PERRINE DUPONT SETTLEMENT
SPELTER VOLUNTEER FIRE DEPARTMENT CLAIMS OFFICE
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June 1, 2011

CONFIDENTIAL and
IN CAMERA

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) - Proposed Health Care Provider Third Party Administrator Agreement
Our File No. 4609-1 {GG}

Dear Judge Bedell:

As the Court will recall, by Order dated February 28, 2011, the Court approved a Health Care Provider Third Party Administrator Request for Proposals ("RFP") and a list of candidates to receive the RFP. In accordance with this Order, the RFP was provided to all listed candidates. After an interview process, CTIA of Des Moines, Iowa was deemed to be the best qualified candidate.

Your Claims Administrator, in collaboration with the Finance Committee, then negotiated the attached proposed Health Care Provider Third Party Administrator Agreement (the "TPA Agreement") with CTIA, which was then approved by the Finance Committee.

We point out to the Court that TPA Agreement Parts II B (vii) and (viii) reflect two issues that need to be resolved by the Court in connection with the execution of the TPA Agreement, namely, (i) whether the Medical Monitoring Program is a secondary plan or a primary plan in the payment of medical testing benefits; and (ii) whether the Claims results database should provide necessary details to facilitate future scientific research. The enclosed, proposed TPA Agreement approval Order therefore contains a briefing schedule on these two topics, to facilitate the Court's resolution thereof prior to the anticipated September 2011 effective date, when testing is projected to begin.

The Claims Administrator has shared with CTIA, the Finance Committee and the guardian *ad litem* for children the enclosed, proposed TPA Agreement, this Report, and the enclosed proposed Order, and we have tried to accommodate all suggested edits to the extent practicable. The proposed Order of your Claims Administrator is hereby submitted for the Court's consideration.

Thank you for the Court's consideration.

Yours very truly,

Edgar C. Gentle, III
Claims Administrator

ECGIII/mgc
Enclosure

cc: (with enclosures)(by e-mail)(confidential)

Mr. Don Brandt of CTIA

Stephanie D. Thacker, Esq.,
DuPont Representative on the Settlement Finance Committee

Virginia Buchanan, Esq.
Plaintiff Class Representative on the Settlement Finance Committee

Meredith McCarthy, Esq.,
Guardian Ad Litem for Children

Michael A. Jacks, Esq.

Clerk of Court of Harrison County,
West Virginia, for filing (via hand delivery)

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al.,

Plaintiffs,

v.

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

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

Defendants.

FINAL ORDER APPROVING TPA AGREEMENT AND ESTABLISHING BRIEFING SCHEDULE ON UNRESOLVED ISSUES

Presently before the Court is the Claims Administrator's June 1, 2011 Report recommending that a proposed Health Care Provider Third Party Administrator Agreement ("TPA Agreement") with CTIA of Des Moines, Iowa be approved. In his report, the Claims Administrator points out that (i) whether the medical monitoring program is a primary or secondary plan for medical testing benefits; and (ii) whether the program database should provide necessary details to facilitate future scientific research, are two issues which have not been resolved by the Finance Committee, with these two issues being referred hereinafter as the "Unresolved Issues". Accordingly, to facilitate the Court's decision on the Unresolved Issues, the following briefing schedule is established:

(i) DuPont, Class Counsel, the Guardian ad litem for children, and any other interested Parties shall provide their initial submissions to the Court on the Unresolved Issues within 30 days; and

(ii) Reply submissions shall be submitted within 15 days thereafter.

After receiving submissions and reply submissions, the Unresolved Issues shall be deemed submitted to the Court for consideration.

After a careful review of the Claims Administrator's submission, and in consideration of the applicable law, the Court ORDERS that the proposed TPA Agreement is hereby APPROVED and that the Claims Administrator, on behalf of the Settlement, is hereby authorized, empowered and directed to enter into the TPA Agreement on behalf of the Settlement, with the Claims Administrator's execution and delivery of the TPA Agreement to CTIA to be conclusively presumed to be the valid and binding act of the Settlement.

IT IS SO ORDERED.

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

Stephanie D. Thacker, Esq.
Allen, Guthrie & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394
DuPont's Finance Committee Representative

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

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

Order Prepared By:

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

Michael A. Jacks, Esq.
Gentle, Turner & Sexton
W.Va. Bar No 11044
Gentle, Turner & Sexton
P. O. Box 257
Spelter, WV 26438

ENTER: _____

_____
Thomas A. Bedell, Circuit Judge

AGREEMENT FOR THIRD PARTY ADMINISTRATOR SERVICES

for the

LENORA PERRINE, ET AL., v. E.I. DuPONT DE NEMOURS AND COMPANY, ET AL.,

SETTLEMENT

by and through

THE SPECIAL MASTER AND CLAIMS ADMINISTRATOR

and

CTIA ADMINISTRATORS, INC.,

Submitted to the Court
in camera, on June 1, 2011
and approved by Court Order
dated June ____, 2011

THIS AGREEMENT, entered into June 1, 2011, and effective upon Court approval ("Effective Date") between CTI Administrators, Inc., a corporation with its principal place of business at 100 Court Avenue, Suite 306, Des Moines, Iowa 50309 ("CTIA" or "CTI Administrators") and the *Lenora Perrine, et al., v. E.I. DuPont de Nemours and Company, et al.*, Settlement (hereinafter "Spelter Settlement") which was approved by the Circuit Court of Harrison County, West Virginia, Case No. 04-C-296-2 (the "Court"), by Order dated January 4, 2011, and January 18, 2011, by and through the appointed Special Master and Claims Administrator, Edgar C. Gentle, III., Esq., of the firm of Gentle Turner & Sexton (hereinafter collectively referred to as "Sponsor"). The principal place of business of the Spelter Settlement, as administered by the Special Master and Claims Administrator is 55 B Street, Spelter, West Virginia, 26438, and the principal place of business of the Special Master and Claims Administrator is Gentle, Turner & Sexton, 500 Riverchase Parkway East, Suite 100, Hoover, Alabama, 35244. A copy of the January 18, 2011 Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, and establishing the authority of the Special Master and Claims Administrator to enter into said Agreement is attached hereto as Exhibit A;

WHEREAS, by Final Order Approving Settlement entered January 4, 2011, in *Lenora Perrine, et al., v. E.I. DuPont de Nemours and Company, et al.*, Case No. Case No. 04-C-296-2 (the "Perrine DuPont Case"), the Court approved the proposed settlement of the parties, providing a Medical Monitoring Plan, to be paid on a "pay-as-you-go" basis by the Defendants for the benefit of the Class (the "Medical Monitoring Plan" or the "Plan"). Said Final Order Approving Settlement is attached hereto as Exhibit B;

WHEREAS, by Final Order dated January 4, 2011 and January 18, 2011, the Court established the Medical Monitoring Plan and appointed Edgar C. Gentle, III., Esq, as Special Master and Claims Administrator of the Plan. Said Final Orders are attached hereto as Exhibits A and B;

WHEREAS, the Court ordered that all participating Class Members may be tested every two years, for a total testing period of 30 years. The voluntary screening exam for participants includes a whole blood test for those below age 15, and blood and urine testing for those from 15 to 35. All ages may be tested for plumbism (lead poisoning) based on the blood test. Those ages 15 and above may be tested for urinary system problems, age 15 and above for skin cancer, age 15 and above for gastrointestinal system problems, and age 35 and above for lung cancer;

WHEREAS, the Court in its January 4, 2011 Order determined that participating Class Members may be eligible for CT scans only where "a competent physician determines that a CT scan is diagnostically medically necessary as relevant to the possible exposure to heavy metal contamination", and the Court also determined that before receiving the non-routine lung system (CT) tests, all females ages 35-55 will receive a rapid pregnancy test, and pregnant class members will not be tested;

WHEREAS, the Court ordered that, after each screening, the Class Member is to receive the confidential test results, and will be entitled to a physician office visit, where said Claimant shall be allowed to discuss her/his medical history, have a physical exam, and review his/her test results with the physician. If there is a positive finding of disease, said Claimant will be referred to a medical specialist for follow-up treatment, but the Settlement will not provide for and DuPont will not pay for such follow-up treatment;

WHEREAS, on February 28, 2011, the Court entered the Final Order Approving Health Care Provider Third Party Administrator Request for Proposals and the Candidate List, in Exhibit C;

WHEREAS, on March 1, 2011, the Sponsor issued the Request for Proposals for Third Party Administrators for the Administration of a Medical Monitoring Program in the Perrine DuPont Case, in Exhibit D;

WHEREAS, on March 31, 2011, a Response to said Request for Proposals was submitted to the Sponsor by CTIA in Exhibit E;

WHEREAS, the Sponsor and the Finance Committee jointly recommend to the Court that CTIA be awarded this Agreement;

WHEREAS, by entering into this Agreement, CTIA agrees to provide Medical Third Party Administrator Services (the "TPA Services"), including negotiating and developing fees for the services required to implement the Medical Monitoring Plan, arranging for Class Members to be tested in accordance with the Medical Monitoring Plan, creating and maintaining a database to implement the Medical Monitoring Plan, communicating with Class Members regarding the Medical Monitoring Plan, processing claims for services performed in accordance with the Medical Monitoring Plan and consulting with the Sponsor on related services as provided herein;

WHEREAS, Sponsor desires to work with CTIA to implement the TPA Services for the Medical Monitoring Plan; and

WHEREAS, Sponsor and CTIA have agreed that CTIA will exclusively provide the TPA Services for the Sponsor for the duration of this Agreement;

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, the parties hereto agree as follows:

I. DEFINITIONS

All words and phrases defined below shall have the following meaning:

A. "Benefits" means:

i. Voluntary screening exams and follow-up physician visits for eligible participating Claimants every two (2) years for a total testing period per Claimant for up to thirty (30) years as described in the March 30, 2007 Dr. Werntz Report as modified by the November 19, 2010 Memorandum of Understanding, both in Exhibit I, as clarified by the Court Orders in Exhibits A and B. If there is a conflict in the construction or interpretation of the Dr. Werntz Report and the Memorandum of Understanding, the Memorandum of Understanding governs. If there is a conflict in the construction or interpretation of the Memorandum of Understanding and a Court Order, the Court Order governs.

ii. Voluntary screening exams include:
1. Those below the age of 15 shall receive a whole blood test;
2. Those from ages 15 to 35 shall receive blood and urine testing;
3. All ages shall receive testing for plumbism based upon blood tests;
4. Those ages 15 and above may be tested for (i) urinary system problems; (ii) skin cancer; and (iii) gastrointestinal system problems; and
5. Those ages 35 and above may be tested for lung cancer.

iii. CT scans may be provided only where "a competent physician determines that a CT scan is diagnostically medically necessary as relevant to the possible exposure to heavy metal contamination"[1];

B. "Business Associate" means an entity, as defined by HIPAA that performs a function or activity on behalf of the Medical Monitoring Plan that has access to individual identifiable protected health information (PHI).

C. "Claim" means a Claim submitted by a Provider to CTIA, which includes all data requirements of a CMS 1500, or UB04 form, and which contains all necessary data to make it understood and clear as to Plan provision payment or denial. Claim includes both approved and disapproved claims.

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[1]Before receiving the non-routine lung system (CT) tests, all females ages 35-55 will receive a rapid pregnancy test, and pregnant class members will not be tested.

D. "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 and/or other developed Medical Networks.

E. "Claim Fund" means the monies provided by Sponsor to pay for Benefits allowable from processed Claims and other obligations specified in this Agreement and the Medical Monitoring Plan.

F. "Claimant" or "Member" means a Medical Monitoring Class Member who has decided to participate in the Medical Monitoring Plan by checking the "yes" box on Part I of his or her Medical Monitoring Registration Form, subject to the Claims Administrator's verification of the individual as a Claimant. The list of Claimants shall be provided by Sponsor to CTIA. There are adult and children Claimants.

G. "Commissioner" refers to the commissioner of insurance of any state in which services are performed under the terms of this Agreement, namely the Commissioner of Insurance of the State of West Virginia, or of other states where services are performed.

H. "Compensation and Pricing Terms" means the negotiated compensation and pricing terms of this Agreement set forth in Exhibit G, which is incorporated by reference.

I. "Complete Claim" means a Claim received by the TPA, which includes all data requirements of a health insurance claim form CMS-1500, or UB-04 form. It is a Claim which contains all necessary data to make it understood and clear as to Plan payment or denial.

J. "CTIA Proposal" collectively means CTIA' s March 31, 2011 written proposal in response to the RFP. CTIA's proposal is attached hereto as Exhibit E.

K. "CTIA Reports" mean the CTIA reports agreed to by CTIA and the Sponsor and described in Exhibit F, which is incorporated by reference.

L. "Eligibility Database" or "Database" means the database of Claimants.

M. "Eligibility Database Maintenance" is the function of entering and maintaining data into CTIA's computer system regarding Claimants in the Medical Monitoring Plan. Pertinent data for this function includes, but is not limited to the Claimant's:

i. Name;
ii. Assigned unique identifier number;
iii. Address;

iv. Social Security Number;
v. Gender;
vi. Date of Birth;
vii. Legal Guardian (if applicable, for minors and incompetents);
viii. Initial Enrollment Date;
ix. Date of Initial Testing Procedure;
x. Subsequent Testing Procedures;
xi. Referrals;
xii. Refusal of any offered testing procedures;
xiii. Termination date.

N. "Fee Schedule" means the allowable fees paid for Benefits services provided for specific Testing and Clinic Procedure Codes, and other fees, which is in Exhibit G and is incorporated by reference. The Fee Schedule will be supplemented from time to time with the actual Provider fees to be charged for Benefits.

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

P. "Incomplete Claim" means a Claimant's claim for Benefits that does not include all of the data requirements of CMS 1500 or UB-04 forms. It is a claim, which does not contain all necessary data to make it understood and clear as to Medical Monitoring Plan provision payment or denial.

Q. "Information" means all information, materials and data relative to this specific Medical Monitoring Plan, of any nature and in whatever medium transmitted by CTIA to Sponsor or submitted or provided by Sponsor to CTIA, including, without limitation, claim data, claim documents, policies, Plan documents, files, records and all other information of any nature transmitted. The term "Information" shall also include all such information, materials and data relative to this specific Medical Monitoring Plan transmitted or submitted to CTIA on behalf of Sponsor by any third party. This term does not include personal information supplied by Claimants or providers relative to specific and individual claim situations.

R. "Mandatory Terms" means the mandatory terms of this Agreement in Exhibit H, as required by the RFP, which CTIA and the Sponsor incorporate into this Agreement.

S. "Medical Monitoring" or "Medical Monitoring Plan" or "Plan" or "Medical Monitoring Program" all refer to the Medical Monitoring Plan as set for in this Court's February 28, 2011 Order, in Exhibit C and the RFP in Exhibit D, and as described herein.

T. "Payment" means the actual amount paid on behalf of the Claimants for Benefits described in the Medical Monitoring Plan.

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

V. "Plan Set-Up" means the work necessary to set the parameters of CTIA's computer system(s) appropriately for the Benefits peculiar to each Plan being administered by CTIA. Examples include Benefit definitions, edit routines, and automated correspondence.

W. "Providers" includes all medical and testing service providers used by the Plan.

X. "RFP" means the Sponsor's March 1, 2011 Request for Proposals for Third Party Administrator ("TPA") services with respect to the TPA Services described herein, a copy of which is Exhibit D and is incorporated by reference.

Y. "Questionable Claim"means all Claims or charges therefrom where the Plans provisions are unclear as to the payment of denial of Claims.

Z. "Received Claim" means any Claim received by CTIA on behalf of a Claimant on or before the last day of the Initial or Renewal Term of this Agreement.

AA. "Services" means Communications, Enrollment Services, Claim and Other Services and obligations to be performed by CTIA for the Medical Monitoring Plan, as stated in Section II of this Agreement.

BB. The terms "TPA", "Third Party Administrator", "CTI Administrators, Inc.," "CTIA", and "CTIA" are used interchangeably.

II. THIRD PARTY ADMINISTRATOR SERVICES PROVIDED BY CTI ADMINISTRATORS, INC.

A. Benefits to Be Administered

Sponsor is securing the services of the TPA to administer the following limited Benefits as provided for in the Orders in Exhibits A, B, and C, and described herein:

i. Testing and follow up doctor visits for eligible Claimants every two (2) years for a total testing for up to thirty (30) years.

ii. Voluntary screening exams:
   1. Those below the age of 15 shall receive a whole blood test;
   2. Those from ages 15 to 35 shall receive blood and urine testing;
   3. All ages shall receive testing for plumbism based upon blood tests;

4. Those ages 15 and above may be tested for (i) urinary system problems; (ii) skin cancer; and (iii) gastrointestinal system problems; and
5. Those ages 35 and above may be tested for lung cancer.

iii. CT scans only where "a competent physician determines that a CT scan is diagnostically medically necessary as relevant to the possible exposure to heavy metal contamination"[1].

B. Initial TPA Services: Medical Monitoring Plan Development. Below is an overview of the initial obligations of the TPA. The TPA commits to act in good faith in working with the Sponsor to complete all of the below tasks and obligations, and to perform all actions required to effectuate the items identified below.

By July 15, 2011, the TPA shall:

i. Interview area medical testing Providers based upon a review of those identified by Claimants in the Medical Monitoring Registration Forms, as compiled by Sponsor, and the TPA's expertise in creating Medical networks as applied to the Claimants' demographics.

ii. Identify and interview other medical Providers for referral services.

iii. Survey Class Area and out-of-Class Area medical monitoring and laboratory prospects for medical testing provisioning. In designing the Provider network, CTIA will work with the Sponsor to balance reasonably the dual goals of Claimant convenience and Plan administration for efficiency. For example, Providers may not be available for Claimants in less populated areas versus more populated areas that have multiple Providers. In addition, Providers for out-of-Class Area Claimants not located to many other Claimants may be a national health testing Provider serving the area.

iv. Work with Providers to determine an appropriate fee schedule and reimbursable CPT codes and/or other applicable codes to be utilized for Medical Monitoring provisioning, reporting, reimbursement, auditing, and quality control.

v. Work with the Sponsor to develop the parameters of a comprehensive Database to facilitate financial projections for the life of the Medical Monitoring Plan and to be used to assist the Medical Advisory Panel when it is created in the future.

vi. Prepare TPA Recommendations to the Sponsor and the Finance Committee regarding

(i) recommended medical testing and health care providers; (ii) recommended protocols with regard to provision of CT scans; (iii) proposed fee schedule and corresponding Medical Monitoring CPT codes; (iv) parameters of a comprehensive Database; and (iv) proposed Medical Monitoring Implementation Plan.

vii. If the Court determines that the Plain is a secondary plan and not a primary plan, private Benefits payment service to reasonably assure that a Claimant's primary payment sources are exhausted before the Plan pays for the Benefits.

viii. If the Court determines that the Database should provide necessary details to facilitate future scientific research, to develop parameters of such a comprehensive Database to facilitate future scientific research. However, in any event there will be a Central Repository which will maintain the testing history of the Project, in terms of Claimants tested, Provider services rendered, and related records. However, the Central Repository will be expanded so as to maintain the actual test results as part of the Database, if the Court determines this is necessary for future scientific research.

By August 1, 2011, the TPA shall:

i. Work with the Claims Administrator to submit the Medical Monitoring Budget for provisioning year one (beginning with a Projected Implementation Date of September 1, 2011). To the extent practicable, CTIA, in working with the Sponsor to create annual budgets and in carrying out the work under this Agreement, will plan to perform the work using competent personnel at the lowest available hourly rate. In addition, working with the Sponsor, CTIA will determine an annual fee and expense cap, based upon assumptions provided under the contract terms. If the assumptions changes, then the cap will be reasonably mediated by the Parties accordingly.

CTIA compensation for these initial Plan development services in this Part IIB of the Agreement, shall be at the hourly rates described in Exhibit G and is estimated for budget purposes to total no more than $50,000.00. However, CTIA shall be paid for all reasonable charges in connection with this portion of the Agreement.

C. **TPA Services**. CTIA shall provide TPA Services to implement and maintain the Benefits of the Medical Monitoring Program described herein, including, but not limited to: (i) maintaining the eligibility database in a HIPAA compliant manner, in a manner consistent with the terms of the Orders in Exhibit A, B and C, and all applicable Federal and State laws; (ii) the administering of the medical and testing services within an annual proposed budget; and (iii) engaging, as needed,

additional Providers. In doing so, CTIA shall provide medical testing and services and follow up physician visits, Medical Monitoring referrals, Medical Monitoring Claimant database development and maintenance, communication, customer service, and related consulting services, which include, but are not limited to, the following:

i. Communications:

a. Prepare communications materials, such as Claimant correspondence and Medical Monitoring Plan change notices. The TPA shall use any future-developed Sponsor logos on communications materials and correspondence with Claimants to be in conformity with established standards of the Sponsor.

b. Obtain approval of Providers and Sponsor for communications materials to include Claimant identification cards and the business relationship of CTIA, Sponsor, and Providers. Plastic ID cards shall be provided as Claimants begin Medical Monitoring, and will not be distributed annually, but only when a Claimant needs a card because the Claimant just is enrolling or needs to have a misplaced card replaced.

c. Provide toll-free telephone service for inquiries from Claimants.

ii. Claimant Service:

a. CTIA shall interface with the Sponsor to accurately develop an Eligibility Database and to ensure that the Claimants are properly enrolled in CTIA's system.

b. Develop and maintain a web site for use by the Providers, Claimants, and the Sponsor to assist Claimants in the Plan to (i) track their HIPAA information; (ii) track tests; (iii) schedule and monitor upcoming appointments; (iv) and provide general information regarding the Medical Monitoring Plan.

c. Prepare and print Plan Benefit booklets for distribution to the Members, as authorized by the Sponsor. The cost of materials, printing, and postage associated with the distribution of Benefit booklets shall be borne by the Sponsor.

d. Distribute Benefits booklets for Members in the Plan within 14 days from implementation of the Medical Monitoring Plan or in response to individual requests from Members. Plan booklets with include identification and relationships of CTIA and the Sponsor and the Providers.

e. Maintain Member enrollment records for a minimum period of ten years after the

individual Members are no longer covered; and on-line history for no less than two years after the individual Members are no longer covered. Such records shall be maintained in accordance with prudent standards of insurance record keeping.

f. Conduct such correspondence and other communications as is necessary for the day-to-day maintenance of the Medical Monitoring Plan.

iii. Database Maintenance: Maintain the Database as described hereinabove in a HIPAA compliant manner and in a manner consistent with all State and Federal laws.

D. Financial Obligations and Representations: CTIA shall:

i. With the aid of Sponsor, establish a "Claim Fund Account", in the name of CTIA, as TPA for Sponsor. The initial funding of the Claim Fund Account shall be the amount given in IIB, above, as the cost estimate for Implementation Plan Development, with the funding to be made by Sponsor within three (3) business days after approval of this Agreement.

ii. Pay Providers used by the Sponsor's Plan from the Claim Fund Account, after CTIA verification and approval.

iii. Perform reconciliation of the Sponsor's Claim Fund Account. (Interest earned on this account, if any, will accrue to the Plan to be used for the benefit of the Claimants. Banking expenses incurred on this account will be borne by the Sponsor.)

iv. Provide the Sponsor with quarterly financial reports on the Plan, and the other Reports described in Exhibit F.

v. Maintain records clearly showing the deposits and withdrawals from the Claim Fund Account. Copies of these records shall be provided to the Sponsor upon their request.

vi. Maintain all books and records for a minimum period of thirty (30) years and in accordance with State and Federal laws, and on-line Claim payment history for no less than two years after the individual Claimants are no longer covered. Books and records shall be maintained in accordance with prudent standards of insurance record keeping.

vii. Sponsor will retain ownership of the Claim Fund Account, with CTIA being an authorized signatory for purposes of carrying out authorized payments only.

viii. CTIA will produce checks once each week drawn on the Claim Fund Account to all

approved Medical Monitoring Plan Providers. CTIA will notify Sponsor via email, before noon each Friday, as to the necessary funding to cover the weekly checks. If necessary, CTIA will hold printing the checks until the following Monday, allowing Sponsor enough time to transfer funds if necessary to notify CTIA to wait on issuing checks.

ix. The Claim Fund Account bank statements will be sent to the Sponsor for reconciliation. CTIA will provide a Claim Fund Account check register to Sponsor on a monthly basis. If checks do not clear after a month, CTIA shall be notified by Sponsor. CTIA will then contact the payee to see if a replacement check needs to be issued.

x. CTIA will maintain a complete record of all Claim Fund Account transactions for review by the Sponsor if and when desired.

xi. The Claim Fund Account will only be used for payment of Claims as identified hereinabove and as identified in the Medical Monitoring Implementation Plan to be approved by the Sponsor, Finance Committee, and by the Court. CTIA will submit an invoice to the Sponsor separately for CTIA's monthly fees and covered expenses per Exhibit G.

E. Claim Processing: CTIA shall:

i. Provide necessary facilities, personnel, databases, software, procedures, forms, and instructions for the prompt processing of any Received Claims.

ii. Certify the eligibility of Claimants to receive Benefits under the Plan by referring to the Claimant database maintained by Sponsor.

iii. Examine each Received Claim for Benefits under the Plan and take necessary steps to validate, compute the amount payable (if any), and disburse Payment or deny the claim in accordance with the administrative procedures set forth by the Sponsor in this Agreement and the Medical Monitoring Plan.

iv. Process Received Claims in accordance with procedures and Fee Schedules established by CTIA and the Sponsor for the Providers.

v. If the Court determines that the Plan is a secondary plan and not a primary plan, private Benefits payment service to reasonably assure that a Claimant's primary payment sources are exhausted before the Plan pays for Benefits.

vi. If the Court determines that the Database and Claim records should provide necessary details to facilitate future scientific research, to develop parameters of such a comprehensive

Database to facilitate future scientific research.

vii. CTIA shall, upon written request of a Claimant, Provider or the Sponsor, review any previously denied Claim in accordance with the Claims Appeal procedure of CTIA agreed to by Sponsor.

viii. Refer to the Sponsor for consideration and final decision any Questionable Claim(s) with a written analysis of the issues to assist the Sponsor in reaching a final decision.

ix. Provide each Claimant submitting a claim with a written Explanation of Benefits (EOB) supporting payment or denial of such Received Claim.

x. Conduct such correspondence and other communications with Claimants, Providers of covered services, and others as is necessary for the day-to-day administration of the Plan.

xi. Provide toll-free telephone service for inquiries from Claimant and Providers.

xii. Take reasonable action to recoup any overpayments to Providers of covered services.

xiii. Maintain Received Claim records for a minimum period of ten years after the individual Claimants are no longer covered and in accordance with State and Federal laws, and on-line claim payment history for no less than two years after the individual Claimants are no longer covered. Claim records shall be maintained in accordance with prudent standards of insurance record keeping.

xiv. Maintain capabilities to receive and transmit Claims in electronic formats to and from Providers, Claim Clearinghouses and other vendors in formats specified by HIPAA regulations.

xv. Claims Data extracts shall be provided at no cost to the Sponsor.

xvi. The per Claimant charge in Exhibit G includes all services described in this Agreement for each active Claimant. The per Claimant charges will be assessed on a per active Claimant basis. All administrative services related to the Claimant are included in the per Claimant charge. Within the next 30 days, the Claims Administrator and CTIA will try to finalize a definition of "active Claimant" for purposes of billing in Exhibit G with the Claims Administrator considering input from the Finance Committee. If these negotiations fail, then CTIA can complete the tasks in Part IIB of this Agreement and terminate this Agreement. If the negotiated definition is unsatisfactory to DuPont, then DuPont can obtain Court review thereof, following briefing by the Parties to this Agreement, DuPont and any other interested Parties.

F. **Engagement of Providers.**

i. Testing Service Providers. All testing providers shall provide "Benefits" in accordance with the Court's Orders in Exhibits A, B and C.

ii. Medical Service Providers. All medical service providers shall provide "Benefits" in accordance with the Court's Orders in Exhibits A, B and C, and as defined herein.

iii. CTIA will enter into written contracts with Providers to carry out this Agreement, upon review and agreement of said Provider agreements by Sponsor.

G. **Miscellaneous.**

i. Reports. CTIA shall provide to Sponsor the reports described in Exhibit F. CTIA may modify said reports at any time provided that the change does not materially change the overall content.

ii. Account Manager. CTIA shall assign an Account Manager who will manage Sponsor's account, serve as the primary contact for Sponsor and supervise the responsibilities of CTIA pursuant to this Agreement.

iii. Plan Consulting and Analytical Services. Upon request of Sponsor, CTIA shall provide Plan consulting and analytical services. For consulting and analytical services that CTIA determines will require time and resources in excess of the time projected in the annual budget, CTIA shall submit a price quote for Sponsor's approval before initiating the services.

iv. Additional Services. CTIA will provide Sponsor programs to encourage proper Medical Monitoring Plan services utilization, including, without limitation, Claimant and Providers compliance programs.

v. Access. CTIA will provide toll-free phone service numbers for Claimants and Providers at all times during CTIA's usual and customary hours of operation. The number is currently 800-245-8813; however, the number may change.

H. **Customer Service:**

i. Conduct such correspondence and other communications with Claimants, Providers, and others as is necessary for the day-to-day administration of the Plan.

ii. Provide patient-sensitive toll-free telephone service for inquiries from Claimants and Providers.

I. Consulting Service:

i. Provide to the Sponsor, or its designated representative, reports, which are described in Exhibit F.

ii. Negotiate Fee Schedules with selected Providers.

iii. Prepare and submit to Providers of service and the Internal Revenue Service form 1099-MISC for Claim payments made in conjunction with the Medical Monitoring Plan.

iv. Assist the Sponsor in obtaining actuarial opinions relating to Plan design, payment rates, and fee schedules.

v. Prepare and recommend Medical Monitoring Program Claim administration procedures and practices for the administration of the Medical Monitoring Plan and consult with the Sponsor on any changes thereto.

J. Other Services and Obligations:

i. Provide the Sponsor access to data as appropriate and reasonable for the purpose of auditing Provider or TPA services. CTIA will provide data necessary to conduct audits on electronic media (diskettes, tapes, etc.) at no additional charge to the Sponsor. The Sponsor will have the right to select an independent audit firm to perform TPA services audits during the term of this agreement. The Sponsor must give forty-five (45) days advance written notice to CTIA to schedule a TPA services audit.

ii. Run back-up data of the Sponsor's data each day. Back-up tapes, or other electronic media, will be stored in an off-site location, which is secure and environmentally suited for the storage of magnetic media.

iii. CTIA shall maintain a fidelity bond in the amount as required by the States of Iowa and/or West Virginia covering CTIA and any of its agents or employees who may collect, disburse or otherwise handle or have possession of any funds of the Medical Monitoring Plan or who may have authority to authorize or order disbursements of claims or other expenses on behalf of the Plan.

iv. CTIA shall maintain coverage for Errors and Omissions Insurance in the amount of no less than one million dollars ($1,000,000).

v. CTIA shall maintain a log of any complaints received from the Commissioner, a Claimant, or a Provider.

vi. CTIA hereby agrees to the mandatory terms in Exhibit H.

III. DUTIES OF THE SPONSOR

A. **Eligible Claimant Database:** The Sponsor shall provide the Member names and addresses on electronic media, for all eligible Plan Claimants, for the purpose of CTIA's administration of the Plan and communicating Plan Benefits.

B. **Establishment of the Claim Fund Account**. The Plan will establish and maintain with CTIA the Claim Fund Account described in Article II, above, with the initial funding described in Article II, to fund payment to testing and medical service Providers. The Sponsor will deposit funds to the designated Claim Fund Account as reasonably requested from time to time by CTIA to provide adequate reserves to be used for the following:

i. Payment for CTIA services, under IIB, following Sponsor approval of the invoice(s);
ii. Disbursement of Benefit payments to service Providers;
iii. Payment of all other expenses of the Plan that are authorized by the Sponsor and deemed appropriate and proper in connection with the Plan; and
iv. Sponsor will pay future CTIA bills directly.

C. **Authorization to Disburse Funds.** The Sponsor, by this Agreement, expressly authorizes CTIA to disburse funds from the Sponsor's Claim Fund Account pursuant to the provisions of this Agreement.

D. **Maintenance of Claim Fund Account.** The Sponsor agrees that it will maintain funds in said Claim Fund Account for the payment of checks issued by CTIA in accordance with the provisions of the Plan and this Agreement. CTIA will notify the Sponsor when additional deposits are required. The Sponsor, in accordance with paragraph II, D (viii) above, will transfer funds to the Claim Fund Account. CTIA shall not be liable for the payment of any Received Claims, fees, or expenses that may be required under the Medical Monitoring Plan and the Sponsor retains responsibility for the payment of all Received Claims under the Medical Monitoring Plan.

E. **Provider Audits.** The Sponsor will reasonably approve Provider audits by organizations other than CTIA as may be recommended from time to time by CTIA.

F. **Fiduciary Duties**. The Sponsor will be responsible for and act as the fiduciary for all activities associated with the administration of the Medical Monitoring Plan not performed by CTIA that are not carried out by CTIA. This includes the interpretation of governmental regulations, Medical Monitoring Plan documents, filing of reports to the Internal Revenue Service, and any communications to the Claimants, Providers, the Finance Committee, and the Court.

