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

May 23, 2012

CLAIMS ADMINISTRATOR'S MAY 23, 2012 REPORT REQUESTING COURT APPROVAL OF FURTHER REVISED PERRINE MEDICAL MONITORING PLAN LIST OF MEDICAL PROVIDERS AND CERTAIN REVISED PLAN PROTOCOLS (THE "FURTHER PLAN REVISION")

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 (the "Further Plan Revision"); Our File Nos. 4609-1 {GG}

Dear Judge Bedell:

Enclosed for the Court's consideration please find a proposed Further Revised Perrine Medical Monitoring Plan (the "Plan") List of Medical Providers and Certain Revised Plan Protocols (the "Further Plan Revision"). If approved by the Court, the Further Plan Revision would (i) replace the previous January 5, 2012 Revised List of Medical Providers which was approved by this Court's January 6, 2012 Order respecting Plan Medical Provider; and (ii) clarify certain Plan protocols.

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

A proposed Order approving the Further Plan Revision is provided for the Court's convenience.

Thank you for the Court's consideration.

Yours very truly,

Edgar C. Gentle, III
Claims Administrator

ECGIII/kah

Attachment (Revised Perrine Medical Monitoring Plan List of Medical Providers and Certain Revised Plan Protocols)

cc: (with enclosures)(by e-mail)(confidential)
Stephanie D. Thacker, Esq., DuPont Representative on the Finance Committee
James S. Arnold, Esq., DuPont Representative on the Finance Committee
David B. Thomas, Esq. DuPont Representative on the 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 DEMOURS & COMPANY, et al.,	)	
Defendants.	)	

ORDER APPROVING REVISED PERRINE MEDICAL MONITORING PLAN LIST OF MEDICAL PROVIDERS AND NEW PROTOCOLS

Presently before the Court is the Claims Administrator's May 23, 2012 Report Requesting Court Approval of Further Revised Perrine Medical Monitoring Plan List of Medical Providers and Certain Revised Plan Protocols (the "Further Plan Revision").

In the Report, the Claims Administrator has explained the Further Plan Revision would (i) replace the previous January 5, 2012 Revised List of Medical Providers which was approved by this Court's January 6, 2012 Order respecting Plan Medical Provider; and (ii) clarify certain Plan protocols. The Claims Administrator has also related that the Further Plan Revision has been reviewed with the Finance Committee and the Guardian AdLitem 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 May 23, 2012 Further Plan Revision, and a consideration of the applicable law, the Court orders that the Further Plan Revision 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 delay 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 D. Thacker, Esq.
James S. Arnold, Esq.
David B. Thomas, 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 AdLitem for Children
901 W. Main Street
Bridgeport, WV 26330

Edgar C. Gentle, III, Esq.
Michael A. Jacks, Esq.
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

May 23, 2012

CLAIMS ADMINISTRATOR'S MAY 23, 2012 REPORT REQUESTING COURT APPROVAL OF FURTHER REVISED PERRINE MEDICAL MONITORING PLAN LIST OF MEDICAL PROVIDERS AND CERTAIN REVISED PLAN PROTOCOLS (THE "FURTHER PLAN REVISION")

I. METHODOLGY AND BACKGROUND

On January 5, 2012, the Claims Administrator provided this Honorable Court with a proposed Revised Perrine Medical Monitoring Plan (the "Plan") List of Medical Providers (the "Previous Plan Revision"). The Previous Plan Revision was based upon CTI Administrators, Inc.'s (hereinafter "CTIA") recommendations of July 22, 2011, and subsequent revisions as described therein.

On July 22, 2011 CTIA recommended six physician clinics, four hospitals and one laboratory (LabCorp) based upon the providers listed by claimants on their Plan Registration Forms.

In the Previous Plan Revision, the Claims Administrator noted that, due to a number of factors, the Plan shifted focus to the facilities which have the largest market share in the area, and recommended one group of Medical Monitoring Providers for In-Area Claimants (within 50 Miles of Spelter) and one group of Medical Monitoring Providers for Out-of-Area Claimants (more than 50 miles from Spelter).

On January 6, 2012, this Honorable Court approved the Previous Plan Revision.

As described below, since the Previous Plan Revision, the Plan has discovered that (i) the Out-of-Area Plan Providers are unable to provide specialty services as required by the Plan; and (ii) it is necessary to contract with entities in addition to UHC to provide CT scan imaging services. These issues and others were identified and resolved in a memo dated April 5, 2012 from the Claims Administrator to the Finance Committee in Addendum A. In addition, this Further Plan Revision suggests certain revisions in Plan protocols, as described below.

II. ADDITIONAL MEDICAL PROVIDERS

A. Revised Proposal for Specialist Services

During the administration of the Plan, the Claims Administrator was informed that the In Area (within 50 mile radius of Spelter) providers were unable to refer claimants to specialists because the Out-of-Area specialists (who were to provide specialist services pursuant to the

Previous Plan Revision) contacted either (i) were unaware of the Plan; and/or (ii) were not interested in providing Plan services.

