PERRINE DUPONT SETTLEMENT
SPELTER VOLUNTEER FIRE DEPARTMENT CLAIMS OFFICE
55 B Street
P. O. BOX 257
Spelter, WV 26438
(304) 622-7443
(800) 345-0837
www.perrinedupont.com
perrinedupont@gtandslaw.com

January 5, 2012

CLAIMS ADMINISTRATOR'S REPORT REQUESTING COURT APPROVAL OF REVISED PERRINE MEDICAL MONITORING PLAN LIST OF MEDICAL PROVIDERS

VIA HAND DELIVERY

The Honorable Thomas A. Bedell
Circuit Judge of Harrison County
301 West Main Street, Room 321
Clarksburg, West Virginia 26301

Re: Perrine, et al. v. DuPont, et al.; Civil Action No. 04-C-296-2 (Circuit Court of Harrison County, West Virginia) - Claims Administrator's Report Requesting Court Approval of Revised Perrine Medical Monitoring Plan List of Medical Providers; Our File Nos. 4609-1 {GG}

Dear Judge Bedell:

Enclosed for the Court's consideration please find a proposed Revised Perrine Medical Monitoring Plan (the "Plan") List of Medical Providers. If approved by the Court, this document would replace the previous July 22, 2011 list of medical providers which was approved by this Court's Final Order Approving Certain Aspects of Settlement Administration and Establishing Briefing Schedule for Preliminarily Recommended or Unresolved Matters dated August 31, 2011.

We have shared this document with the Finance Committee and the Guardian Ad Litem for children, and we have taken into account their suggestions and concerns.

Upon Court approval of this document, the design of the Plan will be substantially complete.

As the Court knows, the implementation of the Plan timely began on November 1, 2011.

Thank you for the Court's consideration.

Yours very truly,

Edgar C. Gentle, III
Claims Administrator

ECGIII/mgc
Attachment (Revised Perrine Medical Monitoring Plan List of Medical Providers)

cc: (with enclosures)(by e-mail)(confidential)
Stephanie D. Thacker, Esq., DuPont Representative on the Settlement Finance Committee
Virginia Buchanan, Esq., Plaintiff Class Representative on the Finance Committee
Meredith McCarthy, Esq., Guardian Ad Litem for Children
Clerk of Court of Harrison County, West Virginia, for filing (via hand delivery)
Terry D. Turner, Jr., Esq.
Diandra S. Debrosse, Esq.
Katherine A. Harbison, Esq.
Paige F. Osborn, Esq.
Michael A. Jacks, Esq.
William S. ("Buddy") Cox, Esq.
J. Keith Givens, Esq.
McDavid Flowers, Esq.
Farrest Taylor, Esq.
Ned McWilliams, Esq.
Perry B. Jones, Esq.
Angela Mason, Esq.
Mr. Don Brandt
Mr. Randy Brandt
Ms. Pat Gagne

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al., individuals residing in West Virginia, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

Case No. 04-C-296-2
Thomas A. Bedell, Circuit Judge

E. I. DUPONT DE NEMOURS & COMPANY, et al.,

Defendants.

ORDER APPROVING REVISED PERRINE MEDICAL MONITORING PLAN LIST OF MEDICAL PROVIDERS

Presently before the Court is the Claim Administrator's January 5, 2012 Report requesting Court approval of revised Perrine Medical Monitoring Plan (the "Plan") List of Medical Providers.

In the Report, the Claims Administrator has explained that this list would replace the July 22, 2011 list approved by previous Court Order dated August 31, 2011. The Claims Administrator has also related that the revised list has been reviewed with the Finance Committee and the Guardian Ad Litem for children, with the Claims Administrator taking into account their suggestions and concerns prior to finalizing the list for submission to the Court with the Report.

After a careful review of the January 5, 2012 Report of the Claims Administrator and the proposed Revised Perrine Medical Monitoring Plan List of Medical Providers, and a consideration of the applicable law, the Court orders that the submitted list and its addenda are hereby approved and shall be used in the administration of the Settlement.

Lastly, pursuant to Rule 54(b) of the West Virginia Rules of Civil Procedure, the Court directs entry of this Order as a Final Order as to the claims and issues above upon an express

determination that there is no just reason for dely and upon an express direction for the entry of judgment.

IT IS SO ORDERED.

The Clerk of this Court shall provide certified copies of this order to the following:

Stephanie Thacker, Esq.
Guthrie & Thomas, PLLC
500 Lee St., East, Suite 800
P.O. Box 3394
Charleston, WV 25333-3394
DuPont's Finance Committee Representative

Virginia Buchanan, Esq.
Levin, Papantonio, Thomas, Mitchell, Rafferty & Proctor, PA
P.O. Box 12308
Pensacola, FL 32591
Plaintiffs' Finance Committee Representative

Meredith McCarthy, Esq.
Guardian Ad Litem for Children
901 W. Main Street
Bridgeport, WV 26330
Guardian Ad Litem for Children

Edgar C. Gentle, III
Michael A. Jacks
Gentle, Turner & Sexton
P. O. Box 257
Spelter, WV 26438
Special Master and Claims Administrator

Order Prepared By:

Edgar C. Gentle, III, Claims Administrator
Gentle, Turner & Sexton
P.O. Box 257
Spelter, WV 26438

Michael A. Jacks, Esq.
W. Va. Bar No. 1044
Gentle, Turner & Sexton
P.O. Box 257
Spelter, WV 26438

ENTER: _____

_____
Thomas A. Bedell, Circuit Judge

PERRINE DUPONT SETTLEMENT CLAIMS OFFICE
ATTN: EDGAR C. GENTLE, CLAIMS ADMINISTRATOR
C/O SPELTER VOLUNTEER FIRE DEPARTMENT OFFICE
55 B Street
P.O. BOX 257
Spelter, West Virginia 26438
(304) 622-7443 / (304) 622-7447 (fax)
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www.perrinedupont.com
perrinedupont@gtandslaw.com

January 5, 2012

REVISED PERRINE MEDICAL MONITORING PLAN (THE "PLAN")
LIST OF MEDICAL PROVIDERS

I. Methodology

On July 22, 2011 CTI Administrators, Inc., (hereinafter "CTIA") in the Court-approved list in Addendum A, recommended six physician clinics, four hospitals and one laboratory based upon the providers listed by claimants on their Plan Registration forms.

Due to a number of factors, the approach has shifted to focusing mainly on the facilities which have the largest market share in the area, and the facilities which are most convenient for the claimants.

It has also become necessary to assess how many claimants reside more than 50 miles from Spelter, West Virginia (referred to here as "out-of-area" claimants). To date, there are 224 out-of-area claimants. Three national provider networks described below will serve these claimants.

9 of the 11 specialists included in the Plan shall be provided by these 3 national provider networks, and 2 of the specialists will be provided by United Hospital Center ("UHC"), of Bridgeport, West Virginia.

II. Participating Providers for In-Area (Within 50 Miles of Spelter) Claimants

Currently, the following in-area providers have signed agreements with the Plan and will provide in-area services:

- United Physicians Care (with locations in Shinnston (Shinnston Healthcare) and Bidgeport (called Bridgeport Physicians Care), a copy of UPC's contract is Addendum B*;
- Bridgeport Express Care, a copy of Bridgeport Express Care's contract is Addendum C;
- MedExpress (Dr. Nelson), a copy of MedExpress's contract is Addendum D; and
- Monongahalia Valley Association of Health Clinics ("MVA") (with locations in Fairmont and Shinnston), a copy of MVA's contract is Addendum E.

*In these contracts, for the listing, "Office Visit Physical Exam, CT Scan Pros & Cons, review of tests," this procedure will only be followed as required by the Court-approved CT Scan guidelines. Please also note that CPT Code 71250 is for the actual scan, while 71250.26 is the fee paid to the radiologist who reads the scan.

Conservatively, with the capacity of these 4 providers, CTIA has the ability to schedule up to 1,000 patients a month beginning in December 2011. Please note that CTIA will probably only be able to schedule no more than approximately 500-600 appointments per month despite capacity based on a number of factors, including, but not limited to, claimant appointment scheduling and appointment cancellation issues typical of any medical program.

III. <u>Participating Providers for Out-Of-Area Claimants (More Than 50 Miles from Spelter)</u>

The following networks will be utilized to serve the out-of-area claimants:

- Multiplan (based in New York);
- Healthsmart HPO (based in Texas); and
- Coalition America's Preferred Provider Network ("NPPN") (based in Georgia).

It is important to note that a few of the out-of-area claimants may not have local Providers within the 3 out-of-area networks, and the Plan may have to contract with physicians out of the out-of-area Plan network at a higher rate. Addendum F describes the Plan's proposed approach in utilizing the 3 out-of-area networks. We estimate that this shall only apply to a few claimants. Unfortunately, it is not fiscally practicable for CTIA to identify these individuals at this time as it would require that for each of the out-of-area claimants, a search would be conducted for the

primary care physician, and each of the specialists over three networks. As such, it would take more than thirty searches per claimant, and would cost the Plan more than it would benefit the Plan to answer this question at this time. Note: There are no specific out-of-area provider contracts because out-of-area providers will be engaged on an as-needed basis for a specific claimant.

IV. **Specialists**

Participating Providers will be directed to utilize, if determined to be necessary by the primary physician, the Plan specialists to be provided by the above 3 out-of-area networks. Within these networks are 9 of the 11 specialists covered by the Plan, namely, anesthesiologists, dermatologists, gastroenterologists, nephrologists, psychologists, pulmonary disease specialists, radiology, cardio-thoracic specialists, and urologists. A list of the recommended specialists is attached in Addendum G.

CT scan and toxicology services will be provided by UHC. Fairmont General Hospital may provide a second CT scan imaging facility for the Plan. The UHC contract is Addendum H.

ADDENDUM A

3. List of Recommended Medical Providers:

CTI ADMINISTRATORS, INC.

MR. EDGAR C. GENTLE, III ESQ.
GENTLE, TURNER, & SEXTON
501 RIVERCHASE PKWY E. STE 100
HOOVER, AL 35244

July 22, 2011

RE: Perrine-DuPont Provider Recommendations

Dear Ed:

We are at a point where we can make a recommendation of providers to be used by the Perrine-DuPont Medical Monitoring Program. We are recommending:

- Six physician clinics;
- Four Hospitals; and
- One Laboratory

I have included a brief description of the methodology and rationale we used in our research. This should be enough background for us to meet and discuss our recommendations.

Methodology

1. You provided a list of providers being used by the persons enrolling in the medical monitoring program. This list was rather incomplete as the enrollees, for the most part, provided as little information as they could about their providers. This list had approximately 900 providers identified. The list included doctors, hospitals, outpatient clinics, & Physician clinics.

2. CTIA used the list provided and obtained additional, necessary information so we could make a recommendation as to providers to be used for the medical monitoring program. The additional information we obtained included the following:

    a. National Provider Identifier (NPI) number
    b. Rendering Provider Name
    c. Billing Provider/Organization Name
    d. Billing Provider/Organization Address

100 Court Avenue – Suite 306, Des Moines, Iowa 50309-2295
Telephone: (515) 244-7322 / Fax: (515) 244-8650
E-Mail: dbrandt@claimtechnologies.com

e. Billing Provider/Organization Phone Number
f. Type of Provider
    i. Hospital
    ii. Outpatient Facility
    iii. Family Medicine
    iv. Internal Medicine
    v. Pediatrics
    vi. Dentist
    vii. Acupuncturist
    viii. Allergist
    ix. Student, Nurse, Nurse Practitioner
g. Contact Person for Business decisions & Phone number

3. We then pared the list by eliminating duplicates, keeping track of how many recommendations there were for each. For example, there were 29 recommendations for Medpointe of Harrison County PLLC.

4. We then separated the Hospitals and Outpatient Facilities from the doctors and Physician Clinics. After initial paring there were:
    a. Six Hospitals
    b. Five Outpatient Facilities
    c. 104 Doctors & Physician Clinics

5. We then eliminated individual physicians, providers outside of the general area (Louisville, Baltimore, Parkersburg, Manassas), and Physician Clinics that had less than 25 recommendations from the enrollees. (If we didn't find a Physician's Clinic in the larger cities, we did not eliminate them.) We recommend that we contact the following providers for support of the clinical testing programs:

    a. Four Hospitals
        i. Shinnston Medical Center (56 recommendations)
        ii. Bridgeport- United Hospital Center (45 recommendations)
        iii. Fairmont General Hospital (8 recommendations)
        iv. Morgantown- WVU Hospital (7 recommendations)

    b. Six Physician Clinics
        i. Farmington- Manchin Clinic (15 recommendations)
        ii. Shinnston Healthcare (118 recommendations)
        iii. Bridgeport- Pediatric Associates (24 recommendations)
        iv. Bridgeport- Medbrook Medical Assoc. (169 recommendations)
        v. Clarksburg- Medpoint of Harrison County (30 recommendations)
        vi. Morgantown- WVU Cheat Lake Physicians (no recommendations)
    c. Laboratory
        i. LabCorp

100 Court Avenue – Suite 306, Des Moines, Iowa 50309-2295
Telephone: (515) 244-7322 / Fax: (515) 244-8650
E-Mail: dbrandt@claimtechnologies.com

Rationale for Selectio..

- We recommended the use of a small number of clinics in lieu of many individual doctors. In the report by Dr. Werntz he recommends a "*small* number of physicians from the community. ..... This is to ensure that the physician is familiar with the program, the diagnosis of the disease of concern, and to ensure consistency." We felt that there would be more long term consistency in contracting with a clinic than with individual physicians.

- We recommended Six Physician Clinics in four cities to provide easy access for a majority of the enrollees.

    - We recommended five of the Physician Clinics since they had the most recommendations from the enrollees.

    - We recommended the WVU Cheat Lake Physicians since we had no other Physician Clinics recommended in Morgantown. Additionally, they are affiliated with the WVU Hospital. We expect the WVU Hospital will be involved with the analysis of the clinical test results (if approved by the court). This will be a good way to keep them current with the testing program.

- We chose LabCorp because

    - We have an ongoing relationship with them for the Tolbert HealthCare Plan;
    - They are the only laboratory that we could find that services the "Spelter Area"; and
    - They are currently implementing an Electronic Medical Records system that would simplify the collection and maintenance of the test results.

Finally, we won't need to contract with the hospitals until the issue related to CT Scans is decided. So, we don't need a decision to approve the hospitals at this time. What we need, at this time, is approval to move forward with the six physician clinics and LabCorp.

Sincerely,

Donald R. Brandt
President

Copy: Diandra Debrosse
Kip Harbison

C:\Documents and Settings\kharbison\Local Settings\Temporary Internet Files\Content.Outlook\CT6M47DF\DRBEGProvider Recommendations.doc

100 Court Avenue – Suite 306, Des Moines, Iowa 50309-2295
Telephone: (515) 244-7322 / Fax: (515) 244-8650
E-Mail: dbrandt@claimtechnologies.com

ADDENDUM B

United Physicians Care Contract
Executed on 11/16/2011

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of November 11, 2011 by and between The Perrine Medical Monitoring Plan (the Plan) and United Physicians Care, Inc., a West Virginia non-profit corporation ("Provider").

RECITALS

WHEREAS, Provider is either (i) an individual health care provider or (ii) a professional corporation, medical corporation, or other entity duly organized and existing under and pursuant to the laws of the state in which it is formed, in either case that is duly licensed and authorized to deliver health care services in the state of West Virginia, or that have employees who are.

WHEREAS, the Plan desires (i) to obtain a network of health care providers for the Plan and (ii) to engage Provider to furnish such services; and

WHEREAS, Provider desires to be engaged by the Plan to furnish such services and shall furnish such services in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I - DEFINITIONS

1.1 **Benefits.** "Benefits" means Medical testing, consultations, and surgeries as defined by the Plan.

1.2 **Claim Clearing House.** "Claim Clearing House" means an organization that receives claims in an electronic format and forwards claims to Insurance Carriers, Third Party Administrators, and/or PPO Networks.

1.3 **Confidential Information.** "Confidential Information" means information of the Plan and Provider that shall be subject to patent, copyright, trademark, trade name or service mark protection, or not otherwise in the public domain and related to the business and operations of the Plan or Provider, including, without limitation, this Agreement and the Exhibits hereto, eligibility data, manuals, software, information relating to financial status of the Plans, and medical records of Participants in control and possession of Provider.

1.4 **Covered Services.** "Covered Services" means the procedures identified in the Fee Schedule subject to the Benefit limitations specified by the Plans.

1.5 **Fee Schedule.** "Fee Schedule" means the allowable fees paid for services provided for specific Clinical Procedure Codes as set forth in EXHIBIT A.

1.6 **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.7 **Informational Packet for Physicians and Health Care Provider.** "Provider Orientation Packet" means a packet of information about the Medical Monitoring Program.

1.8 **Medically Necessary.** "Medically Necessary" or "Medical Necessity" means services or supplies which, under the provision of this Agreement are determined to be (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury or disease; (ii) provided for the diagnosis or direct care and treatment of the injury or disease or preventative services as provided in the Plans; (iv) within good medical practice within the organized medical community; (vi) an appropriate supply or level of service needed to provide safe and adequate care; and (vii) provided in a setting consistent with the required level of care.

1.9 **Participant.** "Participant" means any person who has satisfied the eligibility requirements of the Plan.