G. **Overpayments**. When necessary, the Sponsor will take reasonable actions to assist CTIA in recouping overpayments made to or on behalf of Claimants.

H. **Sponsor Cooperation.** The Sponsor shall cooperate with CTIA in the preparation and distribution of all documents to the eligible Claimants, including Benefit booklets, Claim forms, communications with Claimants and other documents as may be necessary or convenient for the proper administration of the Medical Monitoring Plan or to satisfy legal requirements.

I. **Logo Authorization.** The Sponsor authorizes CTIA to use the name and logo, if developed hereinafter, of the Medical Monitoring Program and/or of the Perrine DuPont Settlement in connection with the services specified by this Agreement.

J. **Amendments to Plan**. The Sponsor shall provide written notification to CTIA of any modifications or amendments to the Medical Monitoring Plan. CTIA or the Sponsor may require the execution of a modified Agreement. Material modifications to the Medical Monitoring Plan may, at CTIA's or the Sponsor's option, result in pricing revisions effective as of the date of Plan revision.

IV. ADMINISTRATIVE FEES

CTIA agrees to provide the Sponsor, upon the terms and conditions set forth herein, the types of claim processing, managed testing services and care, and administrative and other TPA Services described in Article II. The Sponsor agrees to receive and purchase the Services Provided by CTIA (collectively, the "Services"), upon the terms and conditions set forth herein and in Exhibit G.

A. **Service Fees.** The Sponsor acknowledges that it shall be required to pay Service Fees based upon the fees designated in Exhibit G.

B. **Reimbursements**. The Sponsor hereby specifically acknowledges that CTIA will be reimbursed for reasonable expenses incurred in the establishment and maintenance of the Plan Provider network, if any, as depicted in Exhibit G. These reimbursements are limited to fees and expenses in Exhibit G and do not include salaries and benefits of CTIA employees. All reimbursements must be accompanied by an invoice specific to the service provided and specific Providers.

V. ADJUSTMENT OF FEES

Upon agreement of the Sponsor, the fees set forth for the Services in Exhibit G shall be subject to adjustment, effective with each Renewal Term, as defined in Article VIIB, or in such shorter period of time as may be required by any government, judicial, administrative or regulatory authority with respect to any given adjustment. Written notice of the fee adjustments proposed by

CTIA shall specify the services for which fees are being adjusted, and include a full and complete copy of a new Exhibit G which reflects all of the fees for the Services, as so adjusted by CTIA.

VI. BILLING; METHOD OF PAYMENT

The Sponsor agrees that the payments, which may be required of the Sponsor under this Agreement and in Exhibit G, shall be paid to CTIA and shall be due and payable within ten (10) days of receipt of the billing.

VII. TERM

A. **Initial Term.** This Agreement shall become effective following Court approval, and shall continue in full force through the period ending May 31, 2012.

B. **Renewal Terms.** The term of this Agreement shall automatically continue for additional one year terms ("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 as provided in Section C, below.

C. **Termination.**

i. This Agreement will terminate at the end of the Initial Term or at the end of any Renewal Term by one party providing written notice of termination to the other party at least thirty (30) days prior to the date ending the term.

ii. 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.

D. **Termination for Insolvency**. If either party applies for or consents to the appointment of a receiver, trustee, or liquidator of itself or of all, or a substantial part, of its assets; files a voluntary petition in bankruptcy; admits in writing to its inability to pay its debts as they become due; makes a general assignment for the benefit of creditors; files a petition or an answer seeking reorganization or rearrangement with creditors; or, as a debtor, invokes or takes advantage of any insolvency law; or if an order, judgment, or decree is entered by a court of competent jurisdiction upon application of a creditor adjudicating such party bankrupt or insolvent or approving a petition seeking reorganization of such party of all, or a substantial part, of its assets, and such order, judgment, or decree continues unstayed for thirty (30) days, then the other party may, by written

notice, terminate this Agreement effective on any future date specified in such notice.

E. **Effect of Termination**. In the event of a termination, this Agreement shall be of no further force or effect except that each party hereto shall remain liable for any debts and/or liabilities arising from activities under this Agreement occurring prior to the effective date of termination.

F. **Payment of Claims After Termination**. For a period of one hundred eighty (180) days after termination of this Agreement, at the request of Sponsor, CTIA shall continue to process requests for Claims received after the termination date for Medical Monitoring Plan Benefits that were fulfilled on or prior to the date of termination. Sponsor agrees to continue to pay CTIA and the Providers on the same basis as if this Agreement had continued in effect while those services are performed.

G. **Continuation of Services**. Except for termination due to Sponsor's breach, CTIA agrees that upon termination of the Agreement, at Sponsor's request for continuation of services, it will continue to provide services hereunder (including services with respect to Claims received after the effective date of expiration or termination),provided Sponsor complies with all the terms and provisions of this Agreement in effect prior to the termination. The fees for such continuation period shall be the fees in effect at the time the continuation request is made; however, any other obligations on the part of CTIA shall cease.

H. **Information Transfer**. In the event of termination of this Agreement, CTIA agrees to provide Sponsor all Information in CTIA's possession pertaining to all services, records, and efforts related to this Agreement, consistent with reasonable TPA industry norms. It is understood that for retail claims data, CTIA shall provide one billing tape in standard NCPDP format at no cost to Sponsor. If Sponsor or the Replacement TPA require an element of Information that is not in standard NCPDP format, such data element shall be provided, if available in CTIA records, at a mutually agreed cost to Sponsor. For any other data, CTIA will provide data in its possession and reasonably requested by Sponsor or Replacement TPA at a mutually agreed cost. CTIA may provide the data by electronic wire communication or a media type such as disk, tape, or CD. CTIA shall not be required to perform under this paragraph unless Sponsor has provided CTIA with at least ninety (90) days prior written notice of its data needs and the parties have mutually agreed on the fee payable to CTIA. If this Agreement terminates before such ninety (90) day period can occur, CTIA shall still have ninety (90) days to provide the data.

VIII. MODIFICATIONS

Reasonable modifications and improvements in existing procedures and systems may be made by CTIA, in its sole reasonable discretion, after providing prior notice of fourteen (14) days to Sponsor, provided that the modifications do not materially alter the terms of this Agreement. Any such

modifications and improvements, which would affect the Sponsor's procedures, will be communicated to the Sponsor by CTIA. Sponsor may also make, in its sole reasonable discretion, modifications in existing procedures and systems at the sole reasonable request of the Sponsor; provided, however, that the Sponsor shall in all events reimburse CTIA for all reasonable costs and expenses incurred by CTIA to make and effectuate modifications and improvements requested by the Sponsor, and provided that the modifications do not materially alter the terms of this Agreement.

IX. PROPERTY RIGHTS AND CONFIDENTIALITY

A. **Computer Equipment.** All computer equipment owned by CTIA, programs, drawings, diagrams, specifications, manuals, forms, procedures, data files (but not the data therein belonging to the Sponsor), and all other information and materials of any nature furnished, revealed or otherwise made available to the Sponsor by CTIA, whether on CTIA's premises or the Sponsor's premises (the "CTIA Information"), shall remain the sole and exclusive property of CTIA. All other Information generated in carrying out the Plan is hereby designated the "Sponsor's Information." The Sponsor's Information shall be and remain the sole and exclusive property of the Sponsor. CTIA shall return the Sponsor's Information to the Sponsor within thirty (30) days from the date of termination of this Agreement. Notwithstanding anything herein or otherwise which may appear to be to the contrary, CTIA shall be free to dispose of the Sponsor's Information or otherwise delete it from CTIA's system if written notice is not received from the Sponsor within ninety (90) days of the termination date of this Agreement.

B. **HIPAA Compliance.** CTIA is a Business Associate of the Sponsor pursuant to the Health Insurance Portability and Accountability Act of 1996 and the Department of Health and Human Services Privacy Regulations pertaining thereto. Accordingly, CTIA, its subcontractors, and the Sponsor are required to maintain the confidentiality of Protected Health Information that the Medical Monitoring Plan's records and documents may contain. CTIA will take necessary precautions to safeguard the confidentiality of all information and to prevent access thereto by parties not authorized by the Sponsor. It is understood, however, that CTIA may furnish or reveal any information to any state, federal or other governmental regulatory authorities, agencies or commissions who have jurisdiction over the Sponsor or CTIA; or as required by law, legal process, or a court of law.

C. **Storage and Inspection.** All documents, books, and records furnished to CTIA by the Sponsor provided in accordance with this Plan and this Agreement shall remain the property of the Sponsor; and all documents, books, and records of CTIA provided in accordance with the Medical Monitoring Plan and this Agreement pertaining to any individual insurance, group insurance, or services, whether original records of CTIA or furnished by the Sponsor, shall be open for inspection at CTIA's principal place of business, unless otherwise agreed, at all reasonable times. CTIA may store any or all of such documents, books, and records in microfilm, magnetic tape, or other similar

medium.

D. To the extent feasible, upon termination of this agreement, CTIA will destroy or return to the Sponsor all Protected Health Information received or created by CTIA on behalf of the Plan; however if it is not reasonably feasible, the protections of this Agreement shall continue to apply to such information after the termination of this Agreement.

X. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. Unless prior Court or Claimant authorization is required, CTIA may use Protected Health Information and may disclose Protected Health Information to provide its services under this agreement or as required by law. Additionally, CTIA may disclose Protected Health Information to a third party as authorized by the Sponsor or as authorized by a Claimant with respect to his or her own Protected Health Information.

B. CTIA shall use appropriate reasonable safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this agreement.

C. CTIA will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the U.S. Department of Health and Human Services for purposes of determining the Medical Monitoring Plan's compliance with all applicable privacy rules.

XI. LIABILITY

A. **Claim Processing Error or Omission.** In the event of any Claim processing error or omission on the part of CTIA that is reasonably correctable by the reprocessing of Claim information, at the expense of CTIA, CTIA will reprocess such Claim information with the cooperation of the Sponsor and such reprocessing shall be in full satisfaction of all of the Sponsor'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 CTIA and the Sponsor.

B. **Indemnification.**

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

in any negligent or criminal matter. It is recognized that neither DuPont, nor Class Counsel, nor the Finance Committee is responsible for CTIA's performance under this Agreement, as a result, they are not responsible for the conduct of CTIA hereunder. CTIA agrees to use reasonable efforts to add DuPont as an additional loss payee on CTIA's errors and omissions policy, with the cost thereof, if any, to be paid directly by DuPont.

ii. **Indemnification of CTIA.** The Sponsor agrees to indemnify and hold harmless CTIA 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 the Sponsor in the performance of its responsibilities pursuant to the provisions of this Agreement or the provisions of the Plan, except any such claims, losses, liabilities, damages, or expense which arise out of or in connection with CTIA's or any CTIA officers', employees' or agents' sole negligence, willful misconduct, or criminal misconduct.

iii. **Indemnification Notice.** The indemnified party shall notify the indemnifying party in writing promptly upon learning of any Claim for which indemnification may be sought hereunder, and shall tender the defense of such claim to the indemnifying party and give the indemnifying party a reasonable opportunity to comment on such defense. No party shall indemnify the other with respect to any claim settled without the indemnifying party's written consent, which shall not be unreasonably withheld.

XII. RECORD TRANSFER FEES

Upon termination of this Agreement, for whatever reason, the Sponsor shall reimburse CTIA, within thirty (30) days of the date of CTIA' s billing statement, for all costs, expenses and fees as may be incurred by CTIA to fully and completely discontinue the Services to the Sponsor including, without limitation, expenses to delete the Sponsor's Information from CTIA' s systems or to provide the same to the Sponsor. CTIA shall have access to the Sponsor's premises to the extent necessary for CTIA to discontinue the Services to the Sponsor. Total costs, expenses and fees shall not exceed $1,000.00.

XIII. MANDATORY TERMS

The Mandatory Terms in Exhibit H are a part of this Agreement, and are incorporated herein by reference.

XIV. FORCE MAJEURE

Notwithstanding anything herein or otherwise which may appear to be to the contrary, CTIA 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 CTIA or due to or in any way related to

or connected with any act or omission of the Sponsor or any employee, agent, personnel or other representative of the Sponsor. 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.

XV. NOTICES

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

A. If to CTIA to:

CTI Administrators, Inc.
100 Court Avenue
Des Moines IA 50309
Attention: Donald R. Brandt, President
(515) 244-7322 (ext. 233)
(515) 244-8650 (fax)
email: dbrandt@claimtechnologies.com

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

B. If to the Sponsor, to:

Edgar C. Gentle, III, Esq.
Claims Administrator
Perrine v. DuPont Claims Administrator Office
55 B Street
West Virginia, 26438
(304) 622-7443
(304) 622-7447 (fax)
email: escrowagen@aol.com

Edgar C. Gentle, III, Esq.
Claims Administrator
Perrine v. DuPont Claims Administrator Office
501 Riverchase Parkway East
Hoover, AL 35244
(205) 716-3000

(205) 716-3010 (fax)
email: escrowagen@aol.com

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

XVI. ENTIRE AGREEMENT

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 matter hereof. All exhibits and schedules are incorporated into this Agreement as if set forth in their entirety and constitute a part thereof.

XVII. NO WAIVER; MODIFICATIONS IN WRITING

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 Sponsor and CTIA are cumulative and are not exclusive of any remedies that may be available to the Sponsor and CTIA 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.

XVIII. SEVERABILITY

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.

XIX. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of West Virginia but without regard to the provisions thereof relating to conflicts of law. Any disputes

arising out of, or as a result of, this Agreement shall be resolved in accordance with Exhibit H, the Mandatory Terms, and in accordance with the following terms:

TPA, by its execution of the Agreement, submits to the jurisdiction of the Circuit Court of Harrison County, West Virginia in Perrine, et al., v. E. I. DuPont De Nemours and Company, et al., Case No. 04-C-296-2, (the "DuPont Case") for all purposes related to or arising out of the provision of TPA services to the Medical Monitoring Plan. In addition, TPA hereby waives any and all objections it might otherwise assert to the aforesaid jurisdiction, venue, or authority of the Court in the DuPont Case to hear and determine any and all disputes that might arise out of or be related to the Services, reserving its rights to be heard in connection therewith and to appeal, it may be advised, from any adverse determination of the Court in the DuPont Case.

XX. RELATIONSHIP

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.

XXI. HEADINGS AND CAPTIONS

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.

XXII. BINDING EFFECT ON SUCCESSORS AND ASSIGNS

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 Sponsor nor CTIA 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.

XXIII. MISCELLANEOUS

A. **Audits**. Each Party shall be entitled to audit the other Party's records that relate to the other Party's obligations undertaken pursuant to this Agreement. The audit shall be conducted at the auditing Party's expense using either CPA's working for the Party in conducting an internal audit of the other Party, or conducting an outside audit of the other Party, using a mutually acceptable national public accounting or CPA firm, independent accountant, consultant or vendor. The auditing Party shall ensure that its CPA's or the auditing firm, independent accountant, consultant or vendor, as applicable, has entered into a mutually acceptable confidentiality agreement prior to the audit, and Sponsor, and/or auditing party shall indemnify CTIA, or Sponsor, as applicable, for any breach thereof. Audits may be conducted once annually upon sixty (60) days prior written notice, during regular business hours at the place of business of the record holder, and shall be subject to all applicable laws, and including any confidentiality and audit-related provisions in this and other contracts. Additionally, CTIA will make complete Sponsor Plan year Provider claims detail available to Sponsor or Sponsor's designee in a format acceptable to both parties such as CD ROM or magnetic tape, suitable for Sponsor or Sponsor's designee for evaluation of claim payment and administrative accuracy. CTIA shall provide the claims detail file at no charge to Sponsor. Such audit rights shall expire six (6) months after the end of, and are limited to, payments within a current contract term, unless otherwise required by law or in order to reimburse government payors. Each Party reserves the right to maintain the confidentiality of proprietary business information to the extent such information is not required to audit the Party's obligations under this Agreement. Except as otherwise set forth herein, the audit results shall be made available by the auditing Party to the other Party.

B. **Advertising Promotion, and Trade Name**. CTIA may not list Sponsor as one of CTIA's clients in proposals and responses to proposals for the development of new business, without Sponsor's prior written permission. Sponsor may use CTIA's name, in any form other than its logo, in marketing materials, in a form acceptable to CTIA. Sponsor may not use CTIA's name or logo, or any form thereof, in such a way as to convey that CTIA is an administrator and/or fiduciary with regards to Claimants, Benefits, and the Medical Monitoring Plan, including, but not limited to, Medical Monitoring Plan terms, provisions, rights and/or obligations.

C. **Exclusivity**. Sponsor agrees that during the term of this Agreement, it shall not utilize the services of another entity to provide the services CTIA has agreed to perform under this Agreement.

D. **Third Party Beneficiaries**. CTIA and Sponsor specifically state, acknowledge, and agree that it is their intent that no other parties, including, but not limited to, Claimants or Providers, shall be third party beneficiaries to this Agreement.

E. **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.

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

The undersigned certifies that he has legal authority to bind CTIA.
CTI Administrators, Inc.
By:_____
Donald R. Brandt
Title: President
Date: _____

The undersigned certifies that he has legal authority to bind Sponsor upon approval of this Agreement by the Court in the DuPont Case.

The Perrine DuPont Settlement

By: _____
Edgar C. Gentle, III
Title: Special Master and Claims Administrator
Date: _____

EXHIBITS AND SCHEDULES

EXHIBIT A	Final Order dated January 18, 2011 Setting Forth the Scope and Operation of the Medical Monitoring Plan
EXHIBIT B	Final Order dated January 4, 2011 Approving Settlement
EXHIBIT C	Final Order dated February 28, 2011 Approving Health Care Provider Third Party Administrator Request for Proposals and Candidate List
EXHIBIT D	March 1, 2011 Request for Proposals for Third Party Administrators for the Administration of a Medical Monitoring Program
EXHIBIT E	CTIA Medical Monitoring Proposal for the Spelter Claimants in Perrine v. DuPont of March 31, 2011
EXHIBIT F	Details of CTIA Quarterly Reports to be Provided to the Sponsor
EXHIBIT G	CTIA Negotiated Administrative Fee Schedule
EXHIBIT H	Mandatory Terms
EXHIBIT I	Dr. Werntz Report and Memorandum of Understanding

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EXHIBIT A

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. DU PONT DE NEMOURS AND COMPANY, et al.,

Defendants.

FINAL ORDER SETTING FORTH THE SCOPE AND OPERATION OF THE MEDICAL MONITORING PLAN

Presently pending before the Court is the "Special Master's Report No. 1 (Medical Monitoring), Recommendations, Requests for Comments, and Prayer for Relief from the Court," which was prepared at the Order of the Court and filed on or about June 23, 2008. Additionally, the Special Master filed a Supplement to Report No. 1 on or about October 25, 2010. Both the Report and the Supplement outline proposed actions for the Court to take while directing the administration of the medical monitoring program. The Report contemplated the original plan as outlined in the verdict. The Supplement slightly modified the Report to accommodate the judgment granted by this Court to the minors and incompetents in the medical monitoring class. Additionally, the Court previously entered the "Final Order Regarding the Scope, Duration, and Cost of the Medical Monitoring Plan," on February 25, 2008, although certain aspects of that Order have changed in conjunction with the Settlement, as noted in this Order and the Final Order Approving Settlement entered on January 4, 2011.

In relation to the medical monitoring program and the settlement of this case, the Parties have filed several motions. Namely, the Plaintiffs filed the "Motion for Appointment of Claims Administrator for Property Remediation," and the "Motion to Appoint a Claims Administrator & Establish Medical Monitoring Settlement Executive Committee," on December 22, 2010. On December 27, 2010, the Defendants filed a "Motion to Establish Medical Monitoring Settlement Executive Committee." On December 28, 2010, the Defendants filed a Response to the Plaintiffs' Motion to state that the Parties are not in agreement about the function of the proposed settlement executive committees.

Finally, the Parties and the Settlement Administrator, Edgar Gentle, executed the "Stipulation of Parties and Settlement Administrator," on or about January 10, 2011, for the purpose of "acknowledg[ing] the clear meaning of the aforesaid Memorandum of Understanding." The Stipulation includes two (2) provisions, the first, generally stated, is that DuPont has fully funded the administrative start up costs for the medical monitoring program through the seventy ($70,000,000.00) million dollar settlement and will only have to provide additional administrative costs once testing commences. The second provision is that "there shall be no requirement that a medical monitoring class member register for or avail themselves of the medical monitoring program or service in order to receive a cash payment from the medical monitoring fund, provided that class membership is proven."

The Court will now address the Parties' Motions as to the Claims Administrator and proposed settlement executive committees.

Two primary observations greatly simplify the Court's decision on these Motions: first, there is no need to appoint a claims administrator for either the property class or the medical monitoring class because Edgar Gentle, of the law firm Gentle, Turner and Sexton, is the Claims Administrator for both classes as of the February 25, 2008, Order of this Court. Second, the Parties are not in dispute about the property remediation class, so its administration will proceed under the direction of Mr. Gentle, as previously Ordered by this Court.

The February 25, 2008, "Order Appointing Claims Administrator," specifically held that:

> The Court hereby engages Edgar C. Gentle, III, as the Claims Administrator and Special Master to aid the Court in carrying out the medical monitoring, property remediation, and punitive damages distribution aspects of this case. Mr. Gentle will serve as Claims Administrator and Special Master at the discretion of the Court. The Court may modify this Order at any time... Mr. Gentle's appointment is under the authority of West Virginia law[1] allowing the Court to exercise general powers and responsibilities over class actions. His actions as Claims Administrator and Special Master (and those of his agents and employees), in accordance with this Order and all future Orders of this Court, will constitute judicial actions of this Court and be protected, to the maximum extent allowable by law, by the doctrine of judicial immunity. Lastly, pursuant to W. Va. R. Civ. Rule 54(b), the Court directs the entry of this Order as to the claims above upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

The only aspect of the above cited Order which is no longer relevant is the distribution of money for punitive damages, as the award for punitive damages has been eliminated through the settlement, and the Court sees no reason to change the above quoted Order in any other respect.

[1] Aluise v. Nationwide Mutual Fire Insurance, 218 W. Va. 498, 625 S.E.2d 260 (2005); State ex rel Mantz v. Zakaib, 216 W. Va. 656, 609 S.E.2d 870 (2004).

Therefore, although the Court has the power to revisit its previous Orders as necessary, both of the Plaintiffs' Motions are **DENIED** as **MOOT**, because Mr. Gentle is the Claims Administrator for both classes pursuant to Order of the Court dated February 25, 2008.[2]

Next, the Court has considered the Defendants' arguments in the "Motion to Establish Medical Monitoring Settlement Executive Committee" and compared the function of said committee against the recommended plan in the Report and Supplement to the Report. Further, the Court has reviewed the November 19, 2010, Memorandum of Understanding, which outlines several agreed provisions of the medical monitoring plan, and the Stipulation of January 10, 2011. The Defendants now request, in contradiction to the Memorandum of Understanding and prior February 25, 2008, "Order Appointing Claims Administrator," that the ultimate administrative authority for running the medical monitoring plan should rest with a three person panel serving two year terms, with the authority to hire or fire the actual administrator of the plan and the authority to act as an intermediate appeal board for issues regarding exclusion or inclusion of potential class members. The Defendants assert that the power to administer the plan should not be vested in one individual due to the thirty (30) year length of the plan and that control of the plan needs to be "institutional."

The Court understands and appreciates the Defendant's concern with the course of the plan over the next thirty years, but the proposed settlement executive committee is unnecessary. First, the Court notes that Mr. Gentle and his firm have the prior

[2] However, the Parties should note, as further outlined in this Order, the Finance Committee as established by the Court will have many of the responsibilities that the Parties have requested for the proposed settlement executive committees.

experience and expertise[3] needed to administer this plan, while the members of the proposed committee are unknown and likely would not have the same experience. Second, Mr. Gentle has been involved with this case for more than two (2) years and is ready to begin to administer the plan, while it would take time to form a committee, whose members would need even more time to understand the massive undertaking presented by this case. Third, a committee is unnecessarily expensive because Mr. Gentle can administer the plan with the oversight of the Court as a safeguard. Fourth, the creation of unnecessary committees is better suited to the legislative and executive branches of government. Fifth, the Court alone is the institutional oversight that the Defendants seek; namely, should Mr. Gentle retire, pass away, or commit some malfeasance, the Court will replace him. The Circuit Court has been serving the Citizens of Harrison County since 1863 and, from all indications, will continue to do so for the next thirty (30) years while the medical monitoring plan is implemented.

Mr. Gentle has not been appointed for life, but instead serves under the supervision and direction of the Court. Mr. Gentle, as Special Master and Claims Administrator, answers to the Court, and the Court serves the Citizens of this County and the State of West Virginia. Should the administration of the plan fail to satisfy any

[3] The Court notes that Mr. Gentle has administered large class action settlements for approximately twenty years. Specifically, Mr. Gentle has served as a Special Master for the MDL 926 Court in the Baxter, Bristol, and 3M Breast Implant Settlement since 1992 which has involved more than 1.1 billion dollars, worldwide claimants, and over two hundred thousand (200,000) checks issued to claimants. Additionally, Mr. Gentle has been in charge of more than 1 billion dollars in investments for the Dow Corning breast implant settlement. Next, Mr. Gentle has administered the settlement of a class action over PCB contamination involving more than 18,000 claimants, a fund of approximately 300 million dollars, and the defendants Solutia, Inc., Monsanto Co., and Pharmacia Corporation. Said administration has resulted in more than seventy thousand checks being issued to claimants. *See* Gentle, Edgar C., III, "Administration of the 2003 Tolbert PCB Settlement in Anniston, Alabama: An Attempted Collaborative and Holistic Remedy," 60 Ala. L. Rev. 1249 (2009). Finally, Mr. Gentle is a Rhodes Scholar, and along with his law partner Terry Turner, drafted a complete and revised Constitution for the State of Alabama from 2000 to 2001.

of the Parties, they may petition the Court to change the administrator of the plan, and as outlined in the settlement, this Court retains jurisdiction over this case, and the Court's decisions are always subject to review by the Supreme Court.

The Court finds that it is critical that the Administrator be answerable to the Court and not subject to influential pressure from one side or the other or subject to deal making by the Parties. To create an executive committee with such vast authority as proposed by the Defendants would be an impermissible delegation of the Court's authority and responsibilities to the Parties. To do so would be tantamount to the inmates running the asylum.

For the foregoing reasons, the Court hereby **DENIES** the Defendants' "Motion to Establish Medical Monitoring Settlement Executive Committee."

Next, the Court **ORDERS** the following as to the establishment of the medical monitoring plan:

a. There shall be an initial enrollment period of six (6) months, beginning no later than **April 15, 2011**, whereby the Claims Administrator, Edgar Gentle, will set up a system for any Plaintiff who is a member of the medical monitoring class to enroll in the medical monitoring program to avail themselves of the future monitoring benefits of the program. During this six (6) month enrollment period, any qualified Member of the Plaintiff Medical Monitoring Class may enroll in the medical monitoring program. No class member shall be entitled to participate in said program unless he or she has enrolled during the initial six (6) month enrollment period. However, if a purported class member submits an application to enroll

during the six (6) month period and such enrollment is disputed or unclear and a final determination as to the eligibility of the class member is made outside of the six (6) month period, said enrollment shall be retroactive to the application date, assuming that the individual is eligible, and the individual shall have timely enrolled in the Class. As long as the Class Member has continuously lived in the Class Area prior to reaching the minimum residence threshold, a Class Member's number of years of residence in each respective Class Area will be accumulated to determine if the threshold has been met. For example, if a Class Member lived ½ year in Zone 1 and 1 ½ years in Zone 2, he or she would qualify for medical monitoring, having fulfilled 50% of the residency required in each zone.

b. A Finance Committee, comprised of three individuals, including one representative from class counsel, one from Dupont, and the Claims Administrator, Edgar Gentle, shall be created for purposes of advising the Court on the structure and execution of the medical monitoring program. Class Counsel and DuPont shall inform the Court of their respective choices for representatives on the Finance Committee within five (5) days of the entry of this Order.

c. The Finance Committee shall exist for the purpose of providing guidance and advice for the operation of the medical monitoring program. In the event any decision is made by the Claims Administrator with respect to the payment for services or costs in the medical monitoring program to which

either Party takes exception, then either Party shall have the right to bring such objection or exception to the Court and, if necessary, may appeal the determination of the Court within the West Virginia judicial system.

d. The Finance Committee will provide guidance and, hopefully, will operate in a collaborative fashion to provide an effective and efficient medical monitoring program. In the event that the Finance Committee cannot reach an agreement on how to proceed on any issue before it, final decision making authority shall rest with the Claims Administrator, Edgar Gentle, with such decision(s) reviewable by the Court.

e. The Parties reserve the right to reasonably challenge the enrollment of any class member in the medical monitoring program. With respect to any challenge relevant to the issue of eligibility for enrollment, the challenger shall pay reasonable costs and attorney fees if the challenge is unsuccessful. The Court will hear any disputes as to the inclusion or exclusion of a potential class member.

f. On an annual basis the Court, upon recommendation of the Finance Committee, shall direct DuPont to pay a sum certain that will be set aside for each such calendar year to reasonably secure such expenditures as are reasonably necessary to execute the Medical Monitoring Program, in advance, for such following calendar year. In each subsequent year after the first, DuPont shall be credited with any amounts remaining from the prior year in determining the amount of payment for the subsequent year. Additionally, should there be a monetary shortfall during a calendar year

due to reasonable expenditures exceeding the budget; the Class Administrator shall petition DuPont for such reasonable and necessary monies as to remedy the shortfall. DuPont shall provide such monies within twenty (20) business days of receipt of the Petition.

g. The program shall be implemented consistent the Court's Order of February 25, 2008, and as modified by the Final Order Approving Settlement and this Order. The program shall provide those examinations and tests set forth in the Court's Order of February 25, 2008, with the exception that the duration of the program shall be thirty (30) years in length, and that no routine CT scans shall be performed. CT scans will only be performed as part of the medical monitoring program when a competent physician determines that a CT scan is diagnostically medically necessary as relevant to the possible exposure to heavy metal contamination. Any disputes and/or objections to the necessity of providing a CT scan in a given situation shall be decided by the Claims Administrator with such decision reviewable by this Court.

h. Additionally, after the initial six (6) month sign-up period has concluded and the number of participating Plaintiffs, be they adults or minors, is known, Defendant DuPont, in the ordinary course of its business, shall set aside reasonable reserves as required by applicable law which shall cover the estimated cost of the entire thirty (30) year medical monitoring program.

i. In regards to the four (4) million dollar ($4,000,000.00) fund specifically ear-marked for cash payments to the medical monitoring class by the Memorandum of Understanding, the Court makes the following Orders:

i. The four (4) million dollar ($4,000,000.00) fund is specifically for the sole benefit of the medical monitoring class and shall provide cash payments to the same, in a form and fashion to be determined by the Finance Committee and Claims Administrator and approved by the Court.

ii. There shall be two separate lists of medical monitoring claimants: the first shall be for only cash payments, and the second shall be for medical monitoring. Class members may sign up for either or both lists.

iii. There shall be no requirement that a medical monitoring class member register for or avail themselves of the medical monitoring program or service in order to receive a cash payment from the medical monitoring fund, provided that class membership is proven.

j. The money to fund the administrative start-up expenses of the medical monitoring program, including providing notice to potential class members, shall come from the four million dollar ($4,000,000.00) Qualified Settlement Fund. The Court finds that the most equitable solution to funding the start up costs of the medical monitoring program is to have only those individuals who are members of the medical

monitoring class shoulder the burden. Distribution of start up expenses from the sixty-six million dollar fund would negatively impact those property class members who do not participate, or are not eligible to participate, in the medical monitoring program.

k. DuPont, by paying the sum of seventy million dollars ($70,000,000.00) as part of the settlement of this matter, has paid in full for any and all start up costs and expenses necessary for the medical monitoring program, and DuPont will not be billed for or responsible for any associated costs or expenses until the testing commences. At that time, consistent with the yearly budget procedure outlined above, DuPont shall fund the medical monitoring program, including administrative costs, on an annual basis. Finally, the Claims Administrator shall attempt to combine administrative expenses between the property and medical monitoring classes to be as cost effective as possible. For such costs that are equally attributable to either class, the Claims Administrator shall establish an equitable ratio to split the costs between the property and medical monitoring classes.

l. Any and all decisions of the Claims Administrator shall be reviewable by this Court, and each Settling Party shall have the right to pursue any and all appeals of this Court's final orders and decisions to the extent such is permissible under West Virginia law.

To accomplish the above stated guidelines, the Claims Administrator, Edgar Gentle, is hereby **ORDERED** to accomplish the following:

1. Within ten (10) days after the entry of this Order, the Claims Administrator should submit to the Parties and the Court the proposed Class Member Medical Monitoring registration forms and the recommended criteria for proof of Class Member Medical Monitoring eligibility. To the extent practicable, objective and easily obtained proof of residency in the Class Area for the period necessary to be eligible for Medical Monitoring will be utilized, with source documents such as Class Area voter registration rolls, Class Area ad valorem property tax records, Class Area Medical Clinic patient rolls, and Class Area utility billing records. For children, source documents will include Class Area school registration rolls and Class Area Medical Clinic patient rolls. To the extent possible, such source documents will be kept confidential.