As a result, during the February 14, 2012 First Quarterly Meeting of the Plan, UHC was approached and exhibited interest in providing specialists to render the 11 Plan specialty services.

The Finance Committee and the Claims Administrator have agreed that CTIA should be allowed to contract with UHC and large networks to secure specialists as necessary at already budgeted rates, plus or minus 5%. See Addendum A.

B. CT Scan Imaging Provider and Changes to Fee Schedule and Fee Reimbursement Protocol

UHC was previously selected as the CT Scan imaging facility in the Previous Plan Revision.

After commencing CT Scan negotiations with UHC, the Finance Committee was informed that an additional entity was necessary to actually conduct the CT Scan Imaging, but that UHC would be responsible for reading the image and providing feedback to the Claimant. As UHC works closely with Radiological Physicians Associates ("RPA"), CTIA recommended that the Plan contract with RPA to provide the additional CT Scan services.

On February 14, 2012, the Plan contracted with RPA to provide the additional CT Scan services. The Contract is Addendum B.

III. REVISED PLAN PROTOCOLS

A. CT Scan Protocol Revisions

During the First Quarterly Meeting, UHC and RPA suggested that the best CT Scan protocol was to allow CT scanning with contrast (as opposed to the CT Scan without contrast which was allowed under the initial fee schedule and initial contracts with UHC and RPA). See Addendum A.

This protocol modification has been approved by the Claims Administrator and the Finance Committee. The UHC and RPA Contract Addenda are in Addendum C.

B. Additional Services and Protocol Revisions

By agreement of the Claims Administrator and the Finance Committee, 480020 B-2 Microglobulin Serum Test is to be replaced with a 01073 Beta-2 Microglobulin Urine test. See Addendum A.

The Claims Administrator and the Finance Committee have agreed to allow for re-testing pursuant to the parameters in Addendum A.

The Claims Administrator and the Finance Committee have agreed to allow Primary Care Physicians to perform the following tests previously designated for a Dermatologist: a 30 minute office visit, and order of a biopsy/tissue exam.

C. Toxicologist

Despite extensive efforts, CTIA was unable to identify a toxicologist for the Plan in West Virginia. On April 6, 2012, the Plan contracted with the Department of Emergency Medicine ("UPP") at the University of Pittsburgh Medical Center ("UPMC") to provide toxicology services. The Contract is attached hereto as Addendum D.

D. CT Scan Releases as a Pre-Requisite to Reimbursement

As noted in Addendum A, the Claims Administrator and the Finance Committee agree that reimbursement to Medical Monitoring Providers for CT Scans is dependent upon their satisfactory submission of claimant CT scan release forms.

IV. CONCLUSION

Based upon the foregoing, the Claims Administrator requests authority from the Court to revise the Plan as described above.

LIST OF ADDENDA TO FURTHER PLAN REVISION

A	APRIL 5, 2012 MEMORANDUM
B	RPA CONTRACT
C	UHC AND RPA CONTRACT ADDENDA RESPECTING CT SCANS
D	UPP MEDICAL PROVIDER CONTRACT

ADDENDUM A
TO FURTHER PLAN REVISION

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
(800) 345-0837
www.perrinedupont.com
perrinedupont@gtandslaw.com

MEMORANDUM

BY E-MAIL
CONFIDENTIAL

TO: **Virginia Buchanan, Esq.**
Stephanie D. Thacker, Esq.
Meredith McCarthy, Esq.

FROM: **Edgar C. Gentle, III, Esq.**

DATE: **April 5, 2012**

RE: **Perrine v. DuPont Settlement - Resolution of Various Medical Monitoring Issues; Our File No. 4609-1 {GG}**

Dear Virginia, Stephanie and Meredith:

I hope that you are well.

Below, I try to summarize my understanding of our agreed resolution during our March 29, 2012 meeting of the ten issues described in CTIA's e-mail and Diandra's reply e-mail, attached:

Issue 1: Microglobulin test revision. We agree to make the suggested revision, but with previous tests not to be redone.

Issue 2: Monthly reports. At a cost of $350 per month, we tentatively agreed to approve obtaining monthly CTIA reports, subject to DuPont ratification. It was agreed that the monthly reports would be expanded so as to show procedures by specialists for adults and children, which would include CT scans conducted on adults.

Issue 3: Use of UHC Specialists. We agreed to look to UHC to provide specialists for the program to the extent it is able to do so, at budgeted rates, plus or minus 5%.

Issue 4: Proposed Retest Procedure. We agreed to the procedure.

Issue 5: Primary Care Physicians doing the tests which Dr. Wertnz previously designated for a Dermatologist. We agreed.

Issue 6: Replacement of CT scans without contrast by CT scans with contrast. We agreed to the middle ground enhancement depicted in the attached materials with some contrast, which would results in approximately a 25% increase in CT scan costs.

Issue 7: Proposed modification to confirmation of appointment letter to Claimants. We agreed to the changes.