1.10 **PHI.** "PHI" means Protected Health information, which may include Individually Identifiable Health Information as defined by HIPAA.

1.11 **Payment.** "Payment" means the actual value made to or on behalf of the Participants for benefits described in the Plan.

1.12 **Plan.** "Plan" means the Medical Monitoring Plan.

1.13 **Third Party Administrator** "TPA" means CTI Administrators, Inc. 100 Court Avenue, Des Moines, IA 50309. CTI Administrators, Inc. has contracted with the Plan to perform administrative services including, but not limited to, maintenance of participant eligibility, interface with providers, determination of allowable fees, claim payments, communication with Participants and providers and maintenance of test results.

ARTICLE II - OBLIGATIONS OF THE PLAN

2.1 **Information.** The Plan shall make available current information regarding Participants and Plan Benefits to Provider via encrypted or otherwise properly secured internet or other electronic media. The Plan shall make available to Participants information regarding Plan Benefits.

2.2 **Liability for Claims Decisions.**

2.2.1 The Plan shall not be responsible for payment of claims submitted for services that are not covered by the Plan nor to persons that are not eligible Participants.

ARTICLE III – SERVICES AND OBLIGATIONS OF PROVIDER

3.1 **Provider Shall:**

3.1.1 provide physicians and other health care providers with a Provider Information Packet supplied by the Plan;

3.1.2 provide Covered Services to eligible Participants for which Provider is qualified and which Provider customarily furnishes to the general public from the office location indicated on the signature page;

3.1.3 follow the biennial medical monitoring protocols as set forth by the Plan and modified from time to time;

3.1.4 obtain a biennial patient consent/reject authorization for CT Scans after explaining benefits and risks as part of the biennial testing protocols and physical examination with copies to the TPA;

3.1.5 obtain a completed Medicare Benefits Questionnaire from Participant at the time of the first consultation with physician to review test results;

3.1.6 obtain a completed Optional Claimant Authorization of Limited Anonymous Disclosure of Protected Health Information for Possible Scientific and Health Research;

3.1.7 perform Covered Services pursuant to the applicable standards of good medical practice within the organized medical community;

3.1.8 (i) obtain from eligible Participant necessary authorization and confidentiality release forms, including without limitation, written assignment of benefits and an appropriate release to bill the Plan directly for Covered Services furnished by Provider; (ii) bill the Plan directly via electronic transmission of necessary claim data within 60 days of rendering services; (iii) accept as payment in full for Covered Services rendered the reimbursement amount specified in the Fee Schedule shown in EXHIBIT A; and (iv) cooperate and comply with the billing and other procedures established by the Plan.

3.1.9 within ten (10) days of occurrence, notify the Plan and provide the Plan with all information with respect to any disciplinary or malpractice actions or judgments against or settlements by Provider related to providing care under this

Agreement, and then, this information shall be considered and treated as Confidential Information;

3.1.10 treat Participants in all respects no less favorably than Provider treats all other patients. Provider shall not unlawfully discriminate against Participant based upon race, religion, national origin, color, sex, marital status, age, health status, disability, or source of payment. Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of the Plan, or their respective designees, to intervene in any manner with, nor shall it render them responsible for, the provision of Provider services or care to Participants;

3.1.11 submit all tests specified by the Plan to LabCorp for analysis and direct test results, in electronic format, to the servicing provider and to CTI Administrators;

3.1.12 coordinate with the Plan in payment of Participant benefits by Government and other insurance plans, including but not limited to, Medicare, Medicaid, and private health insurance plans (collectively "Third Party Sources") so as to provide reasonable assurance that Third Party Sources are not billed in addition to the Plan.

3.2 **Provider Insurance.** Provider shall maintain during the term of this Agreement, at Provider's expense, general and professional liability insurance with companies reasonably acceptable to the Plan or, at Provider's sole option, through a bona fide program of self-insurance, with annual limits of coverage not less than $1 million per occurrence and $3 million in the annual aggregate. Upon request, Provider shall provide the Plan with evidence of such insurance. Provider shall provide the Plan with prior notification of any cancellation, non-renewal or other material change in such insurance.

ARTICLE IV – CONFIDENTIAL INFORMATION

4.1 **Legal Restrictions.** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law.

4.2 **Non-Disclosure of Confidential Information.** Provider and the respective officers, directors, employees, agents, members, and assigns shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, use, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information without the express written permission of the Plan.

The foregoing obligation shall not apply to any information of the following.

- Information that is currently or becomes part of the public domain through a source other than the parties;
- Information which is subsequently learned from a third party that does not impose an obligation of confidentiality;
- Information that was known to a party prior to this Agreement; and
- Information required to be disclosed by law, subpoena or other legal process after reasonable notice, if reasonably possible, is given to the other party.

ARTICLE V – NEW OR ADDITIONAL SERVICES

6.1 Services. The Plan and Provider may from time to time mutually agree to add new or additional services to those then set forth in Exhibit A, and to amend the allowed fees specified in Exhibit A. The Plan and Provider shall evidence their agreement as to any new or additional services or as to any new Types of Services and Fees by means of a new Exhibit A or by an addendum to Exhibit A, of this Agreement, in either event evidenced by a writing which shall be executed by both the Plan and Provider.

ARTICLE VI – METHOD OF PAYMENT

7.1 Frequency of Payment. The Plan agrees that the payment for Covered Services provided to Participants will be sent to the Provider within five days after the last day of each business week for services incurred and submitted to the Plan for reimbursement during said week.

7.2 Amount of Payment. The Plan will reimburse Provider for Covered Services to Participants according to the Fee Schedule shown in Exhibit A. Medical procedures not included in the Fee Schedule shown in Exhibit A will not be reimbursed.

ARTICLE VII – TERM

8.1 Initial Term. Initial Term Effective Date This Agreement shall become effective November 1, 2011, and shall continue in full force through the period ending December 31, 2013.

8.2 Renewal Term. The term of this Agreement shall automatically continue for an additional term of one year ("Renewal Term") following the expiration of the Initial Term or any Renewal Term, upon the same terms and conditions, unless the Agreement is terminated or amended.

8.3 **Termination.**

8.3.1 **Notification.** This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by providing written notice of termination to the other party at least sixty (60) days prior to the date ending the Term.

8.3.2 **Cure Provision.** If either party materially breaches this Agreement, the other party may terminate the Agreement provided that it notifies, in writing, the breaching party of the specific breach and allows the breaching party the opportunity to cure the breach within sixty (60) days of the date of the notice. If the breach has not been corrected in sixty (60) days, the Agreement may be terminated without further notice

ARTICLE VIII – MODIFICATIONS

9.1 **Modifications and Improvements.** Modifications and improvements in existing procedures and systems may be made by the Plan, in the reasonable exercise of its sole discretion. Any such modifications and improvements, which would affect Provider's procedures, will be communicated to Provider by the Plan. The Plan may also make, in the reasonable exercise of its sole discretion, modifications in existing procedures and systems at the sole request of Provider; provided, however, that Provider shall in all events reimburse the Plan for all costs and expenses incurred by the Plan to make and effectuate modifications and improvements requested by Provider.

ARTICLE IX – LIABILITY

10.1 **Right to Reprocess.** In the event of any error or omission on the part of the Plan that is reasonably correctable by the reprocessing of information, the Plan will reprocess such information with the cooperation of Provider and such successful reprocessing shall be in full satisfaction of all of Provider's claims with respect to the error or omission in question. The conclusion of such error or omission designation shall be a mutual conclusion on behalf of the Plan and Provider.

10.2 **Indemnification.**

10.2.1 **Indemnification of Provider.** The Plan agrees to indemnify and hold harmless Provider with respect to any and all claims, liabilities, losses, damages or expenses including reasonable attorney's fees caused by the Plan's negligence or willful misconduct in its administering and maintaining

the Plan. However, this indemnification provision shall not apply to any claims, liabilities, losses, damages or expenses caused by any action or undertaking of Provider, its agents, servants or employees when acting outside the scope of their authority or in any negligent or criminal matter.

Indemnification of the Plan. Provider agrees to indemnify and hold harmless the Plan or any of its officers, or employees from any and all losses, liability, damages, expenses or other cost or obligation, resulting from or arising out of claims, demands, lawsuits or judgments brought against Provider in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plans, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with the Plan's negligence, willful misconduct, or criminal misconduct.

ARTICLE X – PROVIDER-PATIENT RELATIONSHIP

14.1 Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship.

ARTICLE XI – FORCE MAJEURE

15.1 Notwithstanding anything herein or otherwise which may appear to be to the contrary, neither party shall be responsible for delays or failures in performance under this Agreement resulting from any force majeure or acts beyond the reasonable control of the party. Such acts shall include, without limitation, acts of God, strikes, blackouts, riots, acts of war, epidemics, governmental regulations, fire, communication line failure, power failures, mechanical failures, storms or other disasters.

ARTICLE XII – NOTICES

16.1 Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or three (3) days after deposit in the United States Mail, postage prepaid, sent certified or registered, addressed as follows:

A. If to the Plan, to:
Perrine DuPont Settlement Claims Office
Spelter Volunteer Fire Department Office
55 B Street
PO BOX 257
Spelter, West Virginia 26438

Attention: Edgar C. Gentle, III, Esq.
Claims Administrator

B. If to Provider, to:
United Physicians Care, Inc.
686 S. Pike Street, Suite A
Shinnston WV 26431
Attention: John C. Forester
Chief Executive Officer

or to such other address or person as hereafter shall be designated in writing by the applicable party.

ARTICLE XIII – ENTIRE AGREEMENT

17.1 This Agreement and all exhibits and schedules hereto constitute the entire agreement between the parties hereto pertaining to the subject matters hereof and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings of the parties hereto in connection with the subject matters hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

ARTICLE XIV – NO WAIVER; MODIFICATIONS IN WRITING

18.1 No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy, preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available at law or in equity or otherwise. No amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and signed by or on behalf of the party subject to the enforcement thereof. Any amendment, modification or supplement of or to any provision of the Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provisions of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

ARTICLE XV – SEVERABILITY

19.1 In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and shall be enforced to that extent.

ARTICLE XVI – GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia. Additional governance regarding resolution of disputes is described in Article XXI.

ARTICLE XVII – RELATIONSHIP

22.1 Nothing contained in this Agreement and no action taken by the parties pursuant hereto shall be deemed to constitute the parties as a partnership, an association, a joint venture or other entity. It is expressly agreed that neither party for any purpose shall be deemed to be an agent, ostensible or apparent agent, employee, or servant of the other party.

ARTICLE XVIII – HEADINGS AND CAPTIONS

23.1 The titles or captions of sections and paragraphs in this Agreement are provided for convenience of reference only, and shall not be considered a part hereof for purposes of interpreting or applying this Agreement, and such titles or captions do not define, limit, extend, explain or describe the scope or extent of this Agreement or any of its terms or conditions.

ARTICLE XIX – BINDING EFFECT ON SUCCESSORS AND ASSIGNS

24.1 This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns. In the event of assignment, all of the terms, covenants and conditions of this Agreement shall remain in full force and effect and the party making the assignment shall remain liable and responsible for the due performance of all of the terms, covenants and conditions of this Agreement that it is obligated to observe and perform. Nothing in this Agreement, express or implied, is intended to confer upon

any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. However, neither the Provider nor the Plan may assign the rights and obligations provided hereunder without the prior written express permission of the other party. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, and in making proof hereof, it shall not be necessary to produce or account for more than one such counterpart.

ARTICLE XX – MISCELLANEOUS

25.1 **Changes in Laws.** If changes in the laws materially affect a party's rights and obligations under this Agreement or render any portion illegal or unenforceable, then the parties agree to negotiate modifications to the terms of this Agreement in good faith. If the parties cannot agree to modify terms that comply with the changes in laws, then either party may terminate this Agreement upon thirty (30) days prior written notice.

ARTICLE XXI – RESOLUTION OF DISPUTES

26.1 The Circuit Court in Harrison County, West Virginia retains continuous and exclusive jurisdiction and supervision over the Plan and over this Agreement. Any judicial proceeding arising out of or relating to this Agreement may be brought only before the Court, and any judgment against a Party may be enforced only by a proceeding before the Court. The Parties irrevocably submit to the jurisdiction of the Court over any such proceeding. The Parties irrevocably waive any objection that they might now or hereafter have to the laying of venue for such proceeding in the Court and any claim that any such proceeding in the Court has been brought in an inconvenient forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

The undersigned certifies that he or she has legal authority to bind the Plan.	The undersigned certifies that he or she has legal authority to bind Provider.
The Perrine Medical Monitoring Plan	**United Physicians Care, Inc.**
By: Edgar C. Gentle, III, Esq.	By: John C. Forester
Title: Claims Administrator	Title: Chief Executive Officer
Date: 11/11/2011	Date: 11/16/2011

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees			
Initial Testing	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99201	10 Minute OFFICE VISIT OP NEW	$60.00
	99211	5 Minute OFFICE VISIT OP ESTABLISHED	$32.00
	99000	SPECIMEN HANDLING	$12.00
	36415	ROUTINE VENIPUNCTURE	$10.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	82274	OCCULT BLOOD, FECES	LabCorp
	82232	ASSAY OF BETA-2 PROTEIN	LabCorp
	82565	ASSAY OF CREATININE	LabCorp
	84520	ASSAY OF UREA NITROGEN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Follow-up Consultation	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99242	30 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$135.00
	99243	40 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$170.00
Skin Test with Dermatologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Dermatologist	$140.00
	11100	BIOPSY, SKIN LESION	$110.00
	88304	TISSUE EXAM BY PATHOLOGIST	LabCorp
Consultation with Urologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Urologist	$140.00
	88142	CYTOPATH, CELL ENHANCE TECH	LabCorp
	52000	CYSTOSCOPY	$250.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	OP Facility	Out Patient Facility Charge	$850.00
Anesthesiologist	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	$350.00
	74176	CT Scan Abdomen & Pelvis	
Radiologist	74176.26	Radiologist	$350.00
	72192	CT PELVIS W/O DYE	$110.00
	72192.26	Radiologist	$800.00
			$100.00

Consultation with Nephrologist	Procedure Code	Description	Allowable Fee
	99242	Consultation with Nephrologist	$140.00
	99000	SPECIMEN HANDLING	$12.00
	36415	ROUTINE VENIPUNCTURE	$10.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	84520	ASSAY OF UREA NITROGEN	LabCorp
Consultation with Gastroenterologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Gastroenterologist	$140.00
Proctologist	82274	OCCULT BLOOD, FECES	LabCorp
	99242	Consultation with Proctologist	$160.00
	82274	OCCULT BLOOD, FECES	LabCorp
	43239	UPPER GI ENDOSCOPY, BIOPSY	$350.00
	OP Facility	Out Patient Facility Charge	$850.00
Anesthesiologist	00910	ANESTH, BLADDER SURGERY (3base:@$70 + time)	$350.00
Consultation with Toxicologist & Psychologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Toxicologist	$140.00
	36415	ROUTINE VENIPUNCTURE	$10.00
	85025	COMPLETE CBC W/AUTO DIFF WBC	LabCorp
	84202	ASSAY RBC PROTOPORPHYRIN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Psychologist	96118	NEUROPSYCH TST BY PSYCH/PHYS	$100.00
Other Specialties	**Procedure Code**	**Description**	**Allowable Fee**
	71250	CT THORAX W/O DYE	$300.00
	71250.26	CT THORAX W/O DYE	$100.00
	71250	Repeat CT Scan of Chest	$300.00
	71250.26	Repeat CT Scan of Chest	$100.00
Pulmonologist	99242	Consultation with Pulmonologist	$140.00
Cardiologist	99242	Consultation with Cardiologist	$140.00
General Surgeon	99242	Consultation with General Surgeon	$140.00
	32095	BIOPSY THROUGH CHEST WALL	$425.00
	OP Facility	Out Patient Facility Charge	$850.00
Anesthesiologist	00910	ANESTH, (3base @$70 + time)	$350.00
	99242	Consultation with Pulmonologist	$140.00
	32095	BIOPSY THROUGH CHEST WALL	$425.00
	OP Facility	Out Patient Facility Charge	$850.00
	00910	ANESTH, (3base @$70 + time)	$350.00

ADDENDUM C

Bridgeport Express Care Contract
Executed on 11/28/11

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of November 1, 2011 by and between The Perrine Medical Monitoring Plan (the Plan) and Bridgeport Express Care, a West Virginia corporation ("Provider").

RECITALS

WHEREAS, Provider is either (i) an individual health care provider or (ii) a professional corporation, medical corporation, or other entity duly organized and existing under and pursuant to the laws of the state in which it is formed, in either case that is duly licensed and authorized to deliver health care services in the state of West Virginia.

WHEREAS, the Plan desires (i) to obtain a network of health care providers for the Plan and (ii) to engage Provider to furnish such services; and

WHEREAS, Provider desires to be engaged by the Plan to furnish such services and shall furnish such services in accordance with the terms of this agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I - DEFINITIONS

1.1 **Benefits.** "Benefits" means Medical testing, consultations, and surgeries as defined by the Plan.

1.2 **Claim Clearing House.** "Claim Clearing House" means an organization that receives claims in an electronic format and forwards claims to Insurance Carriers, Third Party Administrators, and/or PPO Networks.