2. Additionally, within ten (10) days after the entry of this Order, the Claims Administrator shall submit a timeline of reasonable goals and dates to accomplish the directives of the Court and any other administrative details that may be necessary to the Parties and the Court, including starting class sign ups on or before April 15, 2011.

3. The putative Class Members shall be given appropriate notice of and information concerning the Medical Monitoring Program's terms. Notice measures shall include a notice mail-out to those putative Class Members which have been identified, and publication of notice in local or prominent West Virginia newspapers. To facilitate notice to putative Class Members living outside the Class Area, the registering Class Members will be asked to complete a questionnaire providing the names and address of relatives and acquaintances known to live or to have previously lived in the Class Area, followed by a notice mail-out to these additional putative Class Members. No additional

funding beyond the seventy million dollar settlement funds shall be required from DuPont to accomplish these preliminary notices.

4. In order to organize and coordinate the medical monitoring program inside and outside of the Class Area, which will involve the completion of detailed health questionnaires, direct physical examinations, and collection of lab samples for analysis, the Claims Administrator shall create a computer-based data gathering system, with data for all Class Members to be entered into the same database wherever the participating medical provider and Class Member are located. Subject to the terms of a Protective Order, which shall be considered by the Finance Committee and the Claims Administrator and recommended to the Court, and after signing a Confidentiality Agreement, which shall likewise be considered by the Finance Committee and the Claims Administrator and recommended to the Court, the Claims Administrator shall have real time access to the database, and DuPont and Class Counsel shall have access to the database with claimant-specific information redacted and unique identifiers, such as a numbering system, used instead of names.

5. Next, the Claims Administrator shall initiate a bidding process through a Third Party Administrator of health plans who shall be engaged to facilitate identification of a national laboratory or other such vendor to provide out-of-Class Area medical monitoring and in-Class Area medical providers, located in or near the Class Area, to provide medical monitoring in the Class Area, while assuring testing and access to care per the Medical Monitoring Order of February 25, 2008, at page 10. The Third Party Administrator of health plans using the CPT Codes contained in Appendix A to Dr. Werntz's March 30, 2007 Proposed Medical Monitoring, shall negotiate prices charged

by in-Class Area and out-of-Class Area medical providers, subject to review by the Parties through the Finance Committee and approval by the Claims Administrator and, ultimately, the Court. In the medical monitoring registration process, Class Members living both inside and outside the Class Area will be asked which medical providers they prefer to conduct the testing, which will be a material factor in selecting the providers utilized for medical monitoring along with the lowest cost per unit of testing.

6. The Court has determined that there shall be a Medical Advisory Panel to facilitate the Claims Administrator's quality control audits of the medical monitoring program, and to advise the Claims Administrator and the Court, with input from the Parties, on periodically updating medical monitoring protocols based on scientific and medical developments following the first five years of medical monitoring, as contemplated on page 15, decretal paragraph 1 of the Medical Monitoring Order of February 25, 2008. The Parties, via the Finance Committee, shall have input concerning the appropriate make up of the Medical Advisory Panel, its membership and its specific duties for the Court's review.

7. Next, the Court Orders that the Claims Administrator, Edgar Gentle, establish a Claimants' Advisory Committee, to consist of class members willing and able to provide input as to the administration of the medical monitoring plan. Said Committee shall only have an advisory capacity. The Committee will exist in order to ensure that Class Members are heard in the design and implementation of the Medical Monitoring Program, and other aspects of the Claim Administrator's duties. The Claimants' Advisory Committee shall be established as soon after the Effective Date as practicable, with 5 members to be residents of the Class Area and 4 to be non-residents of the

Class Area. It is requested that Claimants Advisory Committee nominations be provided by Class Counsel within 15 days after the Effective Date. In nominating potential Committee members, Class Counsel should provide adequate facts to facilitate the Court's determination of each candidate. To the extent practicable, Committee members will be incumbent Class Representatives, and the Parties, via their role on the Finance Committee, will be invited to provide input on the proposed Committee members prior to their selection. The Committee will have an initial organizational meeting with the Court, the Claims Administrator, and the Finance Committee in person, conduct periodic telephonic meetings, and have one annual meeting with the Court, the Claims Administrator and the Parties in person thereafter.

8. In order for the Claims Administrator, in collaboration with the Finance Committee, to prepare the initial budget and administrative actions for the Medical Monitoring Program for review and approval by the Court, the logistics for this aspect of the case should be finalized as soon as practicable. The Claims Administrator shall attempt to find usable office space for lease in the Class Area in or near Spelter and utilize the same office space for both the property and medical monitoring classes.

9. To facilitate efficient utilization of the class funds and to minimize administrative expenses, the Claims Administrator shall look into obtaining living quarters in the Class Area for the first two (2) years of medical monitoring, during which time the Claims Administrator's staff will have an ongoing presence. Such a residence will be more cost effective than a hotel, and create less of a burden on the classes. Additionally, the Claims Administrator shall look into the cost effectiveness of obtaining a vehicle to reduce rental car bills. Said living quarters and/ or administrative vehicle

shall be discussed by the Finance Committee and recommended by the Claims Administrator to the Court for final approval.

The Court, as noted in the Final Order Approving Settlement, shall retain continuing jurisdiction and the ultimate authority over the administration of this settlement.

Next, because the administration of the property remediation settlement has not yet been brought before the Court, the Claims Administrator is directed to prepare a proposed time line and punch list for the same and submit it to the Parties and the Court within twenty (20) business days of the entry of this Order.

The Court intends to retain the services of the Guardian *ad litem*, Meredith McCarthy, for the purposes of providing legal representation to the minors and incompetents in the classes, assuming that she is still ready and willing to serve. The details and necessary duties of the Guardian *ad litem* can be determined as a need for such services becomes apparent. The Court directs the Finance Committee and the Claims Administrator to orchestrate such necessary services for the classes and provide direction to Mrs. McCarthy. The Guardian *ad litem* shall serve at the previously established rate, or such additional just rate of compensation to be determined by the Finance Committee and the Claims Administrator and paid along with the administrative and start up costs for each of the classes.

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 for judgment.

IT IS SO ORDERED.

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

David B. Thomas
James S. Arnold
Stephanie Thacker
Allen Guthrie & Thomas, PLLC
500 Lee St., East, Suite 800
P.O. Box 3394
Charleston, WV 25333-3394

Meredith McCarthy
901 W. Main St.
Bridgeport, WV 26330
Guardian ad litem

Edgar Gentle, III
Gentle, Turner, & Sexton
501 Riverchase Parkway East,
Suite 100
Hoover, AL 35244
Special Master

J. Farrest Taylor
Cochran, Cherry, Givens, Smith,
Lane & Taylor, P.C.
163 West Main St.
Dothan, AL 36301.

ENTER: January 18, 2011

Thomas A. Bedell, Circuit Judge

EXHIBIT B

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. DU PONT DE NEMOURS AND COMPANY, et al.,

Defendants.

FINAL ORDER APPROVING SETTLEMENT

Presently pending before the Court is the proposed settlement and compromise of this case, as incorporated in a Memorandum of Understanding prepared and executed by the Parties on November 19, 2010. In light of the challenges and nuances of the continued mass litigation presented by this case, the Parties have agreed to settle their dispute.

This settlement resolves a class action which is larger than any before seen in Harrison County, and is one of the largest in the history of the judicial system of West Virginia. The Court Record, which consists of all the motions, briefs, documents and other filings made by the Parties over the nearly seven years since this case filed, currently encompasses thirty thousand three hundred and fifteen (30,315) pages, and it will continue to expand.

This case has taken on a life of its own; it has grown larger than any one attorney or firm, and beyond the individuals who make up the Plaintiff classes. This case has

been before the Federal Court for the Northern District of West Virginia, it has spent more than two years on appeal before the West Virginia Supreme Court of Appeals, and it has spent many years before this Court. Despite all of the work and time of so many people,[1] this case has not reached an end within the judicial system.

There have been many battles fought by the Parties and both sides have had victories. However, winning a battle or a skirmish does not end the war. The potential for lengthy future conflict still looms on the horizon, and, without this settlement, this war is not over.

Presently before the Court is the "Motion and Memorandum in Support of Motion for Final Approval of Proposed Class Settlement, Approval of Class Notice, and Class Representative's Incentive Award," filed by Counsel for the Plaintiffs on December 20, 2010.

The Parties appeared by counsel on December 30, 2010, at a fairness hearing and presented to the Court a proposed compromise and settlement through counsel Farrest Taylor, Virginia Buchanan, Mark Proctor, Edison Hill, Angela Mason and Perry Jones. The Defendants were represented by James Lees, David Thomas, and Stephanie Thacker. The previously appointed Guardian *ad litem*, Meredith McCarthy, appeared on behalf of the minors and incompetents in the classes.

The Court heard the evidence and representations of counsel for the Plaintiffs, who presented the testimony of Edgar C. Gentle, the previously appointed settlement and claims administrator, Lenora Perrine and Carolyn Holbert as members of the

[1] The Plaintiffs' attorneys have documented more than fifty-five thousand hours of work and the Defendants' attorneys have surely billed as many hours, and likely more.

classes, and Barry Hill, as an expert witness in support of the claimed attorneys' fees and expenses. These witnesses spoke in support of the nature and fairness of the proposed settlement. Edgar Gentle testified as to the nature of the proposed administration of the settlement. The Court also permitted an opportunity for any Class members having objection to the settlement of the case to be heard. Thereafter, the Court heard the viewpoints and arguments of Burl Davis, Albert Shaffer, Craig E. Ferrell, Thelma Valerio, and Hubert E. Ferrell.

The only class member who was adamantly against the settlement was Burl Davis, while others presented questions as to the nature and effect of the settlement, and the availability of cash payments instead of remediation or medical monitoring services, and these questions were addressed by Counsel for the Plaintiffs and Mr. Gentle. Even Mr. Davis's objection was based upon his belief that he would get "nothing" and his home's value would not increase due to contamination in the area in and around Spelter. However, although the final amount is yet to be determined, there will be tens of millions of dollars available for remediation of property which will help to increase home values in the class area.

After reviewing the proposed settlement and hearing the evidence presented by the Parties, as well as carefully considering the viewpoints of the class members, the Court hereby ORDERS that the Proposed Settlement be **APPROVED**.

The pertinent background is set forth below:

FACTUAL BACKGROUND

1. This action was filed on June 15, 2004, against Defendants E.I. du Pont de Nemours and Company ("DuPont"), T. L. Diamond & Company, Inc., Meadowbrook

Corporation, Matthiessen & Hegeler Zinc Company, Inc., Nuzum Trucking Company ("Nuzum"), and Joseph Paushel ("Mr. Paushel")(collectively "Defendants").

2. On September 14, 2006, this Court granted class certification and certified both a Property Class and a Medical Monitoring Class ("Plaintiff Classes") in this case pursuant to the provisions of Rule 23 of the West Virginia Rules of Civil Procedure. Upon appeal, the certification of both classes was upheld by the Supreme Court. "Having found no error in the circuit court's disposition of each of the elements to be considered in certifying a class under Rule 23(a) and (b), we find that certification was proper. Consequently, DuPont's claim that class certification violated its due process rights by preventing it from presenting individualized evidence and individualized defenses is without merit." *Perrine v. E.I. du Pont de Nemours and Co.*, 225 W.Va. 482, ___, 694 S.E.2d 815, ___, (2010).

3. The Court approved Plaintiffs' notice plan on December 21, 2006, which gave absent Class members until February 15, 2007, to opt out or exclude their claims from this litigation. The Notice specifically informed the Class members: "If you are a member of the Property Class and/or Medical Monitoring Class and do not request exclusion from the class action, you will be bound by any judgment whether favorable or not, or any settlement in this case."[2] Following this Notice, a number of persons and entities opted out.

[2] The Court notes that the Defendant has filed a "Memorandum of Law on Opt-Out Exclusion From the Certified Classes." However, the issue argued by the Defendant (that there should be no second chance for class members to opt out) is not before the Court. None of the class members have argued that they have the right to opt out of the settlement either in writing or at the Fairness Hearing. Accordingly, the Court will not address the issue.

4. Prior to the 2007 trial of this Class Action, the Plaintiff Classes agreed to dismiss Defendants Mr. Joseph Paushel and Nuzum. As a result, on or about March 5, 2007, this Court dismissed Defendants Mr. Paushel and Nuzum, with prejudice.

5. After extensive discovery and pre-trial litigation, this matter proceeded to trial beginning on September 10, 2007, and the trial lasted for approximately six (6) weeks. The trial consisted of four (4) phases, and the jury returned verdicts in favor of the Plaintiffs. The verdicts were ultimately rendered as awards of fifty-five million five hundred and thirty-seven thousand five hundred and twenty-two dollars and twenty-five cents ($55,537,522.25) for property damage and associated remediation costs, an estimated award of approximately one hundred and thirty million dollars ($130,000,000.00) for a future medical monitoring program to last for forty (40) years, and a punitive damages award of one hundred and ninety-six million and two hundred thousand dollars ($196,200,000.00).

6. Said verdicts were the result of the jury finding that the Plaintiffs' property and persons were exposed to elevated and dangerous levels of lead, cadmium, and arsenic, among other heavy metals, due to the long operation of a smelting facility in Spelter which polluted the class area.

7. On November 16, 2007, this Court entered an Amended Final Judgment Order finalizing the jury's verdict in the amounts described above against Defendant DuPont.

8. Thereafter, both the Plaintiffs and Defendants appealed numerous aspects of this Court's pre-trial, trial, and post-trial rulings to the West Virginia Supreme Court of Appeals.

9. On March 26, 2010, after a lengthy appellate process, the West Virginia Supreme Court of Appeals remanded this litigation to the Court with directions to conduct a trial on DuPont's statute of limitations defense. The opinion, when counting the pages of the majority and individual concurring and dissenting opinions, was the longest ever written by the Supreme Court.

10. The Supreme Court modified the punitive damages award, but conditionally affirmed the remainder of the verdict, which then consisted of approximately three hundred million dollars ($300,000,000.00). The Supreme Court determined that this Court erred in granting judgment as a matter of law in favor of the Plaintiffs on the affirmative defense of the statute of limitations, and directed this Court to hold a second trial to determine if the defense was merit worthy.

11. The effect of the Supreme Court's directive created an all or nothing proposition for the Parties. If the Plaintiffs prevailed on the statute of limitations issue, they would receive the relief obtained in the 2007 trial, as modified by the Supreme Court opinion. If DuPont prevailed, this Court would set aside the 2007 verdicts and render judgment in favor of DuPont, and the Plaintiffs would receive nothing. *Perrine v. E.I. du Pont de Nemours and Co.*, 225 W.Va. 482, ___, 694 S.E.2d 815, 854 (2010).

12. The Plaintiffs and Defendant both considered the directives of the Supreme Court's opinion and prepared for trial, which was set for the month of March, 2011. The Parties reached this settlement after considering the substantial amount of risk and expense remaining in the case for both sides. On November 19, 2010, the Parties advised the Court that a proposed compromise and settlement had been reached. Thereafter, on November 24, 2010, the Court set a December 30, 2010,

hearing to hear the Parties and to receive evidence and argument as to the fairness of the proposed settlement.

13. On December 6, 2010, the Court appointed Meredith McCarthy, a discrete and competent attorney practicing before this Court who is familiar with the facts involved in this case, to serve as Guardian *ad litem* to protect the interests of any minors who may be members of the Plaintiff Classes. Mrs. McCarthy previously served as a Guardian *ad litem* in this matter and is uniquely familiar with this issues presented.

14. *Rule 23(e) of the West Virginia Rules of Civil Procedure requires that* notice of the proposed compromise and settlement be given to the Plaintiff Classes in such manner as directed by the Court.

15. Plaintiffs' Counsel mailed individual "Notice of Proposed Settlement Regarding the Former Zinc Smelter in Spelter, West Virginia" ("Settlement Notice") to all reasonably identifiable Class members, including some approximate two thousand and five hundred (2500) property parcels and their respective owners. The Settlement Notice informed the absent Class members of the nature and terms of the proposed settlement, the date and time of the fairness hearing, the right to object, and the procedure for objection. Additionally, the Settlement Notice directed Class members to an informational website[3] at which they could review the November 19, 2010 Memorandum of Understanding between the Parties, which further details the terms of the settlement; and the November 30, 2010 Petition for Attorney Fees and Litigation Expenses filed by Plaintiffs' Counsel.

[3] The website, which was established by Settlement Administrator Edgar Gentle, can be reached at www.perrinedupont.com.

16. Additionally, the Settlement Notice was published in the Clarksburg Exponent newspaper on four separate dates: December 1st, 5th, 15th and 22nd, 2010; and in the Shinnston News on three separate dates: December 9th, 16th, and 23rd, 2010. Finally, the Notice was published in the Charleston Gazette on December 3rd, 10th, 17th, and 24th.

17. The Settlement Notice provided an opportunity for Class Members to file any written objections to the proposed settlement with the Claims Administrator and with the Court by December 20, 2010. Only two written objections to the settlement were received.

Having heard argument of counsel and the objections from the class members as noted herein, and considering the entire record of submissions and testimony in this case, and all applicable law, the Court makes the following Conclusions of Law.

Conclusions of Law

1. The Court finds that the Settlement Notice in this case was reasonable and afforded the Class Members an opportunity to be heard prior to approval of the settlement pursuant to the requirements of Rule 23.

2. Rule 23(e)(2) of the West Virginia Rules of Civil Procedure provides that a class action may not be dismissed or compromised without approval of the Court. Rule 23 does not provide any more direction for the Court, nor does the common law of West Virginia. However, it is clear that the primary inquiry of the Court must focus on the fairness and adequacy of the proposed settlement.

3. This Proposed Settlement affects the interests of the Classes as Certified by this Court on September 14, 2006, in the "Order Granting Class Certification."

Additionally, said class definitions for the medical monitoring class were modified by the June 14, 2007, "Order Granting Plaintiffs' Motion to Modify Class Definition and Denying Defendant DuPont's Motion to Decertify Class." For purposes of clarity, the Proposed Settlement affects the following classes as previously defined by Order of this Court.

a. The Property Class consists of "those who currently own, or who on or after December 1, 2003, have owned private real property lying within the below referenced communities or any other private real property lying closer to the Spelter Smelter facility than one or more of the below referenced communities." (Sept. 14, 2006, Order at 3).

b. The Medical Monitoring Class consists of "those who currently or at any time in the past since 1966 have resided on private real property in the Class Area for at least the minimum total residency time for a zone depicted on the map attached hereto as Exhibit A:[4] Zone 1: Minimum total residency time of one year since 1966. Zone 2: Minimum total residency time of three years since 1966. Zone 3: Minimum total residency time of five years since 1966. Residency time within a zone or zones closer to the former smelter facility but not meeting the minimum total residency time for a closer zone is accumulated with any residency time within a zone or zones further away in determining total residency time." (June 14, 2007, Order)

[4] Said Legal Notice, including the map with zones 1, 2, and 3, is attached as Exhibit 1 to this Order.

c. The General Provisions as to the geographic area are described as follows, and the Court further incorporates the boundary map as prepared and attached to this Order as Exhibit 1 to be read in concert with the following description:

i. "General Provisions. The initial proposed class area includes the following communities within Harrison County, West Virginia, and all other private real property lying closer to the Spelter Smelter facility than one or more of these communities: Spelter, Erie, Hepzibah, Lambert's Run, Meadowbrook, Gypsy, Seminole, Lumberport, Smith Chapel, and as further modified to include additional impacted areas as described in Plaintiffs' air model. The Court finds that private real property lying within these communities, as well as any other private real property lying closer to the Spelter Smelter facility, has been impacted by the release of hazardous substances at or from the Spelter Smelter facility." (Sept. 14, 2006, Order at 4).

4. In assessing the "fairness" of a proposed settlement, the Court has considered the following four factors as provided by persuasive common law from the Federal District Court of the Eastern District of Virginia: 1) the posture of the case at the time the settlement was proposed; 2) the extent of discovery that had been conducted; 3) the circumstances surrounding the negotiations; and 4) the experience of counsel in the area of class action litigation. *In re MicroStrategy, Inc. Securities Litigation*, 148 F.Supp.2d 654, 663-665 (E.D. Va. 2001); *Strang v. JHM Mortgage Sec. Ltd. P'ship*, 890 F.Supp 499, 501 (E.D. Va. 1995).

5. The Court finds that the Settlement in this action satisfies the fairness test because it has been negotiated between counsel who are experienced litigators and can accurately weigh the potential risk of a trial on the statute of limitations defense. This action has been pending for nearly seven years. In that time, the Parties have

actively pursued discovery, pre-trial litigation, a lengthy trial, and a lengthy appellate process.

6. Class Counsel, with the aid of their experts, has been able to determine the nature and strength of the Class Members' claims and to make reasonable calculations as to damages. Additionally, DuPont has been able to weigh their chances at trial in light of the original verdict and post-judgment interest. Both Parties are represented by able counsel who are experienced in class action litigation and who have spent tens of thousands of hours litigating this case. Therefore, under the four factors enumerated above, this settlement meets the fairness test because: (1) there is a substantial amount of risk facing both sides such that the settlement provides a fair compromise of the previously rendered verdict, (2) discovery has been extensively conducted and the Parties are well aware of the facts of the case, (3) the negotiations for the settlement were formally and fully conducted at arms length, and (4) both Parties are ably represented by experience counsel.

7. In determining the "adequacy" of the settlement, the Court looks to the following: 1) the relative strength of the Plaintiffs' case on the merits; 2) the existence of any difficulties of proof or strong defenses the Plaintiffs are likely to encounter if the case goes to trial; 3) the anticipated duration and expense of additional litigation; 4) the solvency of the Defendants and the likelihood of recovery on a litigated judgment; and 5) the degree of opposition to the settlement. *MicroStrategy*, 148 F.Supp.2d 665; *see also Strang*, 890 F.Supp at 501

8. The Court also finds that the Settlement satisfies the adequacy test. There is no certainty that the Plaintiffs will prevail at trial if the Settlement is not

approved. The sole issue of statute of limitations presents an all-or-nothing defense such that if Defendants were to prevail, the Plaintiffs would receive nothing. Alternatively, if Plaintiffs were to prevail at the trial, the case would nonetheless continue for years in appeal and the Defendants, unless they found relief on appeal, would be liable for approximately three hundred million dollars ($300,000,000.00), plus post-judgment interest accruing since 2007. Accordingly, both Parties are intimately familiar and engaged with this case, and have been able to negotiate a fair and adequate settlement to eliminate the risk presented to both sides by the second trial and future appellate litigation. Finally, despite the Settlement Notice provided to the Classes, there has been very little opposition voiced against the settlement. There were only two (2) written objections filed against the settlement, and the substance of the objections was against the claimed litigation expenses of the Attorneys, not the fairness of the settlement. Further, of the class members who spoke at the fairness hearing, only two were strongly opposed to the settlement, and both seemed to believe that cash payments based on the amount of the original verdicts were superior to remediation and medical monitoring plans. There are an estimated eight thousand five hundred (8,500) medical monitoring class members, and approximately two thousand eight hundred (2,800) property parcels in the two classes, and only two people voiced written opposition, and only one person voiced opposition to the settlement at the hearing. Therefore, the Court finds that there is not strong opposition to the settlement from within the classes.

9. Accordingly, the Court finds that the Settlement meets the adequacy test because although the Plaintiffs have a conditionally affirmed verdict, they face a

substantial challenge in overcoming the Defendants' statute of limitations defense. Without a settlement, litigation in this case would continue for a minimum of three to five (3-5) years, as the verdict at the second trial on the statute of limitations would be appealed to the West Virginia Supreme Court of Appeals by the losing party, and potentially appealed to the United States Supreme Court thereafter. Finally, there is very little opposition to the settlement from the Plaintiff Classes.

10. The Court-appointed Guardian *ad litem* in this case has stated to the Court that she has conducted an independent investigation into the facts contained in the record, the Petition for Approval of Settlement, and the Memorandum of Understanding between the Parties, and that the proposed settlement is fair, just, reasonable, equitable, and in the best interests of any minor members of the Plaintiff Classes.

11. The Court **FINDS** in view of all of the circumstances that the proposed settlement is fair, just, reasonable, equitable, and in the best interest of the Parties.

Accordingly, the Court **ORDERS** that:

1. The Petition seeking approval of the Settlement is **GRANTED**, and, therefore, the proposed settlement, which is found to be fair, reasonable, and in the best interests of the Parties, is hereby **APPROVED**.

2. Defendant DuPont is **ORDERED** to pay the total sum of seventy million dollars ($70,000,000.00) to Plaintiffs in accordance with the November 19, 2010, Memorandum of Understanding, and the prior Order of the Court dated December 23, 2010, which established two separate and distinct Qualified Settlement Funds.

Additionally, said Qualified Settlement Fund Accounts have been established at MVB Bank by Edgar Gentle at the direction of the Court.

3. Sixty-six million ($66,000,000.00) of the total seventy million ($70,000,000.00) payment shall be available to the Plaintiffs as directed by the Court, or it's designee, for the purposes of paying for remediation services and attorneys' fees and expenses for Plaintiffs' Counsel.

4. The remaining four million ($4,000,000.00) of the total seventy million ($70,000,000.00) payment shall be made available only for the medical monitoring sub-class of Plaintiffs as directed by the Court, or the Court's designee. Said sum shall not be used for any purpose other than for the sole benefit of the medical monitoring sub-class and shall be deposited in the Qualified Settlement Fund Account created solely for this amount and this purpose.[5]

5. Defendant DuPont is ORDERED to pay for the cost of a medical monitoring program on a "pay-as-you-go" basis, consistent with the February 25, 2008, "Final Order Regarding the Scope, Duration and Cost of the Medical Monitoring Plan," except as modified by the Memorandum of Understanding, for a period of thirty (30) years.

6. The Court recognizes that the issue as to the amount of attorney's fees and costs to be awarded remains to be determined. After weighing the evidence presented at the December 30, 2010, Fairness Hearing, and such filings as have been

[5] The Court recognizes that the Defendants assert that the administration of the medical monitoring program should be governed by a proposed executive committee instead of by the Court and the previously appointed Special Master/ Claims Administrator. Said argument and accompanying motions, as well as the exact use of the four million dollars, will be addressed by the Court in a later Order after the Court has had the time to review the matter.

made by the Plaintiffs' Counsel, the Court will promptly make a determination and enter an Order directing disbursement of fees and costs from the sixty-six million dollar ($66,000,000.00) Qualified Settlement Fund created, in part, for that purpose.

7. The Court further **ORDERS** that the Defendant DuPont pay such fees as incurred by the Guardian *ad litem*. The Court has determined that six thousand two hundred and fifty dollars ($6,250.00) is a reasonable and fair amount based on the time expended by the Guardian *ad litem* before and during the Fairness Hearing, which was stated to the Court as twenty-five (25) hours of work at a rate determined by the Court of two hundred and fifty dollars ($250.00) per hour.

8. Finally, as agreed to in the Memorandum of Understanding, DuPont is hereby **ORDERED** to pay the Court's costs associated with this matter, as taxed by the Clerk of this Court, in the amount of fifty-five thousand three hundred and thirteen dollars and eighty-nine cents ($55,313.89), which represents only the actual out-of-pocket expenses that have been borne by the citizens of Harrison County to date.[6]

9. It is **ORDERED** that this is a full and final settlement of all claims of the Plaintiff Classes in this action, that all claims of the Plaintiff Classes in this action are **DISMISSED, with prejudice**, against all Defendants, and that the Defendants are hereby released from any and all liability associated with this litigation, provided that the Defendants fulfill any and all obligations Ordered herein.

10. Further, the Court **ORDERS** that this is a Final Order pursuant to Rule 54(b) of the West Virginia Rules of Civil Procedure and constitutes a "final judgment [as]

[6] Said Taxation of Costs is Attachment B to this Order.

there is no just reason for delay and upon an express direction for the entry of judgment."

11. It is ORDERED that any and all prior judgments of liability and damages against all Defendants in this case are VACATED and shall have no collateral estoppel or *res judicata* effect against any Defendant in any pending or future claim against any of the Defendants arising from the operation or ownership of the zinc smelter that is the subject of this litigation. However, the Court notes that the judgment in favor of T.L. Diamond against DuPont, entered on February 15, 2008, which was upheld by the Supreme Court after a review of the indemnification agreement between T. L. Diamond and DuPont, shall not be vacated. Additionally, the Final Order which dismissed Defendants Nuzum Trucking and Joseph Paushel, with prejudice, on or about March 5, 2007, is not vacated. Finally, the jury's verdict found that the "other entities," including Nuzum Trucking, were not liable for negligence, public nuisance, private nuisance, trespass, and strict liability, and those findings are upheld and not vacated.

12. Further, the pending Motion for Sanctions, filed by the Plaintiffs on September 8, 2010, is "deemed moot" and thereby withdrawn, according to paragraph 8 of the Memorandum of Understanding. Although the Defendant has requested that "all pending motions" be deemed moot, upon a review of the record, the only other pending motions are not moot and are related to the administration of the settlement.

13. Without affecting the finality of this Final Judgment as to the Plaintiff Classes, the Court hereby retains exclusive jurisdiction over this action, and every aspect of the interpretation, implementation and enforcement of the Settlement, until the Settlement has been consummated and each and every act agreed to be performed by

the Parties thereto shall have been performed, and thereafter for all other purposes necessary to interpret and enforce the terms of the Settlement, the Orders of this Court, and in aid of this Court's jurisdiction and to protect and effectuate its judgments.

IT IS SO ORDERED.

Finally, the Clerk of this Court shall provide copies of this Order to the following:

David B. Thomas
James S. Arnold
Stephanie Thacker
Allen Guthrie & Thomas, PLLC
500 Lee St., East, Suite 800
P.O. Box 3394
Charleston, WV 25333-3394

Edgar Gentle, III
Gentle, Turner, & Sexton
501 Riverchase Parkway East,
Suite 100
Hoover, AL 35244
Special Master

Meredith McCarthy
901 W. Main St.
Bridgeport, WV 26330
Guardian ad litem

J. Farrest Taylor
Cochran, Cherry, Givens, Smith,
Lane & Taylor, P.C.
163 West Main St.
Dothan, AL 3630

ENTER: January 4, 2011

Thomas A. Bedell, Circuit Judge

LEGAL NOTICE

If you are a current or former property owner or resident near the former Spelter Smelter facility in Harrison County, West Virginia, changes to a Class Action may affect your rights.

Lenora Perrine, et al. v.
E.I. Dupont De Nemours and Company, et al. Case No: 04-C-296-2

NOTICE OF CHANGES TO MEDICAL MONITORING CLASS DEFINITION

As previously noticed, the Circuit Court of Harrison County, West Virginia has certified a class action in this case against defendants E.I. Dupont De Nemours and Company, Inc., Meadowbrook Corporation, Mathiessen & Hegeler Zinc Company, Inc., and T.L. Diamond & Company, Inc. concerning the former zinc smelter facility in Spelter, Harrison County, West Virginia.[1] Prior notice of the class action was issued by the Court on December 21, 2006. The prior notice and other information about the class action may be viewed or downloaded at www.Spelterclass.com. In addition, a copy of the prior notice and other information about the class action may be obtained by contacting the Class Administrator at:

Class Administrator, Analytics, Inc.
P.O. Box 2002
Chanhassen, MN 55317-2002
1-866-233-0124

The Property Class definition[2] and the class boundaries (generally shown on the below map) set forth in the prior notice of the class action remain unchanged.[3]

However, the Medical Monitoring Class definition has been changed as follows:

Previously the Medical Monitoring Class definition was based on total residency time within the class area of 277 days. However, this definition has been changed to require one, three, or five years of total residency time since 1966, depending on where one lives or lived within the class area. Total residency time of one year since 1966 is required for Zone 1. Total residency time of three years since 1966 is required for Zone 2. Total residency time of five years since 1966 is required for Zone 3. Residency time within a zone or zones closer to the former smelter facility but not meeting the total residency time for a closer zone is accumulated with any residency time within a zone or zones further away in determining total residency time.

Zone 1 is the zone closest to the former smelter facility, and Zones 2 and 3 are further away from the former smelter facility but still within the class area. Zones 1, 2, and 3 are generally shown on this map.

If you have questions as to whether a particular parcel lies within Zone 1, 2, or 3, please contact the Class Administrator.

If you previously were in the Medical Monitoring Class based on total residency time of 277 days within the class area but do not have sufficient residency time under the amended Medical Monitoring Class definition stated above, you are no longer in the Medical Monitoring Class and are no longer represented by Class Counsel. You will need to take whatever action you deem appropriate to protect your rights, if any, which will no longer be protected in this class action and which will be subject to limitations on the timely bringing of claims.