Issue 8: CTIA explanation of how they will delete test results data for those Claimants that did not authorize use of their test results for possible subsequent scientific research. The proposal is approved, with the understanding that data for Claimants that have not consented to the potential use of their data for scientific research is not being maintained by CTIA.

Issue 9: CTIA to prepare an explanation about the nature of the 3 Preferred Physician Organization networks (PPO's) that are being used to obtain specialists instead of listing individual specialists, who will drop out or be added from time to time by the PPO network. This was approved. CTIA is asked to prepare this description ASAP.

Issue 10: CTIA to maintain CT scan release forms from primary care physicians, with failure to secure this form by the primary care physician resulting in non-reimbursement, and with CTIA not paying anything for CT scans until the form is secured. This procedure was approved, with DuPont questioning paying $1.40 for each reminder letter to physicians plus postage, as physicians should obtain the completed form anyway.

After reviewing the attached, please let me know if you have any suggested edits or comments.

I have copied Don and Randy Brandt of CTIA on this memo. Don and Randy, please note your ASAP homework.

Yours very truly,

Ed Gentle,
Claims Administrator

ECGIII/mgc
Attachment

cc: (via e-mail)(confidential)
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

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
(800) 345-0837
www.perrinedupont.com
perrinedupont@gtandslaw.com

MEMORANDUM

BY E-MAIL
CONFIDENTIAL

TO: Virginia Buchanan, Esq.
Stephanie D. Thacker, Esq.
Meredith McCarthy, Esq.

FROM: Edgar C. Gentle, III, Esq.

DATE: March 22, 2012

RE: Perrine v. DuPont Settlement - Medical Monitoring Issues; Our File No. 4609-1 {GG}

Dear Virginia, Stephanie and Meredith:

I hope that you are well.

Enclosed, please find a summary of the status of the follow-up issues from our February 14, 2012 Quarterly Meeting, and the meeting that CTIA and I had with the Medical Providers the same day. As you can see, we need your thoughts on many of the items. The solutions are still evolving, but I think many of the proposed solutions are now ripe enough for us to address them.

If convenient, let's plan to discuss these issues in detail on our weekly call next week.

Thank you for the opportunity to help administer this very interesting Settlement.

Yours very truly,

Ed Gentle,
Claims Administrator

ECGIII/mgc
Attachment

cc: (via e-mail)(confidential)
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

Melissa Cooper

From: EscrowAgen@aol.com
Sent: Wednesday, March 14, 2012 9:45 AM
To: Diandra Debrosse; Melissa Cooper
Subject: Fwd: DuPont MM Monitoring Update, Issues and Recommendations; 4609-6 and 4609...
Attachments: CTIARecommendations.docx

we need to run this by finance committee melissa dlioad n print

From: ddebrosse@gtandslaw.com
To: escrowagen@aol.com
Sent: 3/14/2012 9:42:52 A.M. Central Daylight Time
Subj: DuPont MM Monitoring Update, Issues and Recommendations; 4609-6 and 4609-10

Dear Ed:

I had a long discussion with Don and Randy regarding specialists and other follow up necessary items from the quarterly meeting. Attached are there recommendations to which I've provided my own recommendations and comments below.

With regard to Issue 1, we've agreed the microglobuin test should replace the serum as recommended by the physicians, and there is no impact on the budget.

With regard to Issue 2, CTIA has confirmed that the battery of initial tests do not look for arsenic and cadmium. I am looking at Dr. Werntz report to determine whether the MM program is supposed to identify arsenic and cadmium. If so, initial tests would be required. CTIA will also be determining the cost of preparing month reports, but has not provided that yet.

Issue 3- I think you and I discussed allowing the plan to utilize specialists from UHC. They would be paid the same rate as that negotiated with the specialist networks. With your approval, UHC counsel and I can execute that agreement easily, as we handled the other k together.

Issue 4- CTIA has established a protocol for re-testing. The protocol does not address some of the issues identified by the physicians during our meeting- i.e. seeing a trace of blood in urine and being able to re-test rather than automatically recommending that patient to a more expensive specialist. Don and Randy are re-drafting for re-submission to us.

Issue 5- The primary care physicians asked whether they could perform some of the tests which are only allowed for the specialists. After research CTIA determine that only tests they could perform are some of the dermatology test. We recommend an addendum to the contracts allowing only for these tests and not for specialist tests. This may also save $$ in that they won't be automatically referring to the derm for minor issues.

Issue 6- **CT Scan Issue and Budget Bump**- As you recall, the physicians recommended CT Scans with contracts and notes that this was a big issue- specifically it allows for more accurate findings. This change from w/o contrast to w/ contrast will result in a $150,000 increase to the existing budget. Please advise.

Issue 7- CTIA has provided their revised confirmation of appointment letter as requested for our review (see attachment).

Issue 8- CTIA confused DuPont with regard to the "cloud". This is information maintained in a cloud manner by practitioners independent of the Settlement. The only information CTIA is maintaining are for those claimants who have elected to have their info retained for research purposes. Their proposed methodology is included in the attachment, but I think we need to clarify this issue with the parties.