1.3 **Confidential Information.** "Confidential Information" means information of the Plan and Providers that shall be subject to patent, copyright, trademark, trade name or service mark protection, or not otherwise in the public domain and related to the business and operations of the Plan or Providers, including, without limitation, this Agreement and the Exhibits hereto, eligibility data, manuals, software, information relating to financial status of the Plans, and medical records of Participants in control and possession of Provider.

1.4 **Covered Services.** "Covered Services" means the procedures identified in the Fee Schedule subject to the Benefit limitations specified by the Plans.

1.5 **Fee Schedule.** "Fee Schedule" means the allowable fees paid for services provided for specific Clinical Procedure Codes as set forth in EXHIBIT A.

1.6 **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.7 **Informational Packet for Physicians and Health Care Providers.** "Provider Orientation Packet" means a packet of information about the Medical Monitoring Program.

1.8 **Medically Necessary.** "Medically Necessary" or "Medical Necessity" means services or supplies which, under the provision of this agreement are determined to be (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury or disease; (ii) provided for the diagnosis or direct care and treatment of the injury or disease; (iii) preventative services as provided in the Plans; (iv) within good medical practice within the organized medical community; (v) not primarily for the convenience of the Participant or of any Provider providing Benefits to the Participant; (vi) an appropriate supply or level of service needed to provide safe and adequate care: and (vii) provided in a setting consistent with the required level of care.

1.9 **Participant.** "Participant" means any person who has satisfied the eligibility requirements of the Plan.

1.10 **PHI.** "PHI" means Protected Health Information. It is the Individually Identifiable Health Information as defined by HIPAA.

1.11 **Payment.** "Payment" means the actual value made to or on behalf of the participants for benefits described in the Plan.

1.12 **Plan.** "Plan" means the Medical Monitoring Plan.

1.13 **Third Party Administrator** "TPA" means CTI Administrators, Inc. 100 Court Avenue, Des Moines, IA 50309. CTI Administrators, Inc. has contracted with the Plan to perform administrative services including; but not limited to, maintenance of participant eligibility, interface with Providers, determination of allowable fees, claim payments, communication with Participants and Providers and maintenance of test results.

ARTICLE II - OBLIGATIONS OF THE PLAN

2.1 **Information.** The Plan shall make available current information regarding Participants and Plan Benefits to Provider via the internet or other electronic media. The Plan shall make available to Participants information regarding Plan Benefits.

2.2 **Liability for Claims Decisions.**

2.2.1 The Plan shall not be responsible for payment of claims submitted for services that are not covered by the Plan of benefits nor to persons that are not eligible Participants.

ARTICLE III – SERVICES AND OBLIGATIONS OF PROVIDER

3.1 **Provider Shall:**

3.1.1 Provide Physicians and other Health Care Providers with a Provider Information Packet supplied by the Plan;

3.1.2 provide Covered Services to eligible Participants for which Provider is qualified and which Provider customarily furnishes to the general public from the office location indicated on the signature page;

3.1.3 follow the biennial medical monitoring protocols as set forth by the Plan and modified from time to time;

3.1.4 obtain a biennial patient consent/reject authorization for CT Scans after explaining benefits and risks as part of the biennial testing protocols and physical examination with copies to the TPA;

3.1.5 obtain a completed Medicare Benefits Questionnaire from Participant at the time of the first consultation with Physician to review test results;

3.1.6 obtain a completed Optional Claimant Authorization of Limited Anonymous Disclosure of Protected Health Information for Possible Scientific and Health Research;

3.1.7 perform Covered Services pursuant to the standards of good medical practice within the organized medical community;

3.1.8 (i) obtain from eligible Participant necessary authorization and confidentiality release forms, including without limitation, written assignment of benefits and an appropriate release to bill the Plan directly for Covered Services furnished by Provider; (ii) bill the Plan directly via electronic transmission of necessary claim data within 60 days of rendering services; (iii) accept as payment in full for Covered Services rendered the reimbursement amount specified in the Fee

Schedule shown in EXHIBIT A; and (iv) cooperate and comply with the billing and other procedures established by the Plan.

3.1.9 within ten (10) days of occurrence, notify the Plan and provide the Plan with all information with respect to any disciplinary or malpractice actions or judgments against or settlements by Provider;

3.1.10 treat Participants in all respects no less favorably than Provider treats all other patients. Provider shall not discriminate against Participant based upon race, religion, national origin, color, sex, marital status, age, health status, disability, or source of payment. Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of the Plan, or their respective designees, to intervene in any manner with, nor shall it render them responsible for, the provision of Provider services or care to Participants;

3.1.11 submit all tests specified by the Plan to LabCorp for analysis and direct test results, in electronic format, to the servicing provider and to CTI Administrators;

3.1.12 coordinate with the Plan in payment of Participant benefits by Government and other insurance plans, including but not limited to, Medicare, Medicaid, and private health insurance plans (collectively "Third Party Sources") so as to provide reasonable assurance that Third Party Sources are not billed in addition to the Plan.

3.2 **Provider Insurance.** Provider shall maintain during the term of this agreement, at Providers expense, in amounts reasonably satisfactory to the Plan policies of general and professional liability insurance with companies reasonably acceptable to the Plan. Upon request, Provider shall provide the Plan with evidence of such insurance. Provider shall provide the Plan with prior notification of any cancellation, non-renewal or other material change in such insurance.

ARTICLE IV – CONFIDENTIAL INFORMATION

4.1 **Legal Restrictions.** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law.

4.2 **Non-Disclosure of Confidential Information.** Provider and the respective officers, directors, employees, agents, members, and assigns shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, use, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information without the express written permission of the Plan.

ARTICLE V – NEW OR ADDITIONAL SERVICES

5.1 **Services.** The Plan and Provider may from time to time mutually agree to add new or additional services to those then set forth in Exhibit A, and to amend the allowed fees specified in Exhibit A. The Plan and Provider shall evidence their agreement as to any new or additional services or as to any new Types of Services and Fees by means of a new Exhibit A or by an addendum to Exhibit A, of this agreement, in either event which shall be executed by both the Plan and Provider.

ARTICLE VI – METHOD OF PAYMENT

6.1 **Frequency of Payment.** The Plan agrees that the payment for Covered Services provided to Participants will be sent to the Provider within five days after the last day of each business week for services incurred and submitted to the Plan for reimbursement during said week.

6.2 **Amount of Payment.** The Plan will reimburse Provider for Covered Services to Participants according to the Fee Schedule shown in Exhibit A. Medical procedures not included in the Fee Schedule shown in Exhibit A will not be reimbursed.

ARTICLE VII – TERM

7.1 **Initial Term.** Initial Term Effective Date This Agreement shall become effective November ___, 2011, and shall continue in full force through the period ending December 31, 2013.

7.2 **Renewal Term.** The term of this Agreement shall automatically continue for an additional term of one year ("Renewal Term") following the expiration of the Initial

Term or any Renewal Term, upon the same terms and conditions, unless the Agreement is terminated or amended.

7.3 **Termination.**

7.3.1 **Notification.** This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by providing written notice of termination to the other party at least sixty (60) days prior to the date ending the Term.

7.3.2 **Cure Provision.** If either party materially breaches this Agreement, the other party may terminate the Agreement provided that it notifies, in writing, the breaching party of the specific breach and allows the breaching party the opportunity to cure the breach within sixty (60) days of the date of the notice. If the breach has not been corrected in sixty (60) days, the Agreement may be terminated without further notice

ARTICLE VIII – MODIFICATIONS

8.1 **Modifications and Improvements.** Modifications and improvements in existing procedures and systems may be made by the Plan, in its sole discretion. Any such modifications and improvements, which would affect Provider's procedures, will be communicated to Provider by the Plan. The Plan may also make, in its sole discretion, modifications in existing procedures and systems at the sole request of Provider; provided, however, that Provider shall in all events reimburse the Plan for all costs and expenses incurred by the Plan to make and effectuate modifications and improvements requested by Provider.

ARTICLE IX – LIABILITY

9.1 **Right to Reprocess.** In the event of any error or omission on the part of the Plan that is reasonably correctable by the reprocessing of Information, the Plan will reprocess such Information with the cooperation of Provider and such reprocessing shall be in full satisfaction of all of Provider's claims with respect to the error or omission in question. The conclusion of such error or omission designation shall be a mutual conclusion on behalf of the Plan and Provider.

9.2 **Indemnification.**

9.2.1 **Indemnification of Provider** the Plan agrees to indemnify and hold harmless Provider with respect to any and all claims, liabilities, losses, damages or expenses including reasonable attorney's fees caused by the Plan's sole negligence or willful misconduct in its administering and maintaining the Plans. However, this indemnification provision shall not apply to any claims, liabilities,

losses, damages or expenses caused by any action or undertaking of Provider, its agents, servants or employees when acting outside the scope of their authority or in any negligent or criminal matter.

9.2.2 **Indemnification of the Plan** Provider agrees to indemnify and hold harmless the Plan or any of its officers, or employees from any and all losses, liability, damages, expenses or other cost or obligation, resulting from or arising out of claims, demands, lawsuits or judgments brought against Provider in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plans, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with the Plan's sole negligence, willful misconduct, or criminal misconduct.

ARTICLE X – PROVIDER-PATIENT RELATIONSHIP

10.1.1 Nothing contained in this Agreement shall interfere with or in any way alter any Provider-patient relationship.

ARTICLE XI – FORCE MAJEURE

11.1.1 Notwithstanding anything herein or otherwise which may appear to be to the contrary, the Plan shall not be responsible for delays or failures in performance under this Agreement resulting from any force majeure or acts beyond the reasonable control of the Plan or due to or in any way related to or connected with any act or omission of Provider or any employee, agent, personnel or other representative of Provider. Such acts shall include, without limitation, acts of God, strikes, blackouts, riots, acts of war, epidemics, governmental regulations, fire, communication line failure, power failures, mechanical failures, storms or other disasters.

ARTICLE XII – NOTICES

12.1.1 Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or three (3) days after deposit in the United States Mail, postage prepaid, sent certified or registered, addressed as follows:

A. If to the Plan, to:
Perrine DuPont Settlement Claims Office
Spelter Volunteer Fire Department Office
55 B Street
PO BOX 257
Spelter, West Virginia 26438
Attention: Edgar C. Gentle, III, Esq.

Claims Administrator

B. If to Provider, to:
Bridgeport Express Care
2 Chenoweth Drive
Bridgeport WV 26330
Attention: Dr. Eric Gulley

or to such other address or person as hereafter shall be designated in writing by the applicable party.

ARTICLE XIII – ENTIRE AGREEMENT

13.1 This Agreement and all exhibits and schedules hereto constitute the entire agreement between the parties hereto pertaining to the subject matters hereof and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings of the parties hereto in connection with the subject matters hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

ARTICLE XIV – NO WAIVER; MODIFICATIONS IN WRITING

14.1 No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy, preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein to the Plan are cumulative and are not exclusive of any remedies that may be available to the Plan at law or in equity or otherwise. No amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and designed by or on behalf of the party to be charged with the enforcement thereof. Any amendment, modification or supplement of or to any provision of the Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provisions of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

ARTICLE XV – SEVERABILITY

15.1 In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and shall be enforced to that extent.

ARTICLE XVI – GOVERNING LAW

16.1 This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia. Additional governance regarding resolution of disputes is described in Article XXI.

ARTICLE XVII – RELATIONSHIP

17.1 Nothing contained in this Agreement and no action taken by the parties pursuant hereto shall be deemed to constitute the parties a partnership, an association, a joint venture or other entity.

ARTICLE XVIII – HEADINGS AND CAPTIONS

18.1 The titles or captions of sections and paragraphs in this Agreement are provided for convenience of reference only, and shall not be considered a part hereof for purposes of interpreting or applying this Agreement, and such titles or captions doe not define, limit, extend, explain or describe the scope or extent of this Agreement or any of its terms or conditions.

ARTICLE XIX – BINDING EFFECT ON SUCCESSORS AND ASSIGNS

19.1 This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns. In the event of assignment, all of the terms, covenants and conditions of this Agreement shall remain in full force and effect and the party making the assignment shall remain liable and responsible for the due performance of all of the terms, covenants and conditions of this Agreement that it is obligated to observe and perform. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. However, neither the Provider nor the Plan may assign the rights

and obligations provided hereunder without the prior written express permission of the other party. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, and in making proof hereof, it shall not be necessary to produce or account for more than one such counterpart.

ARTICLE XX – MISCELLANEOUS

20.1 **Changes in Laws.** If changes in the laws materially affect a party's rights and obligations under this Agreement or render any portion illegal or unenforceable, then the parties agree to negotiate modifications to the terms of this Agreement in good faith. If the parties cannot agree to modify terms that comply with the changes in laws, then either party may terminate this Agreement upon thirty (30) days prior written notice.

ARTICLE XXI – RESOLUTION OF DISPUTES

21.1 The Circuit Court in Harrison County, West Virginia retains continuous and exclusive jurisdiction and supervision over the Plan and over this Agreement. Any judicial proceeding arising out of or relating to this Agreement may be brought only before the Court, and any judgment against a Party may be enforced only by a proceeding before the Court. The Parties irrevocably submit to the jurisdiction of the Court over any such proceeding. The Parties irrevocably waive any objection that they might now or hereafter have to the laying of venue for such proceeding in the Court and any claim that any such proceeding in the Court has been brought in an inconvenient forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

The undersigned certifies that he or she has legal authority to bind the Plan.

The Perrine Medical Monitoring Plan

By: Edgar C. Gentle, III, Esq.

Title: Claims Administrator

Date: 11/23/11

The undersigned certifies that he or she has legal authority to bind Provider.

Bridgeport Express Care

By: _____

Title: Mgr

Date: 11/22/11

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees			
Initial Testing	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99201	10 Minute OFFICE VISIT OP NEW	$60.00
	99211	5 Minute OFFICE VISIT OP ESTABLISHED	$32.00
	99000	SPECIMEN HANDLING	$12.00
	36415	ROUTINE VENIPUNCTURE	$10.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	82274	OCCULT BLOOD, FECES	LabCorp
	82232	ASSAY OF BETA-2 PROTEIN	LabCorp
	82565	ASSAY OF CREATININE	LabCorp
	84520	ASSAY OF UREA NITROGEN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Follow-up Consultation	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99242	30 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$135.00
	99243	40 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$170.00
Skin Test with Dermatologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Dermatologist	$140.00
	11100	BIOPSY, SKIN LESION	$110.00
	88304	TISSUE EXAM BY PATHOLOGIST	LabCorp
Consultation with Urologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Urologist	$140.00
	88112	CYTOPATH, CELL ENHANCE TECH	LabCorp
	52000	CYSTOSCOPY	$250.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	OP Facility	Out Patient Facility Charge	$850.00
Anesthesiologist	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	$350.00
	74176	CT Scan Abdomen & Pelvis	
Radiologist	74176.26	Radiologist	$350.00
	72192	CT PELVIS W/O DYE	$110.00
	72192.26	Radiologist	$300.00
			$100.00

Consultation with Nephrologist	Procedure Code	Description	Allowable Fee
	99242	Consultation with Nephrologist	
	99000	SPECIMEN HANDLING	$140.00
	36415	ROUTINE VENIPUNCTURE	$12.00
	81001	URINALYSIS, NONAUTO W/SCOPE	$10.00
	84520	ASSAY OF UREA NITROGEN	LabCorp
			LabCorp
Consultation with Gastroenterologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Gastroenterologist	
	82274	OCCULT BLOOD, FECES	$140.00
Proctologist	99242	Consultation with Proctologist	LabCorp
	82274	OCCULT BLOOD, FECES	$160.00
	43239	UPPER GI ENDOSCOPY, BIOPSY	LabCorp
	OP Facility	Out Patient Facility Charge	$350.00
	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	$850.00
Anesthesiologist			$350.00
Consultation with Toxicologist & Psychologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Toxicologist	
	36415	ROUTINE VENIPUNCTURE	$140.00
	85025	COMPLETE CBC W/AUTO DIFF WBC	$10.00
	84202	ASSAY RBC PROTOPORPHYRIN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Psychologist	96118	NEUROPSYCH TST BY PSYCH/PHYS	LabCorp
			$100.00
Other Specialties	**Procedure Code**	**Description**	**Allowable Fee**
	71250	CT THORAX W/O DYE	
	71250.26	CT THORAX W/O DYE	$300.00
	71250	Repeat CT Scan of Chest	$100.00
	71250.26	Repeat CT Scan of Chest	$300.00
Pulmonologist	99242	Consultation with Pulmonologist	$100.00
Cardiologist	99242	Consultation with Cardiologist	$140.00
General Surgeon	99242	Consultation with General Surgeon	$140.00
	32095	BIOPSY THROUGH CHEST WALL	$140.00
	OP Facility	Out Patient Facility Charge	$425.00
Anesthesiologist	00910	ANESTH, (3base @$70 + time)	$850.00
	99242	Consultation with Pulmonologist	$850.00
	32095	BIOPSY THROUGH CHEST WALL	$140.00
	OP Facility	Out Patient Facility Charge	$425.00
	00910	ANESTH, (3base @$70 + time)	$850.00
			$350.00

ADDENDUM D

Urgent Care Mso, LLC ("MedExpress")
Contract
Executed on 11/14/11

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of November 13, 2011 by and between The Perrine Medical Monitoring Plan (the Plan) and **Urgent Care Mso, LLC**, a Delaware Limited Liability Company ("Provider").