If you meet the Property Class definition and did not previously "opt out" of the class action by filing a timely exclusion form as provided under the prior notice, you remain in the class action for purposes of the Property Class even if you do not meet the amended Medical Monitoring Class definition stated above. However, if you now wish to opt out of the class action entirely because you will no longer be part of the Medical Monitoring Class, you have until August 6, 2007 to submit an exclusion form. Otherwise, you will remain within the Property Class even if this means you will no longer be part of the Medical Monitoring Class under the amended Medical Monitoring class definition.

If you are a member of the Property Class and/or the amended Medical Monitoring Class and wish to remain in the class action, you do not need to take any action. If you are a member of the Property Class and/or the amended Medical Monitoring Class and do not request exclusion from the class action, you will be bound by any judgment whether favorable or not, or any settlement in this case.

To the extent the class action claims seek monetary damages, including punitive damages, they only relate to the Property Class. To the extent the class action claims seek medical monitoring, they relate to eligible past and present residents, whether or not they are in the Property Class. If money is awarded to the Property Class, Property Class members may be entitled to a share of that money. If remediation costs and/or medical monitoring are awarded, common funds may be established to efficiently manage remediation and/or medical monitoring on behalf of multiple class members. The precise monetary, remediation and/or medical monitoring remedies and distribution, if any, are to be determined in the class action proceedings. Litigation costs and legal fees for plaintiffs' attorneys may be deducted from awards to class members. The class action does not seek damages for personal injuries, and class members may risk being barred from pursuing any such potential claims in the future if they do not opt out of the class action.

If you are in the Property Class and/or the amended Medical Monitoring Class but do not want to be a part of this class action, you have the option of excluding yourself from the class action. Your written request to be excluded from the class action must be mailed to the Class Administrator and must include (1) your full name, and (2) your current mailing address. You also must sign the request and clearly state your intention to be removed from the class action. If your request is postmarked after August 6, 2007 you automatically will be included in the class action. A copy of the Exclusion Form is found below and may also be obtained at www.Spelterclass.com or by contacting the Class Administrator.

PLEASE DO NOT CONTACT THE COURT, THE CLERK'S OFFICE OR THE JUDGE, AND PLEASE DIRECT ANY QUESTIONS TO THE CLASS ADMINISTRATOR.

By order of the Honorable Thomas A. Bedell, Circuit Court Judge, Circuit Court of Harrison County, West Virginia. Date: _____, 2007.

[1] Plaintiffs allege that hazardous substances from the former Spelter Smelter facility have been released onto private real property in the class area and that those substances have health risks. Plaintiffs allege that the released hazardous substances include arsenic, cadmium, and lead. Specifically, plaintiffs allege that, as a result of those substances, they are entitled to property damages, including remediation costs, and medical monitoring. Plaintiffs also seek punitive damages, litigation costs, and legal fees for their attorneys. Defendants dispute that the plaintiffs are entitled to any damages, medical monitoring, or other relief. Defendants dispute that hazardous substances from the Spelter Smelter facility have covered the entire class area and that the health of class members is at risk. Defendants also raise various affirmative defenses.

[2] The Property Class is comprised of those who currently own, or who as of after December 1, 2003 have owned, private real property lying within the class area, excluding those who owned property only before December 1, 2003 or only after September 14, 2006 (the date of entry of the Order Granting Class Certification).

[3] Also, the class definition continue to exclude defendants in the case, any entity in which a defendant in the case has a controlling interest, or a current employee, officer, director, legal representative, heir, successor, assign, or spouse of a defendant in the case.

REQUEST FOR EXCLUSION: MUST MAIL BY AUGUST 6, 2007

In the Circuit Court of Harrison County, West Virginia *Lenora Perrine, et al. v. E.I. Dupont De Nemours and Company, et al.*, Case No. 04-C-296-2

(Print or Type)

Full Name: _____
First Middle Last

Current Mailing Address: _____
City State Zip (if known)

( ) _____
Telephone Number (optional)

Mail to:
Class Administrator, Analytics, Inc.
P.O. Box 2002
Chanhassen, MN 55317-2002

I DO NOT wish to be a Member of the Class Action.
I have read the Notice Of Changes To Medical Monitoring Class Definition in the above-referenced case.

_____ _____
Signature Date

Number: 0006014 * A S S E S S M E N T * January 03, 20

Assessed to. E. I. DUPONE DE NRMOURS & CO. $55,313.

The exact sum of Fifty Five Thousand Three Hundred Thirteen Dollars and 89 Cents
Victim..... LENORA PERRINE ET, AL

Assess Due Retrib [

Case #: 04-C-296

Assessment conducted at :

HARRISON COUNTY COURTHOUSE
CLARKSBURG, WV 26301

DONALD L. KOPP II, CLERK

Deputy

Distribution to Accounts...

5001 OTHER PARTIES	405.00	4013 PARENT ED-MEDIATION	25835.3
2002 COURT REPORTER	570.00	1004 SHERIFF'S FEES	1.0
4014 DOMESTIC VIOLENCE-LE	25835.30	1003 POSTAGE/COPIES	2667.1

Jan. 4. 2011 1:22PM THOMAS A. BEDELL, Chief Judge No. 4992 P. 20

Clerk of the Circuit Court
Harrison County

Donald L. Kopp II, Clerk

301 WEST MAIN STREET
CLARKSBURG, WEST VIRGINIA 26301

Telephone (304) 624-8685
Fax (304) 624-8710

Karen G. Nestor
Chief Deputy

Lenora Perrine Et. Al

Gary W. Rich

04-C-296-2

E.I. DuPont D E Nrmours & Co.

David Thomas

Taxation of Cost

5/7/2007	Postage to Mail 1,500 Questionnaires (.42)	$630.00
	Return Postage (.42)	$630.00
7/11/2007	Jurors paid for Orientation	$22,476.69
9/10/2007	Jurors seated & 2nd Orientation	$12,748.79
	Jury 9/24 - 10/5/07	$5,197.00
	Jury 10/8/07 - 10/19/07	$5,197.00
9/12/2007	Jurors	$6,051.29
	Sub Total	$52,930.77
10/15/2010	Questionnaires Mail 1481	$656.04
	(.44) Return Postage 1259	$553.96
	Letter to Jurors 448	$197.12
	Sub Total	$1,407.12
	Court Reporter	$570.00
	Filing Fee	$145.00
	Jury Costs to SHC	$1.00
	Docket Fee	$10.00
	For Service	$250.00
	Sub Total	$976.00
	Grand Total	$55,313.89

Cost to be paid by Defendants

EXHIBIT C

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al.,

Plaintiffs,

v.

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

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

Defendants.

FINAL ORDER APPROVING HEATLH CARE PROVIDER THIRD PARTY ADMINISTRATOR REQUEST FOR PROPOSALS AND CANDIDATE LIST

Presently pending before the Court are (i) the proposed Health Care Provider Third Party Administrator's Request for Proposals ("RFP"); and (ii) the proposed list of candidates to receive the RFP.

After a careful review of the proposed RFP and proposed candidate's list, and in consideration of the applicable law, the Court **ORDERS** that the same are hereby **APPROVED** and shall be used during the administration of the Settlement.

The Court has reviewed the Health Care Provider Third Party Administrator's RFP, which shall guide all Third Party Administrator candidates in their submission of proposals for coordinating the administering the Medical Monitoring Program, and in their submission of competitive bids to accomplish the same. The Court approves of the language and effect of the RFP and the proposed candidate list, and hereby **ORDERS** that the RFP shall be used during the administration of the Settlement, and shall be submitted to the proposed candidates, who shall be screened in accordance with the RFP's schedule to determine the most qualified candidate.

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 Thacker, Esq.
Allen, Guthrie & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394
DuPont's Finance Committee Representative

Meredith McCarley, Esq.
901 W. Main St.
Bridgeport, WV 26330
Guardian Ad Litem

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

Edgar C. Gentle, III, Esq.
Settlement Claims Office
P.O. Box 257
Spelter, WV 26438
Claims Administrator

This Order Agreed to By:

Stephanie Thacker, Esq.
Allen, Guthrie & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394
DuPont's Finance Committee Representative

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

This Order Agreed By:

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

Michael A. Jacks, Esq.
Gentle, Turner & Sexton
W. Va. Bar No: 11044
P.O. Box 257
Spelter, WV 26438

ENTER: February 28 2011

Thomas A. Bedell, Circuit Judge

STATE OF WEST VIRGINIA
COUNTY OF HARRISON, TO-WIT:

I, Donald L. Kopp II, Clerk of the Fifteenth Judicial Circuit and the 18th Family Court Circuit of Harrison County, West Virginia, hereby certify the foregoing to be a true copy of the ORDER entered in the above styled action on the 28th day of February, 2011.

IN TESTIMONY WHEREOF, I hereunto set my hand and affix Seal of the Court this 28th day of February, 2011.

Donald L. Kopp II

Fifteenth Judicial Circuit & 18th Family Court
Circuit Clerk
Harrison County, West Virginia

EXHIBIT D

REQUEST FOR PROPOSALS FROM THIRD PARTY HEALTH CARE ADMINISTRATORS FOR THE ADMINISTRATION OF A MEDICAL MONITORING PROGRAM
IN THE MATTER OF
PERRINE, ET AL., v. E.I. DUPONT DE NEMOURS AND COMPANY, ET AL.,

Issued: March 1, 2011
Submissions Due: April 1, 2011

I. INTRODUCTION

a. CONTACT INFORMATION

Any inquiries or requests regarding this procurement should be submitted in writing or by e-mail to:

Edgar C. Gentle, III, Esq.
Special Master and Claims Administrator
DuPont Medical Monitoring Administration
GENTLE TURNER & SEXTON
501 Riverchase Parkway East
Suite 100
Hoover, AL 35244
(205) 716-3000 (telephone)
(205) 716-3010 (facsimile)
escrowagen@AOL.com

b. BACKGROUND

Unlike the majority of plans administered by third party administrators ("TPA"), the following project does not concern the administration of medical benefits for an employee group. Rather, it concerns the administration of a court-supervised medical monitoring program (the "Program"). The Program was established as part of a class-action settlement of a lawsuit in the Circuit Court of Harrison County, West Virginia. The Program involves diagnostic testing of a fixed number of individuals who (a) qualify as class members and (b) elect to participate (the "Program Participants"). As outlined by the Court, the third-party administrator (the "TPA") will be responsible for (1) identifying vendor(s) or other medical provider(s) to facilitate medical testing of the Program Participants as explained more fully below; (2) negotiating with vendor(s)

and medical provider(s) the prices charged for such medical testing; and (3) performing the other tasks identified in this Request for Proposal to assist the Claims Administrator implement the Program.

The following attachments provide the background for this Request for Proposal:

1. Class Area Map in Exhibit A.

2. Final Order Regarding the Scope Duration and Cost of the Medical Monitoring Plan, entered February 25, 2008 ("Initial Medical Monitoring Order"). The Initial Medical Monitoring Order is attached as Exhibit B.

3. The Memorandum of Understanding, entered November 19, 2010, among the parties. The Memorandum of Understanding is attached as Exhibit C and sets forth the terms and conditions of a settlement of the medical monitoring claims in this case. The Memorandum of Understanding modifies the prior Initial Medical Monitoring Order.

4. Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, entered January 18, 2011 (the "Final Order"). The Final Order is attached as Exhibit D.

5. The Special Masters Report No. 1 of June 23, 2008, and Special Master's Supplement to the June 23, 2008 Report are attached hereto as Exhibits E and F. These attachments provide the Special Masters final recommendation and plan with regard to the administration of the medical monitoring component with regard to all claimants. However, the Memorandum of Understanding and Final Order modify these

recommendations and where there is a conflict, the Memorandum of Understanding and Final Order govern.

6. Dr. Werntz's Proposed Medical Monitoring Report, in Exhibit G, among other things, suggests CPT codes for the program.

7. The Medical Monitoring Time Line approved by the court, in Exhibit H, provides the suggested Medical Monitoring roll out punch list.

8. The Medical *Monitoring* Registration Form, in Exhibit I, provides the participating class member data fields we anticipate having.

The January 18, 2011 Final Order provided, in relevant part, that (i) the initial enrollment period for the Program would last for six (6) months, commencing no later than April 15, 2011; (ii) only members of the class who have enrolled in the program within the six (6) month enrollment period may enroll in the medical monitoring program; (iii) class members who elect to become Program Participants will be required to complete detailed health questionnaires and submit to direct physical examinations and collection of lab samples for analyses; and (iv) a TPA will be selected to help establish a plan for the claimants subject to approval by the Court.

II. SCOPE OF WORK

a. STATUS OF THE PROJECT and TESTING TO BE PROVIDED

As noted in the above segment, the Project is commencing from the ground up, and we seek a uniquely qualified TPA to help design the medical monitoring component, and to provide exceptional administration services.

We are currently unsure as to the exact number of Program Participants. There will be a six (6) month enrollment period commencing on February 28, 2011 and ending August 31, 2011, in which class members will be able to register for medical monitoring. The Program will last

up to 30 years. The services provided to Program Participants vary by age. Those Program Participants below the age of 15 receive a whole blood analysis for the presence of lead. Those Program Participants between the ages of 15 and 35 receive a whole blood analysis for the presence of lead and a urine test. In addition to blood and urine tests, those Program Participants above the age of 35 may be prescribed non-routine CT scans under certain circumstances.

If there is a positive finding of disease possibly associated with exposure to cadmium, arsenic or lead, the Program Participant will be referred to a medical specialist for treatment. For other disease findings, the physician will also recommend treatment. The Program does not provide any funding for medical treatment. A copy of the proposed Registration Form is attached hereto as Exhibit I. See Dr. Werntz's suggested CPT codes for the services in Exhibit G.

b. SERVICES TO BE PROVIDED

The following list is representative, but not necessarily exhaustive, of the responsibilities that will be required in a TPA contract resulting from this RFP. The bidder must have the capacity and experience to provide these services. Should the TPA disagree with, or would not be able to meet, a specific responsibility, please indicate such and/or any revisions you would like to make to this list.

The TPA shall:

1. Prepare a draft Plan Document/ Summary Plan Description for review and final approval by the Special Master/ Claims Administrator, the Finance Committee, the Claimant Advisory Board, and the Court;

2. Upon acceptance, the Third Party Administrator will furnish copies of the Summary Plan Description/ Plan Document to the Special Master/ Claims Administrator, the Finance Committee, the Claimant Advisory Board, and the Court;

3. Work with service providers, locally and nationally, to negotiate per unit prices, to develop a raport with said providers, and to assist in the development of a project specific plan document;

4. Produce participant communication materials announcing the Plan to the claimants who will be identified by the Court;

5. Maintain Plan records based on eligibility information submitted by the Special Master/Claims Administrator;

6. Maintain Plan records regarding payment of Medical Monitoring Provider Claims, denial of Claims and Claims pending;

7. Maintain enrollment records, answering enrollee inquiries, distribute participating Claimant identification cards, create and distribute a list of current service providers, and other Plan materials;

8. Adjudicate and pay Claims incurred by Medical Monitoring Plan providers according to the terms of the Plan Document. These Claims will be adjudicated and paid in accordance with industry practices and the TPA will use an industry-recognized method of determining usual, customary and reasonable charges.

10. Provide a toll-free telephone number so that participating claimants may contact the TPA's "Customer Service Unit" during the regular business hours of 8:00am to 5:00pm Eastern Standard Time .

11. Notify Medical Monitoring Plan providers, in writing through electronic mail, of ineligible Claims received, indicating the specific Plan provisions attributable to the delineation of the Claims pursuant to the written Claims review and appeal procedure in the Plan. This notification will be made within 10 business days of the date in which the TPA receives the complete Claim, including any information received and any Plan interpretations by the Special Master/ Claims Administrator.

12. Respond to service inquiries of participating claimants or Medical Monitoring Plan providers.

13. Maintain a record of all Medical Monitoring provider referrals to a medical specialist, and all recommendations for treatment.

14. Maintain information that identifies participating claimants in a confidential manner and in compliance with Health Insurance Portability & Accountability Act ("HIPAA"). The TPA agrees to take precautions to prevent unauthorized disclosure of or the unauthorized use of participating

claimant medical information for a purpose unrelated to the administration of the Plan.

15. The TPA will only release participating claimant medical information for medically necessary determinations, for screening/ testing purposes, to set uniform data standards, to use in Claims analysis, to further cost containment programs, to verify eligibility, to comply with federal, state or local laws, for coordination of benefits, for subrogation, in response to a civil or criminal action upon issuance of a subpoena (after giving the Special Master/ Claims Administrator prior and timely notice), or with the written consent of the participating claimant or his or her legal representative;

16. Maintain a Claim file on every Claim reported to it by the participating Medical Monitoring providers. Such files and all Plan-related information shall be made available to the Special Master/ Claims Administrator for consultation, review and audit upon reasonable notice and request, during the business day and at the office of the TPA. This audit shall be conducted by an auditor prescribed by the Special Master/ Claims Administrator, with input from the Finance Committee, and will include, but not be limited to, a review of claims data, a review of system controls, a review of compliance with Plan provisions, and a review of personnel and administration;

17. Upon termination of this Agreement, all participating Medical Monitoring provider files, eligibility information filings with governmental entities and Plan documents will be transmitted to the Special Master/Claims Administrator, and/or his successor. Until that time, these records will be securely maintained at the TPA's principal administrative office, or secure storage facilities for at least (7) years following the termination of a Plan year.

It is envisioned that, by contracting with a cost-effective third party administrator, the Project may provide cost-effective and high-quality Medical Monitoring services to the Program Participants for the next thirty (30) years.

III. PROPOSAL SUBMISSION GUIDELINES

This section of the RFP contains the schedule for the submission and review of proposals, and describes the major proposal submission and review events, and the conditions governing the award.

a. SEQUENCE OF EVENTS

The Special Master/ Claims Administrator will make reasonable efforts to adhere to the following schedule:

Action	Date
Request for Proposal (RFP Issued)	March 1, 2011
Pre-Proposal Teleconference with Bidder	March 14, 2011
Completed Appendix A sent by Bidders to Special Master/Claims Administrator	March 16, 2011
Receipt of Written Bidder Questions	March 18, 2011
Special Master Response to Written Bidder Questions	March 22, 2011
Written Bidder Proposals Submitted to Special Master	April 1, 2011
Selection of Bidder Finalists for Interviews	April 15, 2011
Best and Final Offers and Oral Presentations from Finalists	April 29, 2011
Final Selection of TPA Subject to Court Approval	May 4, 2011
Court Considers Approval of TPA	May 16, 2011
TPA surveys Class Area and Out-of-Class Area medical monitoring physicians and laboratory prospects, including West Virginia University, and prepares for Claims Administrator and Financial Committee for review: (A) Medical monitoring implementation recommendations, based on "retail model" of paying for medical monitoring building blocks; (B) List of in-Class Area and Out-of-Class area potential medical monitoring physicians and laboratories; and (C) draft medical monitoring roll-out time line draft (collectively, the Medical Monitoring Implementation Plan)	May 16, 2011
Medical Monitoring Implementation Plan is finalized by Claims Administrator, Finance Committee and TPA	July 15, 2011
Claims Administrator prepares for review by TPA and Finance Committee Medical Monitoring implementation budget for year one	July 25, 2011
TPA and Claims Administrator, after consulting with the Finance Committee, submit medical monitoring implementation budget for year one to the Court for review	August 1, 2011
Class Medical Monitoring Registration Ends	August 15, 2011

Medical Monitoring Testing begins	September 8, 2011
Final List of Medical Monitoring Class members is approved by the Court	November 15, 2011

b. EXPLANATION OF EVENTS

The following paragraphs describe the activities listed in the sequence of events shown in Section III, Paragraph A.

i. Issuance of RFP

This RFP is being issued by the Special Master/ Claims Administrator, in connection with the medical monitoring program for the registered claimants in the case of Perrine, et al., v. E. I. DuPont De Nemours and Company, et al., Case No. 04-C-296-2.

ii. Pre-Proposal Teleconference with Bidder

The Pre-Proposal Teleconference with Bidder provides the Bidders with an opportunity to ask any questions related to this RFP and to this project prior to submitting a bid. The teleconference will be held on March 14, 2011 at 1:00PM Central Standard Time, 2:00PM Eastern Standard Time.

iii. Confirmation of Mandatory Requirements

Potential bidders should hand deliver, email or return by facsimile or by registered or certified mail, completed Appendix A to have their organization placed on the procurement distribution list. The appendices should be signed by an authorized representative of the organization, dated and returned by close of business on March 16, 2011.
EACH BIDDER MUST AGREE TO THE MANDATORY REQUIREMENTS AND CONTRACT TERMS AND CONDITIONS IN APPENDIX A. FAILURE TO SUBMIT AGREEMENT TO THE MANDATORY REQUIREMENTS AND CONTRACT TERMS WILL ELIMINATE BIDDER FROM FURTHER CONSIDERATION.

The acceptance of Mandatory Requirements is in Appendix A.

Once you are approved as a viable bidder, you will be placed on the procurement distribution list. The procurement distribution list will be used for the notification of the availability of responses to bidder questions and any RFP amendments on the Project website at http://www.perrinedupont.com.

iv. Deadline to Submit Bidder Questions

Bidders may submit questions as to the intent or clarity of this RFP until the close of business on March 18, 2011. All questions must be emailed to escrowagent@AOL.com and ddebrosse@gtandslaw.com.

v. Response to Bidder Questions/ RFP Amendments

Responses to questions and any RFP amendments will be posted on the Project website, http://www.perrinedupont.com, and sent via electronic mail, no later than March 18, 2011.

vi. Submission of Proposal

ONE (1) PAPER COPY, AND ONE (1) ELECTRONIC DISC OF THE PROPOSAL ARE TO BE SUBMITTED NO LATER THAN April 1, 2011. An email copy of any correspondence relating to your proposal should also be emailed to:

Edgar C. Gentle, III, Esq.
Special Master and Claims Administrator
DuPont Medical Monitoring Administration
GENTLE TURNER & SEXTON
501 Riverchase Parkway East
Suite 100
Hoover, AL 35244
(205) 716-3000 (telephone)
(205) 716-3010 (facsimile)
escrowagen@AOL.com

Proposals received after this deadline will not be accepted. The receipt date will be recorded by the Project on each proposal. Proposals must be addressed and delivered to the above. Proposals must be sealed and labeled as described below on the outside of the package to indicate clearly that they are in response to the DuPont Medical Monitoring Administration Request for Proposals.

vii. Proposal Evaluation

An Evaluation Committee comprised of the Special Master/ Claims Administrator, the Finance Committee, and the Claimant Advisory Board, will perform the initial evaluation of proposals.

During this time, the Evaluation Committee may initiate discussions with bidders to clarify any aspect of the proposals, but proposals may be accepted and evaluated without such discussion.

The factors listed are among those which will be considered by the Evaluation Committee: price competitiveness, service, completeness of Proposal, responsiveness to proposal requests, ability to interface with other components of the project, references, claims processing organization and procedures, management information reporting capabilities, qualifications of responsible personnel, claims turnaround time, and similar experience.

viii. Selection of Finalists

The Evaluation Committee will select and the Claims Administrator will notify the bidder finalists by April 15, 2011. Only finalists will be invited to participate in the subsequent steps of

the procurement. The schedule for the oral presentations will be determined as finalists are contacted.

ix. Best and Final Offers from Finalists

Bidder finalists may be asked to submit revisions to their proposals for the purpose of obtaining best and final offers by April 29, 2011. Best and final offers may be clarified and amended at the finalist's oral presentation.

x. Oral Presentation by Finalists

Bidder finalists may orally present proposals to the Evaluation Committee. The oral presentations will be conducted in Harrison County, West Virginia on April 29, 2011.

xi. Contract Award

After review of the bids by the Claims Administrator, the Finance Committee, and the Claimants Advisory Board, the Claims Administrator may award the contract, which is anticipated to occur, with Court approval, by May 16, 2011.

c. RESPONSE FORMAT AND ORGANIZATION

Proposals should respond clearly and concisely to all of the questions contained in this RFP. All exhibits should be completed as requested and returned as part of your proposal.

i. Numbers of Copies of Response

Bidder should submit one (1) paper copy and one (1) electronic disc of their proposal in a sealed envelope or package to the Special Master Claims Administrator at the address listed previously. The electronic copy shall be in Word or WordPerfect format. Each copy should be clearly marked:
MEDICAL MONITORING PROPOSAL FOR THE SPELTER CLAIMANTS IN PERRINE, ET AL., V. DUPONT, ET AL., IN HARRISON COUNTY, WEST VIRGINIA

ii. Proposal Format

All Proposals must be typewritten on standard 8-1/2 x 11 paper (larger paper is permissible for charts, spreadsheets, etc.) and placed within a binder with tabs delineating each section. Succinctness is strongly encouraged.

iii. Proposal Substance

Bidders must review and accept in their entirety the mandatory requirements detailed in Appendix A. Your submission of the Proposal should include:

a. Letter of Transmittal: The Letter of Transmittal must:

i. Identify the name and title of the person authorized by the organization to contractually obligate the organization;
ii. Identify the name, title and telephone number of the person authorized to negotiate the contract on behalf of the organization;
iii. Identify the names, titles, telephone numbers and email addresses of persons to be contacted for clarification; and
iv. Be signed by the person authorized to contractually obligate the organization;

b. Proposal:
i. Proposal Summary;
ii. Qualifications of principals and staff members;
iii. Proposed strategy for medical monitoring:administration;
iv. Questionnaire Responses/ Information Production
v. Other Supporting Material;
vi. Mandatory Requirements – Appendix A

IV. PROPOSAL QUESTIONNAIRE/ INFORMATION REQUEST

a. GENERAL

This section contains the Proposal questions to be addressed by bidders. Proposals shall address the questions in the order presented, identifying the proposal questions by including the number of the corresponding question with your answer. Proposals need to be specific, detailed, and straightforward, using clear, concise, and easily understood language.

b. COMPANY INFORMATION

i. Provide the complete name, address and federal tax identification number of the organization with whom the proposed third party administrator contract would be written. Indicate how many years the organization has been providing third party medical claims administration services.

ii. Please provide the name of the primary contact for your organization that will be readily available to answer questions on the proposal, as well as his/her title, address, email address, telephone and cell phone numbers, and fax number.

iii. Explain the organization's ownership structure, listing all separate legal entities and their relationship within the structure.

iv. Describe recent (within the last 36 months) or planned changes in your organization, such as mergers, stock issues, acquisitions, spin-offs, etc.

v. Please provide an annual report for the past two years. If you do not provide an annual report specific to the TPA service business, please provide a balance sheet and income statement for the same period specific to the TPA business, and also include a synopsis of your company's history including length of time in the TPA business.

vi. Please demonstrate and report on your organizations performance as a TPA against other competitors in the TPA service business.

vii. Are there any restrictions or pending reviews by state or federal authorities for non-compliance with state or federal regulations? YES NO
If yes, please provide details for the past three years, including disposition.

viii. Are there any legal, administrative, and/or regulatory investigations and/or inquiries currently pending? YES NO
If yes, please provide details for the past three years, including disposition.

ix. Have there been legal, administrative, and/or regulatory investigations and/or inquiries within the past 36 months? YES NO
If yes, please provide details for the past three years, including disposition.

x. Please disclose any potential conflicts of interest in serving as the TPA for this project, including, but not limited to, any personal, business, and/or professional relationships with DuPont or any of its affiliates, Plaintiffs' Counsel, Defense Counsel, and/or the Special Master, including, but not limited to, Edgar C. Gentle, III, Esq., David B. Thomas, of Allen Guthrie & Thomas, Virginia Buchanan, Steve Medina and Ned McWilliams of Levin, Papantonio, Thomas, Mitchell, Eschsner & Proctor, Kevin Madonna of Kennedy & Madonna, Angie Mason of Cochran, Cherry, Givens, Smith, Lane & Taylor, Jerry Jones of West & Jones, James Lee, Esq., of Hunt & Lees, LC, of West Virginia, William Dodds, Esq., of Dechert, LLP, New York, Boyd Warner, Esq., of Waters, Warner & Harris, PLLC of West Virginia, Richard Gallagher, Esq., of Robinson & McElwee, PLLC, West Virginia, Frank E. Simmerman, Jr, Esq., of Simmerman Law Office, PPLC, West Virginia, Brent R. Austin, Esq., of Wildman Harrold, Allen & Dixon, LLP of Illinois, Jim Arnold, Esq.,and Stephanie Thacker, Esq., of Allen Guthrie & Thomas, PLLC of West Virginia, Edison Hill, Esq., of Hill, Peterson, Carper, Bee & Deitzler, West Virginia, J. Michael Papantionio, Esq., of Levin, Papantonio, Thomas, Mitchell, Eschsner & Proctor, Florida, Robert F. Kennedy, Jr., Esq., of Kennedy & Madonna, LLP, New York, J. Farrast Taylor, Esq., of Cochran, Cherry, Givens, Smith, Lane & Taylor, Alabama, Perry Jones, Esq., of West & Jones, West Virginia, Gary Rich, Esq., of Law Office of Gary Rich, LC, West Virginia, Julie Mazza, Esq., of DuPont, and William "Buddy" Cox, III, Esq., Lighfoot Franklin & White, Alabama.

xi. Is your organization HIPAA compliant? YES NO

xii. Please provide proof of General Liability and Professional Liability coverage. The Program is to be held harmless and fully indemnified in the event of any action arising out of the operation of the program by vendors or providers.

9. PROVIDER EXPERIENCE INFORMATION

i. Have you ever administered a plan focused solely on medical testing? If so, please describe in detail.

ii. Is your primary medical care/ primary medical testing network nationwide? If not, who do you use for a secondary network and how are thy reimbursed?

iii. If available, please provide a primary care medical provider/ primary care medical testing network directory for Harrison County, West Virginia.

iv. How do you monitor physician/ screening personnel compliance with contract standards and protocols of care? What procedure will you follow to review a provider's standard of care?

v. Do you currently contract with any national laboratories on behalf of your clients for primary medical care or testing? If so, which?

vi. Have you ever performed client-specific contracting to establish specific rate levels for primary medical care or testing for a primary care client in Harrison County, West Virginia? If so, please describe.

vii. Have you ever performed client-specific contracting to establish specific rate levels for one client in West Virginia? If so, please describe.

viii. What type of plan material will be provided to registered claimants to guide them in using the primary medical care or testing network providers? Please provide an example, if available?

ix. Please review your credentialing process for various primary medical care or testing providers. Do your credentialing requirements meet National Committee for Quality Assurance (NCQA) standards? Do you make primary medical care or testing provider on-site visits? How often are credentialed primary medical care or testing providers reviewed?

x. What is your process for complaints on care or service issues?

d. MEDICAL MONITORING EXPERIENCE INFORMATION

i. Have you ever been a part of a medical monitoring program?

ii. Have you ever provided administrative services with regard to the large scale screening of a population or plan for zinc, arsenic, cadmium, or other metals or chemicals?

iii. Have you ever worked with a university regarding screening of a population?

iv. If you have answered yes to either question IV(d)(i), IV(d)(ii) or IV(d)(iii) above, please provide a detailed description.

e. ACCOUNT SERVICE

i. Provide an organizational chart for the account service team proposed for this project with name, title, responsibility and office location of each account service team member. At a minimum, the proposed account team should consist of an Account Manager who is responsible for daily account issues.

ii. Supply the name and the following information for each member of the proposed account service team: education, experience, years with company, years in current position, and number of current clients.

iii. Identify which team member is responsible for day-to-day account issues and communication with the Special Master and staff. Please confirm that this person will respond to all account inquiries from the Special Master and/or his staff within one (1) business day. If this individual is unavailable to respond, please describe the process for escalating or delegating this responsibility to another account team member.

iv. Please indicate the percentage of time that the assigned Account Manager will be dedicated to working with this project. Is your organization willing to guarantee this percentage? YES NO

v. Confirm your willingness to meet with management and/or staff from this project quarterly and annually to review plan performance and utilization trends. YES NO

CONTINUED ON THE NEXT PAGE

vi. Using the table below, provide at least three (3) references of current accounts with over 4,000 members that are similar to this project in demographics (please refer to Exhibit A).