Issue 9 and 10 are aptly covered in their Recommendations, which are attached.

Sincerely, Fu

Scheduling has decreased substantially- 115 appointments for March. Difficult time getting in touch with people. They are calling people at night to try to get them enrolled. Tomorrow we will receive the report showing who has never been scheduled for the 1st time blood draw and stool sampling, and so we'll

Diandra S. "Fu" Debrosse

Shareholder

GENTLE TURNER & SEXTON

501 Riverchase Parkway East

Suite 100
Hoover, AL 35244
(205) 716-3000 (telephone)

(205) 716-3010 (facsimile)

ddebrosse@gtandslaw.com

www.gtandslaw.com

From: Randy Brandt [mailto:rbrandt@claimtechnologies.com]
Sent: Wednesday, March 14, 2012 8:47 AM
To: Diandra Debrosse
Subject: discussion topics for our call at 9:00

Talk to you in a little bit.

Randy Brandt

Vice President

CTI Administrators, Inc.

100 Court Ave, Suite 306

Des Moines, IA 50309

515-244-7322 ext. 246

515-244-8650 (fax)

Perrine Medical Monitoring Plan Quarterly Meeting
February 14, 2012
Follow-up Activities

Issue 1 Dr. Dubberke from Shinnston Healthcare recommended that LabCorp test; 480020 B-2 Microglobulin, Serum be replaced with a 01073 Beta-2 Microglobulin Urine test.
Dr. Dubberke's recommendation is supported by Dr. Werntz's report on page 7. The report specifies a "Urine Beta-2 Microglobulin" not a Serum test.
CTIA recommends that the Serum test be replaced with the Urine test. Specifically:
Remove CPT Code 82232 LabCorp test 480020 B-2 Microglobulin(Serum)as soon as approved. LabCorp charge is $20.00.
Replace withCPT Code 82232 LabCorp test 010173 B-2 Microglobulin (Urine)as soon as approved. LabCorp charge is $24.00.
CTIA does not recommend that Serum tests that have already been taken be retaken with a Urine test.

Issue 2 CTIA was asked to prepare monthly reports in a format similar to the quarterly reports. These reports will be sent to Ed/Diandra for distribution. First "Monthly" Report will be prepared by March 15th for the Month of February.

Scheduling Appointments report will be modified to add sub-totals and grand totals.

CTIA confirmed with LabCorp that the battery of initial tests do not look for Arsenic and Cadmium.

Initial battery of tests:

81001	URINALYSIS, NONAUTO W/SCOPE
83655	ASSAY OF LEAD
82274	OCCULT BLOOD, by FECAL HEMOGLOBIN
82232	ASSAY OF BETA-2 PROTEIN URINE
82565	ASSAY OF CREATININE
84520	ASSAY OF UREA NITROGEN

CTIA will follow-up with Primary Care Physicians to get reports on "no-shows".

CTIA will determine cost of preparing monthly reports.

Issue 3 CTIA will follow up with Jeffrey Bolyard at United Hospital Center (UHC) to see what specialists have affiliations with UHC to use in the Medical Monitoring Plan. CTIA will send draft agreements with respective fee schedules to Diandra for her to finalize.

CTIA recommends using UHC affiliates to provide the specialties needed by the Medical Monitoring Plan. UHC has affiliations with most, but not all, of the specialists required by the Plan. Mr. Bolyard, General Counsel for UHC, is preparing a list of their affiliates that we can contact for use by the Plan.

List of Specialists Affiliated with UHC that CTIA will Contact

Urologist	Gastroenterologist	Anesthesiologist	Radiologist
Cardiologist	Cardiothoracic Surgeon	Pulmonologist	

Issue 4 **CTIA was asked to establish rules for retests and prepare recommendations.**

Retests have been included in the budget estimates but should only be used on a limited basis. Retest should be taken based upon the best judgment of the attending physician using the following guidelines:

- Test specimens were lost or damaged by the laboratory (retest should not be charged to the Plan by LabCorp);
- Test results appear to be unreliable, unrealistic, or improbable based upon the patient's medical history;
- Test results were very close to exceeding the normal range and other symptoms of poor health were present. In this case, a retest should be taken in six months

A modifier (.76) should be added to the procedure codes for the venipuncture or specimen handling to indicate a repeat procedure.

- SPECIMEN HANDLING 99000.76
- ROUTINE VENIPUNCTURE 36415.76

Issue 5 **Primary Care Physicians want to be able to order some of the tests currently scheduled for the specialists. CTIA was asked to review and prepare a recommendation.**

Primary Care Physicians (Family Physicians) are representative of the physicians providing services at the five clinics contracted with the Perrine Medical Monitoring Plan.

The intent of Dr. Werntz was to have patients referred to specialists when positive laboratory results were present. CTIA believes that the services designated for the Dermatologist could also be provided by the Primary Care Physicians. All other services designated for a specialist should not be provided by the Primary Care Physicians.