RECITALS

WHEREAS, Provider is either (i) an individual health care provider or (ii) a professional corporation, medical corporation, or other entity duly organized and existing under and pursuant to the laws of the state in which it is formed, in either case that is duly licensed and authorized to deliver health care services in the state of West Virginia, or that has employees or contractors who are.

WHEREAS, the Plan desires (i) to obtain a network of health care providers for the Plan and (ii) to engage Provider to furnish such services; and

WHEREAS, Provider desires to be engaged by the Plan to furnish such services and shall furnish such services in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I - DEFINITIONS

1.1 **Benefits.** "Benefits" means Medical testing, consultations, and surgeries as defined by the Plan.

1.2 **Claim Clearing House.** "Claim Clearing House" means an organization that receives claims in an electronic format and forwards claims to Insurance Carriers, Third Party Administrators, and/or PPO Networks.

1.3 **Confidential Information.** "Confidential Information" means information of the Plan and Provider that shall be subject to patent, copyright, trademark, trade name or service mark protection, or not otherwise in the public domain and related to the business and operations of the Plan or Provider, including, without limitation, this Agreement and the Exhibits hereto, eligibility data, manuals, software, information relating to financial status of the Plans, and medical records of Participants in control and possession of Provider.

1.4 **Covered Services.** "Covered Services" means the procedures identified in the Fee Schedule subject to the Benefit limitations specified by the Plans.

1.5 **Fee Schedule.** "Fee Schedule" means the allowable fees paid for services provided for specific Clinical Procedure Codes as set forth in EXHIBIT A.

1.6 **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.7 **Informational Packet for Physicians and Health Care Provider.** "Provider Orientation Packet" means a packet of information about the Medical Monitoring Program.

1.8 **Medically Necessary.** "Medically Necessary" or "Medical Necessity" means services or supplies which, under the provision of this Agreement are determined to be (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury or disease; (ii) provided for the diagnosis or direct care and treatment of the injury or disease or preventative services as provided in the Plans; (iv) within good medical practice within the organized medical community; (vi) an appropriate supply or level of service needed to provide safe and adequate care; and (vii) provided in a setting consistent with the required level of care.

1.9 **Participant.** "Participant" means any person who has satisfied the eligibility requirements of the Plan.

1.10 **PHI.** "PHI" means Protected Health Information, which may include Individually Identifiable Health Information as defined by HIPAA.

1.11 **Payment.** "Payment" means the actual value made to or on behalf of the Participants for benefits described in the Plan.

1.12 **Plan.** "Plan" means the Medical Monitoring Plan.

1.13 **Third Party Administrator** "TPA" means CTI Administrators, Inc. 100 Court Avenue, Des Moines, IA 50309. CTI Administrators, Inc. has contracted with the Plan to perform administrative services including, but not limited to, maintenance of participant eligibility, interface with providers, determination of allowable fees, claim payments, communication with Participants and providers and maintenance of test results.

ARTICLE II - OBLIGATIONS OF THE PLAN

2.1 **Information.** The Plan shall make available current information regarding Participants and Plan Benefits to Provider via encrypted or otherwise properly secured internet or other electronic media. The Plan shall make available to Participants information regarding Plan Benefits.

2.2 **Liability for Claims Decisions.**

2.2.1 The Plan shall not be responsible for payment of claims submitted for services that are not covered by the Plan nor to persons that are not eligible Participants.

ARTICLE III – SERVICES AND OBLIGATIONS OF PROVIDER

3.1 **Provider Shall:**

3.1.1 provide physicians and other health care providers with a Provider Information Packet supplied by the Plan;

3.1.2 provide Covered Services to eligible Participants for which Provider is qualified and which Provider customarily furnishes to the general public from the office location indicated on the signature page;

3.1.3 follow the biennial medical monitoring protocols as set forth by the Plan and modified from time to time (which shall be provided to Provider in writing);

3.1.4 obtain a biennial patient consent/reject authorization for CT Scans after explaining benefits and risks as part of the biennial testing protocols and physical examination with copies to the TPA;

3.1.5 obtain a completed Medicare Benefits Questionnaire from Participant at the time of the first consultation with physician to review test results;

3.1.6 obtain a completed Optional Claimant Authorization of Limited Anonymous Disclosure of Protected Health Information for Possible Scientific and Health Research;

3.1.7 perform Covered Services pursuant to the applicable standards of care;

3.1.8 (i) obtain from eligible Participant necessary authorization and confidentiality release forms, including without limitation, written assignment of benefits and an appropriate release to bill the Plan directly for Covered Services furnished by Provider; (ii) bill the Plan directly via electronic transmission of necessary claim data within 60 days of rendering services; (iii) accept as payment in full for Covered Services rendered the reimbursement amount specified in the Fee Schedule shown in EXHIBIT A; and (iv) cooperate and comply with the billing and other procedures established by the Plan. All of the above as provided in section 3.1.8 shall be provided by the Third Party Administrator to the Provider.

3.1.9 within ten (10) days of occurrence, notify the Plan and provide the Plan with all information with respect to any disciplinary or malpractice actions or judgments against or settlements by Provider related to providing care under this

Agreement, and then, this information shall be considered and treated as Confidential Information;

3.1.10 treat Participants in all respects no less favorably than Provider treats all other patients. Provider shall not unlawfully discriminate against Participant based upon race, religion, national origin, color, sex, marital status, age, health status, disability, or source of payment. Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of the Plan, or their respective designees, to intervene in any manner with, nor shall it render them responsible for, the provision of Provider services or care to Participants;

3.1.11 submit all tests specified by the Plan to LabCorp for analysis and direct test results. All analysis and test results rendered by LabCorp shall be provided to the servicing provider and to CTI Administrators;

3.1.12 coordinate with the Plan in payment of Participant benefits by Government and other insurance plans, including but not limited to, Medicare, Medicaid, and private health insurance plans (collectively "Third Party Sources") so as to provide reasonable assurance that Third Party Sources are not billed in addition to the Plan.

3.2 **Provider Insurance.** Provider shall maintain during the term of this Agreement, at Provider's expense, general and professional liability insurance with companies reasonably acceptable to the Plan or, at Provider's sole option, through a bona fide program of self-insurance, with annual limits of coverage not less than $1 million per occurrence and $3 million in the annual aggregate. Upon request, Provider shall provide the Plan with evidence of such insurance. Provider shall provide the Plan with prior notification of any cancellation, non-renewal or other material change in such insurance.

ARTICLE IV – CONFIDENTIAL INFORMATION

4.1 **Legal Restrictions.** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law.

4.2 **Non-Disclosure of Confidential Information.** Provider and the respective officers, directors, employees, agents, members, and assigns shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, use, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information without the express written permission of the Plan.

The foregoing obligation shall not apply to any information of the following.

- Information that is currently or becomes part of the public domain through a source other than the parties;
- Information which is subsequently learned from a third party that does not impose an obligation of confidentiality;
- Information that was known to a party prior to this Agreement; and
- Information required to be disclosed by law, subpoena or other legal process after reasonable notice, if reasonably possible, is given to the other party.

ARTICLE V – NEW OR ADDITIONAL SERVICES

5.1 Services. The Plan and Provider may from time to time mutually agree to add new or additional services to those then set forth in Exhibit A, and to amend the allowed fees specified in Exhibit A. The Plan and Provider shall evidence their agreement as to any new or additional services or as to any new Types of Services and Fees by means of a new Exhibit A or by an addendum to Exhibit A, of this Agreement, in either event evidenced by a writing which shall be executed by both the Plan and Provider.

ARTICLE VI – METHOD OF PAYMENT

6.1 Frequency of Payment. The Plan agrees that the payment for Covered Services provided to Participants will be sent to the Provider within five days after the last day of each business week for services incurred and submitted to the Plan for reimbursement during said week.

6.2 Amount of Payment. The Plan will reimburse Provider for Covered Services to Participants according to the Fee Schedule shown in Exhibit A. Medical procedures not included in the Fee Schedule shown in Exhibit A will not be reimbursed.

ARTICLE VII – TERM

7.1 Initial Term. Initial Term Effective Date This Agreement shall become effective November 13, 2011, and shall continue in full force through the period ending December 31, 2013.

7.2 Renewal Term. The term of this Agreement shall automatically continue for an additional term of one year ("Renewal Term") following the expiration of the Initial Term or any Renewal Term, upon the same terms and conditions, unless the Agreement is terminated or amended.

7.3 Termination.

7.3.1 **Notification.** This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by providing written notice of termination to the other party at least sixty (60) days prior to the date ending the Term.

7.3.2 **Cure Provision.** If either party materially breaches this Agreement, the other party may terminate the Agreement provided that it notifies, in writing, the breaching party of the specific breach and allows the breaching party the opportunity to cure the breach within sixty (60) days of the date of the notice. If the breach has not been corrected in sixty (60) days, the Agreement may be terminated without further notice

ARTICLE VIII – MODIFICATIONS

8.1 **Modifications and Improvements.** Modifications and improvements in existing procedures and systems may be made by the Plan, in the reasonable exercise of its sole discretion, and subject to the restrictions and covenants contained within this Agreement, including, but not limited to, those related to all reimbursement provisions. Any such modifications and improvements, which would affect Provider's procedures, will be communicated to Provider by the Plan. The Plan may also make, in the reasonable exercise of its sole discretion, modifications in existing procedures and systems at the sole request of Provider; provided, however, that Provider shall in all events reimburse the Plan for all costs and expenses incurred by the Plan to make and effectuate modifications and improvements requested by Provider.

ARTICLE IX – LIABILITY

9.1 **Right to Reprocess.** In the event of any error or omission on the part of the Plan that is reasonably correctable by the reprocessing of information, the Plan will reprocess such information with the cooperation of Provider and such successful reprocessing shall be in full satisfaction of all of Provider's claims with respect to the error or omission in question. The conclusion of such error or omission designation shall be a mutual conclusion on behalf of the Plan and Provider.

9.2 **Indemnification.**

9.2.1 **Indemnification of Provider.** The Plan agrees to indemnify and hold harmless Provider with respect to any and all claims, liabilities, losses,

damages or expenses including reasonable attorney's fees caused by the Plan's negligence or willful misconduct in its administering and maintaining the Plan. However, this indemnification provision shall not apply to any claims, liabilities, losses, damages or expenses caused by any action or undertaking of Provider, its agents, servants or employees when acting outside the scope of their authority or in any negligent or criminal matter.

10 **Indemnification of the Plan.** Provider agrees to indemnify and hold harmless the Plan or any of its officers, or employees from any and all losses, liability, damages, expenses or other cost or obligation, resulting from or arising out of claims, demands, lawsuits or judgments brought against Provider in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plans, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with the Plan's negligence, willful misconduct, or criminal misconduct.

ARTICLE X – PROVIDER-PATIENT RELATIONSHIP

10.1 Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship.

ARTICLE XI – FORCE MAJEURE

11.1 Notwithstanding anything herein or otherwise which may appear to be to the contrary, neither party shall be responsible for delays or failures in performance under this Agreement resulting from any force majeure or acts beyond the reasonable control of the party. Such acts shall include, without limitation, acts of God, strikes, blackouts, riots, acts of war, epidemics, governmental regulations, fire, communication line failure, power failures, mechanical failures, storms or other disasters.

ARTICLE XII – NOTICES

12.1 Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or three (3) days after deposit in the United States Mail, postage prepaid, sent certified or registered, addressed as follows:

A. If to the Plan, to:
Perrine DuPont Settlement Claims Office
Spelter Volunteer Fire Department Office
55 B Street

PO BOX 257
Spelter, West Virginia 26438
Attention: Edgar C. Gentle, III, Esq.
Claims Administrator

B. If to Provider, to:
Urgent Care Mso, LLC
1370 Johnson Avenue
Bridgeport, WV 26330
Attention: Dr. Kelly Nelson
Chief Executive Officer

or to such other address or person as hereafter shall be designated in writing by the applicable party.

ARTICLE XIII – ENTIRE AGREEMENT

13.1 This Agreement and all exhibits and schedules hereto constitute the entire agreement between the parties hereto pertaining to the subject matters hereof and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings of the parties hereto in connection with the subject matters hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

ARTICLE XIV – NO WAIVER; MODIFICATIONS IN WRITING

14.1 No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy, preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available at law or in equity or otherwise. No amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be ~~effective unless the same shall be in writing and signed by or on behalf of the~~ party subject to the enforcement thereof. Any amendment, modification or supplement of or to any provision of the Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provisions of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

ARTICLE XV – SEVERABILITY

15.1 In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and shall be enforced to that extent.

ARTICLE XVI – GOVERNING LAW

16.1 This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia. Additional governance regarding resolution of disputes is described in Article XXI.

ARTICLE XVII – RELATIONSHIP

17.1 Nothing contained in this Agreement and no action taken by the parties pursuant hereto shall be deemed to constitute the parties as a partnership, an association, a joint venture or other entity. It is expressly agreed that neither party for any purpose shall be deemed to be an agent, ostensible or apparent agent, employee, or servant of the other party.

ARTICLE XVIII – HEADINGS AND CAPTIONS

18.1 The titles or captions of sections and paragraphs in this Agreement are provided for convenience of reference only, and shall not be considered a part hereof for purposes of interpreting or applying this Agreement, and such titles or captions do not define, limit, extend, explain or describe the scope or extent of this Agreement or any of its terms or conditions.

ARTICLE XIX – BINDING EFFECT ON SUCCESSORS AND ASSIGNS

19.1 This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns. In the event of assignment, all of the terms, covenants and conditions of this Agreement shall remain in full force and effect and the party making the assignment shall remain liable and responsible for the due performance of all of the terms,

covenants and conditions of this Agreement that it is obligated to observe and perform. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. However, neither the Provider nor the Plan may assign the rights and obligations provided hereunder without the prior written express permission of the other party. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, and in making proof hereof, it shall not be necessary to produce or account for more than one such counterpart.

ARTICLE XX – MISCELLANEOUS

20.1 **Changes in Laws.** If changes in the laws materially affect a party's rights and obligations under this Agreement or render any portion illegal or unenforceable, then the parties agree to negotiate modifications to the terms of this Agreement in good faith. If the parties cannot agree to modify terms that comply with the changes in laws, then either party may terminate this Agreement upon thirty (30) days prior written notice.

20.2 **Court Order Approving Provider as Medical Provider for the Perrine Medical Monitoring Plan and Disclosure of Potential Conflict.** On August 31, 2011, the Circuit Court of Harrison County, West Virginia, entered the Final Order Approving Certain Aspects of Settlement Administration and Establishing Briefing Schedule for Preliminary Recommended or Unresolved Matters in the matter of Lenora Perrine, et al., v. E.I. DuPont DeNemours & Company, et al., Case No. 04-C-296-2. In said order, Provider, referred to as "Medbrook Medical Association", is listed as an approved medical provider for the Perrine Medical Monitoring plan. Both parties acknowledge that Dr. Nelson, the principal for Provider, testified on behalf of DuPont in the matter described hereinabove prior to the Settlement of said matter.

ARTICLE XXI – RESOLUTION OF DISPUTES

21.1 The Circuit Court in Harrison County, West Virginia retains continuous and exclusive jurisdiction and supervision over the Plan and over this Agreement. Any judicial proceeding arising out of or relating to this Agreement may be brought only before the Court, and any judgment against a Party may be enforced only by a proceeding before the Court. The Parties irrevocably submit to the jurisdiction of the Court over any such proceeding. The Parties irrevocably waive any objection that they might now or hereafter have to the laying of venue for such proceeding in the Court and any claim that any such proceeding in the Court has been brought in an inconvenient forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

The undersigned certifies that he or she has legal authority to bind the Plan.

The Perrine Medical Monitoring Plan

By: Edgar C. Gentle, III, Esq.

Title: Claims Administrator

Date: 11-14-11

The undersigned certifies that he or she has legal authority to bind Provider.