Client Name	Location	Length of Relationship	Number of Covered Lives	Contact Name, Title and Phone

f. ELIGIBILITY AND SERVICE

i. Please describe how your organization maintains eligibility data.

ii. Please indicate which personnel shall be responsible for the maintenance of eligibility data for the Project.

iii. Please describe your organization's ability to provide a toll-free telephone number during regular business hours (8:00am to 5:00pm EST) providing the following services:

a. Answer questions concerning member's eligibility and Plan benefits;
b. Research questions;
c. Monitor complaints; and
d. Answer written correspondence regarding any of the issues necessary.

g. REPORTING CAPABILITIES

i. Please describe your organization's ability to report monthly and/or quarterly on claims volume, turnaround, accuracy by entity and by demographic profile.

ii. Please describe your organization's ability to report on utilization by service, by diagnosis and by demographic profiles.

iii. Please describe your ability to report on Third Party claims activity, including

Medicare, Medicaid, and other third party insurers (if applicable in this context- which has yet to be determined).

iv. Please describe your ability to track claims payment errors, corrections and recovery of errors.

v. Please describe your ability to track and report timely on large claims activity and case management status;

vi. Please describe your ability to report on grievances/ appeals and appeals status and turn-around performance.

vii. Please describe your ability to prepare an annual report of payments.

viii. Please provide a sample copy of the reports you prepare for clients.

ix. Please describe your ability to provide a Plan Cash Flow Report on a quarterly basis.

x. Please describe your ability to provide a Paid Claims report for Screening Paid Claims on a quarterly basis.

h. DATA AND SYSTEMS

i. Please describe the manner in which your organization assures claims payment.

ii. Please describe the electronic methods of primary medical care or testing claims filing and adjudication including telecommunications and/or web applications.

iii. Please describe the manner in which network primary medical care or testing providers have access to your organization's systems.

iv. Are network primary medical care or testing providers are trained in the usage of your organization's systems? If so, please describe the manner in which they are trained, the hours of training, and the training personnel. If available, please provide a copy of the training manual, or a description of training services.

v. Explain your internet capabilities for providing reports to the Project and primary medical care or testing providers.

i. MEDICAL MONITORING PLAN DESIGN and IMPLEMENTATION

i. Currently, the Project anticipates the development of a medical monitoring plan with the input of the Claims Administrator, the Finance Committee, the Claimants Advisory Committee now, and also a Medical Advisory Panel in the future. The

objective of this RFP is to secure a Network model for the implementation and monitoring of a full fledged medical monitoring plan, in order to ensure that funds are utilized solely for services rendered to our claimants. Utilizing a projected thirty year program with participants to be tested every two (2) years, the provision of service to an unknown amount of claimants (but equal to or less than 8,500), and the information provided in this RFP and the attached exhibits, please provide an overview of the method by which your organization would develop a medical monitoring plan design.

ii. Please describe your organization's experience with directly contracted or sub-leased primary medical care or testing provider networks. Provide examples and details.

iii. Please provide the contact information for two of the directly contracted primary medical care or testing provider network and/or sub-leased provider network.

iv. Please describe your organization's experience with developing a custom network. Please provide examples and details.

v. Does your organization currently have a primary health care provider network established in Harrison County, West Virginia? If yes, please provide details with regard to the primary health care provider network (i.e. length of time established, number of providers, etc.,).

vi. Utilizing the information referenced above, the overview of the Project, and your Organization's expertise, please indicate which model would be best for the Project.

vii. Describe the oversight programs for the following activities:

a. Claim paying accuracy and audits;
b. Customer (participating class members and primary medical care and testing providers) service and support;
c. Collection of overpayments;
d. Facility Provider & Physician medical reviews.

I. FINANCIAL PROPOSAL

i. Fee Pricing Schedule

Medical Screening Admin.	_____ (per claim)	_____ (per claim)	_____ (per claim)
Referral Tracking	_____ (per claim)	_____ (per claim)	_____ (per claim)
Setup	(per claim)	(per claim)	(per claim)

Case Management	_____ (per claim)	_____ (per claim)	_____ (per claim)
Plan Document Development	_____ (per claim)	_____ (per claim)	_____ (per claim)
Communication Production	_____ (per claim)	_____ (per claim)	_____ (per claim)
Communication Postage	_____ (per claim)	_____ (per claim)	_____ (per claim)
Provider Access	(per claim)	(per claim)	(per claim)
HIPPAA Admin	(per claim)	(per claim)	(per claim)
Other (Explain)	(per claim)	(per claim)	(per claim)
Other (Explain)	(per claim)	(per claim)	(per claim)

ii. How are your fees computed? Please provide a detailed description of your fee structure? Are your fees based upon a percentage of participants who participate?

iii. Please describe how your fee structure has been adjusted based upon the specific needs of this Project.

iv. Please describe how your organization shall set network discount and utilization goals over the next 36 months if awarded this contract.

v. Please describe how your organization plans to meet these network discount and utilization goals over the next 36 months.

vi. Will you put a portion of your fees "at risk" to meet certain network discount and utilization goals? For example, what if only a portion of registered participants actually participate?

vii. Do your contracts have prompt pay stipulations with the providers?

viii. Define a "clean claim".

ix. An accurate accounting of a "clean claim" may require an audit of itemized statements requested of the providers. Please review and describe your contractual wording for this.

x. Do the contracts have any wording that would give the Project's TPA the authority to determine if charges are properly payable under the developed Project Plan Document?

xi. Are Total Eligible Charges defined as the charges from the primary healthcare and testing providers for covered services after the contracted discounts/pricing has been applied?

xii. Does the term "Providers" mean all physician, physician assistant, nurse practitioner, laboratories, screening facilities, and ancillary providers of medical testing services?

xiii. Do your contracts have any guarantee that the primary health care provider/ tester will not be "balanced billed" for repayment of claims discounts for claims not paid in a timely manner?

xiv. Would you negotiate on behalf of this client amended language to your contracts with the primary health care providers/ testers for this Project?

xv. Utilizing your organization's proposed medical monitoring care plan design, please provide an overview of how your chosen fee pricing schedule would ensure that plan participants will receive services below or within the proposed budget.

k. MISCELLANEOUS

i. Please provide your analysis of how you would be able to perform within the time frame for implementation set forth in the Punch List in Exhibit I.

ii. Please provide samples of the informational brochures and/or materials sent to participating members.

iii. Please state whether your organization currently provides a toll free number for customer assistance. Please provide your toll free number.

iv. Are there any other matters which the Special Master and the Evaluation Committee should be aware of in reviewing your organization's proposals?

REQUEST FOR PROPOSALS FROM THIRD PARTY HEALTH CARE ADMINISTRATORS FOR THE ADMINISTRATION OF A MEDICAL MONITORING PROGRAM
IN THE MATTER OF
PERRINE, ET AL., v. E.I. DUPONT DE NEMOURS AND COMPANY, ET AL.

APPENDIX A
ACCEPTANCE OF MANDATORY RFP REQUIREMENTS

The following are the mandatory RFP requirements that shall be met by the successful bidder:

General

1. Bidder agrees that the response to the RFP and any subsequent documentation (best and final offer, finalist presentation, or memo) shall be considered part of the final agreement and contract.

2. Bidder will report internal fraud unit findings on book-of-business on an annual basis.

3. The initial TPA contract term shall be three (3) years, renewable in one-year extensions at the option of the Claims Administrator. However, bidder agrees to a termination without cause provision whereby the Special Master may terminate the agreement upon 30 days prior written notice to Bidder. Bidder will be allowed to terminate the agreement upon 180 days prior written notice to the Special Master.

Account Management

4. Bidder will provide a representative to attend the Project meetings on a quarterly basis in West Virginia.

5. Bidder will maintain claims data, including utilization at no additional charge to the Project.

6. Bidder will assign a team to work with the Claims Administrator/Special Master, Finance Committee, and Claimant Advisory Board to create the medical monitoring plan.

Plan Design

7. Bidder will provide the Special Master with relevant plan management decisions that lower cost trend.

Data, Systems, and Reporting

8. Bidder will accept electronic data transfer and administer claimant information in compliance with HIPAA standards for privacy, security and electronic data interchange.

9. Bidder will provide claims data to the Project. Claims data extracts shall be provided at a reasonable fee to the Project.

10. Bidder will maintain complete records of all claims and payments for a minimum of seven (7) years or greater as required by law.

11. Bidder will provide comprehensive financial and utilization reports. Reports shall be provided on a monthly, quarterly and annual plan year basis via hard copy and by electronic mail.

Audit Rights

12. Bidder agrees to provide unrestricted operational and financial audit rights to the Project in relation to the provision of services to the Project claimants.

13. Bidder agrees to properly disclose any and all sources of revenue and other levels of funding aside from that provided by the Project with regard to the administration of services to the Project claimants.

Financial Proposal

14. Bidder agrees to review of the contracted pricing if it is determined to be uncompetitive with the market. An independent third party may be utilized to conduct the pricing review and submit a mutually agreeable methodology for evaluating competitiveness.

15. Bidder guarantees the financial elements of its proposal throughout the term of the contract.

Consent to Jurisdiction and Waiver of Objections

16. Bidder, by its execution of the Agreement, submits to the jurisdiction of the Circuit Court of Harrison County, West Virginia in Perrine, et al., v. E. I. DuPont De Nemours and Company, et al., Case No. 04-C-296-2, (the "DuPont Case") for all purposes related to or arising out of Bidder's proposal to provide, or, if Bidder is selected as a provider, Bidder's provision of medical monitoring administrative services to the Project. In addition, Bidder hereby waives any and all objections it might otherwise assert to the aforesaid jurisdiction, venue, or authority of the Court in the DuPont Case to hear and determine any and all disputes that might arise out of or be related to the Services, reserving its rights to be heard in connection therewith and to appeal, it may be advised, from any adverse determination of the Court in the DuPont Case.

Confidentiality Agreement

17. Bidder understands that the Court in the DuPont Case has ordered that the identity of claimants in the DuPont Case and the details of chemical exposure, medical conditions and histories, and payments fo medical monitoring be kept confidential, and state that Bidder will not reveal this information to anyone outside of authorized personnel in my company unless Bidder has express

permission to do so from the Honorable Thomas A. Beddell or the Special Master/ Claims Administrator. Bidder further understands that if Bidder violates this pledge of confidentiality, Bidder is subject to being brought before the Honorable Thomas A. Beddell for investigation and possible sanctions for this breach.

Company Name:

_____

By: _____ _____
Sign Name Date

_____
Print Name of Signing Person

_____
Title With the Company

By signing the above, I, _____ hereby represent that I have the authority and power to bind _____ (company name), and that I will comply with all of the terms as set forth hereinabove.

SCHEDULE OF EXHIBITS

A. CLASS AREA MAP

B. FINAL ORDER REGARDING THE SCOPE, DURATION AND COST OF THE MEDICAL MONITORING PLAN ENTERED FEBRUARY 25, 2008

C. NOVEMBER 19, 2010 MEMORANDUM OF UNDERSTANDING

D. FINAL ORDER SETTING FORTH THE SCOPE AND OPERATION OF THE MEDICAL MONITORING PLAN DATED JANUARY 18, 2011

E. SPECIAL MASTER'S REPORT NO. 1 DATED JUNE 23, 2008

F. SUPPLEMENT TO SPECIAL MASTER'S REPORT NO. 1

G. DR. WERNTZ'S PROPOSED MEDICAL MONITORING REPORT

H. MEDICAL MONITORING TIME LINE APPROVED BY THE COURT

I. MEDICAL MONITORING REGISTRATION FORM AND LETTER OF EXPLANATION DATED FEBRUARY 15, 2011

EXHIBIT A

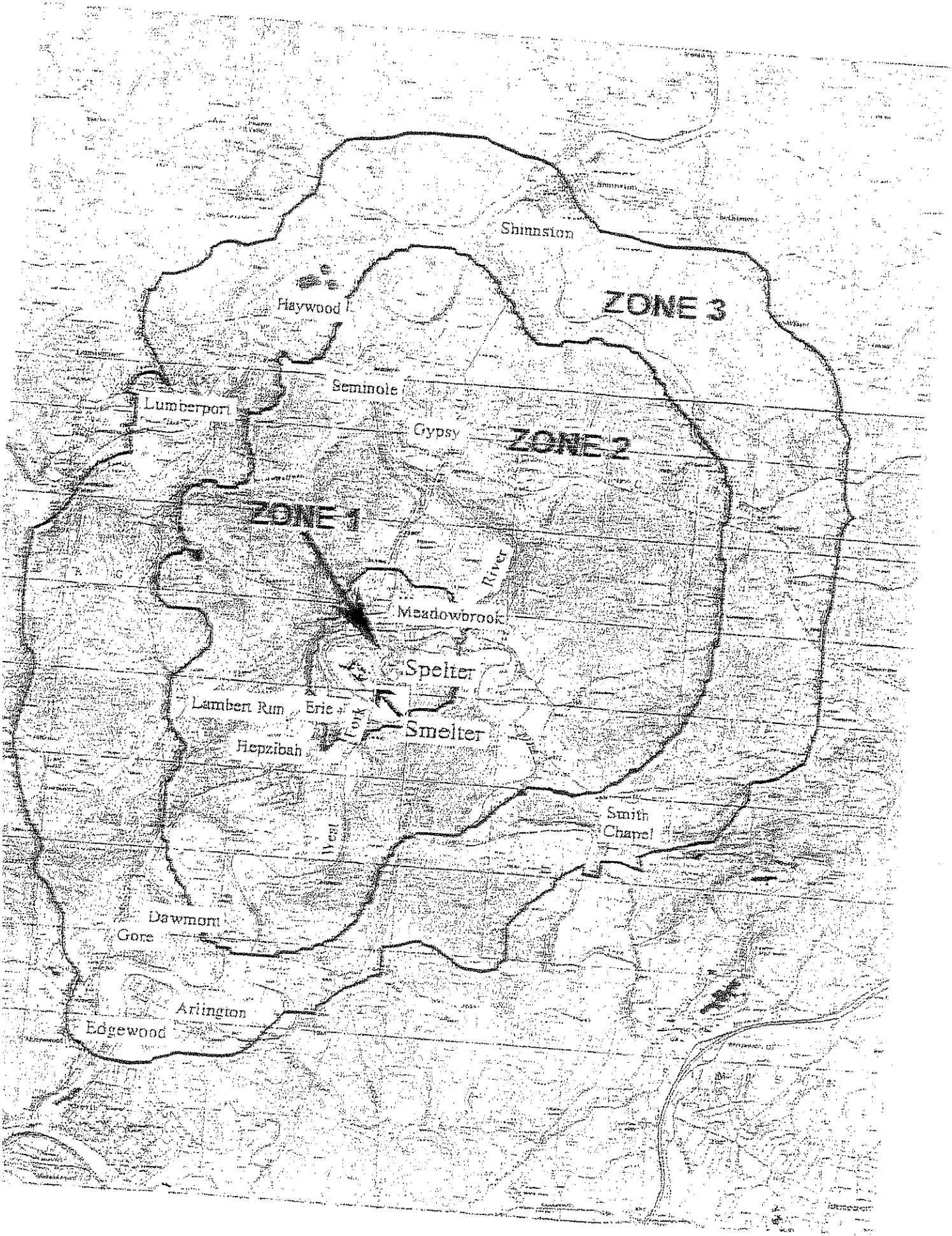
Shinnston
Haywood
ZONE 3
Seminole
Lumberport
Gypsy
ZONE 2
ZONE 1
River
Meadowbrook
Spelter
Lambert Run
Erie
Smelter
Hepzibah
Smith
Chapel
Dawmont
Gore
Arlington
Edgewood

EXHIBIT B

IN THE CIRCUIT COURT OF
HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, CAROLYN HOLBERT,
WAUNONA MESSINGER CROUSER,
REBECCAH MORLOCK, ANTHONY BEEZEL,
MARY MONTGOMERY, MARY LUZADER,
TRUMAN R. DESIST, LARRY BEEZEL, and
JOSEPH BRADSHAW, individuals residing in West Virginia,
on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

Case No. 04-C-296-2

(Honorable Thomas A. Bedell)

E.I. DU PONT DE NEMOURS AND COMPANY,
a Delaware corporation doing business in West Virginia,
MEADOWBROOK CORPORATION, a dissolved
West Virginia corporation, MATTHIESSEN & HEGELER ZINC
COMPANY, INC., a dissolved Illinois corporation formerly
doing business in West Virginia, and
T. L. DIAMOND & COMPANY, INC.,
a New York corporation doing business in West Virginia,

Defendants.

FINAL ORDER REGARDING THE SCOPE, DURATION AND COST OF THE MEDICAL MONITORING PLAN

This Court commenced proceedings in this matter on December 20, 2007 and continued the proceedings at that time, to be resumed on January 15, 2008, for the purpose of receiving evidence to assist the Court in determining the scope, duration and cost of the medical

monitoring plan.[1] After considering the evidence presented by the parties and the written submissions filed in advance of the hearing, the Court makes the following findings and fact, conclusions of law and rulings.

Introduction:

The jury determined, on October 10, 2007, that medical monitoring should be provided to members of the class.[2] The Court reserved in its trial plan the authority to exercise its equitable powers to determine the scope, cost and duration of the medical monitoring program. On January 15, 2008, the Court heard testimony and considered evidence submitted by Plaintiffs and Defendant Dupont regarding the scope, cost and duration of the program.

The court heard testimony on behalf of Plaintiffs from Dr. Charles Werntz (a physician in the department of occupational and environmental medicine at West Virginia University ("WVU") who also testified at trial), Dr. Anthony Sciara (a certified life care planner), and Dr.

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[1]Originally certified in September 2006, the Court modified the medical monitoring class in June 2007, basing membership on the total time of residency within the class area and proximity to the zinc smelter facility. The class includes those who currently reside, or who at any time since 1966 have resided, within the class area for one, three or five years of total residency, depending on where one lives or lived within the class area. The class area has been divided into three zones with Zone 1 closest to the zinc smelter facility and Zone 3 furthest from the zinc smelter facility. Total residency time of one year since 1966 is required for Zone 1, total residency time of three years since 1966 is required for Zone 2, and total residency time of five years since 1966 is required for Zone 3. Based on a demographic survey, 8,528 people are eligible to participate in the medical monitoring program.

[2]Dr. Charles Werntz, Plaintiffs' medical monitoring expert, testified at the trial of this matter, Phase II, and identified a number of cancerous and non-cancerous conditions caused by exposure to arsenic, cadmium and lead. The conditions include lung cancer, skin cancer, stomach cancer, kidney cancer and bladder cancer, as well as decreased renal function, renal failure, plumbism (lead poisoning), and neuro-cognitive injury. The jury found that it is reasonably necessary for the class members to undergo periodic diagnostic medical examinations different from what would be prescribed in the absence of exposure to arsenic, cadmium and lead for the conditions outlined above.

Michael Brookshire (a forensic economist and professor of economics at Marshall University). Defendant offered the testimony of Mr. Todd Menenberg, a certified public accountant, and he was tendered as an expert in projecting future medical costs. Tr. (1/15/08) at 124.

In addition to previously filed materials, the Court received submissions from both parties at the proceedings. The Plaintiffs filed the detailed medical monitoring plan (Pl. Ex. 1), report of medical costs for tests and medical evaluations (Pl. Ex. 2) and the slide presentation shown at trial through the testimony of Dr. Wernitz (Pl. Ex. 3). In addition, Plaintiffs filed the affidavit and curriculum vitae of Dr. Anthony Sciara (Pl. Ex. 4) as well as the report of Dr. Michael Brookshire (Pl. Ex. 5). Defendant's Exhibits included a New England Journal of Medicine article regarding CT scans (Def. Ex. 1),[3] Physician's Fee Reference (Def. Ex. 2), Mr. Menenberg's report and resume (Def. Ex. 3), and the slide presentation displayed during Mr. Menenberg's testimony (Def. Ex. 4). The Court also heard briefly from Mr. Edgar Gentile, an attorney and potential candidate to serve as administrator of some or all of the funds awarded to the class.

Plaintiffs have asked that the medical monitoring program proposed by Dr. Wernitz be adopted in its entirety, that the scope of the program follow the testing protocols and recommendations contained in his detailed medical monitoring report. (Pl. Ex. 1) Defendant has objected to the use of CT scans for lung cancer screening but has offered no alternative screening for lung cancer or for any of the conditions associated with exposure to arsenic, cadmium and lead.

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[3]The article, entitled "Computed Tomography, An Increasing Source of Radiation Exposure" was published November 29, 2007.

Plaintiffs have proposed that the duration of the medical monitoring program be 40 years, as suggested by Dr. Werntz, based upon the latency periods of cancers associated with the exposures to arsenic, cadmium and lead. Defendant has not proposed any alternative duration of the program. Tr. (1/15/08) at 9-10. The Defendant did however request that the Court direct the Special Master to conduct further proceedings to recommend an appropriate testing period.

With respect to the cost issue, Plaintiffs have offered the medical report of Dr. Charles Werntz (Pl. Ex. 2), along with a long term economic analysis of the cost to fund the program over the 40 year period, prepared by Dr. Michael Brookshire. (Pl. Ex. 5) Plaintiffs have moved the Court to accept the calculations and fund the program at the outset in the amount of $129,625,819.00[4]. Tr (1/15/08) at 102. Plaintiffs' calculations call for funding of the program in an amount that is less than the full cost to provide monitoring for all eligible class members. The amount sought would pay for approximately 75% of the class to participate in the first round of screening, with costs reflecting declining participation in each successive round. Tr. (1/15/08) at 83-84. Defendant challenges the cost of the tests and urges that reimbursement rates paid by government or private payers be used instead. Tr. (1/15/08) at 145-146. Defendant also challenges the administrative costs and medical inflation rates claimed by Plaintiffs and seeks to have the Court impose a "pay as you go" approach, in which Defendant would not be required to pay the judgment and fund the program at this time.

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[4]The present funding and deposit of this sum, with earnings of 4.88% per year, would produce the $174,817,539 necessary to fund the program for its life, according to Dr. Brookshire. Tr. (1/15/08) at 102-103.

Findings of Fact and Conclusions of Law:

1. The scope of the program should be in accordance with the medical monitoring plan proposed by Dr. Werntz.

Plaintiffs proposed a general medical monitoring plan to the jury and, after careful deliberation over a number of hours, the jury determined that it was reasonably necessary for all class members to undergo periodic medical examinations. (Phase II, Verdict Form) More recently, Plaintiffs submitted detailed recommendations for the plan.[5] The plan provides periodic medical screening every 2 years and includes a recommendation for periodic review of the plan (i.e., every 5 years or every 2 cycles) and informed consent. (Pl. Ex. 1 at 1/15/08 hearing)

Dr. Werntz testified about the resources available at West Virginia University to implement the medical monitoring program. Tr. (1/15/08) at 20-23. There are five board certified physicians in the occupational and environmental medicine department who can evaluate test results, make referrals and recommendations, analyze and report data, etc. Tr. (1/15/08) at 20. In addition, Dr. Werntz described the ease with which a small clinic office could be operated within the class area for purposes of completing detailed health questionnaires, having directed physical examinations and collecting laboratory samples for analysis. Tr. (1/15/08) at 22-23. He also discussed the potential use of United Hospital Center, a local hospital, to perform CT scans.[6] Tr. (1/15/08) at 22. These services would be convenient for all living within or nearby the class area who are eligible for

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[5]Defendant was provided the detailed medical monitoring report well before the trial and had ample opportunity for cross examination of Dr. Werntz at his deposition on April 12, 2007 and at the proceedings held on January 15, 2008.

[6]Dr. Werntz proposes the use of a single- breath- hold, low dose radiation Computed Tomography scan of the chest to screen for lung cancer, for class members who are 55 years of age or older.

medical monitoring. Moreover, WVU is uniquely qualified to accumulate a mass database of all the data from the class members and provide periodic reports to the plan administrator and court, as well as analyze the data and prepare reports and findings, as appropriate, for publication in medical journals. Tr. (1/15/08) at 15-16

West Virginia University has multi-specialty medical coverage, so class members have the benefit of having procedures performed by well qualified medical specialists. Tr. (1/15/08) at 34-36 WVU also has a fully dedicated cancer center to provide treatment should class members decide to seek treatment at WVU. Tr. (1/15/08) at 20 In addition, with the professional affiliations and relationships WVU and its occupational and environmental physicians maintain with the outlying medical community, Dr. Werntz anticipates that qualified health care providers can be identified who will be able to assist with testing and collecting and transmitting data for class members who live outside the class area. Tr. (1/15/08) at 16-17

Dr. Werntz testified that low dose single-breath hold chest CT scans should be made available to class members for screening for lung cancer, because early stage lung cancer can be detected by CT scan. Tr. (10/02/07) at 4116 Earlier diagnosis allows for consideration of a treatment plan and possible extension of life and long term survival. Tr. (10/02/07) at 4116 At a minimum, it permits the patient to explore treatment options and prepare business and family matters. Some studies have found long term survival with a CT screening program, while others have found no improved survival rates with the use of a CT scan. Tr. (10/02/07) at 4116 Additional studies are underway to gather more information about long-term survival with CT screening programs. Consistent with Bower v. Westinghouse Electric Corp., 206 W.Va. 133, 522 S.E.2d 424 (1999), and the West Virginia Supreme Court's holding that proof of survival is not a necessary

element of plaintiffs' claim for screening for serious medical conditions caused by the tortious conduct of a defendant. Plaintiffs here need not demonstrate likely survival from lung cancer to justify screening for the condition.

An objection to the use of CT scans raised by Defendant is the potential for harm from exposure to ionizing radiation. The doses thought necessary to cause cancer from radiation are derived from studies of people who were present in Hiroshima at the time of the bombing in the 1940's. Dr. Wernitz testified that both he and others question the propriety of comparing the amounts of radiation received to the whole body during the atomic bombing and the days of fallout that followed the doses received in a directed CT scan in a controlled environment. Tr. (1/15/08) at 38-40. He described the past and continuing improvements in technology and reductions in amounts of radiation administered. Tr. (1/15/08) at 41. Dr. Wernitz felt that it was reasonable and prudent to make CT scanning available to the class members. Dr. Wernitz determined, in his professional medical judgment, that the potential benefits of chest CT scans exceed the potential risks to the class members. Tr. (10/02/07) at 4170. There is a high incidence of lung and other cancers in Harrison County, West Virginia.[7]

[7]Dr. Rodricks discusses the cancer statistics at pages 567-572 of the class certification transcript, and Plaintiffs' Exhibit 3 at the hearing contains the graphs referenced in the testimony.

Mr. Menenberg testified on behalf of Dupont as to the medical monitoring issues at the January 15, 2008 hearing.[8] He is a certified public accountant.[9] He is not a physician and, based upon his testimony and review of his curriculum vitae, it is clear that he has never designed or implemented a medical monitoring program. Tr. (1/15/08) at 167; Def. Ex. 3. He was not tendered by Dupont as an expert in medical monitoring, and the Court does not rely upon Mr. Menenberg's testimony or report to determine the scope or duration of the medical monitoring program.[10]

Based upon all the information provided to the Court, the medical monitoring plan proposed by Dr. Werntz should be adopted in its entirety, including the recommendations for periodic reviews of the plan and informed consent for testing.

2. **The duration of the medical monitoring plan should be the 40 year period proposed by Dr. Werntz.**

Dr. Werntz proposes a 40 year medical monitoring plan. The 40 year period is based upon the latency of the majority of the cancers associated with exposure to arsenic, cadmium and lead.

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[8]Dupont offered the testimony of Drs. Nelson, Garabrant and Valberg at trial in opposition to medical monitoring and the utilization of CT scans. The jury rejected the opinions of the witnesses after hearing extensive testimony on the use of CT scans. The Court has also considered the testimony and reports of the witnesses, along with the other submittals.

[9]Of the plethora of witnesses that testified at the course of hearings and trial in this matter, the Court finds Mr. Meneberg to be the least credible of all. It is clear that if one has the money, Mr. Meneberg will provide an opinion whether it is within his field of expertise or not and whether there is any factual or professional basis for the opinion or not. In the sixteen years as a sitting trial judge, Mr. Meneberg is the biggest "hack" to have testified before this Court.

[10]Mr. Menenberg made a reference to CT scans and a New England Journal of Medicine article in his report (Def. Ex. 1), but Mr. Menenberg did not attempt to discuss the article or the specific medical risks and benefits of CT scans. The article discusses certain types of CT scans, but not the type proposed by Dr. Werntz in his program. Tr. (1/15/08) at 31

Tr. (1/15/08) at 9-10. Latency is the period of time from exposure to the time that symptoms manifest. Tr. (10/2/07) at 4065. Evidence was offered at trial and confirmed at the January 15, 2008 proceedings that the latency for cancer takes decades. Tr. (1/15/08) at 9-11; Tr. (10/2/07) at 4092. The Agency for Toxic Substances and Disease Registry ("ATSDR") has noted that cancers have long latency periods, often decades, and skin cancer can take 40 years to manifest. Tr. (1/15/08) at 10. In addition, Dr. Wernitz testified, based upon his research, education and training that lung, skin, bladder and kidney cancer also have very long latency periods, up to and exceeding 40 years. Tr. (1/15/08) at 9-10.

It would deprive the class of meaningful monitoring to utilize a period shorter than the latency periods for these serious and life-threatening medical conditions, and Dupont failed to offer any substantial contrary evidence regarding the duration of the program and the latency periods of these diseases.

5. The cost of the medical monitoring plan should be as calculated by Dr. Michael Brookshire.

Drs. Wernitz, Sciara and Brookshire contributed to Plaintiffs' proof of the cost of the medical monitoring plan. Mr. Menenberg was called by Dupont to testify on the cost issues as well.

A. The cost of the medical monitoring tests should be based upon the accepted base rate.

Dr. Wernitz obtained the cost of the tests set forth in his proposed medical monitoring plan from the professional coders at West Virginia University. Tr. (1/15/08) at 12. The costs of the tests were verified and corroborated by Dr. Sciara. Tr. (1/15/08) at 48-49. Dr. Sciara testified that health care costs are submitted for regulatory approval under West Virginia law, so the costs of West

Virginia University clinics and hospitals are submitted to formal independent review before they can be used as charges for healthcare services. Tr. (1/15/08) at 49. In addition, Dr. Sciara confirmed that the costs included in the Wernitz plan are consistent with those charged by Fairmont Hospital, United Hospital and Marshall University hospitals. Pl. Ex. 4

Dr. Sciara also discussed the methods used by life care planners to calculate the cost of future healthcare. Life care planners use base rates for services, the same approach used by Dr. Wernitz. Tr. (1/15/08) at 50-51. He acknowledged that sometimes discounts can be negotiated, but discounts are short-term, uncertain and can not be reliably counted on in the future. Pl. Ex. 4

Mr. Menenberg testified that the funding for the medical monitoring program should not be based upon the costs charged by healthcare providers, the legislatively approved "base" rates. Instead, the program should only be funded to the extent of reimbursement that Medicaid and Medicare can require healthcare providers to accept for similar services. Tr. (1/15/08) at 128, 145-146. His approach would give Dupont a substantial financial discount and does not take into account the likely difficulties of class members to negotiate the rates he suggests. Neither the class members nor any court appointed plan administrator acting on their behalf should be compelled to negotiate rates and risk a compromise of the quality of the monitoring and data analysis or a lack of access to healthcare providers who will provide the monitoring.

Dr. Sciara testified that Medicaid and Medicare rates are inadequate to assure testing and access to care. The rates are viewed as inadequate by healthcare providers, and providers sometimes drop out of the programs due to the insufficiency of reimbursement rates. Tr. (1/15/08) at 52. Medicaid and medicare rates are heavily discounted and are not reflective of the value of the services

provided. Tr. (1/15/08) at 50-51. Rather, they are minimal rates that are paid to healthcare providers for the care of the poor and elderly. The rates are subject to change, upward or downward, depending upon a number of factors. Tr. (1/15/08) at 51-52. As Dr. Brookshire stated, the Medicare and Medicaid rates are "political decisions." Tr. (1/15/08) at 110.

Mr. Menenberg seems to suggest as a fall-back position that, if the Court declines to accept his Medicaid/Medicare theory about medical costs, the Court should fund the medical monitoring program only to the extent of the reimbursement amounts currently allowed by health insurance carriers. Tr. (1/15/08) at 146. His analysis ignores the reality that health insurance plans are negotiated by health insurance carriers and health care providers who have dedicated resources to negotiate rates for medical services. Insurance carriers are in a unique negotiating position and are able to demand certain discounted rates for medical services in exchange for the assurance that many thousands of insureds will seek a wide range of medical services from the healthcare providers. Tr. (1/15/08) at 177-178. Even so, the rates paid for specific services by a health insurer are short-term rates and are subject to frequent re-negotiation. Pl. Ex. 4. Based upon the information Mr. Menenberg provided, it is clear that there is great variation between the health insurance carriers and the rates they pay for the same service. Tr. (1/15/08) at 149, 178. Moreover, as Dr. Sciara pointed out, there are generally co-pays and deductibles charged to the insured person, over and above the "approved" rate of the insurance carrier, and the out of pocket cost to insureds have been increasing. Tr. (1/15/08) at 53.

The health care providers who provide valuable assessments, monitoring and data collection should receive a reasonable fee commensurate with the value of the services provided. Neither the class members nor the healthcare providers upon whom the class members are dependent should be

subject to the uncertainties and inadequacies in the payment plan Dupont proposes, particularly when it is solely for Dupont's financial benefit. Dupont caused the class members to require medical monitoring. Dupont should pay the fair and reasonable rates for the services required by the medical monitoring plan, consistent with the costs set forth in the cost report prepared by Dr. Werntz (Pl. Ex. 2).

B. Plaintiffs have met their burden of demonstrating the number of class members eligible for participation in the medical monitoring class.