Issue 6 **UHC Imaging and Radiological Physicians Associates recommend that CT Scans "w/o contrast" be replaced "with contrast". CTIA was asked to research and prepare recommendations.**

The following tables show the existing arrangements with UHC to perform CT Scans and with Radiological Physicians Associates to read the images:

Existing Fee Schedule for UHC:

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 the CT Scan.	$300.00
74176 or 74150	CT SCAN ABDOMEN & PELVIS 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 these codes for the CT Scan.	$325.00

Existing Fee Schedule for Radiological Physicians Associates:

EXHIBIT "A" FEE SCHEDULE		
Anticipated Procedures and Allowable Fees		
Procedure Code	Description	Allowable Fee
71250.26	Professional Component CT THORAX W/O DYE	$100.00
74176.26 or 74150.26	Professional Component CT Scan Abdomen & Pelvis or CT Scan Abdomen	$100.00

UHC and Radiological Physicians Associates have asked to change the procedures so that contrast material (dye) can be used as part of the imaging procedure.

Ramifications of this change:

- The Radiologists would be able to provide more accurate findings
- This would increase the Allowable Fees by approximately 25% for both the imaging center (UHC) and the radiologists (Radiological Physicians Associates)
- This will add approximately $150,000 to the Budget
- The fee schedules would need to be amended for UHC and Radiological Physicians Associates. Revised Fee Schedules follow:

Revised Fee Schedule for UHC:

EXHIBIT "A" FEE SCHEDULE			
Anticipated Procedures and Allowable Fees			
Procedure Code	Description	Billing Information	Allowable Fee
71250	CT THORAX W/O CONTRAST MATERIAL	At the discretion of the Primary Care Physician, some adults may be recommended to have a CT Scan.	$300.00
71260	CT THORAX WITH CONTRAST MATERIAL	At the discretion of the Primary Care Physician, some adults may be recommended to have a CT Scan. Use these codes for the CT Scan.	$375.00
74176 or 74150	CT SCAN ABDOMEN & PELVIS WITH CONTRAST MATERIAL CT SCAN ABDOMEN WITH CONTRAST MATERIAL	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 these codes for the CT Scan.	$325.00 $325.00
74177 or 74160 or 74178	CT SCAN ABDOMEN & PELVIS WITH CONTRAST MATERIAL CT SCAN ABDOMEN WITH CONTRAST MATERIAL CT ABDOMEN & PELVIS W/O CONTRAST IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIALS IN ONE OR BOTH BODY REGIONS	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 these codes for the CT Scan.	$405.00 $405.00 $520.00

Revised Fee Schedule for Radiological Physicians Associates:

EXHIBIT "A" FEE SCHEDULE Anticipated Procedures and Allowable Fees		
Procedure Code	Description	Allowable Fee
71250.26	Professional Component CT THORAX W/O CONTRAST	$100.00
71260.26	Professional Component CT THORAX WITH CONTRAST	$125.00
74176.26 or 74150.26	Professional Component CT ABDOMEN & PELVIS WITH CONTRAST Professional Component CT ABDOMEN WITH CONTRAST	$100.00 $100.00
74177.26 or 74160.26 or 74178.26	Professional Component CT ABDOMEN & PELVIS WITH CONTRAST Professional Component CT ABDOMEN WITH CONTRAST Professional Component CT ABDOMEN & PELVIS W/O CONTRAST IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIALS IN ONE OR BOTH BODY REGIONS	$125.00 $125.00 $175.00

Issue 7 CTIA was asked to modify the "Confirmation of Appointment" letter to better emphasize the importance of not missing appointments. Recommended changes are shown in red.

PRINTED ON PERRINE LETTERHEAD

October 26, 2011

JANE DOE
1234 ANY STREET
BRIDGEPORT, WV 26330

RE: Confirmation of your appointment

Dear Ms. Doe:

Thank you for talking with our office regarding the Perrine Medical Monitoring Plan (the Plan).

Your Appointment is scheduled for:
November 1, 2011 at 2:30 PM.

Your Appointment for Testing is with:
Shinnston Healthcare
686 S Pike St
Shinnston, WV26431
Telephone: 304 592-2100

~~If you cannot keep your appointment, please call as soon as possible.~~
~~If you need any additional assistance, please call me at (800) 245-8813, Extension 224.~~
It is very important to keep your appointment.
If you need to cancel or reschedule, please contact us immediately at (800) 245-8813.

The Plan will pay 100% of the cost of the scheduled benefits. There are no deductibles, co-payments, or coinsurance to be paid by you. Since the Plan will pay at 100% of Allowable Fees, providers will not balance bill you nor collect co-payments at the time of service.

We are pleased that you have agreed to participate in the Plan. As explained to you, CTI Administrators, Inc. (CTIA) will provide assistance in scheduling your medical testing as well as claim payments and customer service. We look forward to serving you and other participants in the Perrine Medical Monitoring Plan.

Testing protocols for the Plan have been set by the Circuit Court of Harrison County and need to be followed by the participating providers. Following are the initial testing protocols.

Two biennial testing protocols have been adopted for the Plan based upon the age of the participant. Initial testing begins with:
Adult Testing for participants ages 18 and above;

Child Testing for participants under age 18.