Urgent Care Mso, LLC

By: Kelly R Nelson, MD

Title: Senior VP

Date: 11-14-11

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees			
Initial Testing	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99201	10 Minute OFFICE VISIT OP NEW	$60.00
	99211	5 Minute OFFICE VISIT OP ESTABLISHED	$32.00
	99000	SPECIMEN HANDLING	$12.00
	36415	ROUTINE VENIPUNCTURE	$10.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	82274	OCCULT BLOOD, FECES	LabCorp
	82232	ASSAY OF BETA-2 PROTEIN	LabCorp
	82565	ASSAY OF CREATININE	LabCorp
	84520	ASSAY OF UREA NITROGEN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Follow-up Consultation	**Procedure Code**	**Description**	**Allowable Fee**
Primary Care Physician	99242	30 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$135.00
	99243	40 Minute Office Visit Physical Exam, CT Scan Pros & Cons, review of tests	$170.00
Skin Test with Dermatologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Dermatologist	$140.00
	11100	BIOPSY, SKIN LESION	$110.00
	88304	TISSUE EXAM BY PATHOLOGIST	LabCorp
Consultation with Urologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Urologist	$140.00
	88112	CYTOPATH, CELL ENHANCE TECH	LabCorp
	52000	CYSTOSCOPY	$250.00
	81001	URINALYSIS, NONAUTO W/SCOPE	LabCorp
	OP Facility	Out Patient Facility Charge	$850.00
Anesthesiologist	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	$350.00
	74176	CT Scan Abdomen & Pelvis	
Radiologist	74176.26	Radiologist	$350.00
	72192	CT PELVIS W/O DYE	$110.00
	72192.26	Radiologist	$300.00
			$100.00

Consultation with Nephrologist	Procedure Code	Description	Allowable Fee
	99242	Consultation with Nephrologist	
	99000	SPECIMEN HANDLING	$140.00
	36415	ROUTINE VENIPUNCTURE	$12.00
	81001	URINALYSIS, NONAUTO W/SCOPE	$10.00
	84520	ASSAY OF UREA NITROGEN	LabCorp
			LabCorp
Consultation with Gastroenterologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Gastroenterologist	
Proctologist	82274	OCCULT BLOOD, FECES	$140.00
	99242	Consultation with Proctologist	LabCorp
	82274	OCCULT BLOOD, FECES	$160.00
	43239	UPPER GI ENDOSCOPY, BIOPSY	LabCorp
	OP Facility	Out Patient Facility Charge	$350.00
	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	$850.00
Anesthesiologist			$350.00
Consultation with Toxicologist & Psychologist	**Procedure Code**	**Description**	**Allowable Fee**
	99242	Consultation with Toxicologist	
	36415	ROUTINE VENIPUNCTURE	$140.00
	85025	COMPLETE CBC W/AUTO DIFF WBC	$10.00
	84202	ASSAY RBC PROTOPORPHYRIN	LabCorp
	83655	ASSAY OF LEAD	LabCorp
Psychologist	96118	NEUROPSYCH TST BY PSYCH/PHYS	LabCorp
			$100.00
Other Specialties	**Procedure Code**	**Description**	**Allowable Fee**
	71250	CT THORAX W/O DYE	
	71250.26	CT THORAX W/O DYE	$300.00
	71250	Repeat CT Scan of Chest	$100.00
	71250.26	Repeat CT Scan of Chest	$300.00
Pulmonologist	99242	Consultation with Pulmonologist	$100.00
Cardiologist	99242	Consultation with Cardiologist	$140.00
General Surgeon	99242	Consultation with General Surgeon	$140.00
	32095	BIOPSY THROUGH CHEST WALL	$140.00
	OP Facility	Out Patient Facility Charge	$425.00
Anesthesiologist	00910	ANESTH, (3base @$70 + time)	$850.00
	99242	Consultation with Pulmonologist	$350.00
	32095	BIOPSY THROUGH CHEST WALL	$140.00
	OP Facility	Out Patient Facility Charge	$425.00
	00910	ANESTH, (3base @$70 + time)	$850.00
			$350.00

ADDENDUM E

Monongahalia Valley Association of Health Clinics ("MVA") Contract Executed on 12/12/11

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of November 13, 2011 by and between The Perrine Medical Monitoring Plan (the Plan) and **Monongahela Valley Association of Health Centers, Inc.,** a private non-profit West Virginia corporation ("Provider").

RECITALS

WHEREAS, Provider is either (i) an individual health care provider or (ii) a professional corporation, medical corporation, or other entity duly organized and existing under and pursuant to the laws of the state in which it is formed, in either case that is duly licensed and authorized to deliver health care services in the state of West Virginia, or that have employees who are.

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3.1.6 obtain a completed Optional Claimant Authorization of Limited Anonymous Disclosure of Protected Health Information for Possible Scientific and Health Research;

3.1.7 perform Covered Services pursuant to the applicable standards of care;

3.1.8 (i) obtain from eligible Participant necessary authorization and confidentiality release forms, including without limitation, written assignment of benefits and an appropriate release to bill the Plan directly for Covered Services furnished by Provider; (ii) bill the Plan directly via electronic transmission of necessary claim data within 60 days of rendering services; (iii) accept as payment in full for Covered Services rendered the reimbursement amount specified in the Fee Schedule shown in EXHIBIT A; and (iv) cooperate and comply with the billing and other procedures established by the Plan. All of the above as provided in

section 3.1.8 shall be provided by the Third Party Administrator to the Provider.

3.1.9 within ten (10) days of occurrence, notify the Plan and provide the Plan with all information with respect to any disciplinary or malpractice actions or judgments against or settlements by Provider related to providing care under this Agreement, and then, this information shall be considered and treated as Confidential Information;

3.1.10 treat Participants in all respects no less favorably than Provider treats all other patients. Provider shall not unlawfully discriminate against Participant based upon race, religion, national origin, color, sex, marital status, age, health status, disability, or source of payment. Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of the Plan, or their respective designees, to intervene in any manner with, nor shall it render them responsible for, the provision of Provider services or care to Participants;

3.1.11 submit all tests specified by the Plan to LabCorp for analysis and direct test results. All analysis and test results rendered by LabCorp shall be provided to the servicing provider and to CTI Administrators;

3.1.12 coordinate with the Plan in payment of Participant benefits by Government and other insurance plans, including but not limited to, Medicare, Medicaid, and private health insurance plans (collectively "Third Party Sources") so as to provide reasonable assurance that Third Party Sources are not billed in addition to the Plan.

3.2 **Provider Insurance.** Provider shall maintain during the term of this Agreement, at Provider's expense, general and professional liability insurance with companies reasonably acceptable to the Plan or, at Provider's sole option, through a bona fide program of self-insurance, with annual limits of coverage not less than $1 million per occurrence and $3 million in the annual aggregate. Upon request, Provider shall provide the Plan with evidence of such insurance. Provider shall provide the Plan with prior notification of any cancellation, non-renewal or other material change in such insurance.

ARTICLE IV – CONFIDENTIAL INFORMATION

4.1 **Legal Restrictions.** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law.

4.2 **Non-Disclosure of Confidential Information.** Provider and the respective officers, directors, employees, agents, members, and assigns shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, use, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information without the express written permission of the Plan.

The foregoing obligation shall not apply to any information of the following.

- Information that is currently or becomes part of the public domain through a source other than the parties;
- Information which is subsequently learned from a third party that does not impose an obligation of confidentiality;
- Information that was known to a party prior to this Agreement; and
- Information required to be disclosed by law, subpoena or other legal process after reasonable notice, if reasonably possible, is given to the other party.

ARTICLE V – NEW OR ADDITIONAL SERVICES

5.1 **Services.** The Plan and Provider may from time to time mutually agree to add new or additional services to those then set forth in Exhibit A, and to amend the allowed fees specified in Exhibit A. The Plan and Provider shall evidence their agreement as to any new or additional services or as to any new Types of Services and Fees by means of a new Exhibit A or by an addendum to Exhibit A, of this Agreement, in either event evidenced by a writing which shall be executed by both the Plan and Provider.

ARTICLE VI – METHOD OF PAYMENT

6.1 **Frequency of Payment.** The Plan agrees that the payment for Covered Services provided to Participants will be sent to the Provider within five days after the last day of each business week for services incurred and submitted to the Plan for reimbursement during said week.

6.2 **Amount of Payment.** The Plan will reimburse Provider for Covered Services to Participants according to the Fee Schedule shown in Exhibit A. Medical procedures not included in the Fee Schedule shown in Exhibit A will not be reimbursed.

ARTICLE VII – TERM

7.1 **Initial Term.** Initial Term Effective Date This Agreement shall become effective November 13, 2011, and shall continue in full force through the period ending December 31, 2013.

7.2 **Renewal Term.** The term of this Agreement shall automatically continue for an additional term of one year ("Renewal Term") following the expiration of the Initial Term or any Renewal Term, upon the same terms and conditions, unless the Agreement is terminated or amended.

7.3 **Termination.**

7.3.1 **Notification.** This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by providing written notice of termination to the other party at least sixty (60) days prior to the date ending the Term.

7.3.2 **Cure Provision.** If either party materially breaches this Agreement, the other party may terminate the Agreement provided that it notifies, in writing, the breaching party of the specific breach and allows the breaching party the opportunity to cure the breach within sixty (60) days of the date of the notice. If the breach has not been corrected in sixty (60) days, the Agreement may be terminated without further notice

ARTICLE VIII – MODIFICATIONS

8.1 **Modifications and Improvements.** Modifications and improvements in existing procedures and systems may be made by the Plan, in the reasonable exercise of its sole discretion, and subject to the restrictions and covenants contained within this Agreement, including, but not limited to, those related to all reimbursement provisions. Any such modifications and improvements, which would affect Provider's procedures, will be communicated to Provider by the Plan. The Plan may also make, in the reasonable exercise of its sole discretion, modifications in existing procedures and systems at the sole request of Provider; provided, however, that Provider shall in all events reimburse the Plan for all costs and expenses incurred by the Plan to make and effectuate modifications and improvements requested by Provider.

ARTICLE IX – LIABILITY

9.1 **Right to Reprocess.** In the event of any error or omission on the part of the Plan that is reasonably correctable by the reprocessing of information, the Plan will reprocess such information with the cooperation of Provider and

such successful reprocessing shall be in full satisfaction of all of Provider's claims with respect to the error or omission in question. The conclusion of such error or omission designation shall be a mutual conclusion on behalf of the Plan and Provider.

9.2 **Indemnification.**

9.2.1 **Indemnification of Provider.** The Plan agrees to indemnify and hold harmless Provider with respect to any and all claims, liabilities, losses, damages or expenses including reasonable attorney's fees caused by the Plan's negligence or willful misconduct in its administering and maintaining the Plan. However, this indemnification provision shall not apply to any claims, liabilities, losses, damages or expenses caused by any action or undertaking of Provider, its agents, servants or employees when acting outside the scope of their authority or in any negligent or criminal matter.

10 **Indemnification of the Plan.** Provider agrees to indemnify and hold harmless the Plan or any of its officers, or employees from any and all losses, liability, damages, expenses or other cost or obligation, resulting from or arising out of claims, demands, lawsuits or judgments brought against Provider in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plans, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with the Plan's negligence, willful misconduct, or criminal misconduct.

ARTICLE X – PROVIDER-PATIENT RELATIONSHIP

10.1 Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship.

ARTICLE XI – FORCE MAJEURE

11.1 Notwithstanding anything herein or otherwise which may appear to be to the contrary, neither party shall be responsible for delays or failures in performance under this Agreement resulting from any force majeure or acts beyond the reasonable control of the party. Such acts shall include, without limitation, acts of God, strikes, blackouts, riots, acts of war, epidemics, governmental regulations, fire, communication line failure, power failures, mechanical failures, storms or other disasters.

ARTICLE XII – NOTICES

12.1 Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or three (3) days after deposit in the United States Mail, postage prepaid, sent certified or registered, addressed as follows:

A. If to the Plan, to:
Perrine DuPont Settlement Claims Office
Spelter Volunteer Fire Department Office
55 B Street
PO BOX 257
Spelter, West Virginia 26438
Attention: Edgar C. Gentle, III, Esq.
Claims Administrator

B. If to Provider, to:
Monongahalia Valley Association of Health Clinics
1322 Locust Avenue
Fairmont, West Virginia, 26554
Attention: Lori Martino
Director of Information Technology

or to such other address or person as hereafter shall be designated in writing by the applicable party.

ARTICLE XIII – ENTIRE AGREEMENT

13.1 This Agreement and all exhibits and schedules hereto constitute the entire agreement between the parties hereto pertaining to the subject matters hereof and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings of the parties hereto in connection with the subject matters hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

ARTICLE XIV – NO WAIVER: MODIFICATIONS IN WRITING

14.1 No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy, preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available at law or in equity or otherwise. No amendment, modification, supplement, termination or waiver of or to any

provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and signed by or on behalf of the party subject to the enforcement thereof. Any amendment, modification or supplement of or to any provision of the Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provisions of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

ARTICLE XV – SEVERABILITY

15.1 In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and shall be enforced to that extent.

ARTICLE XVI – GOVERNING LAW

16.1 This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia. Additional governance regarding resolution of disputes is described in Article XXI.

ARTICLE XVII – RELATIONSHIP

17.1 Nothing contained in this Agreement and no action taken by the parties pursuant hereto shall be deemed to constitute the parties as a partnership, an association, a joint venture or other entity. It is expressly agreed that neither party for any purpose shall be deemed to be an agent, ostensible or apparent agent, employee, or servant of the other party.

ARTICLE XVIII – HEADINGS AND CAPTIONS

18.1 The titles or captions of sections and paragraphs in this Agreement are provided for convenience of reference only, and shall not be considered a part hereof for purposes of interpreting or applying this Agreement, and such titles or captions do not define, limit, extend, explain or describe the scope or extent of this Agreement or any of its terms or conditions.

ARTICLE XIX – BINDING EFFECT ON SUCCESSORS AND ASSIGNS

19.1 This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns. In the event of assignment, all of the terms, covenants and conditions of this Agreement shall remain in full force and effect and the party making the assignment shall remain liable and responsible for the due performance of all of the terms, covenants and conditions of this Agreement that it is obligated to observe and perform. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. However, neither the Provider nor the Plan may assign the rights and obligations provided hereunder without the prior written express permission of the other party. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, and in making proof hereof, it shall not be necessary to produce or account for more than one such counterpart.

ARTICLE XX – MISCELLANEOUS

20.1 **Changes in Laws**. If changes in the laws materially affect a party's rights and obligations under this Agreement or render any portion illegal or unenforceable, then the parties agree to negotiate modifications to the terms of this Agreement in good faith. If the parties cannot agree to modify terms that comply with the changes in laws, then either party may terminate this Agreement upon thirty (30) days prior written notice.

20.2 **Court Order Approving Provider as Medical Provider for the Perrine Medical Monitoring Plan and Disclosure of Potential Conflict.** On August 31, 2011, the Circuit Court of Harrison County, West Virginia, entered the Final Order Approving Certain Aspects of Settlement Administration and Establishing Briefing Schedule for Preliminary Recommended or Unresolved Matters in the matter of Lenora Perrine, et al., v. E.I. DuPont DeNemours & Company, et al., Case No. 04-C-296-2. In said order, Provider, referred to as "Medbrook Medical Association", is listed as an approved medical provider for the Perrine Medical Monitoring plan. Both parties acknowledge that Dr. Nelson, the principal for Provider, testified on behalf of DuPont in the matter described hereinabove prior to the Settlement of said matter.

ARTICLE XXI – RESOLUTION OF DISPUTES

21.1 The Circuit Court in Harrison County, West Virginia retains continuous and exclusive jurisdiction and supervision over the Plan and over this Agreement. Any judicial proceeding arising out of or relating to this Agreement may be brought only before the Court, and any judgment against a Party may be enforced only by a proceeding before the Court. The Parties irrevocably submit to the jurisdiction of the Court over any such proceeding. The Parties irrevocably waive any objection that they might now or hereafter have to the laying of venue for such proceeding in the Court and any claim that any such proceeding in the Court has been brought in an inconvenient forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

The undersigned certifies that he or she has legal authority to bind the Plan.

The Perrine Medical Monitoring Plan

By: Edgar C. Gentle, III, Esq.

Title: Claims Administrator

Date: 12/12/11

The undersigned certifies that he or she has legal authority to bind Provider.

Monongahela Valley Association of Health Centers, Inc.