Dr. Randall Jackson, a WVU professor and professional demographer, did an analysis of the class area demographics. He determined the number of class members by age groupings. He also estimated the number of class members who no longer live in the class area, but did not ascertain how many people live outside the class area but remain in close proximity. Dr. Jackson also calculated the mortality rates over time, based upon mortality data from the past. Pl. Ex. 5; Def. Ex. 3

Dr. Werntz offered his opinion that as many as 1/4 of the class may not participate in the initial screening. Pl. Ex. 2; Tr. (1/15/08) at 26. He further opined that others would leave the program, for whatever reason, during each successive round of testing during each 2 year cycle.[1] Dr. Brookshire accepted the Werntz participation projections and applied them to the testing

[1]Participants may decline to participate or discontinue to participate based upon a myriad of reasons, including dislike of medical testing, "normal" test results in an earlier round, testing fatigue, etc. Tr. (1/15/08) at 74

protocols to eliminate any charges associated with the class members who either would not participate at all or who would drop out at each successive stage of the testing. Tr. (1/15/08) at 74

Dr. Brookshire went several steps beyond the Werntz projections, though, to conservatively calculate the cost of the program. He omitted all costs for any testing of anyone who stopped testing at a particular point in the cycle, he deleted any claims for costs associated with class members who go to treatment for any condition, and he also omitted any charges for the entire family if a parent discontinued participation. Dr. Brookshire's numbers substantially reduce the projected participation rates that Dr. Werntz proposed. Tr. (1/15/08) at 103-105

Dupont takes issue with Plaintiffs' position. Dupont, again through Mr. Menenberg, implies that people who no longer live in the immediate class area will have low participation rates. He further urges that a large deduction should be made from the total cost of the program because of the allegation that living outside the class boundaries necessarily lowers participation. Def. Ex. 3; Tr. (1/15/08) at 132-133 He also opines, without any scientific or sound medical support, that people will not undergo CT scans. Def. Ex. 3 He criticizes the participation rates used by Dr. Werntz and uses a single Colorado study with 50% participation rates to suggest that Dr. Werntz used an inflated 75% initial participation rate. Def. Ex. 3 Mr. Menenberg admitted that he did not know anything about the demographics of the Colorado group, the ethnicity or otherwise. Tr. (1/15/08) at 167-168 He simply found a report of some limited testing of a group in Colorado on the internet and used that as the basis to attack the numbers Dr. Werntz expressed. Tr. (1/15/08) at 133

Mr. Menenberg was questioned about a medical monitoring program with participation rates much higher than those used by Dr. Werntz. The report addressed the status of a medical monitoring

program 12 years into its operation, and the ATSDR representative testifying before congress said the participation rates remained high at the 12th year, with participation ranging from 82-92%. Tr. (1/15/08) at 170-172.

Dr. Wernz testified that he was familiar with a number of programs in which participation rates were greater than or consistent with his estimates, including reports in governmental publications and presentations at national meetings. Tr. (1/15/08) at 27, 36-38. He also explained that participation rates will depend in part on how the program is set up. Tr. (1/15/08) at 27. Based upon his education, training, experience and research, Dr. Wernz has a sufficient basis to opine as to the reasonably expected participation rates for the proposed medical monitoring program.

C. The medical monitoring program will be funded by a "pay as you go" approach

Plaintiffs seek to have the medical monitoring program fully funded at the outset. On the other hand, Dupont urges a "pay as you go" approach to the funding of the medical monitoring program. At the January 15, 2007, hearing, Mr. Gentle indicated that a "pay as you go" funding mechanism is appropriate. He testified to this view that "we might do a pay-go approach as long as it's fully secured and it's with a sound budget. (1/15/08 Tr. at 188-89.)

The Court believes the most appropriate and equitable approach is to have a "pay as you go" approach to fund the medical monitoring program so that the medical monitoring remedy is funded and paid for based on actual experience and costs incurred over time. Furthermore, the precise mechanism by which any amounts are escrowed, how the escrow is replenished, how funds are disbursed, and other similar matters should be evaulated by the Special Master, who should in turn make a prompt recommendation to the Court.

IT IS THEREFORE ORDERED AND ADJUDGED AS FOLLOWS:

1. The scope of the class medical monitoring program will be in accordance with the Wernicke medical monitoring plan, and it is adopted entirely. The program will be reviewed at regular intervals, every 5 years.

2. The duration of the program is 40 years, commencing at the first round of medical screening, and the Court will retain jurisdiction over the program for its duration.

3. The cost of the program is $129,625,819, and the program will be funded by a "pay as you go" approach.

4. The funds will be deposited at a reputable institution(s), to be approved by the Court, with disbursements subject to court approval. The Court may utilize a special master to provide assistance in the various functions of overseeing the medical monitoring program and its fund. Annual audits of the fund will be periodically performed as well, by an independent accounting firm, to be appointed by the Court. Quarterly financial reports will be filed with the Court for the first four years of the program and semi-annual financial reports will be filed with the Court thereafter.

5. Lastly, pursuant to W.Va. R. Civ. Rule 54(b), the Court directs the entry of this Order as to the claims above upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

DONE AND ORDERED at Clarksburg, Harrison County, West Virginia, this 25 day of [signature], nunc pro tunc November 16, 2007, the date of entry of the Amended Final

Judgment Order in this matter, and the amounts awarded herein shall bear interest at the rate of nine and three quarters per centum (9.75%) per annum from the date of entry of this Order until paid.

It is ORDERED that the Clerk of this Court shall provide certified copies of this Order to the following:

David B. Thomas
James S. Arnold
Allen Guthrie McHugh & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394

J. Farrest Taylor
Cochran, Cherry, Givens, Smith, Lane & Taylor, P.C.
163 W. Main Street
Dothan, AL 36301

THOMAS A. BEDELL, JUDGE

STATE OF WEST VIRGINIA
COUNTY OF HARRISON, TO-WIT:

I, Donald L. Kopp II, Clerk of the Fifteenth Judicial Circuit and the 18th Family Court Circuit of Harrison County, West Virginia, hereby certify the foregoing to be a true copy of the ORDER entered in the above styled action on the 25th day of February, 2008.

IN TESTIMONY WHEREOF, I hereunto set my hand and affix Seal of the Court this 25th day of February, 2008.

Donald L. Kopp II
Fifteenth Judicial Circuit & 18th Family Court
Circuit Clerk
Harrison County, West Virginia

EXHIBIT C

MEMORANDUM OF UNDERSTANDING

Lenora Perrine et. al. v. E.I. du Pont de Nemours and Company, et. al., Civil Action No. 04-C-296-2 (Cir. Ct. of Harrison County, W. Va.)

Comes now this 19th day of November 2010 the Plaintiffs in the above-captioned matter by Ed Hill, Esq. and comes the Defendant E.I. du Pont de Nemours and Company ("Defendant")in the above-captioned matter by James B. Lees Jr., Esq. and hereby set forth the terms and conditions of a proposed global resolution of this pending litigation as between these parties:

1. Plaintiffs shall dismiss any and all pending claims against Defendant with prejudice and shall release Defendant from any and all liability in this litigation, except as provided by this agreement.

2. The Defendant shall pay to the Plaintiffs the sum of $70,000,000.00 plus medical monitoring consistent with the Court Order dated February 25, 2008, as only modified by this agreement, under the following terms and conditions:

a. Although the parties understand that the final date of payment by Defendant to Plaintiffs depends on a number of factors and cannot be guaranteed, the parties agree to make all reasonable efforts to accomplish payment of the $70,000,000.00 from Defendant to a Qualified Settlement Fund on or before December 31, 2010.

b. $66,000,000.00 of the total $70,000,000.00 payment shall be available to the Plaintiffs as directed by the Court for the purposes of paying for remediation services, medical monitoring costs and expenses, and attorney fees and expenses.

c. The remaining $4,000,000.00 of the total $70,000,000.00 payment shall be made available only for a cash payment program for the medical monitoring sub-class of Plaintiffs as directed by the Court. Said sum shall not be used for any purpose other than for the sole benefit of the medical monitoring sub-class.

3. In addition to the above, Defendant shall provide on a pay-as-you-go basis a medical monitoring program for all enrolled Plaintiffs consistent with the previous referenced Court Order as only modified by this agreement, under the following terms and conditions:

a. There shall be an initial enrollment period of six (6) months beginning at a time reasonably determined by the Settlement Administrator for all Plaintiffs at which time any Plaintiff may enroll in the medical monitoring program to avail themselves of the future monitoring benefits of the program. No Plaintiff shall be entitled to participate in said program unless they have enrolled during the initial six (6) month enrollment period.

b. After said enrollment period has expired, a Finance Committee comprised of representatives from class counsel, DuPont, and the Settlement Administrator shall be created for purposes of advising the Court on the structure and execution of the medical monitoring program. On an annual basis the Court, with the recommendation of the Finance Committee, shall direct DuPont to pay a sum certain that will be set aside for each such calendar year that reasonably secures such expenditures for each such calendar year. In each subsequent year after year one DuPont shall be credited with any amounts remaining from the prior year in determining the amount of payment for the subsequent year.

c. 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.

d. Additionally, after the initial six (6) month sign-up period has concluded and the number of participating Plaintiffs, be they adults or minors, is known, the Defendant in the ordinary course of their business shall set aside reasonable reserves as required by applicable law which shall cover the estimated cost of such medical monitoring program.

e. Public notice to class members to notify them of the initial six (6) month sign-up period shall be deemed sufficient if done on a state-wide basis. All advertising and other costs associated with any and all notice requirements under this agreement shall be paid from the $1,000,000.00 start-up expenses referenced above. Notice of this settlement and court costs shall be paid by the defendant.

f. It is contemplated by the parties that a Finance Committee shall exist for purposes of helping provide guidance and advice for the operation of this medical monitoring program with each party hereto having one (1) representative on said Committee. In the event any decision is reached with respect to the payment for services or costs in the medical monitoring program to which the Defendant takes exception, the Defendant shall have the right to have such objection or exception reviewed by the Court and,

if necessary, appealed within the West Virginia judicial system.

4. Defendant reserves the right to reasonably challenge the enrollment of any Plaintiff in the medical monitoring program and/or property remediation class. With respect to any challenge relevant to the issue of eligibility for enrollment the challenger shall pay reasonable costs and attorney fees if the challenge is not successful.

5. It shall be expressly understood by the parties that Defendant shall not be responsible for the payment of any other monies for any purposes associated with the execution of this agreement and that any and all Plaintiff attorney fees and Plaintiff expenses associated with the execution of this agreement shall come from the $70,000,000.00 paid by the Defendant pursuant to this agreement.

6. It is expressly understood by the parties that no part or portion of the payments agreed to by the Defendant pursuant to this agreement are or should be considered a compromise or settlement of any punitive damage award returned against the Defendant, which shall now be vacated.

7. The parties agree that pursuant to any final settlement of this matter the Court, if at the conclusion of the Fairness Hearing approves the final settlement of this matter, will vacate any and all prior judgments relevant to this matter and enter a new judgment order accurately reflecting the terms and conditions of the final settlement of this matter.

8. Any and all pending motions and/or unresolved issues shall be deemed moot by this agreement, including, but not limited to, the pending motion for sanctions filed by the Plaintiffs in this action.

9. Plaintiffs shall maintain any and all copies, including electronic copies, of discovery which has been produced by Defendant to Plaintiffs in this litigation in a manner consistent with all Protective Orders entered in this case, and any and all Protective Orders are understood to continue in effect.

10. In the event members of the Plaintiff class are legally permitted to opt-out of this settlement at the discretion of the Court, the participation rate of the Plaintiffs participating in a final settlement of this matter, consistent with the terms and conditions set forth herein, must equal or exceed 90%. If this 90% participation rate is not achieved, Defendant shall have the option to void the settlement. However op-outs totaling 10% or less shall not reduce DuPont's obligations under this agreement.

11. Defendant understands and agrees that this proposed agreement must be approved by the Plaintiffs' class representatives and the Court pursuant to a Fairness Hearing and that counsel for the Plaintiffs shall strive to obtain such approval of the class representatives by the close of business on Monday November 22, 2010. Plaintiffs understand and agree that this proposed agreement must be approved by certain officers within the Defendant organization and that Defendant shall strive to obtain that approval by the close of business on Monday November 22, 2010. It is understood that neither party currently has legal authority to bind their respective clients today, but does agree to make a good faith effort to obtain the approval of the terms and conditions of this Memorandum of Understanding by their respective clients by the close of business on Monday November 22, 2010.

Agreed to:

Lenora Perring, et al. by

E. I. du Pont de Nemours and Company et al. by

Dated: NOVEMBER 19, 2010

EXHIBIT D

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. DU PONT DE NEMOURS AND COMPANY, et al.,

Defendants.

FINAL ORDER SETTING FORTH THE SCOPE AND OPERATION OF THE MEDICAL MONITORING PLAN

Presently pending before the Court is the "Special Master's Report No. 1 (Medical Monitoring), Recommendations, Requests for Comments, and Prayer for Relief from the Court," which was prepared at the Order of the Court and filed on or about June 23, 2008. Additionally, the Special Master filed a Supplement to Report No. 1 on or about October 25, 2010. Both the Report and the Supplement outline proposed actions for the Court to take while directing the administration of the medical monitoring program. The Report contemplated the original plan as outlined in the verdict. The Supplement slightly modified the Report to accommodate the judgment granted by this Court to the minors and incompetents in the medical monitoring class. Additionally, the Court previously entered the "Final Order Regarding the Scope, Duration, and Cost of the Medical Monitoring Plan," on February 25, 2008, although certain aspects of that Order have changed in conjunction with the Settlement, as noted in this Order and the Final Order Approving Settlement entered on January 4, 2011.

In relation to the medical monitoring program and the settlement of this case, the Parties have filed several motions. Namely, the Plaintiffs filed the "Motion for Appointment of Claims Administrator for Property Remediation," and the "Motion to Appoint a Claims Administrator & Establish Medical Monitoring Settlement Executive Committee," on December 22, 2010. On December 27, 2010, the Defendants filed a "Motion to Establish Medical Monitoring Settlement Executive Committee." On December 28, 2010, the Defendants filed a Response to the Plaintiffs' Motion to state that the Parties are not in agreement about the function of the proposed settlement executive committees.

Finally, the Parties and the Settlement Administrator, Edgar Gentle, executed the "Stipulation of Parties and Settlement Administrator," on or about January 10, 2011, for the purpose of "acknowledg[ing] the clear meaning of the aforesaid Memorandum of Understanding." The Stipulation includes two (2) provisions, the first, generally stated, is that DuPont has fully funded the administrative start up costs for the medical monitoring program through the seventy ($70,000,000.00) million dollar settlement and will only have to provide additional administrative costs once testing commences. The second provision is that "there shall be no requirement that a medical monitoring class member register for or avail themselves of the medical monitoring program or service in order to receive a cash payment from the medical monitoring fund, provided that class membership is proven."

The Court will now address the Parties' Motions as to the Claims Administrator and proposed settlement executive committees.

Two primary observations greatly simplify the Court's decision on these Motions: first, there is no need to appoint a claims administrator for either the property class or the medical monitoring class because Edgar Gentle, of the law firm Gentle, Turner and Sexton, is the Claims Administrator for both classes as of the February 25, 2008, Order of this Court. Second, the Parties are not in dispute about the property remediation class, so its administration will proceed under the direction of Mr. Gentle, as previously Ordered by this Court.

The February 25, 2008, "Order Appointing Claims Administrator," specifically held that:

> The Court hereby engages Edgar C. Gentle, III, as the Claims Administrator and Special Master to aid the Court in carrying out the medical monitoring, property remediation, and punitive damages distribution aspects of this case. Mr. Gentle will serve as Claims Administrator and Special Master at the discretion of the Court. The Court may modify this Order at any time... Mr. Gentle's appointment is under the authority of West Virginia law[1] allowing the Court to exercise general powers and responsibilities over class actions. His actions as Claims Administrator and Special Master (and those of his agents and employees), in accordance with this Order and all future Orders of this Court, will constitute judicial actions of this Court and be protected, to the maximum extent allowable by law, by the doctrine of judicial immunity. Lastly, pursuant to W. Va. R. Civ. Rule 54(b), the Court directs the entry of this Order as to the claims above upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

The only aspect of the above cited Order which is no longer relevant is the distribution of money for punitive damages, as the award for punitive damages has been eliminated through the settlement, and the Court sees no reason to change the above quoted Order in any other respect.

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[1] Aluise v. Nationwide Mutual Fire Insurance, 218 W. Va. 498, 625 S.E.2d 260 (2005); State ex rel Mantz v. Zakaib, 216 W. Va. 656, 609 S.E.2d 870 (2004).

Therefore, although the Court has the power to revisit its previous Orders as necessary, both of the Plaintiffs' Motions are DENIED as MOOT, because Mr. Gentle is the Claims Administrator for both classes pursuant to Order of the Court dated February 25, 2008.[2]

Next, the Court has considered the Defendants' arguments in the "Motion to Establish Medical Monitoring Settlement Executive Committee" and compared the function of said committee against the recommended plan in the Report and Supplement to the Report. Further, the Court has reviewed the November 19, 2010, Memorandum of Understanding, which outlines several agreed provisions of the medical monitoring plan, and the Stipulation of January 10, 2011. The Defendants now request, in contradiction to the Memorandum of Understanding and prior February 25, 2008, "Order Appointing Claims Administrator," that the ultimate administrative authority for running the medical monitoring plan should rest with a three person panel serving two year terms, with the authority to hire or fire the actual administrator of the plan and the authority to act as an intermediate appeal board for issues regarding exclusion or inclusion of potential class members. The Defendants assert that the power to administer the plan should not be vested in one individual due to the thirty (30) year length of the plan and that control of the plan needs to be "institutional."

The Court understands and appreciates the Defendant's concern with the course of the plan over the next thirty years, but the proposed settlement executive committee is unnecessary. First, the Court notes that Mr. Gentle and his firm have the prior

[2] However, the Parties should note, as further outlined in this Order, the Finance Committee as established by the Court will have many of the responsibilities that the Parties have requested for the proposed settlement executive committees.

experience and expertise[3] needed to administer this plan, while the members of the proposed committee are unknown and likely would not have the same experience. Second, Mr. Gentle has been involved with this case for more than two (2) years and is ready to begin to administer the plan, while it would take time to form a committee, whose members would need even more time to understand the massive undertaking presented by this case. Third, a committee is unnecessarily expensive because Mr. Gentle can administer the plan with the oversight of the Court as a safeguard. Fourth, the creation of unnecessary committees is better suited to the legislative and executive branches of government. Fifth, the Court alone is the institutional oversight that the Defendants seek; namely, should Mr. Gentle retire, pass away, or commit some malfeasance, the Court will replace him. The Circuit Court has been serving the Citizens of Harrison County since 1863 and, from all indications, will continue to do so for the next thirty (30) years while the medical monitoring plan is implemented.

Mr. Gentle has not been appointed for life, but instead serves under the supervision and direction of the Court. Mr. Gentle, as Special Master and Claims Administrator, answers to the Court, and the Court serves the Citizens of this County and the State of West Virginia. Should the administration of the plan fail to satisfy any

[3] The Court notes that Mr. Gentle has administered large class action settlements for approximately twenty years. Specifically, Mr. Gentle has served as a Special Master for the MDL 926 Court in the Baxter, Bristol, and 3M Breast Implant Settlement since 1992 which has involved more than 1.1 billion dollars, worldwide claimants, and over two hundred thousand (200,000) checks issued to claimants. Additionally, Mr. Gentle has been in charge of more than 1 billion dollars in investments for the Dow Corning breast implant settlement. Next, Mr. Gentle has administered the settlement of a class action over PCB contamination involving more than 18,000 claimants, a fund of approximately 300 million dollars, and the defendants Solutia, Inc., Monsanto Co., and Pharmacia Corporation. Said administration has resulted in more than seventy thousand checks being issued to claimants. *See* Gentle, Edgar C., III, "Administration of the 2003 Tolbert PCB Settlement in Anniston, Alabama: An Attempted Collaborative and Holistic Remedy," 60 Ala. L. Rev. 1249 (2009). Finally, Mr. Gentle is a Rhodes Scholar, and along with his law partner Terry Turner, drafted a complete and revised Constitution for the State of Alabama from 2000 to 2001.

of the Parties, they may petition the Court to change the administrator of the plan, and as outlined in the settlement, this Court retains jurisdiction over this case, and the Court's decisions are always subject to review by the Supreme Court.

The Court finds that it is critical that the Administrator be answerable to the Court and not subject to influential pressure from one side or the other or subject to deal making by the Parties. To create an executive committee with such vast authority as proposed by the Defendants would be an impermissible delegation of the Court's authority and responsibilities to the Parties. To do so would be tantamount to the inmates running the asylum.

For the foregoing reasons, the Court hereby **DENIES** the Defendants' "Motion to Establish Medical Monitoring Settlement Executive Committee."

Next, the Court **ORDERS** the following as to the establishment of the medical monitoring plan:

a. There shall be an initial enrollment period of six (6) months, beginning no later than **April 15, 2011**, whereby the Claims Administrator, Edgar Gentle, will set up a system for any Plaintiff who is a member of the medical monitoring class to enroll in the medical monitoring program to avail themselves of the future monitoring benefits of the program. During this six (6) month enrollment period, any qualified Member of the Plaintiff Medical Monitoring Class may enroll in the medical monitoring program. No class member shall be entitled to participate in said program unless he or she has enrolled during the initial six (6) month enrollment period. However, if a purported class member submits an application to enroll

during the six (6) month period and such enrollment is disputed or unclear and a final determination as to the eligibility of the class member is made outside of the six (6) month period, said enrollment shall be retroactive to the application date, assuming that the individual is eligible, and the individual shall have timely enrolled in the Class. As long as the Class Member has continuously lived in the Class Area prior to reaching the minimum residence threshold, a Class Member's number of years of residence in each respective Class Area will be accumulated to determine if the threshold has been met. For example, if a Class Member lived ½ year in Zone 1 and 1 ½ years in Zone 2, he or she would qualify for medical monitoring, having fulfilled 50% of the residency required in each zone.

b. A Finance Committee, comprised of three individuals, including one representative from class counsel, one from Dupont, and the Claims Administrator, Edgar Gentle, shall be created for purposes of advising the Court on the structure and execution of the medical monitoring program. Class Counsel and DuPont shall inform the Court of their respective choices for representatives on the Finance Committee within five (5) days of the entry of this Order.

c. The Finance Committee shall exist for the purpose of providing guidance and advice for the operation of the medical monitoring program. In the event any decision is made by the Claims Administrator with respect to the payment for services or costs in the medical monitoring program to which

either Party takes exception, then either Party shall have the right to bring such objection or exception to the Court and, if necessary, may appeal the determination of the Court within the West Virginia judicial system.

d. The Finance Committee will provide guidance and, hopefully, will operate in a collaborative fashion to provide an effective and efficient medical monitoring program. In the event that the Finance Committee cannot reach an agreement on how to proceed on any issue before it, final decision making authority shall rest with the Claims Administrator, Edgar Gentle, with such decision(s) reviewable by the Court.

e. The Parties reserve the right to reasonably challenge the enrollment of any class member in the medical monitoring program. With respect to any challenge relevant to the issue of eligibility for enrollment, the challenger shall pay reasonable costs and attorney fees if the challenge is unsuccessful. The Court will hear any disputes as to the inclusion or exclusion of a potential class member.

f. On an annual basis the Court, upon recommendation of the Finance Committee, shall direct DuPont to pay a sum certain that will be set aside for each such calendar year to reasonably secure such expenditures as are reasonably necessary to execute the Medical Monitoring Program, in advance, for such following calendar year. In each subsequent year after the first, DuPont shall be credited with any amounts remaining from the prior year in determining the amount of payment for the subsequent year. Additionally, should there be a monetary shortfall during a calendar year

due to reasonable expenditures exceeding the budget; the Class Administrator shall petition DuPont for such reasonable and necessary monies as to remedy the shortfall. DuPont shall provide such monies within twenty (20) business days of receipt of the Petition.

g. The program shall be implemented consistent the Court's Order of February 25, 2008, and as modified by the Final Order Approving Settlement and this Order. The program shall provide those examinations and tests set forth in the Court's Order of February 25, 2008, with the exception that the duration of the program shall be thirty (30) years in length, and that no routine CT scans shall be performed. CT scans will only be performed as part of the medical monitoring program when a competent physician determines that a CT scan is diagnostically medically necessary as relevant to the possible exposure to heavy metal contamination. Any disputes and/or objections to the necessity of providing a CT scan in a given situation shall be decided by the Claims Administrator with such decision reviewable by this Court.

h. Additionally, after the initial six (6) month sign-up period has concluded and the number of participating Plaintiffs, be they adults or minors, is known, Defendant DuPont, in the ordinary course of its business, shall set aside reasonable reserves as required by applicable law which shall cover the estimated cost of the entire thirty (30) year medical monitoring program.

i. In regards to the four (4) million dollar ($4,000,000.00) fund specifically ear-marked for cash payments to the medical monitoring class by the Memorandum of Understanding, the Court makes the following Orders:

i. The four (4) million dollar ($4,000,000.00) fund is specifically for the sole benefit of the medical monitoring class and shall provide cash payments to the same, in a form and fashion to be determined by the Finance Committee and Claims Administrator and approved by the Court.

ii. There shall be two separate lists of medical monitoring claimants: the first shall be for only cash payments, and the second shall be for medical monitoring. Class members may sign up for either or both lists.

iii. There shall be no requirement that a medical monitoring class member register for or avail themselves of the medical monitoring program or service in order to receive a cash payment from the medical monitoring fund, provided that class membership is proven.

j. The money to fund the administrative start-up expenses of the medical monitoring program, including providing notice to potential class members, shall come from the four million dollar ($4,000,000.00) Qualified Settlement Fund. The Court finds that the most equitable solution to funding the start up costs of the medical monitoring program is to have only those individuals who are members of the medical

monitoring class shoulder the burden. Distribution of start up expenses from the sixty-six million dollar fund would negatively impact those property class members who do not participate, or are not eligible to participate, in the medical monitoring program.

k. DuPont, by paying the sum of seventy million dollars ($70,000,000.00) as part of the settlement of this matter, has paid in full for any and all start up costs and expenses necessary for the medical monitoring program, and DuPont will not be billed for or responsible for any associated costs or expenses until the testing commences. At that time, consistent with the yearly budget procedure outlined above, DuPont shall fund the medical monitoring program, including administrative costs, on an annual basis. Finally, the Claims Administrator shall attempt to combine administrative expenses between the property and medical monitoring classes to be as cost effective as possible. For such costs that are equally attributable to either class, the Claims Administrator shall establish an equitable ratio to split the costs between the property and medical monitoring classes.

l. Any and all decisions of the Claims Administrator shall be reviewable by this Court, and each Settling Party shall have the right to pursue any and all appeals of this Court's final orders and decisions to the extent such is permissible under West Virginia law.

To accomplish the above stated guidelines, the Claims Administrator, Edgar Gentle, is hereby ORDERED to accomplish the following:

1. Within ten (10) days after the entry of this Order, the Claims Administrator should submit to the Parties and the Court the proposed Class Member Medical Monitoring registration forms and the recommended criteria for proof of Class Member Medical Monitoring eligibility. To the extent practicable, objective and easily obtained proof of residency in the Class Area for the period necessary to be eligible for Medical Monitoring will be utilized, with source documents such as Class Area voter registration rolls, Class Area ad valorem property tax records, Class Area Medical Clinic patient rolls, and Class Area utility billing records. For children, source documents will include Class Area school registration rolls and Class Area Medical Clinic patient rolls. To the extent possible, such source documents will be kept confidential.

2. Additionally, within ten (10) days after the entry of this Order, the Claims Administrator shall submit a timeline of reasonable goals and dates to accomplish the directives of the Court and any other administrative details that may be necessary to the Parties and the Court, including starting class sign ups on or before April 15, 2011.

3. The putative Class Members shall be given appropriate notice of and information concerning the Medical Monitoring Program's terms. Notice measures shall include a notice mail-out to those putative Class Members which have been identified, and publication of notice in local or prominent West Virginia newspapers. To facilitate notice to putative Class Members living outside the Class Area, the registering Class Members will be asked to complete a questionnaire providing the names and address of relatives and acquaintances known to live or to have previously lived in the Class Area, followed by a notice mail-out to these additional putative Class Members. No additional

funding beyond the seventy million dollar settlement funds shall be required from DuPont to accomplish these preliminary notices.

4. In order to organize and coordinate the medical monitoring program inside and outside of the Class Area, which will involve the completion of detailed health questionnaires, direct physical examinations, and collection of lab samples for analysis, the Claims Administrator shall create a computer-based data gathering system, with data for all Class Members to be entered into the same database wherever the participating medical provider and Class Member are located. Subject to the terms of a Protective Order, which shall be considered by the Finance Committee and the Claims Administrator and recommended to the Court, and after signing a Confidentiality Agreement, which shall likewise be considered by the Finance Committee and the Claims Administrator and recommended to the Court, the Claims Administrator shall have real time access to the database; and DuPont and Class Counsel shall have access to the database with claimant-specific information redacted and unique identifiers, such as a numbering system, used instead of names.

5. Next, the Claims Administrator shall initiate a bidding process through a Third Party Administrator of health plans who shall be engaged to facilitate identification of a national laboratory or other such vendor to provide out-of-Class Area medical monitoring and in-Class Area medical providers, located in or near the Class Area, to provide medical monitoring in the Class Area, while assuring testing and access to care per the Medical Monitoring Order of February 25, 2008, at page 10. The Third Party Administrator of health plans using the CPT Codes contained in Appendix A to Dr. Werntz's March 30, 2007 Proposed Medical Monitoring, shall negotiate prices charged

by in-Class Area and out-of-Class Area medical providers, subject to review by the Parties through the Finance Committee and approval by the Claims Administrator and, ultimately, the Court. In the medical monitoring registration process, Class Members living both inside and outside the Class Area will be asked which medical providers they prefer to conduct the testing, which will be a material factor in selecting the providers utilized for medical monitoring along with the lowest cost per unit of testing.

6. The Court has determined that there shall be a Medical Advisory Panel to facilitate the Claims Administrator's quality control audits of the medical monitoring program, and to advise the Claims Administrator and the Court, with input from the Parties, on periodically updating medical monitoring protocols based on scientific and medical developments following the first five years of medical monitoring, as contemplated on page 15, decretal paragraph 1 of the Medical Monitoring Order of February 25, 2008. The Parties, via the Finance Committee, shall have input concerning the appropriate make up of the Medical Advisory Panel, its membership and its specific duties for the Court's review.

7. Next, the Court Orders that the Claims Administrator, Edgar Gentle, establish a Claimants' Advisory Committee, to consist of class members willing and able to provide input as to the administration of the medical monitoring plan. Said Committee shall only have an advisory capacity. The Committee will exist in order to ensure that Class Members are heard in the design and implementation of the Medical Monitoring Program, and other aspects of the Claim Administrator's duties. The Claimants' Advisory Committee shall be established as soon after the Effective Date as practicable, with 5 members to be residents of the Class Area and 4 to be non-residents of the

Class Area. It is requested that Claimants Advisory Committee nominations be provided by Class Counsel within 15 days after the Effective Date. In nominating potential Committee members, Class Counsel should provide adequate facts to facilitate the Court's determination of each candidate. To the extent practicable, Committee members will be incumbent Class Representatives, and the Parties, via their role on the Finance Committee, will be invited to provide input on the proposed Committee members prior to their selection. The Committee will have an initial organizational meeting with the Court, the Claims Administrator, and the Finance Committee in person, conduct periodic telephonic meetings, and have one annual meeting with the Court, the Claims Administrator and the Parties in person thereafter.

8. In order for the Claims Administrator, in collaboration with the Finance Committee, to prepare the initial budget and administrative actions for the Medical Monitoring Program for review and approval by the Court, the logistics for this aspect of the case should be finalized as soon as practicable. The Claims Administrator shall attempt to find usable office space for lease in the Class Area in or near Spelter and utilize the same office space for both the property and medical monitoring classes.

9. To facilitate efficient utilization of the class funds and to minimize administrative expenses, the Claims Administrator shall look into obtaining living quarters in the Class Area for the first two (2) years of medical monitoring, during which time the Claims Administrator's staff will have an ongoing presence. Such a residence will be more cost effective than a hotel, and create less of a burden on the classes. Additionally, the Claims Administrator shall look into the cost effectiveness of obtaining a vehicle to reduce rental car bills. Said living quarters and/ or administrative vehicle

shall be discussed by the Finance Committee and recommended by the Claims Administrator to the Court for final approval.

The Court, as noted in the Final Order Approving Settlement, shall retain continuing jurisdiction and the ultimate authority over the administration of this settlement.

Next, because the administration of the property remediation settlement has not yet been brought before the Court, the Claims Administrator is directed to prepare a proposed time line and punch list for the same and submit it to the Parties and the Court within twenty (20) business days of the entry of this Order.

The Court intends to retain the services of the Guardian *ad litem*, Meredith McCarthy, for the purposes of providing legal representation to the minors and incompetents in the classes, assuming that she is still ready and willing to serve. The details and necessary duties of the Guardian *ad litem* can be determined as a need for such services becomes apparent. The Court directs the Finance Committee and the Claims Administrator to orchestrate such necessary services for the classes and provide direction to Mrs. McCarthy. The Guardian *ad litem* shall serve at the previously established rate, or such additional just rate of compensation to be determined by the Finance Committee and the Claims Administrator and paid along with the administrative and start up costs for each of the classes.

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 for judgment.

IT IS SO ORDERED.