Both protocols assume that there will be an initial set of tests followed by a **Consultation and Physical Examination** with a Participating Physician to review your test results. The initial tests will be:
urinalysis for all participants over age 15,
blood tests for all participants, and
stool sample cards will be given to all participants over age 17.

Depending on the test results and physical examination, referrals may be made by your Participating Physician to a specialist including:
Urologist, for consultations and Cytopathology for patients testing positive to Urinary system tests;
Dermatologist, for skin tests for some patients testing positive to Urinary system tests;
Gastroenterologist, for consultations, additional stool sample tests, and upper GI endoscopy; and/or
Medical Toxicologist, forconsultations and complete blood count, lead and zinc tests.
Subsequent referrals may then be made to an Anesthesiologist, Psychologist,Pulmonologist, and/orRadiologist,

All participants must use Participating Providers who have contracted with the Plan. We will keep you apprised of the Participating Providers in your area. Please call 800-245-8813 if you have questions.

Sincerely,

Lynn Gozad, HIA
Manager, Enrollment

P.S. Don't forget to let me know if you cannot make your appointment and need to reschedule.

PRINTED ON PERRINE LETTERHEAD

Issue 8 CTIA was asked explain how they will delete test result data maintained by CTIA in a secured environment for those participants that did not authorize use of their test results for subsequent research.

LabCorp HL7 system maintains test results for secured access by physicians. It isnow standard practice to share the test results between laboratories and physicians via online access.CTI recommends not altering the process LabCorp and the clinics have in place.

Proposed Methodology for Maintaining Test Results
LabCorp will send test results to the Primary Care Physicians and to CTIA via secured file transfers. They will also maintain test results in their secured database for shared access with the physicians. Test results will be transmitted on a daily basis.
Mr. Jacks will maintain an electronic file of all participants that do not want their test results used for subsequent research purposes. This file, the "don't use file", will be available to CTIA on an as needed basis.
As test results are received, CTIA will download the individual test results to the "test results file".

- As part of the download process the "don't use file" will be cross referenced to eliminate test results from those participants that don't want their results used for subsequent research.
- All downloaded records will also be de-identified as part of the download process. Only the social security number (encrypted) will remain with the test results. This is necessary in case the test results need to be linked backed to the participant at some point in the future. For instance; ten years from now the participant wants to have their test results deleted from the file. In that case we would need to be able to tie the test results back to the participant in order to delete the records.
- A backup of the "test results file" will be sent to a secured off site facility on a daily basis.

Issue 9. CTIA will prepare an explanation about the nature of the three PPO networks that are being used. Specifically addressing how individual providers change from time to time and that the contracts are between CTIA and the networks not the individual providers. Hopefully, this will eliminate the need to notify the court every time individual specialists drop out or are added to the PPO network.

Currently we are accessing the NPPN, Multiplan, & HealthSmart HPO networks for the Perrine Medical Monitoring Plan when the contracted clinics and specialists are not being used.. PPO networks are in a state of constant change. Many factors account for the ongoing change which include physicians retiring, not accepting new patients, and not renewing their participation in the network.

CTIA recommends continuing the use these three networks. In addition, CTIA recommends to it have the ability to engage other PPO networks as long as they agree to the fees approved by the court. By allowing these enhancements to the networks used by the Plan, CTIA will not burden the Court each time there is a change.

Issue 10 **CTIA is to maintain CT Scan Release Forms from Primary Care Physicians. This form is in the packet of information provided to the physician's offices. CTIA is not required to obtain copies of the release from imaging center (UHC's standard release form).**

Email From Diandra: "The CT Scan Authorization form must be secured for each claimant. Primary care physician signs the form, the form is sent electronically to you. The form is maintained in a CT Scan Authorization database securely maintained by CTIA. The radiologist must see this form before performing the CT Scan. Failure to secure this form will result in non-reimbursement. CTIA will not pay anything for CT Scans until this form is secured."

Proposed Methodology for use of the CT Scan Authorization Forms

The CT Scan Authorization form has been provided to the Primary Care Physicians in their "Packet of Information" along with instructions regarding the necessity of completing the form and forwarding to CTIA and to the Imaging Center (UHC).

CTIA will print a supply of the forms and distribute to the contracted clinics along with instructions on how to use. A small supply of the CT Scan Authorization forms will be sent to the Claim Office in Spelter.

The Primary Care Physicians will complete the forms and provide a copy to:

- The Patient
- The Imaging Facility
- CTIA (form can be sent via mail or faxed to CTIA)

The Imaging Center will not provide CT Scans without a copy of the completed CT Scan Authorization.

CTIA will scan the Authorizations and create an electronic image that will become part of the patients secured claim record. All claims from the Imaging Center will require a copy of the Authorization before payment is made. If the Authorization is not provided, CTIA will send up to three follow-up letters to the Primary Care Physician in an effort to obtain the required Authorization Form. When the Authorization form is received, the claim will be paid. If the Authorization is not received, the claim will be denied.