By: [signature]

Title: PRESIDENT

Date: 12/12/2011

EXHIBIT "A" FEE SCHEDULE

Effective November 1, 2011

Anticipated Procedures and Allowable Fees

Initial Testing Visit	Procedure Code	Description	Billing Information	Allowable Fee
Primary Care Physician	99201 - or - 99211	10 Minute OFFICE VISIT OP NEW 5 Minute OFFICE VISIT OP ESTABLISHED	Use this code for Initial visit with Perrine Medical Monitoring Plan patient. Do not use for retests.	$60.00
	99000	SPECIMEN HANDLING (age 16 and above)	Use this code for subsequent biennial tests. Do not use for retests. Use this code for conveyance of specimen to LabCorp.	$32.00 $12.00
	36415	ROUTINE VENIPUNCTURE	Use this code for collection of blood by venipuncture & conveyance to LabCorp.	$10.00
	———	STOOL SAMPLE CARD (age 18 & above)	Provide stool sample card to adult patients to be returned to LabCorp by mail. Do not bill for this service.	
	———	MEDICARE QUESTIONNAIRE FORM (age 65 & above, disabled, or otherwise Medicare eligible)	Patient to complete. Send to Spelter Claim office. Do not bill for this service.	
	———	AUTHORIZATION TO MAINTAIN TEST RESULTS	Patient to complete. Send to Spelter Claim office. Do not bill for this service.	
	81001	URINALYSIS, NONAUTO W/SCOPE	All Laboratory tests must be performed by LabCorp with test results sent to Primary Care Physician and to CTI Administrators via HL7 EDI format.	LabCorp
	88112	CYTOPATHOLOGY		LabCorp
	82274	OCCULT BLOOD, by FECAL HEMOGLOBIN		LabCorp
	82232	ASSAY OF BETA-2 PROTEIN		LabCorp
	82565	ASSAY OF CREATININE		LabCorp
	84520	ASSAY OF UREA NITROGEN		LabCorp
	83655	ASSAY OF LEAD		LabCorp

Follow-up Consultation	Procedure Code	Description		Allowable Fee
Primary Care Physician	99243	40 Minute OFFICE VISIT OP NEW, Physical Exam, review of tests, referrals if medically necessary.	Use this code for Initial consultation with Perrine Medical Monitoring Plan patient. Physicians should use their best medical judgment when providing services to participants in the Plan. General guidelines: if there is blood on the UA or positive cytology refer to Urologist, if there is Beta-2-microglobulin or BUN/Creatinine elevated refer to Nephrologist. If there is a Child with greater than 10ug/dl of lead or adult with greater than 30ug/dl lead refer to a Medical Toxicologist. If there is a child lead level above 5ug/dl or an adult lead level above 20ug/dl refer for Neuropsychiatric evaluation. If stool quaic test is positive for blood refer to a Gastroenterologist. Physical should include head to toe review for skin lesions. If suspicious skin lesion is noted refer to Dermatologist. If medically indicated, recommend a CT scan and if positive to refer to a Pulmonologist or Cardiothoracic Surgeon. For referrals, see list of specialists authorized for payment by Plan.	$170.00
	- or - 99242	30 Minute OFFICE VISIT OP NEW, Physical Exam, review of tests, referrals if medically necessary.	Use this code for Subsequent biennial consultations with Plan patient.	$135.00

Skin Test with Dermatologist	Procedure Code	Description		Allowable Fee
Dermatologist	99242	Consultation with Dermatologist	At the discretion of the Primary Care Physician, some patients may be referred to a Dermatologist for a Skin Test. Use this code for consultation with Dermatologist.	$140.00
	11100	BIOPSY, SKIN LESION	Use this code for Biopsy. Send to LabCorp with instructions to send test results via EDI to Physicians & to CTIA.	$110.00
	88304	TISSUE EXAM BY PATHOLOGIST	All Laboratory tests must be performed by LabCorp with test results sent to Primary Care Physician and to CTI Administrators via HL7 EDI format.	LabCorp

Consultation with Urologist	Procedure Code	Description		Allowable Fee
Urologist	99242	Consultation with Urologist (2 consultations expected)	At the discretion of the Primary Care Physician, some patients may be referred to a Urologist for additional tests. Use this code for consultation with Urologist.	$140.00
	52000	CYSTOSCOPY WITH BIOPSY	At the discretion of the Urologist, a Cystoscopy with biopsy may be recommended. Use this code for a Cytopathology with Biopsy.	$370.00
Anesthesiologist	00910	ANESTH, BLADDER SURGERY (3base @$70 + time)	Use this code for Anesthesiologist.	$350.00
	OP Facility	Out Patient Facility Charge		$850.00
	88305	Level IV SURGICALPATHOLOGY,GROSS &MICROSCOPIC EXAMINATION	All Laboratory tests must be performed by LabCorp with test results sent to Urologist and to CTI Administrators via HL7 EDI format.	LabCorp
	81001	URINALYSIS, NONAUTO W/SCOPE		LabCorp
Imaging Facility	74176 or 74150	CT Scan Abdomen & Pelvis or CT Scan Abdomen	At the discretion of the Urologist, some patients may be recommended to have a CT Scan of the Abdomen & Pelvis or CT Scan of the Abdomen . Use one of these codes for CT Scan; fee is the same.	$475.00
Radiologist	74176.26 or 74150.26	Professional Component	Use one of these codes for evaluating CT Scan.	$200.00
	OP Facility	Out Patient Facility Charge		$850.00

Consultation with Nephrologist	Procedure Code	Description		Allowable Fee
Nephrologist	99242	Consultation with Nephrologist. Two consultations are expected. A blood and Urine test are recommended.	At the discretion of the Primary Care Physician or the Urologist, some Adults testing positive to the Urinary system tests will require follow-up with a Nephrologist to test for kidney failure. Use this code for consultation with Nephrologist.	$140.00
	99000	SPECIMEN HANDLING	Use this code for conveyance of specimen to LabCorp.	$12.00
	36415	ROUTINE VENIPUNCTURE	Use this code for collection of blood by venipuncture & conveyance to LabCorp.	$10.00
	81001	URINALYSIS, NONAUTO W/SCOPE	All Laboratory tests must be performed by LabCorp with test results sent to Urologist and to CTI Administrators via HL7 EDI format.	LabCorp
	84520	ASSAY OF UREA NITROGEN		LabCorp
	82565	ASSAY OF CREATININE		LabCorp
	82947	GLUCOSE QUANTATIVE, BLOOD (except reagent strip)		LabCorp
	85652	SEDIMENTATION RATE, ERYTHROCYTE; AUTOMATED		LabCorp

Consultation with Gastroenterologist	Procedure Code	Description		Allowable Fee
Gastroenterologist	99242	Consultation with Gastroenterologist (Two consultations expected)	At the discretion of the Primary Care Physician, some Adults testing positive to the stool sample tests will require follow-up with a Gastroenterologist & require another stool sample test. Use this code for consultation with Gastroenterologist.	$140.00
	82274	OCCULT BLOOD, BY FECAL HEMOGLOBIN	All Laboratory tests must be performed by LabCorp with test results sent to Primary Care Physician and to CTI Administrators via HL7 EDI format.	LabCorp
Gastroenterologist	99242	Consultation with Gastroenterologist. Each patient shall receive an Upper GI Endoscopy and a stool sample test.	At the discretion of the Primary Care Physician or Gastroenterologist, some Adults testing positive to the stool sample tests will require additional consultations with a Gastroenterologist and may require another stool sample test. Use this code for consultation with Gastroenterologist.	$160.00
	82274	OCCULT BLOOD, FECES	All Laboratory tests must be performed by LabCorp with test results sent to Primary Care Physician and to CTI Administrators via HL7 EDI format.	LabCorp
	88305	Level IV SURGICALPATHOLOGY,GROSS &MICROSCOPIC EXAMINATION		LabCorp
	43239	UPPER GI ENDOSCOPY, BIOPSY	Use this code for the Upper GI Endoscopy.	$650.00
	99143	Moderate Sedation Services		$150.00
	OP Facility	Out Patient Facility Charge		$850.00

Consultation with Toxicologist & Psychologist	Procedure Code	Description		Allowable Fee
Toxicologist	99242	Consultation with Toxicologist. Each patient will require a complete blood count, lead & zinc test.	At the discretion of the Primary Care Physician , some Adults testing positive to the lead blood tests will require up to four (4) consultations with a Toxicologist. Use this code for consultation with Toxicologist.	$140.00
	36415	ROUTINE VENIPUNCTURE	Use this code for collection of blood by venipuncture & conveyance to LabCorp.	$10.00
	85025	COMPLETE CBC W/AUTO DIFF WBC	All Laboratory tests must be performed by LabCorp with test results sent to Primary Care Physician and to CTI Administrators via HL7 EDI format.	LabCorp
	84202	ASSAY RBC PROTOPORPHYRIN		LabCorp
	83655	ASSAY OF LEAD		LabCorp
Psychologist	96118	NEUROPSYCH TST BY PSYCH/PHYS	At the discretion of the Primary Care Physician or the Toxicologist, up to four (4) one hour tests with a Psychologist may be required.	$225.00

Adult CT Scans	Procedure Code	Description		Allowable Fee
Imaging Facility	71250	CT THORAX W/O DYE (repeat may be necessary)	At the discretion of the Primary Care Physician , some Adults may be recommended to have a CT Scan. Use these codes for CT Scan.	$300.00
Pulmonologist	71250.26	CT THORAX W/O DYE		
	99242	Consultation with Pulmonologist	At the discretion of the Primary Care Physician and a Pulmonologist , some Adults may be referred to a Cardiothoracic Surgeon. Use this codes for Pulmonologist.	$100.00 $140.00
Cardiothoracic Surgeon	99242	Consultation with Cardiothoracic Surgeon	At the discretion of the Primary Care Physician, Pulmonologist, and/or Cardiothoracic Surgeon, some Adults may be recommended for a lung biopsy. Use this codes for Cardiothoracic Surgeon.	$130.00
	32095 or	BIOPSY THROUGH CHEST WALL	Use one of these codes for Lung biopsy and retests as necessary.	$380.00
	32405 or	BIOPSY LUNG, PERCUTANEOUS NEEDLE		$380.00
	31628	BRONCHOSCOPY		$710.00
Anesthesiologist	OP Facility	Out Patient Facility Charge		$850.00
	00910	ANESTH, (3base @$70 + time)	Use this code for Anesthesiologist.	$350.00

ADDENDUM F

Recommended Game Plan for Processing Out-of-Area Participants

There are approximately 220 (three under age 18) participants that live more than 50 miles from Spelter West Virginia. We have not tried to schedule these participants with the contracted Primary Care Physicians at this time. Following is CTIA's recommendation for processing the out-of-area participants. Recommendations are for adults. We will address children after we agree on adults.

Step 1. Initial Letter to Participants to be mailed after vetting with the Finance Committee

- Letter would be to participants on Perrine letterhead, carrier envelope, & return envelope.
- These persons have already received ID cards.
- Letter would explain:
  - Purpose of biennial testing plan;
  - Testing Protocols;
  - Cost to Participants;
  - Three forms for participants to complete and return:
    - Medicare Questionnaire
    - Authorization to Retain De-identified Test Results for Research Purposes
    - Name, address, & phone number of their Primary Care Physician

Step 2. Receipt of responses from participants

- CTIA would receive responses, scan forms & send originals to Mike Jacks
- Send follow-up letter to participants that don't respond

Step 3. Contacting Primary Care Physician starting January 20th

- CTIA would look-up to see if PCP participates in NPPN, Multiplan, or Healthsmart HPO
- CTIA would call PCP. Conversation would cover:
  - Explanation of Plan & Anticipated Protocols;
  - Explanation of PCP role;
  - CTIA to send follow-up letter thanking them for participating &, if not in network, asking for normal billing fees for five procedure codes.
    - If fees out-of-line, will try to negotiate; or
    - find another PCP for the participant
    - letter will explain no deductibles & no co-pays
    - letter will include "how plan works" brochure
    - letter will include Provider Orientation Package previously vetted with the Finance Committee
    - letter will ask about using LabCorp

Step 4. Receipt of responses from PCPs

- CTIA to review responses from PCP
  - If fees out-of-line, will try to negotiate; or
  - find another PCP for the participant
- Send follow-up letter to PCPs that don't respond
- Send confirmation letter (fees) to those that respond
- Prepare list of PCP's normal charge vs. budget assumptions

Step 5. Scheduling Appointments starting January 25th

- CTIA would send letter to participant suggesting that they schedule appointment with their PCP ASAP (or with other PCP, if deemed necessary by CTIA)
  - Letter would include packet to give to PCP,
    - Packet would explain tests required
    - Use of LabCorp or alternative labs
    - Need for test results
    - How to refer specialists (call CTIA)
    - Billing instructions

ADDENDUM G

PERRINE DUPONT MEDICAL MONITORING PLAN
RECOMENDED SPECIALIST LIST 12/7/2011

Specialty	Name	Address	City	St	Zip	Phone
Anesthesiology	DOMBKOSKI, FRANK	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-3100
Anesthesiology	DOMBKOSKI, FRANK	301 THREE HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Anesthesiology	FOLIO, JOSEPH	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-3100
Anesthesiology	FOLIO, JOSEPH	301 THREE HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Anesthesiology	KESSEL, JAMES	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-3100
Anesthesiology	KESSEL, JAMES	301 THREE HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2213
Anesthesiology	LOPEZ, AMANTE	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-3100
Anesthesiology	LOPEZ, AMANTE	301 THREE HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Anesthesiology	LOPEZ, AMANTE	3 HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Anesthesiology	MILLER, MELISSA	3 HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Anesthesiology	WALKER, THOMAS	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-3100
Anesthesiology	WALKER, THOMAS	3 HOSPITAL PLZ	Clarksburg	WV	26301	304-624-2217
Dermatology	CARLISLE, DAVID	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	DODSON, JEFFREY	RR 2 BX333D	Clarksburg	WV	26301	304-709-7000
Dermatology	DODSON, JEFFREY	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	FRANZ, CHARLES	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	HANCOX, JOHN	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	HANCOX, JOHN	RT 2 BOX 353 D	Clarksburg	WV	26301	304-709-7000
Dermatology	HARRIS, JEFFREY	164 THOMPSON DR	Bridgeport	WV	26330	304-842-3494
Dermatology	HROVATH, DAYNA	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	JACKSON, JEFFREY	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	LOUDEN, BARRETT	120 MEDICAL PARK DR	Bridgeport	WV	26330	--
Dermatology	LOUDEN, BARRETT	399 EMILY DR	Clarksburg	WV	26301	304-485-4885
Dermatology	MATHIAS, MEGAN	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	NORTON, AMY	RR 2 BX333D	Clarksburg	WV	26301	304-709-7000
Dermatology	NORTON, AMY	399 EMILY DR	Clarksburg	WV	26301	304-624-7200
Dermatology	PALMER, LOUIS CURROLL	105 Doctors Drive	Bridgeport	WV	26330	304-842-5210
Dermatology	SAOUD, ALAN	164 THOMPSON DR	Bridgeport	WV	26330	304-842-2273
Dermatology	SCOTT, FRED	164 THOMPSON DR	Bridgeport	WV	26330	304-842-3494
Gastroenterology	MAILLOUX, RICHARD	300 DAVISSON RUN RD	Clarksburg	WV	26301	304-326-3870
Gastroenterology	MEDINA, TEODORO	2 CHENOWETH DR STE A	Bridgeport	WV	26330	304-842-5449
Gastroenterology	MEDINA, TEODORO	100 HOLYMAN DR	Bridgeport	WV	26330	304-364-5156
Gastroenterology	PICKHOLTZ, PAUL	300 DAVISSON RUN RD STE 302	Clarksburg	WV	26301	304-623-5711

PERRINE DUPONT MEDICAL MONITORING PLAN
RECOMENDED SPECIALIST LIST 12/7/2011

Gastroenterology	PICKHOLTZ, PAUL	200 ROUTE 98 W ST STE 107	Clarksburg	WV	26301	304-623-5711
Nephrology	DEMARCO, JAMES	327 MEDICAL PARK DR	Bridgeport	WV	26330	681-342-1000
Nephrology	DEMARCO, JAMES	4 HOSPITAL PLZ STE 205	Clarksburg	WV	26301	304-622-5196
Nephrology	GUIRGUIS, NABIL GABALLA	166 THOMPSON DR	Bridgeport	WV	26330	304-842-6001
Nephrology	KHAN, ALI	200 ROUTE 98 W ST STE 107	Clarksburg	WV	26301	304-623-5711
Psychology	COLVIN, DAVID	1160 JOHNSON AVE STE 105	Bridgeport	WV	26330	304-842-9084
Psychology	GARCIA, ANGELA	RR 2, BOX 233	Mount Clare	WV	26408	304-622-6404
Psychology	GOODYKOONTZ, TONI	1514 BUCKHANNON PIKE	Clarksburg	WV	26301	304-622-8511
Psychology	KOJSZA, DENNIS	6 HOSPITAL PLZ	Clarksburg	WV	26301	304-623-5661
Psychology	LEVIN, MARTIN	168 West Main Street	Clarksburg	WV	26301	304-624-5945
Psychology	MCCLURE, SIMON	1160 JOHNSON AVE STE 105	Bridgeport	WV	26330	304-842-9084
Psychology	NUGENT, DANA	STE 6 HOSPITAL PLZ	Clarksburg	WV	26301	304-623-5661
Psychology	SALMAN, MUHAMMAD	200 ROUTE 98 W ST STE 310	Clarksburg	WV	26301	304-624-0980
Psychology	SIAS, WALTER	RR 2 BX233	Mount Clare	WV	26408	304-622-6404
PULMONARY DISEASE	AHMED, JAMIL	527 MEDICAL PARK DR STE 102	Bridgeport	WV	26330	304-933-3816
PULMONARY DISEASE	RAJJOUB, SALAM H	300 DAVISSON RUN RD STE 303A	Clarksburg	WV	26301	304-326-5864
RADIOLOGY	BLOM, PAUL	1 AMALIA DR ST JOSEPH'S HOSPITAL	BUCKHANNON	WV	26201	304-522-1550
RADIOLOGY	BUCKHANNON MEDICAL CARE	11 N LOCUST ST	BUCKHANNON	WV	26201	304-472-1600
RADIOLOGY	CUNANAN, ROBERTO	10 AMALIA DR	BUCKHANNON	WV	26201	304-473-2200
RADIOLOGY	CUNANAN, ROBERTO	1322 LOCUST AVE	FAIRMONT	WV	26554	304-366-0700
RADIOLOGY	CUNANAN, ROBERTO	1 COLUMBIA RD	SHINNSTON	WV	26431	304-592-1040
RADIOLOGY	KEADLE, DAVID	1 AMALIA DR ST JOSEPH'S HOSPITAL	BUCKHANNON	WV	26201	304-522-1550
RADIOLOGY	LEONARD, ERIC	1 AMALIA DR ST JOSEPH'S HOSPITAL	BUCKHANNON	WV	26201	304-522-1550
RADIOLOGY	PERSON, RICHARD	2 HARTMAN PLZ	BUCKHANNON	WV	26201	866-338-6463
RADIOLOGY	PERSON, RICHARD	700 VILLAGE DR	FAIRMONT	WV	26554	304-366-2600
RADIOLOGY	PERSON, RICHARD	48 VIP WAY	FAIRMONT	WV	26554	866-338-6463
RADIOLOGY	STEWART, JASON	2 HARTMAN PLZ	BUCKHANNON	WV	26201	866-388-6463
RADIOLOGY	STEWART, JASON	700 VILLAGE DR	FAIRMONT	WV	26554	304-366-2600
RADIOLOGY	STEWART, JASON	48 VIP WAY	FAIRMONT	WV	26554	866-338-6463
RADIOLOGY	TAN, WILSON	230 HOSPITAL PLZ	WESTON	WV	26452	304-269-8000

