through its delegation oversight program which may include an annual audit. FDR will cooperate with this process.
(iv) CareOregon has the right to review the credentials of medical professionals affiliated with FDR and the right to approve the credentialing process. CareOregon will have the right to audit the credentialing process on an annual basis, or more frequently if necessary and FDR will cooperate with the effort.
(v) If CareOregon has delegated the selection of providers, contractors, or subcontractor, the CareOregon retains the right to approve, suspend, or terminate any such arrangement.