There are no additional fees for these services by CTIA except for the follow-up letters when CT Scan Authorization Forms were not provided. (Per agreement: Follow-up letters, as required, @ $1.40 each plus postage.)

ADDENDUM B
TO FURTHER PLAN REVISION

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of February 9, 2011, by and between The Perrine Medical Monitoring Plan (the Plan) and Radiological Physician Associates, Inc. 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.

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** (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 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;

3.1.2 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);

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

3.1.4 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;

3.1.5 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;

3.1.6 submit all testresults to the Participant, the servicing provider, and to TPA;

3.1.7 ensure that only CTIA is billed for the provision of 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 January1, 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.

7.3Termination.

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, and Provider will be provided with thirty (30) days to object to any such modification and improvement. 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 and Special Master

B. If to Provider, to:
Radiological Physician Associates, Inc.
700 Village Drive
Fairmont, WV 26554
Attention: Samuel J. Merandi
Administrative Vice President

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 and Special Master

Date: 2-14-12

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

Radiological Physician Associates, Inc.

By: Samuel J. Merandi

Title: Administrative Vice Pres.

Date: 2-7-2012

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees		
Procedure Code	Description	Allowable Fee
71250.26	Professional Component CT THORAX W/O DYE	$100.00
74176.26 or 74150.26	Professional Component CT Scan Abdomen & Pelvis or CT Scan Abdomen	$100.00

ADDENDUM C
TO FURTHER PLAN REVISION

ADDENDUM TO
PARTICIPATING PROVIDER AGREEMENT

THIS ADDENDUM TO THE PARTICIPATING PROVIDER AGREEMENT ("Addendum") is made and entered into as of April __, 2012, and serves as an addendum to the Participating Provider Agreement executed on March 29, 2012 ("Agreement"), by and between The Perrine Medical Monitoring Plan (the Plan) and United Hospital Center, Inc., a West Virginia corporation ("Provider"), and which is attached hereto as Exhibit 1.

RECITALS

WHEREAS, Provider and Plan entered into a Participating Provider Agreement ("Agreement") on March 29, 2012, a copy of which is attached hereto as Exhibit 1.

WHEREAS, the Provider desires to be engaged by the Plan to furnish services in addition to those as set forth in the Agreement.

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 Addendum and the terms of the 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:

I. AMENDMENT OF ARTICLE V – NEW OR ADDITIONAL SERVICES TO THE AGREEMENT

1.1 **Additional Services.** Pursuant to Article V and Section 8.1 of the Agreement, the Plan and the Provider agree to add additional services to those as set forth in Exhibit A to the Agreement, and to revise fee schedules with regard to said services. Pursuant to Article V and Section 8.1 of the Agreement, the Plan and the Provider mutually agree to the provision of additional services as set forth in the Revised Fee Schedule in Exhibit 2.

1.2 **Fee Schedule in this Addendum to Supersede Fee Schedule in Exhibit A to Agreement.** Any and all prior Fee Schedules and Fee Agreements are hereby superseded by this Addendum to the Agreement and the Revised Fee Schedule in Exhibit 2 to this Agreement.

II. EXPLICIT LIMITATION OF THIS ADDENDUM

2.1 Full Force and Effect. The execution of this Addendum and the implementation of the Revised Fee Schedule in Exhibit 2 shall not and are not intended to alter any other term of the Agreement, and does not serve as a revocation, termination, amendment, and/or alteration of any or all terms of the Agreement, except as set forth explicitly hereinabove. The Agreement remains in full force and effect.

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 Hospital Center, Inc.**
By: Edgar C. Gentle, III, Esq.	By: Bruce Carter
Title: Claims Administrator and Special Master	Title: President
Date: _____	Date: _____

FEE SCHEDULE			
Anticipated Procedures and Allowable Fees			
Procedure Code	Description	Billing Information	Allowable Fee
71260	CT THORAX WITH CONTRAST MATERIAL (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 the CT Scan.	$375.00
74177 or 74160	CT SCAN ABDOMEN & PELVIS WITH CONTRAST MATERIAL CT SCAN ABDOMEN WITH CONTRAST MATERIAL	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 these codes for the CT Scan.	$405.00

ADDENDUM TO
PARTICIPATING PROVIDER AGREEMENT

THIS ADDENDUM TO THE PARTICIPATING PROVIDER AGREEMENT ("Addendum") is made and entered into as of April __, 2012, and serves as an addendum to the Participating Provider Agreement executed on February 14, 2012 ("Agreement"), by and between The Perrine Medical Monitoring Plan (the Plan) and Radiological Physician Associates, Inc. a West Virginia corporation ("Provider"), and which is attached hereto as Exhibit 1.

RECITALS

WHEREAS, Provider and Plan entered into a Participating Provider Agreement ("Agreement") on February 14, 2012, a copy of which is attached hereto as Exhibit 1.

WHEREAS, the Provider desires to be engaged by the Plan to furnish services in addition to those as set forth in the Agreement.