PERRINE DUPONT MEDICAL MONITORING PLAN
RECOMENDED SPECIALIST LIST 12/7/2011

SURGERY-CARDIOTHORACIC	KAY, JOHN	2115 CHADUNI ST	WHEELING	WV	26003 403-233-5937
SURGERY-CARDIOTHORACIC	MAHER, THOMAS	2416 PENNSYLVANIA AVE	WEIRTON	WV	26062 304-723-0352
SURGERY-CARDIOTHORACIC	PARK, CHONG	2416 PENNSYLVANIA AVE	WEIRTON	WV	26062 304-723-0352
SURGERY-CARDIOTHORACIC	PARK, KYUNG	2416 PENNSYLVANIA AVE	WEIRTON	WV	26062 304-723-0352
SURGERY-CARDIOTHORACIC	PARK, SANG	2416 PENNSYLVANIA AVE	WEIRTON	WV	26062 304-723-0352
SURGERY-CARDIOTHORACIC	SAN PABLO, WILLIAM	205 S MAIN ST	ELKINS	WV	26241 304-637-4004
SURGERY-CARDIOTHORACIC	SAN PABLO, WILLIAM	112 N WOODS ST	PHILIPPI	WV	26416 304-457-1306
SURGERY-CARDIOTHORACIC	SHACKELFORD, HOWARD	2115 CHAPLINE ST STE 108	WHEELING	WV	26003 304-233-5937
SURGERY-CARDIOTHORACIC	SHACKELFORD, HOWARD	2115 CHAPLINE ST	WHEELING	WV	26003 304-243-3070
SURGERY-CARDIOTHORACIC	SHAH, SAMIR	300 DAVISSON RUN RD STE 303A	Clarksburg	WV	26301 304-622-3300
THORACIC SURGER	MOSSALLATI, SAAD	527 MEDICAL PARK DR #204	Bridgeport	WV	26330 304-933-3800
Urology	BYRNE, RICHARD	9 CHENOWETH DR # B	Bridgeport	WV	26330 304-848-0844
Urology	DEMBY, ALAN	300 DAVISSON RUN RD STE 307	Clarksburg	WV	26301
Urology	FRANKLIN JR, GRANT	135 PROFESSIONAL PL	Bridgeport	WV	26330 681-342-3660
Urology	FRANKLIN, GRANT	527 MEDICAL PARK DR STE 304	Bridgeport	WV	26330 681-342-3595
Urology	HOFFMAN, MANDOLIN	527 MEDICAL PARK DR STE 304	Bridgeport	WV	26330 681-342-3595
Urology	HOFFMAN, MANDOLIN	135 PROFESSIONAL PL	Bridgeport	WV	26330 681-342-3660
Urology	TUONG, WILLIAM	527 MEDICAL PARK DR STE 202A	Bridgeport	WV	26330 681-342-3595
Urology	TUONG, WILLIAM	135 PROFESSIONAL PL	Bridgeport	WV	26330 681-342-3660

ADDENDUM H

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of December29th, 2011 by and between The Perrine Medical Monitoring Plan(the Plan) and **United Hospital Center**, a West Virginia corporation ("Provider").

RECITALS

WHEREAS, Provider is either (i) an individual health care provider or (ii) a professional corporation, medical corporation, or other entity duly organized and existing under and pursuant to the laws of the state in which it is formed, in either case that is duly licensed and authorized to deliver health care services in the state of West Virginia, or that have employees who are.

WHEREAS, the Plan desires (i) to obtain a network of health care providers for the Plan and (ii) to engage Provider to furnish such services; and

WHEREAS, Provider desires to be engaged by the Plan to furnish such services and shall furnish such services in accordance with the terms of this Agreement, specifically with the provision of low dose CT Scans and toxicology services.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I - DEFINITIONS

1.1 **Benefits.** "Benefits" means Medical testing, consultations, and surgeries as defined by the Plan.

1.2 **Claim Clearing House.**"Claim Clearing House" means an organization that receives claims in an electronic format and forwards claims to Insurance Carriers, Third Party Administrators, and/or PPO Networks.

1.3 **Confidential Information.**"Confidential Information" means information of the Plan and Provider that shall be subject to patent, copyright, trademark, trade name or service mark protection, or not otherwise in the public domain and related to the business and operations of the Plan or Provider, including, without limitation, this Agreement and the Exhibits hereto, eligibility data, manuals, software, information relating to financial status of the Plans, and medical records of Participants in control and possession of Provider.

1.4 **Covered Services.**"Covered Services" means the procedures identified in the Fee Schedule subject to the Benefit limitations specified by the Plans.

1.5 **Fee Schedule.** "Fee Schedule" means the allowable fees paid for services provided for specific Clinical Procedure Codes as set forth in EXHIBIT A.

1.6 **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.7 **Informational Packet for Physicians and Health Care Provider.** "Provider Orientation Packet" means a packet of information about the Medical Monitoring Program.

1.8 ***Medically Necessary.*** "Medically Necessary" or "Medical Necessity" means services or supplies which, under the provision of this Agreement are determined to be (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury or disease; (ii) provided for the diagnosis or direct care and treatment of the injury or disease or preventative services as provided in the Plans; (iv) within good medical practice within the organized medical community; (vi) an appropriate supply or level of service needed to provide safe and adequate care; and (vii) provided in a setting consistent with the required level of care.

1.9 **Participant.** "Participant" means any person who has satisfied the eligibility requirements of the Plan.

1.10 **PHI.** "PHI" means Protected Health Information, including, but not limited to, Individually Identifiable Health Information as defined by HIPAA.

1.11 **Payment.** "Payment" means the actual value made to or on behalf of the Participants for benefits described in the Plan.

1.12 **Plan.** "Plan" means the Perrine Medical Monitoring Plan.

1.13 **Third Party Administrator. Third Party Administrator (hereinafter** "TPA") means CTI Administrators, Inc., (hereinafter "CTIA"), 100 Court Avenue, Des Moines, IA 50309. CTIA has contracted with the Plan to perform administrative services including, but not limited to, maintenance of participant eligibility, interface with providers, determination of allowable fees, claim payments, communication with Participants and providers and maintenance of test results.

ARTICLE II - OBLIGATIONS OF THE PLAN

2.1 **Information.** The Plan shall make available current information regarding Participants and Plan Benefits to Provider via encrypted or otherwise properly secured internet or other electronic media. The Plan shall make available to Participants information regarding Plan Benefits.

2.2 **Liability for Claims Decisions.**

2.2.1 The Plan shall not be responsible for payment of claims submitted for services that are not covered by the Plan or to persons that are not eligible Participants.

ARTICLE III – SERVICES AND OBLIGATIONS OF PROVIDER

3.1 Provider Shall:

3.1.1 provide physicians and other health care providers with a Provider Information Packet supplied by the Plan;

3.1.2 provide Covered Services to eligible Participants for which Provider is qualified and which Provider customarily furnishes to the general public from the office location indicated on the signature page, solely with regard to the provision of low dose CT Scans;

3.1.3 follow the biennial Medical Monitoring CT Scan utilization protocols and the CT Scan guidelines as set forth by the Plan, as provided for in Exhibit A to this Agreement, and modified from time to time (which shall be provided to Provider in writing);

3.1.4 obtain a Patient Consent Authorization for CT Scans after explaining benefits and risks as part of the biennial testing protocols and physical examination with copies to the TPA. Specifically, the recommending Perrine Medical Monitoring Plan approved physician has secured the CT Scan Verification form, as provided for in Exhibit C to this Agreement, and a copy of said CT Scan Verification form shall be secured by the Provider prior to the provision of a CT Scan to a claimant pursuant to the Court's Order of October 21, 2011, which is enclosed hereto as Exhibit D. The provider shall be responsible for providing the eligible Participant who has been referred by a Perrine Medical Monitoring Plan approved physician with the Provider's standard Consent Authorization for CT Scans, which, at a minimum, must explain the benefits and risks of participating in a CT Scan.

3.1.5 provide reimbursable toxicology services to the Patient where recommended by a Perrine Medical Monitoring Plan approved physician pursuant to the Fee Schedule as provided in Exhibit A.

3.1.6 perform Covered Services pursuant to the applicable standards of care and;

3.1.7 (i) obtain from eligible Participant necessary authorization and confidentiality release forms, including without limitation, written assignment of benefits and an appropriate release to bill the Plan directly for Covered Services furnished by Provider; (ii) bill the Plan directly via electronic transmission of necessary claim data within 60 days of rendering services; (iii) accept as payment in full for Covered Services rendered the reimbursement amount specified in the Fee Schedule shown in EXHIBIT A; and (iv) cooperate and comply with the billing and other procedures established by the Plan.

3.1.8 within ten (10) days of occurrence, notify the Plan and provide the Plan with all information with respect to any disciplinary or malpractice actions or judgments against or settlements by Provider related to providing care under this Agreement, and then, this information shall be considered and treated as Confidential Information;

3.1.9 treat Participants in all respects no less favorably than Provider treats all other patients. Provider shall not unlawfully discriminate against Participant based upon race, religion, national origin, color, sex, marital status, age, health status, disability, or source of payment. Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of the Plan, or their respective designees, to intervene in any manner with, nor shall it render them responsible for, the provision of Provider services or care to Participants;

3.1.10 submit analysis and test results to the participant, the servicing provider, and to TPA;

3.1.11 ensure that only CTIA is billed for the provision of CT Scan services as provided for in the Plan, and that no other parties are billed, including, but not limited to, private insurers, Medicare, and/or Medicaid.

3.2 **Provider Insurance.** Provider shall maintain during the term of this Agreement, at Provider's expense, general and professional liability insurance with companies reasonably acceptable to the Plan or, at Provider's sole option, through a bona fide program of self-insurance, with annual limits of coverage not less than $1 million per occurrence and $3 million in the annual aggregate. Upon request, Provider shall provide the Plan with evidence of such insurance. Provider shall provide the Plan with prior notification of any cancellation, non-renewal or other material change in such insurance.

ARTICLE IV – CONFIDENTIAL INFORMATION

4.1 **Legal Restrictions.** Neither party hereto shall be in default for failure to supply information which such party, in good faith, believes cannot be supplied due to prevailing law, or for supplying information which such party, in good faith, believes is required to be supplied due to prevailing law.

4.2 **Non-Disclosure of Confidential Information.** Provider and the respective officers, directors, employees, agents, members, and assigns shall hold any and all Confidential Information in the strictest confidence as a fiduciary, and shall not, voluntarily or involuntarily, use, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information without the express written permission of the Plan.

The foregoing obligation shall not apply to any information of the following.

- Information that is currently or becomes part of the public domain through a source other than the parties;
- Information which is subsequently learned from a third party that does not impose an obligation of confidentiality;
- Information that was known to a party prior to this Agreement; and
- Information required to be disclosed by law, subpoena or other legal process after reasonable notice, if reasonably possible, is given to the other party.

ARTICLE V – NEW OR ADDITIONAL SERVICES

5.1 Services. The Plan and Provider may from time to time mutually agree to add new or additional services to those then set forth in Exhibit A, and to amend the allowed fees specified in Exhibit A. The Plan and Provider shall evidence their agreement as to any new or additional services or as to any new Types of Services and Fees by means of a new Exhibit A or by an addendum to Exhibit A, of this Agreement, in either event evidenced by a writing which shall be executed by both the Plan and Provider.

ARTICLE VI – METHOD OF PAYMENT

6.1 Frequency of Payment. The Plan agrees that the payment for Covered Services provided to Participants will be sent to the Provider within five days after the last day of each business week for services incurred and submitted to the Plan for reimbursement during said week.

6.2 Amount of Payment. The Plan will reimburse Provider for Covered Services to Participants according to the Fee Schedule shown in Exhibit A. Medical procedures not included in the Fee Schedule shown in Exhibit A will not be reimbursed.

ARTICLE VII – TERM

7.1 Initial Term. Initial Term Effective Date This Agreement shall become effective December 31, 2011, and shall continue in full force through the period ending December 31, 2013.

7.2 Renewal Term. The term of this Agreement shall automatically continue for an additional term of one year ("Renewal Term") following the expiration of the Initial Term or any Renewal Term, upon the same terms and conditions, unless the Agreement is terminated or amended.

7.3 Termination.

7.3.1 Notification. This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by providing written notice of termination to the other party at least sixty (60) days prior to the date ending the Term.

7.3.2 Cure Provision. If either party materially breaches this Agreement, the other party may terminate the Agreement provided that it notifies, in writing, the breaching party of the specific breach and allows the breaching party the opportunity to cure the breach within sixty (60) days of the date of the notice. If the breach has not been corrected in sixty (60) days, the Agreement may be terminated without further notice

ARTICLE VIII – MODIFICATIONS

8.1 **Modifications and Improvements.** Modifications and improvements in existing procedures and systems may be made by the Plan, in the reasonable exercise of its sole discretion, and subject to the restrictions and covenants contained within this Agreement, including, but not limited to, those related to all reimbursement provisions. Any such modifications and improvements, which would affect Provider's procedures, will be communicated to Provider by the Plan. The Plan may also make, in the reasonable exercise of its sole discretion, modifications in existing procedures and systems at the sole request of Provider; provided, however, that Provider shall in all events reimburse the Plan for all costs and expenses incurred by the Plan to make and effectuate modifications and improvements requested by Provider.

ARTICLE IX – LIABILITY

9.1 **Right to Reprocess.** In the event of any error or omission on the part of the Plan that is reasonably correctable by the reprocessing of information, the Plan will reprocess such information with the cooperation of Provider and such successful reprocessing shall be in full satisfaction of all of Provider's claims with respect to the error or omission in question. The conclusion of such error or omission designation shall be a mutual conclusion on behalf of the Plan and Provider.

9.2 **Indemnification.**

9.3 **Indemnification of Provider.** The Plan agrees to indemnify and hold harmless Provider with respect to any and all claims, liabilities, losses, damages or expenses including reasonable attorney's fees caused by the Plan's negligence or willful misconduct in its administering and maintaining the Plan. However, this indemnification provision shall not apply to any claims, liabilities, losses, damages or expenses caused by any action or undertaking of Provider, its agents, servants or employees when acting outside the scope of their authority or in any negligent or criminal matter.

9.4 **Indemnification of the Plan.** Provider agrees to indemnify and hold harmless the Plan or any of its officers, or employees from any and all losses, liability, damages, expenses or other cost or obligation, resulting from or arising out of claims, demands, lawsuits or judgments brought against Provider in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plans, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with the Plan's negligence, willful misconduct, or criminal misconduct.

ARTICLE X – PROVIDER-PATIENT RELATIONSHIP

10.1 Nothing contained in this Agreement shall interfere with or in any way alter any provider-patient relationship.

ARTICLE XI – FORCE MAJEURE

11.1 Notwithstanding anything herein or otherwise which may appear to be to the contrary, neither party shall be responsible for delays or failures in performance under this Agreement resulting from any force majeure or acts beyond the reasonable control of the party. Such acts shall include, without limitation, acts of God, strikes, blackouts, riots, acts of war, epidemics, governmental regulations, fire, communication line failure, power failures, mechanical failures, storms or other disasters.

ARTICLE XII – NOTICES

12.1 Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or three (3) days after deposit in the United States Mail, postage prepaid, sent certified or registered, addressed as follows:

A. If to the Plan, to:
Perrine DuPont Settlement Claims Office
Spelter Volunteer Fire Department Office
55 B Street
PO BOX 257
Spelter, West Virginia 26438
Attention: Edgar C. Gentle, III, Esq.
Claims Administrator and Special Master

B. If to Provider, to:
United Hospital Center
327 Medical Park Drive
Bridgeport, WV 26330
Attention: Bruce Carter
President and CEO

or to such other address or person as hereafter shall be designated in writing by the applicable party.

ARTICLE XIII – ENTIRE AGREEMENT

13.1 This Agreement and all exhibits and schedules hereto constitute the entire agreement between the parties hereto pertaining to the subject matters hereof and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings of the parties hereto in connection with the subject matters hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

ARTICLE XIV – NO WAIVER; MODIFICATIONS IN WRITING

14.1 No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy, preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available at law or in equity or otherwise. No amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and signed by or on behalf of the party subject to the enforcement thereof. Any amendment, modification or supplement of or to any provision of the Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provisions of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

ARTICLE XV – SEVERABILITY

15.1 In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and shall be enforced to that extent.

ARTICLE XVI – GOVERNING LAW

16.1 This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia. Additional governance regarding resolution of disputes is described in Article XXI.

ARTICLE XVII – RELATIONSHIP

17.1 Nothing contained in this Agreement and no action taken by the parties pursuant hereto shall be deemed to constitute the parties as a partnership, an association, a joint venture or other entity. It is expressly agreed that neither party for any purpose shall be deemed to be an agent, ostensible or apparent agent, employee, or servant of the other party.

ARTICLE XVIII – HEADINGS AND CAPTIONS

18.1 The titles or captions of sections and paragraphs in this Agreement are provided for convenience of reference only, and shall not be considered a part hereof for purposes of

interpreting or applying this Agreement, and such titles or captions do not define, limit, extend, explain or describe the scope or extent of this Agreement or any of its terms or conditions.