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

David B. Thomas
James S. Arnold
Stephanie Thacker
Allen Guthrie & Thomas, PLLC
500 Lee St., East, Suite 800
P.O. Box 3394
Charleston, WV 25333-3394

Meredith McCarthy
901 W. Main St.
Bridgeport, WV 26330
Guardian ad litem

Edgar Gentle, III
Gentle, Turner, & Sexton
501 Riverchase Parkway East,
Suite 100
Hoover, AL 35244
Special Master

J. Farrest Taylor
Cochran, Cherry, Givens, Smith,
Lane & Taylor, P.C.
163 West Main St.
Dothan, AL 36301.

ENTER: January 18, 2011

Thomas A. Bedell, Circuit Judge

EXHIBIT E

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al.,

Plaintiffs,

v.

E.I. DU PONT DE NEMOURS AND COMPANY, et al.,

Defendants.

CIVIL ACTION NO. 04-C-296-2
(Judge Bedell)

SPECIAL MASTER'S REPORT NO. 1 (MEDICAL MONITORING), RECOMMENDATIONS, REQUESTS FOR COMMENTS, AND PRAYER FOR RELIEF FROM THE COURT

COMES NOW, Edgar C. Gentle, III, the Special Master appointed by Order of the Court dated February 29, 2008, and hereby submits his Report No. 1 in response to the Court's following direction in paragraph C, page 14 of its February 29, 2008 Final Order Regarding the Scope, Duration and Cost of the Medical Monitoring Plan (the "Medical Monitoring Order"):

> "The precise mechanism by which any amounts are escrowed, how the escrow is replenished, how funds are disbursed, and other similar matters should be evaluated by the Special Master, who should in turn make a prompt recommendation to the Court."

Because this case is stayed pending appeal, no action of the Parties or the Court is being requested by this Report until the date that all appeals are resolved or this case is settled among the Parties (the "Effective Date").

The undersigned took what he believed to be appropriate measures to perform fairly and efficiently this assigned duty, by viewing the Class Area with the Parties, presenting written questions to the Parties for comments and suggestions, and having conference calls with the Parties

to discuss their positions on the matters set forth below, which Party positions, however, are not binding, and with the Parties being invited to make their final comments below.

The undersigned makes the following Report and recommendations:

I.

THE STATUS OF THIS REPORT PRIOR TO THE EFFECTIVE DATE

Your Special Master recommends that this Report be deemed to be part of the record herein for purposes of carrying out the Medical Monitoring Order upon the Effective Date, but it is recommended that this Report not be considered part of the record for purposes of any appeal of previous Orders in this case.

The Parties have agreed that, by participating in the proceedings that led to the submission of this Report and in commenting on this Report, they have not waived or abandoned any of their positions previously taken before, during or after Trial or upon appeal concerning the Medical Monitoring Order or any other Orders or matters addressed in this case, and that they have not thereby waived any appellate rights, or have been deemed to consent to any aspects of the Medical Monitoring Order.

In addition, until the Effective Date, the Parties have agreed to address certain issues contemplated by the Medical Monitoring Order and the Special Master's possible execution thereof following the Effective Date, but that the program contemplated by the Medical Monitoring Order will not be carried out until such time.

II.

RECOMMENDED MEDICAL MONITORING FINANCIAL AND RELATED PARAMETERS

1. Duration of the Program and Class Member Eligibility.

Your Special Master understands that there may be approximately 8,500 Class Members, although the number is unknown at this time, with approximately half living in the Class Area and half no longer living in the Class Area but having done so in the past. It is noted that Dr. Charles Werntz's March 30, 2007 Anticipated Effects of the Contamination of Spelter, at page 4 states that "Medical monitoring shall continue until 40 years past the end of exposure. Generally, there would be either 40 years beyond moving out of the Class Area or 40 years after their residence were remediated." It also appears that the medical monitoring funding recommendations of Dr. Michael Brookshire and approved by the Medical Monitoring Order contemplate 40 years of medical monitoring. See, also, Medical Monitoring Order paragraph 2, pages 8 to 9.

For those Class Members living outside the Class Area, it is recommended that medical monitoring begin as soon after the Effective Date as practicable, because there is no relationship between the 40 years of medical monitoring and the date of substantial property remediation in the Class Area for these claimants. How the 40 years of medical monitoring authorized by the Medical Monitoring Order is to be implemented for those Class Members living in the Class Area is more problematic. Should Class Members living in the Class Area have the right to be medically tested as soon as those living outside of the Class Area, in order to facilitate early detection of disease, or must they wait until the Class Area is substantially remediated so that they will have 40 years of medical monitoring thereafter?

Because I understand the Medical Monitoring Order only to authorize 40 years of medical monitoring, your Special Master is not authorized to recommend that the medical monitoring period be extended in the Class Area by, for example, commencing medical monitoring immediately, then having it continue 40 years after substantial remediation is completed in the Class Area. For example, if Class Area remediation takes 2 ½ years, in-Class Area participants would have 42 ½ years of medical monitoring, which apparently is not authorized by the Medical Monitoring Order.

To try to balance these equities within the parameters of the Medical Monitoring Order, it is recommended that in-Class Area members be given the choice of (i) commencing medical monitoring immediately after the Effective Date and during the same time frame to be enjoyed by out-of-Class Area members; or (ii) waiting until the Class Area is substantially remediated. In either event, the in-Class Area members would enjoy the same 40 years of medical monitoring as out-of-Class Area members, as apparently contemplated by the Medical Monitoring Order.

This approach would result in a "rolling" medical monitoring program, in which each participant's 40 year medical monitoring right would commence on the first date of his or her medical monitoring testing, which the Special Master recommends, so as to tailor this remedy for each Class Member.

Under this approach, in and out of Class Area medical monitoring should be commenced simultaneously, simplifying the budgeting and execution of medical monitoring.

The Special Master understands that the minimum number of years of residence for medical monitoring required in the Class Area are 1 year for Zone 1, 3 years for Zone 2 and 5 years for Zone 3. It is recommended that, as long as the Class Member has continuously lived in the Class Area prior to reaching the minimum residence threshold, a Class Member's number of years of residence

in each respective Class Area be accumulated to determine if the threshold has been met. For example, if a Class Member lived ½ year in Zone 1 and 1 ½ years in Zone 2, he or she would qualify for medical monitoring, having fulfilled 50% of the residency required in each zone. However, if the Class Member has not lived in the Class Area continuously until the participation residency threshold is met, I understand that the Parties reserve the right to make recommendations to the Court concerning his or her qualification for medical monitoring.

Court establishment of criteria for proof of Class Member eligibility to participate in the Medical Monitoring Program will be requested in conjunction with the submission of proposed Class Member Medical Monitoring registration forms for Court review, following the drafting and editing of the forms with input from the Parties.

To the extent practicable, objective and easily obtained proof of living in the Class Area for the period necessary to be eligible for Medical Monitoring will be utilized, with the Class Administrator obtaining the proof from outside sources to the extent possible. For adults, recommended source documents will include Class Area voter registration rolls, Class Area ad valorem property tax records, Class Area Medical Clinic patient rolls, and Class Area utility billing records. For children, source documents will include Class Area school registration rolls and Class Area Medical Clinic patient rolls.

Confidential treatment of the source documents, to the extent legally necessary or reasonable, will be recommended.

Within ten (10) days after the Effective Date, the Class Administrator should submit to the Parties and the Court the proposed Class Member Medical Monitoring registration forms and the recommended criteria for proof of Class Member Medical Monitoring eligibility.

2. Facilitating Claimant Participation in the Medical Monitoring Program.

The putative Class Members shall be given appropriate notice of and information concerning the Medical Monitoring Program's terms.

Notice measures shall include a notice mail-out to those putative Class Members which have been identified, and publication of notice in local or prominent West Virginia newspapers. To facilitate notice to putative Class Members living outside the Class Area, the registering Class Members will be asked to complete a questionnaire providing the names and addresses of relatives and acquaintances known to live or to have previously lived in the Class Area, followed by a notice mail-out to these additional putative Class Members.

Possible payments from the punitive damages award for medical monitoring and remediation participants will be addressed in a subsequent Special Master's Report following discussions with the Parties.

3. Medical Monitoring Provisioning.

In order to organize and coordinate the medical monitoring program inside and outside of the Class Area, which would involve the completion of detailed health questionnaires, having direct physical examinations, and collecting and analyzing lab samples for analysis, it is recommended that a PC-based data gathering system be implemented, with data for all Class Members to be entered into the same database wherever the participating medical provider and Class Member are located. Subject to the terms of a Protective Order, a suggested form of which is in Exhibit A, HIPAA, and other privacy restrictions, and after signing a Confidentiality Agreement in the form of Exhibit B, it is recommendedthat the Special Master and Class Counsel have real time access to the database, and that E. I. DuPont De Nemours and Company ("DuPont") have access to the database with

claimant-specific information redacted and unique identifiers being used instead. The recommended data fields available to DuPont for each claimant would be a unique identifier number, date of birth, sex, years occupying the Class Area Zone(s), medical monitoring participation history, and medical monitoring results.

Following a bidding process, it is recommended that a Third Party Administrator of health plans be engaged to facilitate identification of a national laboratory or other such vendor to provide out-of-Class Area medical monitoring and in-Class Area medical providers, located in or near the Class Area, to provide medical monitoring in the Class Area, while assuring testing and access to care per the Medical Monitoring Order at page 10. A retail model, under which medical monitoring providers are paid for units of medical testing, as opposed to a wholesale model, under which the program pays for medical clinic overhead directly, is recommended, to save costs and facilitate financial oversight.

The Third Party Administrator, using the CPT Codes contained in Appendix A to Dr. Wernitz's March 30, 2007 Proposed Medical Monitoring, should negotiate prices charged by in-Class Area and out-of-Class Area medical providers, subject to review by the Parties and approval by the Special Master and the Court. In the medical monitoring registration process, Class Members living both inside and outside the Class Area will be asked which medical providers they prefer to conduct the testing, which will be a material factor in selecting the providers utilized for medical monitoring.

It is recommended that the Court consider convening a Medical Advisory Panel to facilitate the Special Master's quality control audits of the medical monitoring program, and to advise the Special Master and the Court, with input from the Parties, on periodically updating medical monitoring protocols based on scientific and medical developments following the initial 5 year

period of medical monitoring, as contemplated on page 15, decretal paragraph 1 of the Medical Monitoring Order. An additional role of the Medical Advisory Panel may include analysis of medical monitoring data to determine health trends among Class Members.

We will request input from the Parties concerning the appropriate date for the creation of the Medical Advisory Panel, its membership and its specific duties for the Court's review.

4. The Precise Mechanism by which any Amounts are Escrowed, How the Escrow is Replenished, How Funds are Disbursed, and Other Similar Matters.

A. Recommended Initial Deposit and Down Payment into the Escrow Fund Following Effective Date.

It is recommended that the minimum initial DuPont funding into the medical monitoring Escrow Fund be enough for 5 years of operations according to the projection of Dr. Brookshire, after which the program is to be re-examined per the Medical Monitoring Order. Referencing the attached table in Exhibit C allocating the Brookshire medical monitoring funding estimates into biennial medical monitoring tranches, and applying a 10% factor to take into account estimated administrative expenses of 5% and a FASB material contingency reserve of 5%, this results in a recommended initial DuPont down payment to the Escrow Fund of $25.7 million plus $2.6 million or $28.3 million. This recommendation is tentative, is interrelated with the security that DuPont provides in response to 4C., below, and should be reviewed and finalized by the Special Master and the Court only after the DuPont security proposal is examined.

In arriving at this recommendation, your Special Master reviewed the three comparably sized Mass Tort Cases of which he has been a fiduciary, namely the Settlement Facility - Dow Corning

Trust for which he served as Financial Advisor prior to its effective date, the MDL 926 Breast Implant Settlement for which he is the Escrow Agent, and the Monsanto/Solutia Tolbert PCB Settlement, for which he is Claims Administrator. In the Dow case, the down payment was $985 million of a total estimated revenue requirement of $2.35 billion, or 42%, in MDL 926 the down payment was $375 million of an estimated $1.5 billion, or 25%, and in the Monsanto/Solutia case the down payment was $300 million of an estimated revenue requirement of $327 million or 92%. In the third case, it should be noted that one of the defendants, Solutia, was contemplating Chapter 11 Bankruptcy at the time, which was a factor in obtaining such a large down payment. Refer to Order 27 in MDL 926, at page 9, paragraph J of the attached Revised Settlement Program; The Dow Corning Funding Payment Agreement at page 3, paragraph 2.01(a); and the Monsanto/Solutia Final Order and Judgment at pages 2-3, paragraph 3, all in Exhibit D.

The recommended $28.3 million down payment in this case equals 21.8% of the $129.6 million revenue requirement estimate of Dr. Brookshire, and it is conservative based upon my prior experience. The recommendation takes into account DuPont's obligations under the Jury Verdicts herein to pay $55.5 million for property remediation and $196.2 million for punitive damages, with no installment arrangements being allowed.

Within 15 days after the Effective Date, it is recommended that DuPont remit $500,000 (the "Initial Deposit") to create the Medical Monitoring Escrow Fund, with this Initial Deposit to be a reserve for payment of Medical Monitoring Program expenses until the down payment is determined by the Court and paid by DuPont, and with the down payment to be reduced by the amount of the Initial Deposit.

B. Escrow Fund Replenishment Mechanism.

The Special Master and the Finance Committee described below would monitor the Escrow Fund disbursement rate on a monthly basis, and when the balance of the Escrow Fund is less than either the previous three months of expenditures or the next three months projected expenditures, the Special Master , to the extent reasonably necessary, will request that DuPont replenish the Escrow Fund by an amount so that the Escrow Fund balance equals such a three month reserve within 14 days. This procedure would be repeated every calendar month as needed.

C. Security for Balance Possibly Due Under the Medical Monitoring Program.

It is noted that the Court, in the Medical Monitoring Order, contemplates revisiting the Medical Monitoring Program 5 years after its initiation. Page 15, decretal paragraph 1. As a result, the $129.6 million medical monitoring expense estimate of Dr. Brookshire may be long or short, with DuPont having a reversionary interest in the remainder, if any, of the Escrow Fund, upon completion of medical monitoring, but being responsible for the difference if Dr. Brookshire's estimate is low. However, the estimated $101.3 million Escrow Fund balance due as of the time that the recommended down payment is remitted by DuPont to the Escrow Fund shortly after the Effective Date should be secured to ensure completion of the 40 year Medical Monitoring Program.

It should be noted that no security was provided in the MDL 926 case, referenced above, which will last 15 years, unlike the 40 years of medical monitoring contemplated here. However, three and a half years later, one of the Settling Defendants in MDL 926, the INAMED Corporation, was not able to make its required contributions to the Settlement, and the Parties had to negotiate a separate smaller settlement for this Defendant, of which I am the Escrow Agent. Securing the payments up front may have prevented this unfortunate development.

Moreover, in the Dow case, which is scheduled to last 25 years, there is payment security using a credit facility described in clause (iv) below. Because the percentage of the down payment in the Monsanto/Solutia case is so large, and one co-obligor is solvent, the risk of the Defendants not making the subsequent payments is small, and all payments have been made to date.

At the January 15, 2008 hearing, the undersigned recommended that the Escrow Fund balance be "fully secured". Medical Monitoring Order, paragraph C, page 14.

Subject to due diligence, forms of security for the Escrow Fund balance that the Special Master would recommend to the Court for consideration include (i) an unconditional guaranty agreement of a business entity unaffiliated with DuPont and publicly traded on the New York Stock Exchange or NASDAQ, with a Standard & Poor's ("S & P") quantative evaluation of A+, S & P Fair Value Rank of 5, S & P Investability Quotient Percentile of 90 or above, a S & P Volatility of low, and a S & P relative strength of 90 or above; (ii) the pledge of collateral which is readily marketable and of low value volatility; (iii) a structured settlement funding mechanism provided by an insurance company that is ranked by A. M. Best at A+ or above, with it being recommended that at least 2 insurance companies so secure the balance because of its size; or (iv) a secure credit facility agreement with DuPont affiliates, preferably with the ratings described in (i), such as the credit facility provided in the Dow Corning Funding Agreement in Exhibit E, by Dow's two shareholders, Corning Incorporated and Dow Chemical Company.

It is recommended that, within 15 days after the Effective Date, the Court conduct a hearing to determine whether DuPont is required to provide security for the balance possibly due under the Medical Monitoring Program. If the Court determines that security is required, it is recommended that DuPont make an Escrow Fund balance security proposal within the later to occur of 15 days

after the Court's determination that security is required and 30 days after the Effective Date. It is also recommended that any Court-approved security arrangement be reviewed periodically based on Medical Monitoring Program cost experience to determine if the program is over or under-secured, with the security arrangement to be modified accordingly.

D. Medical Monitoring Escrow Fund Disbursement Mechanism.

It is recommended that a Finance Committee, chaired by the Special Master and with a representative of DuPont and a representative of the Plaintiffs, be formed. The function of the Finance Committee would be to oversee the financial operations of the Medical Monitoring Program. In carrying out this function, this Committee would review proposed annual budgets prepared by the Special Master, for Court approval, approve day-to-day expenditures of the Medical Monitoring Program based on an agreed vouchering and voucher aging process, review Special Master quarterly financial statements and annual financial statements prepared in connection with the Medical Monitoring Program, and the annual financial fiduciary accounting of the Special Master submitted to the Court, and aiding the Special Master in selecting the Escrow Fund Custodian, the Escrow Fund Investment Advisor and Manager, and the Escrow Fund Outside Financial Auditor for recommendation to the Court.

E. Escrow Fund Financial Advisors and Auditor.

It is recommended that, following a bidding process, a financial institution located in Harrison County, West Virginia be selected by the Court, with input from the Finance Committee, to serve as the custodial bank for the Escrow Fund. Written investment protocols for the Escrow Fund should be established by the Finance Committee for Court approval, in collaboration with a Court-selected Investment Advisor, limiting the investment of the Escrow Fund to Federally- insured

securities or money market funds thereof, so as to minimize principal volatility risk. The Finance Committee should consider engaging a Court-selected Investment Manager following a bidding process so to invest the Escrow Fund in safety and within the written investment parameters. An accounting firm approved by the Court, with input from the Finance Committee, will conduct an annual outside financial audit of the Escrow Fund, and the Special Master shall submit quarterly financial reports to the Court and the Finance Committee the first four years of the program and semi-annual financial reports thereafter.

5. Claimants Advisory Committee.

In order to ensure that Class Members are heard in the design and implementation of the Medical Monitoring Program, and other aspects of the Special Master's duties, it is recommended that a Claimants Advisory Committee be established as soon after the Effective Date as practicable, with 5 members to be residents of the Class Area and 4 to be non-residents of the Class Area. It is requested that Claimants Advisory Committee nominations be provided by Class Counsel within 15 days after the Effective Date. In nominating potential Committee members, Class Counsel should provide adequate facts to facilitate the Court's determination of typicality of each candidate. To the extent practicable, Committee members will be incumbent Class Representatives, and the Parties will be invited to provide input on the typicality of proposed Committee members prior to their selection. The Committee would have an initial organizational meeting with the Court, the Special Master and the Parties in person, conduct periodic telephonic meetings, and have one annual meeting with the Court, the Special Master and the Parties in person thereafter. One of the initial tasks of the Committee would be to review and comment upon this Report.

Although the Claimants Advisory Committee would provide input in the design and administration of the Medical Monitoring Program, its role would be advisory and would not bind the Class.

6. Medical Monitoring and Administrative Office Accommodations.

In order for the Special Master, in collaboration with the Finance Committee, to prepare the initial budget for the Medical Monitoring Program for review and approval by the Court, the logistics for this aspect of the case should be finalized as soon after the Effective Date as practicable. It is recommended that the old Spelter plant office not be utilized as the Medical Monitoring Administration Office, but that the office be located in the Class Area in or near Spelter. Counsel for the Parties are asked to recommend Claims Administration Office locations within 15 days after the Effective Date, and they will be examined as soon as practicable.

To facilitate efficient utilization of the Escrow Fund and to minimize administrative expenses, it is recommended that the Special Master obtain living quarters in the Class Area for the first 2 years of medical monitoring, during which the Special Master's staff proposes to have an ongoing presence, and thereby reduce hotel bills, and that there be an administration vehicle to reduce rental car bills.

7. Medical Monitoring Implementation Schedule.

Based upon the foregoing, and to effect the timely, efficient and prudent implementation of the Medical Monitoring Program, the suggested Pre-Implementation Date Medical Monitoring Time Line and Punch List in Exhibit E is submitted for consideration by the Court and the Parties. It would result in implementation of Medical Monitoring 230 days after the Effective Date.

BASED UPON THE FOREGOING, the Special Master makes the following requests:

(i) That this Report lie over for thirty (30) days after the Effective Date, so as to allow the Parties to file objections to or motions to adopt or modify the Report or other recommendations, that the preliminary hearing on the DuPont security issue contemplated in Paragraph II.4.C, above be held within 15 days after the Effective Date, and that Class Counsel nominations for Claimants Advisory Committee members contemplated in Paragraph II.5., above be made;

(ii) Following the Effective Date, that the Court authorize the Special Master and the Parties to convene a Claimants Advisory Committee under the parameters suggested above;

(iii) Following the Effective Date, that the Special Master and the Parties convene a a Finance Committee, subject to Court approval, to carry out the duties described hereinabove, and that the Special Master and the Parties make their recommendations on the creation, date, composition and duties of a Medical Panel, for consideration by the Court;

(iv) Following the Effective Date, and receipt of the comments by the Parties contemplated in Paragraph (i), above, that there be a Fairness Hearing on this Report, and also to address Special Master recommendations concerning property remediation and punitive damages distributions to Class Members to be submitted in separate, subsequent Reports, to which the Parties and Class Members will be invited so as to provide recommendations to the Court;

(v) That, following the Fairness Hearing, the form of Protective Order in Exhibit A, form of Confidential Agreement in Exhibit B, and biennial revenue requirement computations in Exhibit C be approved by the Court;

(vi) That, following the Fairness Hearing, this Report No. 1 and its recommendations, and the materials and recommendations described in Exhibit E submitted by the Special Master prior to the Fairness Hearing be approved by the Court; and

(vii) For such other, general, equitable and more special relief as may be proper under the premises.

Respectfully submitted this 23rd day of June, 2008.

Edgar C. Gentle, III,
Special Master

SCHEDULE OF EXHIBITS

A	Recommended Protective Order
B	Recommended Confidentiality Agreement
C	Allocation of Dr. Brookshire's Medical Monitoring Estimate Into Biennial Tranches
D	Down payment Materials from Other Cases
E	Suggested Medical Monitoring Pre-Implementation Date Time Line and Punch List

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, CAROLYN HOLBERT, WAUNONA MESSINGER CROUSER, REBECCAH MORLOCK, ANTHONY BEEZEL, MARY MONTGOMERY, MARY LUZADER, TRUMAN R. DESIST, LARRY BEEZEL, and JOSEPH BRADSHAW, individuals residing in West Virginia, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

E.I. DU PONT DE NEMOURS AND COMPANY, a Delaware corporation doing business in West Virginia, MEADOWBROOK CORPORATION, a dissolved West Virginia corporation, MATTHIESSEN & HEGELER ZINC COMPANY, INC., a dissolved Illinois corporation formerly doing business in West Virginia, and T.L. DIAMOND & COMPANY, INC., a New York corporation doing business in West Virginia,

Defendants.

Case No. 04-C-296-2

(Honorable Thomas A. Bedell)

PROTECTIVE ORDER

Upon stipulation of the Parties, by and through their counsel, the following Protective Order is entered governing the protection of Class Member identification data, medical test results, medical information and all other such data created or gathered in the Medical Monitoring Program (the "Medical Data").

It is ORDERED and ADJUDGED that the following protective conditions shall apply to the Medical Data.

EXHIBIT A

1. There is to be no claimant identifying information, such as name, social security number or address (other than years of occupancy in the Class Area Zone(s)), with the Medical Data provided to E.I. DuPont De Nemours and Company ("DuPont").

2. All persons receiving the Medical Data must sign the form of Confidentiality Agreement attached to this Order. Neither the Class Administrator nor his staff, nor Class Counsel nor its staff, nor DuPont nor its Counsel or staff, may disclose the Medical Data to any non-party, meaning one not a party to these actions, not an affiliated entity, and not an employee or agent of such party or affiliated entity; and

3. Without further Order of the Court, the Medical Data may be used only for carrying out the Medical Monitoring Program.

Dated this ____ day of _____, 200__.

_____
Thomas A. Bedell
Circuit Judge of Harrison County, West Virginia

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, CAROLYN HOLBERT, WAUNONA MESSINGER CROUSER, REBECCAH MORLOCK, ANTHONY BEEZEL, MARY MONTGOMERY, MARY LUZADER, TRUMAN R. DESIST, LARRY BEEZEL, and JOSEPH BRADSHAW, individuals residing in West Virginia, on behalf of themselves and all others similarly situated,

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Defendants.

Case No. 04-C-296-2

(Honorable Thomas A. Bedell)

CONFIDENTIALITY AGREEMENT

I understand that the Circuit Court of Harrison County, West Virginia, in Perrine v. DuPont, Case No. 04-C-296-2 (the "Spelter Case"), has ordered that the identity of Class Members participating in the Spelter Case Medical Monitoring Program, and the details of their medical conditions and histories be kept confidential, and state that I will not reveal this information to anyone except in conducting work in conjunction with the Medical Monitoring Program for the Class, if Class Counsel; or DuPont, if DuPont Counsel; or the Class Administrator, if I work for the Class Administrator, unless I have express permission to do otherwise by Judge Thomas A. Bedell

EXHIBIT B

or the Class Administrator. I further understand that if I violate this pledge of confidentiality, I am subject to being brought before Judge Bedell for investigation and possible sanction for this breach.

I agree that information about the status of the Medical Monitoring Program generally, or of a specific case in the Medical Monitoring Program, or any data pertaining to the Medical Monitoring Program will not be given to anyone by me unless done in accordance with written procedures of Judge Bedell or the Class Administrator.

This the ____ day of _____, 200__.

_____

_____
PRINT NAME

WITNESS:

_____

EXHIBIT C

Table of Costs Of Medical Monitoring Components Based on Dr. Brookshire's Revised Estimate Dated May 23, 2007 (Does Not Include Costs for Administering Medical Monitoring)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	YEAR	Urinary System Cost Per Period Per 1000 Claimants	Urinary System Cost Per Period Per 1000 Claimants Discounted To Present Value	Lung Systems Cost Per Period Per 1000 Claimants	Lung Systems Cost Per Period Per 1000 Claimants Discounted to Present Value	Phantom Test Cost Per Period Per 1000 Claimants	PhantomTest Cost Per Period Per 1000 Claimants Discounted to Present Value	Skin Tests Cost Per Period Per 1000 Claimants	Skin Tests Cost Per Period Per 1000 Claimants Discounted to Present Value	GI Systems Test Cost Per Period Per 1000 Claimants	GI Systems Tests Cost Per Period Per 1000 Claimants Discounted to Present Value	Total Period Cost Per 1000 Claimants	Total Cost Per Period Per 1000 Claimants Discounted to Present Value	Total Cost Per Period Per 1000 multiplied by 8.524 to Give Total Cost for 8524 Claimants	Total Cost Per Period Per 1000 Multiplied by 8.524 To Give Total Cost for 8524 Claimants Discounted to Present Value
2	2008	$539,219.00	$539,219.00	$889,851.00	$889,851.00	$93,616.00	$93,616.00	$37,568.00	$37,568.00	$31,449.00	$31,449.00	$1,591,704.00	$1,591,704.00	$13,567,684.90	$13,567,684.90
3	2010	$424,760.00	$409,469.00	$440,822.00	$433,628.00	$72,819.00	$70,198.00	$30,155.00	$29,065.00	$25,123.00	$24,216.00	$1,002,679.00	$966,583.00	$8,546,835.80	$8,239,153.19
4	2012	$411,203.00	$382,131.00	$448,816.00	$417,085.00	$71,748.00	$66,677.00	$30,933.00	$27,817.00	$24,816.00	$23,062.00	$986,517.00	$916,772.00	$8,409,070.81	$7,814,564.53
5	2014	$388,102.00	$356,638.00	$447,830.00	$401,187.00	$70,697.00	$63,334.00	$29,715.00	$26,620.00	$24,515.00	$21,962.00	$970,859.00	$869,741.00	$8,275,602.12	$7,413,672.28
6	2016	$432,083.00	$373,153.00	$446,863.00	$385,910.00	$69,679.00	$60,185.00	$28,276.00	$24,415.00	$26,885.00	$23,218.00	$988,966.00	$854,069.00	$8,429,046.18	$7,280,084.16
	2018	$418,373.00	$348,300.00	$445,915.00	$371,229.00	$68,984.00	$57,440.00	$27,061.00	$22,529.00	$26,279.00	$21,879.00	$971,751.00	$808,993.00	$8,283,205.52	$6,895,856.33
	2020	$405,111.00	$325,119.00	$444,986.00	$357,120.00	$68,301.00	$54,822.00	$26,274.00	$21,089.00	$25,677.00	$20,605.00	$956,332.00	$767,497.00	$8,151,773.97	$6,542,144.43
	2022	$392,282.00	$303,497.00	$444,086.00	$343,560.00	$67,628.00	$52,328.00	$25,501.00	$19,731.00	$24,880.00	$19,251.00	$941,395.00	$728,312.00	$8,024,450.68	$6,206,131.48
	2024	$379,899.00	$283,329.00	$443,184.00	$330,527.00	$66,966.00	$49,951.00	$24,783.00	$18,486.00	$24,133.00	$18,000.00	$926,822.00	$691,289.00	$7,901,083.13	$5,893,632.68
	2026	$367,918.00	$264,516.00	$442,309.00	$318,000.00	$66,314.00	$47,688.00	$24,093.00	$17,324.00	$23,733.00	$17,063.00	$912,697.00	$656,331.00	$7,781,534.03	$5,593,565.44
	2028	$356,334.00	$246,965.00	$441,453.00	$305,959.00	$65,676.00	$45,518.00	$23,420.00	$16,231.00	$23,388.00	$16,208.00	$900,326.00	$623,311.00	$7,666,025.30	$5,313,102.96
	2030	$345,133.00	$230,582.00	$440,613.00	$294,385.00	$65,050.00	$43,431.00	$22,730.00	$15,184.00	$24,101.00	$16,102.00	$888,346.00	$593,186.00	$7,564,062.56	$5,053,668.40
	2032	$334,302.00	$215,316.00	$439,791.00	$283,258.00	$64,431.00	$41,431.00	$22,051.00	$14,196.00	$23,857.00	$15,357.00	$888,346.00	$571,657.00	$7,564,062.56	$4,795,278.48
	2034	$323,829.00	$201,061.00	$438,986.00	$272,681.00	$63,823.00	$39,643.00	$21,382.00	$13,281.00	$23,617.00	$14,667.00	$871,637.00	$541,333.00	$7,426,236.68	$4,611,177.60
	2036	$313,700.00	$187,761.00	$438,198.00	$262,278.00	$63,224.00	$37,850.00	$20,725.00	$12,406.00	$23,378.00	$13,993.00	$859,225.00	$514,288.00	$7,321,768.20	$4,383,330.90
	2038	$303,904.00	$175,350.00	$437,426.00	$252,391.00	$62,635.00	$36,146.00	$20,080.00	$11,588.00	$23,143.00	$13,355.00	$847,288.00	$488,830.00	$7,217,532.35	$4,165,118.28
	2040	$294,429.00	$163,767.00	$436,671.00	$242,885.00	$62,055.00	$34,524.00	$19,456.00	$10,823.00	$22,910.00	$12,744.00	$835,552.00	$464,703.00	$7,115,315.28	$3,957,084.86
	2042	$285,264.00	$152,956.00	$435,931.00	$233,746.00	$61,485.00	$32,971.00	$18,850.00	$10,108.00	$22,680.00	$12,159.00	$824,210.00	$441,949.00	$7,019,098.40	$3,763,121.69
	2044	$276,398.00	$142,868.00	$435,207.00	$224,857.00	$60,927.00	$31,487.00	$18,263.00	$9,437.00	$22,455.00	$11,602.00	$813,250.00	$420,051.00	$6,930,199.00	$3,580,330.90
	2046	$267,823.00	$133,453.00	$434,499.00	$216,506.00	$60,380.00	$30,088.00	$17,702.00	$8,820.00	$22,234.00	$11,078.00	$802,638.00	$399,639.00	$6,843,536.00	$3,407,084.86
	Totals**	$7,270,087.00	$6,435,463.00	$8,262,477.00	$6,837,023.00	$1,036,157.00	$783,168.00	$423,936.00	$353,901.00	$383,161.00	$364,176.00	$18,697,661.00	$13,863,722.00	$159,373,747.66	$118,174,383.33

** Numbers vary slightly from Dr. Brookshire's total dollar figure due to rounded figures in his report.
Report indicated that Total Present Value Cost per 1000 was $13,863,721 and Plaintiffs submitted that total Present Value Cost for 8524 claimants is $118,174,383.40

EXHIBIT F

GENTLE, TURNER & SEXTON
ATTORNEYS AND COUNSELLORS AT LAW
SUITE 1200 · TWO NORTH TWENTIETH BUILDING
2 NORTH 20TH STREET
BIRMINGHAM, ALABAMA 35203

EDGAR C. GENTLE, III
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*ALSO ADMITTED IN FLORIDA

CONFIDENTIAL and
IN CAMERA

October 25, 2010

BY FEDERAL EXPRESS

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

FILED UNDER SEAL

Re: Perrine, et al. v. E. I. DuPont De Nemours and Company, et al.;
Civil Action No. 04-C-296-2 (Judge Bedell);
Our File No. 4609-1 - C-1

Dear Judge Bedell:

Enclosed for the Court's review please find our Supplement to the June 23, 2008 Special Master's Report No. 1 (Medical Monitoring), Recommendations, Requests for Comments and Prayer for Relief from the Court, together with Report No. 1, itself, which are being submitted together pursuant to Paragraph 24 of this Court's October 13, 2010 Omnibus Order.