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 Addendum and the terms of the 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:

I. AMENDMENT OF ARTICLE V – NEW OR ADDITIONAL SERVICES TO THE AGREEMENT

1.1 **Additional Services.** Pursuant to Article V and Section 8.1 of the Agreement, the Plan and the Provider agree to add additional services to those as set forth in Exhibit A to the Agreement, and to revise fee schedules with regard to said services. Pursuant to Article V and Section 8.1 of the Agreement, the Plan and the Provider mutually agree to the provision of additional services as set forth in the Revised Fee Schedule in Exhibit 2.

1.2 **Fee Schedule in this Addendum to Supersede Fee Schedule in Exhibit A to Agreement.** Any and all prior Fee Schedules and Fee Agreements are hereby superseded by this Addendum to the Agreement and the Revised Fee Schedule in Exhibit 2 to this Agreement.

II. EXPLICIT LIMITATION OF THIS ADDENDUM

2.1 **Full Force and Effect.** The execution of this Addendum and the implementation of the Revised Fee Schedule in Exhibit 2 shall not and are not intended to alter any other term of the Agreement, and does not serve as a revocation, termination, amendment, and/or alteration of any or all terms of the Agreement, except as set forth explicitly hereinabove. The Agreement remains in full force and effect.

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	**Radiological Physician Associates, Inc.**
By: Edgar C. Gentle, III, Esq.	By: _____
_____	
Title: Claims Administrator and Special Master	Title:
Date: _____	Date: _____

FEE SCHEDULE		
Anticipated Procedures and Allowable Fees		
Procedure Code	**Description**	**Allowable Fee**
71260.26	**Professional Component** CT THORAX WITH CONTRAST	$125
74177.26 or 74160.26	**Professional Component** CT ABDOMEN AND PELVIS WITH CONTRAST **Professional Component** CT ABDOMEN WITH CONTRAST	$125

ADDENDUM D
TO FURTHER PLAN REVISION

PARTICIPATING PROVIDER SERVICES AGREEMENT

THIS PARTICIPATING PROVIDER SERVICES AGREEMENT ("Agreement") is made and entered into as of March 29, 2012 by and between The Perrine Medical Monitoring Plan (the Plan) and University of Pittsburgh Physicians, Department of Emergency Medicine ("UPP"), a Pennsylvania non-profit corporation ("Provider").

RECITALS

WHEREAS, Provider is a Pennsylvania non-profit corporation duly organized and existing under and pursuant to the laws of the state of Pennsylvania and has employed physicians who hold West Virginia medical licenses;

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 and consultations, 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 Plan.

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 **Provider Orientation 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" is defined in the Provider Orientation Package.

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, as described in the Provider Orientation Packet.

1.13 **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 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;

3.1.2 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);

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

3.1.4 (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.

3.1.5 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;

3.1.6 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;

3.1.7 submit all test results to the Participant, the servicing provider, and to TPA;

3.1.8 ensure that only CTIA is billed for the provision of 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.

4.3 **Compliance with Applicable Privacy Law.** The Parties agree to comply with all applicable federal, state and local laws and regulations governing the security and privacy of individually identifiable health information, including without limitation the federal Health Insurance Portability and Accountability Act of 1996

("HIPAA") and its implementing regulations, as applicable and as may be periodically revised or amended from time to time. Unless otherwise permitted by applicable law, each Party to this Agreement will not use or disclose certain confidential, proprietary, and nonpublic financial and other information concerning patients ("Protected Health Information") in violation of the HIPAA requirements. Each Party agrees to use their best efforts to comply with HIPAA in all respects, including the implementation of all necessary safeguards to prevent such disclosure and the assurance that any subcontractors or agents to whom either Party provided Protected Health Information agree to the same restrictions and conditions imposed on the parties hereto under HIPAA.

ARTICLE V – NEW OR ADDITIONAL SERVICES

5.1 **Services.** Within the scope of the Court approved Plan, 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. Both Parties represent that the terms of this Agreement have been negotiated at arms length, are commercially reasonable and that the payment terms are consistent with "fair market value" for general commercial purposes without regard, directly or indirectly, to the volume or value of any referrals or other business generated or which could in the future be generated between the Parties.

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 March 29, 2012, and shall continue in full force through the period ending February 28, 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.

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 claims, losses, liabilities, damages, expenses, including reasonable attorney's fee or other cost or obligation, brought against the Plan resulting from Provider's negligence or willful misconduct 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, healthcare emergencies,

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:

UPP Department of Emergency Medicine
Forbes Tower, Suite 10026
Pittsburgh, PA 15213
Attention: Executive Administrator

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: _____

Name/ Title: Edgar C. Gentle, III, Esq.
Claims Administrator and Special Master

Date: 4-6-12

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

UPP Department of Emergency Medicine

By: _____

Name/Title: Marshall W. Webster, M.D.
President

Date: 3/28/12

EXHIBIT "A" FEE SCHEDULE

Anticipated Procedures and Allowable Fees			
Procedure Code	Description	Billing Information	Allowable Fee
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
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.	$150.00