ARTICLE XIX – BINDING EFFECT ON SUCCESSORS AND ASSIGNS

19.1 This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns. In the event of assignment, all of the terms, covenants and conditions of this Agreement shall remain in full force and effect and the party making the assignment shall remain liable and responsible for the due performance of all of the terms, covenants and conditions of this Agreement that it is obligated to observe and perform. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. However, neither the Provider nor the Plan may assign the rights and obligations provided hereunder without the prior written express permission of the other party. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, and in making proof hereof, it shall not be necessary to produce or account for more than one such counterpart.

ARTICLE XX – MISCELLANEOUS

20.1 Changes in Laws. If changes in the laws materially affect a party's rights and obligations under this Agreement or render any portion illegal or unenforceable, then the parties agree to negotiate modifications to the terms of this Agreement in good faith. If the parties cannot agree to modify terms that comply with the changes in laws, then either party may terminate this Agreement upon thirty (30) days prior written notice.

ARTICLE XXI – RESOLUTION OF DISPUTES

21.1 The Circuit Court in Harrison County, West Virginia, retains continuous and exclusive jurisdiction and supervision over the Plan and over this Agreement. Any judicial proceeding arising out of or relating to this Agreement may be brought only before the Court, and any judgment against a Party may be enforced only by a proceeding before the Court. The Parties irrevocably and expressly submit to the jurisdiction of the Court over any such proceeding. The Parties irrevocably and expressly waive any objection that they might now or hereafter have to the laying of venue for such proceeding in the Court and any claim that any such proceeding in the Court has been brought in an inconvenient forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

The undersigned certifies that he or she has legal authority to bind the Plan.

The Perrine Medical Monitoring Plan

By: Edgar C. Gentle, III, Esq.

_____

Title: Claims Administrator

Date: _____

The undersigned certifies that he or she has legal authority to bind Provider.

United Hospital Center

By: _____

Title:

Date: _____

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees			
Procedure Code	**Description**	**Billing Information**	**Allowable Fee**
71250	CT THORAX W/O DYE (repeat may be necessary)	At the discretion of the Primary Care Physician, some adults may be recommended to have a CT Scan. Use these codes for CT Scan.	$300.00
71250.26	Professional Component		$100.00
74176 or 74150	CT Scan Abdomen & Pelvis or CT Scan Abdomen	At the discretion of the Urologist, some patients may be recommended to have a CT Scan of the Abdomen & Pelvis or CT Scan of the Abdomen. Use one of these codes for CT Scan;	$325.00
74176.26 or 74150.26	Professional Component		$100.00

EXHIBIT B
CT Scan Guidelines and Protocols

CT SCAN UTILIZATION PROTOCOLS

1. CT Scan eligible claimants are described in Dr. Brookshire's report.

2. At the initial medical monitoring testing visit, the attending physician will take the CT scan eligible claimant's vital signs and conduct a general health interview of the claimant.

3. After examining the claimant, the examining physician will make a determination on whether to recommend a CT scan for the claimant as being diagnostically medically necessary based on the CT Scan Utilization Guidelines to be developed by the Claims Administrator and to be ultimately determined by the Court.

4. The claimant can accept or decline the recommendation for a CT scan.

5. Prior to agreeing to a CT scan, a claimant will be told by the physician the benefits and risks of a CT scan.

6. Claimants agreeing to a CT scan shall sign a standard CT scan release.

CT SCAN GUIDELINES

In light of the above, the briefing of the parties, and the expert opinion of Dr. Watts, the below guidelines are recommended:

1. These rules shall be re-evaluated every two years based upon scientific developments in radiology, and following consultation with the Medical Advisory Committee.

2. CT Scan eligible Claimants are described in Dr. Brookshire's Report.

3. During the CT-Scan eligible Claimant's initial medical monitoring visit with the examining physician, the examining physician will:

   a. Take the Claimant's vital signs and reviewed the patient's blood and urine test results (results from skin exam, HEENT exam, peripheral motor function test, and the review of the Hemoccult cards);

   b. Conduct a general health interview which shall include the number of years the Claimant has lived in the Class Area in Exhibit 2, with greater weight being given to:
      i. Zone 1 Claimants who have lived in the Class Area for 2 years or more;
      ii. Zone 2 Claimants who have lived in Class Area for 6 years or more; and
      iii. Zone 3 Claimants who have lived in the Class Area of concern for 10 years or more);

   c. Review the Claimant's prior medical record (necessary to determine propensity for cancer); and

   d. Ensure that all female Claimants receive a pregnancy exam.

4. The Claimant will have paragraph C on page 2 of the Memorandum of Understanding in Exhibit A read to him or her by the examining physician or will be provided a copy to read.

5. The examining physician will ensure informed consent. Specifically, the examining physician will explain the nature of the radiological imaging, that the results may not be definitive, there may be false outcomes, and that there is a risk associated with radiological imaging and CT Scans specifically.

6. After a review of the Claimant's vital signs, general health interview, and prior medical history, the examining physician will, in his discretion, make a determination on whether to recommend a CT Scan for the Claimant as being medically necessary and relevant to possible exposure to heavy metals (cadmium, arsenic, lead or zinc) contamination (which will be documented by the examining physician with the execution of the Perrine Medical Monitoring Program CT Scan Physician Verification Form provided).

7. The lowest possible radiation dose consistent with acceptable diagnostic image quality should be used.

8. The care provider shall not bill Medicaid, Medicare and/or any other third party for the services outlined in these guidelines under any circumstances.

EXHIBIT C
CT Scan
Verification Form

PERRINE MEDICAL MONITORING PROGRAM
CT SCAN PHYSICIAN VERIFICATION FORM TO BE COMPLETED BY THE HEALTH CARE PROVIDER TO BE COMPLETED FOR EACH MEDICAL MONITORING CT SCAN ELIGIBLE PATIENT

I, a licensed physician, in good standing with the West Virginia Board of Medicine, do hereby certify the following:

1. I, a qualified healthcare professional, have personally examined _____ (name of claimant/patient), referred to below as the "patient," in accordance with the protocols in Exhibit 1.

2. In examining the patient, I have:

   a. Taken the patient's vital signs;

   b. Conducted a general health interview which shall include the number of years the patient has lived in the Class Area in Exhibit 2, with greater weight being given to:
      i. Zone 1 patients who have lived in the Class Area for 2 years or more;
      ii. Zone 2 patients who have lived in Class Area for 6 years or more; and
      iii. Zone 3 patients who have lived in the Class Area of concern for 10 years or more);

   c. Reviewed the patient's prior medical record (necessary to determine propensity for cancer); and

   d. Ensured that all female patients receive a pregnancy exam.

3. The patient had paragraph C on page 2 of the Memorandum of Understanding in Exhibit 3 read to him or her by me or was provided a copy to read.

4. As the examining physician, I have ensured informed consent by the patient. Specifically, as the examining physician, I explained the nature of the radiological imaging, that the results may not be definitive, there may be false outcomes, and that there is a risk associated with radiological imaging and CT Scans specifically.

5. After a consideration of my total exam, inclusive of all test results in Paragraph 2, including, but not limited to, a review of the patient's vital signs, the blood and urine test results, general health interview, and prior medical history, I, the examining physician, have, in my discretion, made a determination on whether to recommend a CT Scan for the patient as being medically necessary and relevant to possible exposure to heavy metals (cadmium, arsenic, lead or zinc) contamination.

MY RECOMMENDATION IS AS FOLLOWS (CHECK ONLY ONE):

☐ YES, I RECOMMEND A CT SCAN.

☐ NO, I DO NOT RECOMMEND A CT SCAN.

6. The decision to recommend a CT Scan or not to recommend a CT Scan rests with me, the examining qualified healthcare professional.

7. As the health care provider, I shall not bill Medicaid, Medicare and/or any other third party for the services outlined in this verification form consent under any circumstances.

Physician's Signature: _____

Printed Name of Physician: _____

Date: _____

EXHIBIT D
Court Order of October 21, 2011

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al., individuals residing in West Virginia, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

E. I. DUPONT DE NEMOURS & COMPANY, et al.,

Defendants.

Case No. 04-C-296-2
Thomas A. Bedell, Circuit Judge

ORDER RESOLVING PENDING MEDICAL MONITORING PROGRAM ISSUES IN PREPARATION FOR NOVEMBER 1, 2011 IMPLEMENTATION DATE

Presently before the Court are the unresolved issues described below and related to the November 1, 2011 implementation of the Medical Monitoring Program.

In order to allow the Parties to be heard on these issues and all other issues related to the implementation of the Medical Monitoring Program, this matter came on to be heard on October 17, 2011, at 10:00 o'clock a.m., and said hearing was held before the Honorable Thomas A. Bedell, Judge of the Circuit Court of Harrison County, West Virginia, in the Division 2 Courtroom located on the 4th Floor of the Harrison County Courthouse, 301 West Main Street, Clarksburg, West Virginia.

At the Hearing, the Claims Administrator submitted his Report respecting the recommended resolution of the issues, while presenting the alternative positions of the Parties. Also appearing was Dr. Jubal Watts, an expert sponsored by the Claims Administrator, to address the CT Scan issue. The Claims Administrator and Dr. Watts subjected themselves to cross-examination by the Parties, with the Claims Administrator, as a neutral for the Court, then

resting. Class Counsel, the Guardian ad Litem for Children and DuPont then presented their positions for the Court's consideration.

After a careful review of the Claims Administrator's submission and the submissions of the Parties, and having weighed the evidence and the presentations made at the October 17, 2011 hearing, and in consideration of the applicable law, the Court ORDERS the following:

1. The Parties have stipulated that the Medical Monitoring Program is a primary plan for medical testing benefits, with DuPont being responsible for all costs thereof. The Court accepts this stipulation of the Parties.

2. To facilitate the collection of Medical Monitoring Plan data for possible future scientific and medical research, the Court hereby approves the use by the Medical Monitoring Plan of the final Optional Data Collection Consent Form submitted by the Claims Administrator in Attachment II to his October 10, 2011 Report, with Claimants being allowed to complete and sign the Form, at their option, during their initial Medical Monitoring Provider visit.

3. The Court has carefully considered the positions of the Guardian ad Litem and DuPont on how to handle "No" box minor Medical Monitoring Claimants, whose parent or guardian checked the "No" box and therefore did not choose Medical Monitoring, when these minor "No" box Claimants become adults. The Court further considered their positions on when an "Inactive" Medical Monitoring Claimant (a Claimant who signed up for Medical Monitoring but then fails to use it) may become "Active" again.

The Guardian ad Litem suggests that the Medical Monitoring Plan is a right which cannot be waived through a lack of use by a Claimant, while DuPont argues that the Medical Monitoring Plan is a right that can be waived by a Claimant through lack of use.

DuPont also objects to the use of resources to continue to notify such inactive Claimants of the Program and invite them back in. DuPont, however, does not object to current minors whose parents have marked the "no" box on their behalf being notified once they turn 18 and given the option themselves of participating in the Program. But, DuPont contends that this should be a one-time notification.

Although this is a difficult issue, the Court makes the following determination:

The Medical Monitoring Plan is a right of a Claimant that cannot be waived, with such a waiver not being reflected anywhere in the Settlement Memorandum of Understanding ("MOU") or any related Orders. The Court therefore decides that the Claims Administrator's suggested procedures to notice these Claimants, with the procedures being contained in Attachment III to the Claims Administrator's October 10, 2011 Report, are well taken and are hereby approved.

4. In connection with CT Scans, the Court has carefully reviewed the proposed CT Rule and CT Scan Verification Form provided by the Claims Administrator in his October 10, 2011 Report, as modified on October 19, 2011, based on the October 17, 2011 hearing. The Court understands that DuPont supports the Claims Administrator's suggested approach to CT Scanning and these related forms, but the Guardian ad Litem for Children and Class Counsel suggest that there first be baseline CT scanning made available to all CT Scan eligible Claimants during their first round of Medical Monitoring, and for younger Claimants as they reach age 35, with the CT Rule and the CT Scan Verification Form suggested by the Claims Administrator then being implemented thereafter.

After careful consideration of the submission of the Claims Administrator and the positions of DuPont, the Guardian ad Litem for Children and Class Counsel in this matter, the Court hereby makes the following determination:

The approach suggested by the Claims Administrator best carries out the terms of the MOU which provide that:

> "The program shall provide those examinations and tests set forth in the Court's Order of February 25, 2008 with the exception that no routine CT Scans shall be performed as part of the Medical Monitoring Program. The Defendant does agree to provide CT Scans that are diagnostically medically necessary as determined by a competent physician as relevant to possible exposure to the heavy metal contamination at issue in this litigation." [Emphasis added].

That is, CT Scans cannot be baseline or routine even at the commencement of Medical Monitoring. However, as suggested by all Parties, the Claims Administrator's CT Rule and CT Scan Verification Form vouchsafes the diagnosis of a CT Scan by the attending physician for a decision. Exposure to heavy metals and not a specific diagnosis are all that is required to diagnose a CT Scan.

5. The Claims Administrator has submitted his proposed Budget for Medical Monitoring implementation from November 1, 2011 through August 31, 2012, which is divided into (i) a separate Medical Monitoring Implementation Budget without incremental CT Scan Costs totaling $1,977,207.41 and (ii) an incremental CT Scan Costs Budget, in an effort to ensure the timely commencement of Medical Monitoring on November 1, 2011 even if the CT Scan issue is further litigated.

The two major objections by DuPont to the finalization of the Budget at this time are that the number of Medical Monitoring Participating Claimants is unknown and the Medical Monitoring Medical Provider prices are not finalized.

However, as suggested by the Claims Administrator in his Report and in his Budget and supporting documentation in Attachment VII thereto, a materially accurate projection of the number of Medical Monitoring Participating Claimants was provided on October 3, 2011, and totals 4,000. In addition, Medical Monitoring Provider contracts are in the process of being

finalized, with a letter containing the prices, that was previously vetted with the Parties, having been submitted to the Providers on October 6, 2011, and with Medical Provider contracts, after vetting with the Parties, having been submitted to the Providers for review and possible signature.

The Court also understands that the Medical Monitoring prices that were ably negotiated by CTIA, the Third Party Administrator, are substantially below that originally budgeted on August 19, 2011. The Court therefore finds that these two variables have been reasonably established so that setting a Budget now, funding it by October 31, 2011, and commencing the Medical Monitoring Program on November 1, 2011 are appropriate.

Respecting the second component of the Medical Monitoring Budget, the amount of funding necessary to fund CT scans, the Claims Administrator reports that the amount of funding required depends on (i) whether the CT Rule and CT Scan Verification Form suggested by the Claims Administrator are implemented at the beginning of the Medical Monitoring Plan; or (ii) the baseline CT Scan approach suggested by Class Counsel and the Guardian ad Litem is implemented at the beginning of the Medical Monitoring Plan and as younger Claimants reach age 35; (iii) with the Incremental CT Scan Budget under the Claims Administrator's Proposal being $839,302.10 and with the incremental CT Scan Budget under Class Counsel's and the Guardian ad Litem's proposal being $1,192,414.93.

After carefully considering this matter, the Court makes the following decision:

The Claims Administrator's approach to CT Scans is the correct one, so that the Incremental CT Scan Budget is $839,302.10.

THEREFORE, THE FIRST ALTERNATIVE MEDICAL MONITORING BUDGET IS APPROVED AND THE NEW CONTRIBUTION OF DUPONT TO THE MEDICAL MONITORING FUND DUE TO BE PAID OCTOBER 31, 2011 (FOR NON-CT SCAN AND FOR CT SCAN MEDICAL MONITORING) IS $2,789,984.94.

6. In his August 24, 2011 and September 1, 2011 Reports to the Court, the Claims Administrator suggested that the Court consider whether DuPont should pay an additional $26,524.57 for expenses incurred by CTIA, the Third Party Administrator for the Medical Monitoring Plan, during September and October 2011, as being post-implementation expenses, or whether these expenses should be paid from old money already contributed by DuPont at Settlement, as pre-implementation expenses. In his October 10, 2011, Report, the Claims Administrator now suggests that these expenses are not materially great and the appropriate payment is debatable. He also reports that approximately half of this amount, or $15,440, is attributed to monthly charges of CTIA under its contract with the Settlement, which are not directly related to actual testing. The other costs are for communications materials, production and distribution of ID cards, and the scheduling of appointments and reminder letters and design consulting services. Although some of these costs are reasonably related to actual testing, there is a reasonable basis to find that none of them deal with testing itself until the testing actually begins.

Therefore, the Court accepts the Claims Administrator's proposal that these Bridge Funding expenses will be paid from the initial $4,000,000.00 previously paid by DuPont to start up the Medical Monitoring Program.

7. In his October 14, 2011 Supplement to his October 10, 2011 Report, the Claims Administrator describes a Medicare reporting compliance proposal without admitting that Medicare is applicable to the Medical Monitoring Program. One of the Class Counsel has challenged the need for such reporting, while the Claims Administrator suggests that it is prudent.

After considering this matter carefully, the Court decides the following:

The Claims Administrator is hereby authorized to carry out the Medicare reporting proposal.

IT IS SO ORDERED.

Finally, it is **ORDERED** that the Clerk of this Court shall provide certified copies of this Order to the following:

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Special Master

ENTER: October 21, 2011

Thomas A. Bedell, Circuit Judge