As contemplated by the Omnibus Order, at Paragraph 24, this Supplement, together with Report No. 1, and the measures contemplated therein, constitute our,

> "final recommendation and plan to (A) find out which class members qualify under this Order for summary judgment as to the medical monitoring award, and (B) determine how to implement the medical monitoring program for the qualifying members as soon as is reasonably possible, including what necessary funding must be released by Du Pont to accomplish the same."

We are submitting Report No. 1 and this supplement to the Court, In Camera and Under Seal, for the reasons outlined in the Supplement.

The suggested December 10, 2010 9:00 a.m. Eastern Time hearing date on this matter has been agreed to by the Parties.

Thank you for the Court's consideration.

Yours very truly,

Edgar C. Gentle, III

BCGIII/kjm
Enclosure

cc: (with enclosure)(In Camera) by e-mail and regular U.S. mail)
Farrest Taylor, Esq.
J. Keith Givens, Esq.
Perry B. Jones, Esq.
James B. Lees, Jr., Esq.
John Phillips, Esq.
James S. Arnold, Esq.
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IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	CIVIL ACTION NO. 04-C-296-2
	)	(Judge Bedell)
E.I. DU PONT DE NEMOURS AND COMPANY, et al.,	)	
	)	
	)	
Defendants.	)	
	)	

IN CAMERA AND UNDER SEAL

SPECIAL MASTER'S SUPPLEMENT TO JUNE 23, 2008 REPORT NO. 1 (MEDICAL MONITORING) RECOMMENDATIONS, REQUESTS FOR COMMENTS, AND PRAYER FOR RELIEF FROM THE COURT

COMES NOW, Edgar C. Gentle, III, the Special Master and Class Administrator appointed by Order of the Court dated February 29, 2008, and hereby submits this Supplement to his attached June 23, 2008 Report No. 1 (Medical Monitoring) ("Report No. 1"), with Report No. 1 and this Supplement being submitted together in response to this Court's October 13, 2010 Order, to provide the undersigned's:

> "final recommendation and plan to (A) find out which class members qualify under this Order for summary judgment as to the medical monitoring award, and (B) determine how to implement the medical monitoring program for the qualifying members as soon as is reasonably possible, including what necessary funding must be released by Du Pont to accomplish the same."

This Supplement augments and modifies Report No. 1, to accommodate new developments reflected in the Omnibus Order. Portions of Report No. 1 not so supplemented are hereby ratified and confirmed by the undersigned.

This Supplement and Report No. 1, together with the measures contemplated herein, provide the undersigned's recommendations concerning Medical Monitoring for the Subclass defined below.

According to the Omnibus Order, "The Defendants' argument that the appellate process is not exhausted is without merit." Omnibus Order at Page 18. Therefore, the Court has apparently determined that the Effective Date described in Report No. 1 is October 13, 2010, the date of the Omnibus Order.

In reviewing the Omnibus Order, it appears that the three material changes in the Medical Monitoring Program from that envisioned in Report No. 1 are:

(i) Medical Monitoring is presently limited to Class Members who were not 18 years of age on June 14, 2002 or Class Members who were legally insane during their life up to and on June 14, 2002 (the "Medical Monitoring Subclass" or the "Subclass");

(ii) Preparation for Subclass Medical Monitoring will proceed at the same time that the Court and Counsel for the Parties prepare for and conduct a Statute of Limitations Trial in March 2011, to determine if the remaining Class Members will receive Medical Monitoring or if the Property Remediation and Punitive Damages aspects of the case will proceed (the "Statute of Limitations Proceeding"); and

(iii) Punitive Damages for Medical Monitoring have been disallowed, and the Medical Monitoring Program for the Subclass is scheduled to proceed immediately and prior to the Property Remediation Program and Punitive Damages Distribution Program

contemplated in the undersigned's previously submitted Special Master's Reports No. 2 and No. 3.

I.

THE EFFECTIVE DATE

As the Effective Date apparently has been found by the Court to have occurred, the undersigned requests that Report No. 1 and this Supplement be made part of the record for purposes of carrying out the February 18, 2008 Final Order regarding the scope, duration and costs of the Medical Monitoring Plan (the "Medical Monitoring Order"), as modified by the Omnibus Order. However, in order to prevent publicity respecting Subclass Medical Monitoring planning, so as not to confuse the Class or the potential Jury Venire in connection with the Statute of Limitations Proceeding, it is requested that Report No. 1 and this Supplement be filed Under Seal, with the undersigned recommending that these Subclass proceedings go forward In Camera, until the Jury Trial in the Statute of Limitations Proceeding is completed.

In light of the developments recited in the Omnibus Order, when compared to the Medical Monitoring Order, the undersigned suggests the following revisions to Part II of Report No. 1, which addresses Medical Monitoring parameters:

II.

RECOMMENDED MEDICAL MONITORING PARAMETERS

1. Duration of the Program and Class Member Eligibility.

In drafting Report No. 1, we recommended that in-Class Area members be given the choice of (i) commencing Medical Monitoring immediately after the Effective Date and during the same time frame to be enjoyed by out-of-Class Area members; or (ii) waiting until the Class Area is

substantially remediated. Because Medical Monitoring for the Subclass will proceed immediately, and before the property is remediated, and because the implementation of remediation will be determined at a future date based upon the Statute of Limitations Proceeding, it is suggested that the above choice is now moot, with Subclass Medical Monitoring to begin as soon as practicable.

The only suggested additional edit to this part of Report No. 1 is to revise the last paragraph by suggesting that draft Class Member Medical Monitoring registration forms and proposed criteria for proof of Class Member Medical Monitoring eligibility be submitted to the Court and Counsel by the undersigned by November 8, 2010, as suggested in the revised Subclass Medical Monitoring Timeline and Punch List in Exhibit E-1 (the "Timeline"), attached hereto.

2. Facilitating Claimant Participation in the Medical Monitoring Program.

The only edit we would make to this portion of Report No. 1 is to omit the last sentence, which referenced Punitive Damages, which no longer apply to Medical Monitoring. In addition, as shown in the Timeline, Subclass Medical Monitoring recruitment would not begin until June 2011, after the Statute of Limitations Proceeding Jury Trial.

As suggested in the Timeline, Subclass Members would not be notified of their Medical Monitoring Program until June 2011, after the Statute of Limitations Proceeding Jury Trial.

3. Medical Monitoring Provisioning.

We have no changes to this portion of Report No. 1.

4. The Precise Mechanism by which Any Amounts are Escrowed, How the Escrow is Replenished, How Funds are Disbursed, and Other Similar Matters.

A. Recommended Down Payment and the Escrow Fund Following Effective Date.

Because the Medical Monitoring Subclass is now smaller, it is suggested that the Initial Deposit described in Report No. 1 be reduced from $500,000 to $250,000, to be made by the date provided in Exhibit E-1. In addition, if the Court still decides to fund Medical Monitoring on a "pay as you go" basis, the Down Payment described in this portion of Report No. 1 needs to be reduced following a determination by the Court of the portion of the $129.6 million original Medical Monitoring Revenue Requirement estimate of Dr. Brookshire is applicable to the Medical Monitoring Subclass. It is suggested that Class Counsel and the Defendants prefile expert testimony to facilitate this determination, by November 29, 2010, as indicated in the Timeline in Exhibit E-1 to this Supplement, with the testimony to be heard by the Court at a hearing on December 10, 2010, at 9:00 a.m. or some other date set by the Court (the "Subclass Medical Monitoring Hearing").

It is submitted that determining the Subclass Medical Monitoring Revenue Requirement will not be a simple exercise of projecting the size of the Subclass as compared to the projected size of the Class as a whole. For example, there will be Medical Monitoring fixed costs that may be largely unchanged, children live longer than adults and may therefore participate in the Program longer, and some Medical Monitoring tests may not be conducted on the Subclass Members immediately due to their comparatively young age.

B. Escrow Fund Replenishment Mechanism.

Assuming that the Court decides to continue with the "pay as you go" approach to Medical Monitoring Funding, we have no changes to this portion of Report No. 1.

C. Security for Balance Possibly Due Under the Medical Monitoring Program.

Assuming that the Court decides to continue with the "pay as you go" approach in Medical Monitoring Funding, we note that the $129.6 million Medical Monitoring expense estimate of Dr.

Brookshire should be revised downward by the Court after hearing the above requested expert testimony of the Parties, but that the balance due would still need to be fully secured using one of the forms of security described in this section.

It is recommended that, at the Subclass Medical Monitoring Hearing, the Court consider whether DuPont is required to provide security for the balance possibly due under the Subclass Medical Monitoring Program and, if the Court determines that security is required, it is recommended that DuPont make an escrow fund balance security proposal. These suggestions are reflected in the Timeline in Exhibit E-1. It is still recommended that the Court periodically review any previously approved security arrangement.

D. Medical Monitoring Escrow Fund Disbursement Mechanism.

We have no changes to this portion of Report No. 1.

E. Escrow Fund Financial Advisors and Auditor.

We have no changes to this portion of Report No. 1.

5. Claimants Advisory Committee.

The only change to this section is to suggest that the Claimant's Advisory Committee be comprised of Medical Monitoring Subclass Members and that Subclass Members not be approached about possibly serving on this Committee until after the Statute of Limitations Proceeding. A revised date for making Committee nominations is contained in Exhibit E-1.

6. Medical Monitoring and Administrative Office Accommodations.

The only change to this section in Report No. 1 is to change the suggested date of Claims Administration Office location recommendations as shown in Exhibit E-1.

7. Medical Monitoring Implementation Schedule.

Please consider Exhibit E-1 to replace Exhibit E to Report No. 1. Under this Timeline, it is projected that the implementation of Medical Monitoring for the Medical Monitoring Subclass will commence by June 10, 2011, when Subclass Medical Monitoring recruitment begins.

Based upon the Foregoing, the Special Master makes the following requests, which replace those made in Special Master's Report No. 1:

(i) That this Supplement and Special Master's Report No. 1(Medical Monitoring) now be part of the record, but be considered filed In Camera and Under Seal, and that this Supplement and Report No. 1 lie over for thirty (30) days, so as to allow the Parties to file objections to or motions to adopt or modify this Supplement and Report No. 1, or to provide other recommendations; and that the contemplated recommendations, suggestions and submissions of the Special Master and the Parties described in Exhibit E-1 be made during this same period;

(ii) Following the receipt of the comments by the Parties and the submissions of the Special Master and the Parties listed in Exhibit E-1, that are due within thirty (30) days, that there be an In Camera Fairness Hearing on this Supplement and Report No. 1 at the Subclass Medical Monitoring Hearing held on or about December 10, 2010 at 9:00 a.m. Eastern Time;

(iii) That, following the Subclass Medical Monitoring Hearing, the form of Protective Order in Exhibit A to Report No. 1, the form of Confidential Agreement in Exhibit B to Report No. 1, and biennial revenue requirement computations in Exhibit C to Report No. 1, as modified by the Court based on expert testimony on the revenue requirement for Subclass Medical Monitoring, be approved by the Court;

(iv) That, following the Subclass Medical Monitoring Hearing, this Supplement and Report No. 1 and their recommendations, and the materials and recommendations described in Exhibit E-1 submitted by the Special Master prior to the Subclass Medical Monitoring Hearing be approved by the Court; and

(v) For such other, general, equitable and more special relief as may be proper under the premises.

Respectfully submitted this 25th day of October, 2010.

Edgar C. Gentle, III,
Special Master

THIS EXHIBIT E-1 REPLACES REPORT NO. 1 EXHIBIT E

SUGGESTED SUBCLASS MEDICAL MONITORING PRE-IMPLEMENTATION DATE TIME LINE AND PUNCH LIST

Milestone	Suggested Completion Date
Effective Date	October 13, 2010
Class Administrator Provides the Court and the Parties In Camera Draft Subclass Member Registration Forms and Eligibility Criteria for Subclass Medical Monitoring Program	November 8, 2010
Class Administrator Obtains Tax Identification Number for Medical Monitoring Entity	November 8, 2010
Parties Submit to Special Master In Camera Lists of Candidates for Medical Monitoring Third Party Claims Administrator, Finance Committee (one Member for Plaintiffs and one for Defendants), Custodial Bank and Investment Manager	November 8, 2010
Parties to provide to Special Master In Camera list of suggested Class Administrator Office sites	November 8, 2010
After consulting with the Parties, Class Administrator submits In Camera to the Court a proposed list of Candidates for Medical Monitoring Third Party Claims Administrator, Finance Committee, Custodial Bank and Investment Manager for review by the Parties and the Court	November 15, 2010
After consulting with the Parties, Class Administrator provides In Camera to Court a list of possible Class Administrator Office Sites for review by the Parties and the Court	November 15, 2010
DuPont to remit $250,000 Initial Deposit to the Medical Monitoring Entity	November 15, 2010

Class Administrator provides In Camera to the Parties for review draft Third Party Claims Administrator Request for Proposals	November 22, 2010
Parties submit to the Court and Special Master In Camera prefiled expert testimony on the estimated size and ages of the Medical Monitoring Subclass, and how Dr. Brookshire's previous Medical Monitoring $129.6 million Cost Estimate should be modified	November 29, 2010
Parties provide written comments In Camera to the Court on this Supplement and Special Master Report No. 1 respecting Medical Monitoring	November 29, 2010
Class Administrator tentatively selects initial Office site and submits initial [pre-Implementation Date (pre June 10, 2011)] budget, submitting them In Camera to the Court and the Parties	November 29, 2010
Parties submit Medical Advisory Panel implementation comments to the Court and nominees for the Panel (if any)	November 29, 2010
The Court conducts an In Camera hearing on Subclass Medical Monitoring Implementation	December 10, 2010 9:00 a.m.
The Court issues an Order Under Seal on the pending Medical Monitoring issues, (i) determining (A) the Medical Monitoring revenue requirement for the Medical Monitoring Subclass; (B) the amount, if any, of the DuPont Medical Monitoring Down Payment less the $250,000 Initial Deposit; (C) the security, if any, to be provided by DuPont for the revised projected Subclass 40 Year Medical Monitoring Budget; (D) if there is to be a Medical Advisory Panel, and, if so, its composition; and (ii) approving (A) the selection of the Finance Committee Members; (B) candidates for Medical Monitoring Third Party Claims Administrator, Custodial Bank and Investment Manager; (C) the Third Party Claims Administrator Request for Proposals; (D) the Class Administrator's Office site and initial budget for the Subclass Medical Monitoring Program [pre-Implementation Date (pre June 10, 2011)]; and (E) the Subclass Medical Monitoring Registration Forms and Eligibility Criteria	January 10, 2011
RFP issued by Class Administrator confidentially to Third Party Claims Administrator Candidates	January 24, 2011

EXHIBIT E-1

Finance Committee convenes, establishes written accounting internal controls and payment vouchering procedures, and candidates for Custodial Bank and Investment Manager are interviewed, and Finance Committee submits Report to Court recommending Custodial Bank and Investment Manager. Finance Committee proposes written investment guidelines and decides if an Investment Consultant is needed	February 25, 2011
Third Party Claims Administrator Bids Received by Class Administrator and shared with the Parties	February 25, 2011
Court approves Custodial Bank and Investment Manager	March 10, 2011
DuPont provides the Medical Monitoring Entity Down Payment balance (if any) and Security (if any) for Medical Monitoring Subclass Projected 40 Year Budget	March 10, 2011
Third Party Claims Administrator Candidates interviewed by Class Administrator, Claimants Advisory Committee, Medical Advisory Panel (if any), and Counsel for the Parties. Class Administrator, after consulting with the Parties, submits report to the Court recommending Third Party Claims Administrator	March 15, 2011
Medical Monitoring on-line database and Subclass Member on-line registration is beta-tested by Class Administrator with the Parties	March 30, 2011
The Court approves Medical Monitoring Third Party Claims Administrator	April 11, 2011
Third Party Claims Administrator surveys Class Area and out-of-Class Area Medical Monitoring physicians and laboratory prospects, and medical testing provisioning in the projected testing area, and prepares (i) Medical Monitoring Implementation Plan, based on a "retail model" of paying for Medical Monitoring building blocks; (ii) list of in-Class Area and out-of-Class Area potential Medical Monitoring physicians and laboratories; and (iii) Medical Monitoring roll out Time Line for review by the Parties and the Class Administrator	May 10, 2011

Class Counsel provide the Court and the Special Master, In Camera, with nominations for Subclass Claimants Advisory Committee	May 10, 2011
Finance Committee, Third Party Claims Administrator and Class Administrator submit Medical Monitoring Budget for year one (beginning with Implementation Date) to the Parties for review	May 10, 2011
Court approval of Claimants Advisory Committee	May 20, 2011
After consulting with the Parties, year one budget recommendations are submitted by Class Administrator to the Court for review	May 20, 2011
Class Administrator's Office opens, 800 number goes live	May 25, 2011
Claimants Advisory Committee Convenes	May 25, 2011
Medical Advisory Panel Convenes	May 25, 2011
After vetting with the Medical Advisory Panel, the Claimants Advisory Committee, and Counsel for the Parties, Class Administrator and Third Party Claims Administrator submit Subclass Medical Monitoring Implementation and Time Line Report to the Court	May 30, 2011
The Court approves the year one (beginning with Implementation Date) Subclass Medical Monitoring budget	May 30, 2011
Court Approval of Subclass Medical Monitoring Implementation Report of Third Party Claims Administrator	May 30, 2011
Medical Monitoring On-Line Database and On-Line Registration goes live	June 6, 2011
Class Administrator Subclass Notice and Registration begins, with registration being provided in-person at the Class Administrator's Office site, by mail, on-line, and at selected Medical Clinics	June 10, 2011

Following verification of Subclass Member eligibility, Medical Monitoring begins (Implementation Date)	June 10, 2011

EXHIBIT G

West Virginia University
SCHOOL OF MEDICINE

Anticipated health effects of the contamination of Spelter, WV and surrounding communities with arsenic, cadmium, and lead, and recommendations for medical monitoring.

March 30, 2007

The residents in the area around Spelter have been exposed to arsenic, cadmium, and lead an extended time. There are clear associations between arsenic, cadmium, and lead with significantly increased risks of developing disease, primarily cancers. IARC lists arsenic and cadmium in Group 1 (Carcinogenic to Humans). Lead is listed in Group 2A (Probably Carcinogenic to Humans). Additionally, there have been several studies documenting increased cancer risk around smelter sites[1,2,3,4] where similar exposures have occurred.

I have reviewed the Dr. Kornberg's initial report of November 11, 2005 as well as his rebuttal report of March 3, 2006. I concur with most of Dr. Kornberg's conclusions and recommendations, however I have several updates to both focus the exams to those conditions associated with the arsenic, cadmium and lead exposures as well as to update the science to reflect new technology available for medical monitoring.

DEFINITION OF GEOGRAPHICAL TERMS

Dr Brown, in his incremental cancer risk map, shows the residual contamination across the class area. There are three distinct areas within the class area, separate in their degree of contamination, and thus the risk to the residents in those areas.

- Zone 1 = The area delineated by Dr. Brown as within the 3×10^{-4} incremental risk contour for developing cancer.
- Zone 2 = The area between the 5×10^{-4} incremental risk contour and the 1×10^{-4} incremental risk contour.
- Zone 3 = The area within the class area but outside the 1×10^{-4} cumulative incremental risk contour.

The residents in all areas have a significantly increased risk of developing disease based upon their residence and exposures in the area. The toxic and carcinogenic effects of all

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[1] Brown LM, Pottern LM, Blot WJ. Lung Cancer in Relation to Environmental Pollutants Emitted from Industrial Sources. *Environmental Research* Vol 34, 250-261.

[2] Pershagen G. *Lung Cancer Mortality among Men Living near an Arsenic-Emitting Smelter*. American Journal of Epidemiology. Volume 122, Number 4, *Pp. 684–694*

[3] ATSDR *Public Health Assessment* for National Zinc Company in Bartlesville, OK. Viewable at http://www.atsdr.cdc.gov/HAC/PHA/zinc/nzc_p2.html#PUBLIC

[4] Tokudome S, Kuratsune M. A cohort study on mortality from cancer and other causes among workers at a metal refinery. Int J Cancer. 1976 Mar 15;17(3):310-7.

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three of these agents are cumulative and additive[5]. As such, the longer one is exposed, and the more different toxins, the greater the likelihood of developing disease.

Arsenic is associated with cancers of the skin, lung, bladder, kidney, and liver. Cadmium accumulates in the kidney and can cause renal damage and ultimately renal failure. Cadmium is also a carcinogen, associated with cancer of the lung and kidney. There is also some evidence suggesting cancer of the prostate. Lead is associated with cancers of the lung, brain, stomach, and kidney. Additionally, elevated blood lead causes cognitive and behavioral difficulties and is a disease in its own right.

In response to these facts, I propose the following medical monitoring program for the residents of the affected area.

Residency Time Requirement

- For residents within Zone 1, an accumulation of one year of residence shall be required for entry into medical monitoring.
- For residents in the Zone 2, the accumulation of three years of residence in the class area shall be required for entry into medical monitoring.
- For residents in the Zone 3, the accumulation of five years of residence in the class area shall be required for entry into medical monitoring.
- Once a resident has qualified for entry into medical monitoring based upon their residence in the area, they shall remain in medical monitoring for 40 years past the remediation of their residence.

BASIS FOR THE RESIDENCY TIME RECOMMENDATIONS

My goal is to ensure that residents with a significantly increased risk are offered medical monitoring. However, reasonableness demands establishing a threshold for the minimum residency requirement. I also believe that it is appropriate to be moderate at each decision point.

In his report, Dr. Kornberg did calculations to estimate risk using the difference between the measured soil Arsenic levels to calculate the incremental risk, and concluded that 277 days of exposure would be required to reach an "action level". This was adequate to demonstrate the presence of increased risk, however more precise calculations of risk are now available on Dr. Brown's map titled "Incremental Total Cancer Risk for All Pathways" (copy attached as Appendix A), and these are the basis of the minimum residency time requirements for entry into the medical monitoring program delineated here.

General logic:

Based solely upon the risk of skin cancer from arsenic exposure via ingestion, and lung cancer from arsenic and cadmium inhalation, Dr. Brown has calculated the total cancer risk from the exposures in the class area. Clearly there are multiple additional cancer risks for the exposed population from the arsenic, cadmium, and lead that are not

[5] EPA Risk Assessment Guidance for Superfund Volume I Human Health Evaluation Manual (Part A), sections 8.2.2 and 8.3; viewable at http://www.epa.gov/oswer/riskassessment/ragsa/pdf/ch8.pdf

included in these calculations, which would only increase the calculated risk. Starting with the 30 year total risk from Dr Brown's model, I calculated the time duration that would expose a person to a 1:100,000 risk of developing these two cancers for each of the zones.

Calculations:
Using a simple proportion, with the goal of calculating the total risk then the proportion was solved for time (X)

$$\frac{\text{Total Risk}}{\text{30 Years}} = \frac{\text{Significant Risk}}{X}$$

$$X \times \text{Total Risk} = \text{30 Years} \times \text{Significant Risk}$$

$$X = \frac{\text{30 Years} \times \text{Significant Risk}}{\text{Total Risk}}$$

Zone 1 (Inner)

$$X = \frac{30 \text{ Years} \times 10^{-5}}{1 \times 10^{-3}} = \frac{30 \times 10^{-5} \text{ Years}}{1 \times 10^{-3}} = 0.3 \text{ Years} = 109.5 \text{ Days}$$

Zone 1 (Outer)

$$X = \frac{30 \text{ Years} \times 10^{-5}}{5 \times 10^{-4}} = \frac{30 \times 10^{-5} \text{ Years}}{5 \times 10^{-4}} = 0.6 \text{ Years} = 217 \text{ Days}$$

Zone 2

$$X = \frac{30 \text{ Years} \times 10^{-5}}{1 \times 10^{-4}} = \frac{30 \times 10^{-5} \text{ Years}}{1 \times 10^{-4}} = 3 \text{ Years}$$

Zone 3

$$X = \frac{30 \text{ Years} \times 10^{-5}}{7 \times 10^{-5}} = \frac{30 \times 10^{-5} \text{ Years}}{7 \times 10^{-5}} = 4.28 \text{ Years}$$

Notes and codicils about residency time:

1. The contours on the map indicate that the area within the contour is at or above the listed risk. Thus, while a few residents just inside the contour line may have the risk level equal to the listed contour, most of the residents within the contour are exposed to a higher risk than that portrayed by the contour.

2. The exposure at individual residences will end only with the remediation of the contamination in the residences. Thus residence time calculations will end with the remediation of each individual residence.
3. The waste piles were capped in 2004, thus residence time in any home whose construction or installation was begun in 2005 or later would be excluded from the time calculations for medical monitoring, due to the much lower likelihood of the presence of large quantities of contaminated dust within the residence (although soil exposure risk remains).

I believe that it is appropriate to include moderating measures at each point in setting the minimum residency time.

Moderating measures used in calculating residency time included:

1. Using 1:100,000 as the threshold for "significant risk", rather than 1:1,000,000, which is a more common threshold.
2. The model discussed by Dr. Brown includes only skin cancer risk from arsenic and lung cancer risk from arsenic and cadmium. There are significant additional cancer risks that are not considered in this calculation. Thus, the actual cancer risk would be greater if these additional risks were considered.
3. The residence time was rounded up to the next reasonable interval (i.e. full year).
4. No cancer risk for lead was considered in the model

Moderating measures in medical surveillance program:

1. Only diseases clearly associated with arsenic, cadmium, and lead are monitored for.
2. Testing is limited to diseases and medical tests clearly supported by the literature or general medical practice.

GENERAL PRINCLPLES:

Once the entry criteria has been satisfied, the monitoring program shall be the same for all medical monitoring group members, except for differences by member age mentioned below.

Medical monitoring shall be conducted every 2 years for members of the medical monitoring group once entry criteria are met. While this spacing could miss some rapidly developing diseases, it will catch most diseases, and will not significantly increase the risk to the patients from the testing.

Medical monitoring shall continue until 40 years past the end of exposure. Generally this would be either 40 years beyond moving out of the class area or 40 years after their residence is remediated. This is based on the usual latencies of the diseases of interest.

Any resident whose residency within the class area ended more than 40 years ago, and has not resided within the class area within the past 40 years, shall be excluded from the medical monitoring eligibility.

Remediation

The residents in this community have been exposed to arsenic, cadmium, and Lead from the Spelter smelter site through breathing plant emissions during operations, soil contamination, exposure to fugitive emissions from the waste piles, living in houses contaminated with dust from the plant, soil contamination around their residence, incidental soil and dust ingestion, and consumption of contaminated vegetables, and perhaps drinking water contaminated by emissions from the plant site.

While clearly not of the magnitude as during smelter operations, exposure to arsenic, cadmium, and lead is ongoing for residents in the community. Several interventions have been undertaken to limit exposure, including extinguishing the fires in the piles, limiting access to the waste piles, and the capping of the piles to limit fugitive emissions, and establishment of municipal water for the affected area. I would encourage that additional interventions be undertaken to decrease or eliminate the exposure through the remaining routes. This would include remediating the homes to remove contaminated dust from the living spaces as well as the dust reservoir areas within the home (attic, basement, etc.), and remediating the soil around the residences.

Diseases considered to be related to the exposures from Spelter site. (Unfortunately, medical monitoring is not possible for all diseases associated with these exposures)

Arsenic[6,7]
Skin Cancer
Lung Cancer
Bladder Cancer
Kidney Cancer

Cadmium[8]
Lung Cancer
Kidney Cancer
Decreased Renal Function[9]
Renal Failure
Bone Fragility

Lead[10,11]
Plumbism (Lead Poisoning) – Having elevated whole blood lead is a disease in itself, causing mental retardation, poor school performance, and behavioral problems. In

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[6] Ferreccio C, Sancha AM. Arsenic exposure and its impact on health in Chile. J Health Popul Nutr. 2006 Jun;24(2):164-75
[7] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[8] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol58/volume58.pdf
[9] NIOSH Worker Notification Program; Cadmium Recovery Workers (Cadmium); Viewed at: http://www.cdc.gov/niosh/pgms/worknotify/cadmium.html#estimated
[10] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[11] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol87/volume87.pdf

children, there is clear evidence of this effect at levels well below the CDC action level of 10 µg/dl.
Lung Cancer
Stomach Cancer[12]
Kidney Cancer
Decreased Renal Function[13]
Renal Failure[13]
Bone Fragility
Loss of teeth
Hypertension
Increased rates of criminal activity[14,15]

There are several additional cancers that have been proposed as due to lead exposure, but for which I do not yet find the literature compelling. At the present I would not recommend screening for these diseases, but I would recommend a review of the literature in several years to consider these conditions.
Brain Cancer
Stomach Cancer
Rectal Cancer
Prostate Cancer
Colon Cancer

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
    a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
    b. Referral to PCP for findings not associated with the exposures

The screening examination will be the same for all participants, except

- Start screening chest CT scans at age 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine pregnancy test for females age 35-55 prior to scan unless surgical sterilization.
- Below age 15, screen ONLY whole blood lead (capillary or venous)

[12] Steenland K, Boffetta P. Lead and cancer in humans: where are we now? Am J Ind Med. 2000 Sep;38(3):295-9.
[13] Ekong EB, Jaar BG, Weaver VM. Lead-related nephrotoxicity: a review of the epidemiologic evidence. Kidney Int. 2006 Dec;70(12):2074-84. Epub 2006 Oct 25
[14] Needleman HL, McFarland C, Ness RB, Fienberg SE, Tobin MJ. Bone lead levels in adjudicated delinquents. A case control study. Neurotoxicol Teratol. 2002 Nov-Dec;24(6):711-7
[15] Stretesky PB, Lynch MJ. The relationship between lead exposure and homicide. Arch Pediatr Adolesc Med. 2001 May;155(5):579-82.

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest[16] (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Calculated glomerular filtration rate (GFR)
  d. Whole Blood Lead
- Stool Blood (Hemoccult)
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/Interaction
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards
  f. Review results of blood and urine screening
  g. Review CT scan results
  h. Order re-testing or make referrals based upon findings

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
- Urine Cytology
- Urine Beta-2 microglobulin
- BUN and Creatinine
- Calculated Glomerular Filtration Rate

Follow-up examination (Blood on UA or positive cytology)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy
- CT scan of Abdomen

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine elevated)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis

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16 Bach PB, Jett JR, Pastorino U, Tockman MS, Swensen SJ, Begg CB. Computed tomography screening and lung cancer outcomes. JAMA. 2007 Mar 7;297(9):953-61

- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Lungs

Medical Surveillance Examination (For persons >= age 35): Perform every 2 years
- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest

First Cycle Positives
- Repeat same CT scan several months later
- Consultation with ordering physician to review changes over time and refer as appropriate

Subsequent Cycle Positives
- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later
- Lung Biopsy
  - By Cardiothoracic surgeon or
  - Pulmonologist, depending upon the location of the lesion within the lungs

Plumbism (Lead Poisoning)

Screening Examination
- Whole Blood Lead
  - Medical Action Level (above which additional investigation is needed):
    - Children (<18 Years Old): 10 µg/dl
    - Adults (>18 years old): 30 µg/dl
  - Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
    - Children (<18 Years Old): 5 µg/dl
    - Adults (>18 years old): 20 µg/dl

    Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead

Medical Follow-up examination
- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (veinous) (Children 15%, Adults 15%)
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin
- Complete Blood Count
- Bone x-ray fluorescence testing to assess body burden

Neuropsychiatric follow-up
- Formal neuropsychiatric evaluation

Skin

Screening Examination

- Head-to-toe examination of the skin by the screening physician as part of the physical examination.

Follow-up examination

- Consultation with Dermatologist (1-2 visits)
- Biopsy by dermatologist if indicated

GI system (stomach, intestines, rectum)

Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination
- Follow-up examination
  - Refer to PCP for evaluation for colon disease
  - IF negative colon disease workup, then re-enter screening program to look for stomach cancer
    - Refer to Gastroenterologist for stomach evaluation
    - EGD (Endoscopic Gastroduodenoscopy)

Overall medical surveillance assumptions:

- Participation in the entire program is voluntary, and that a participant can choose to participate or discontinue participation at any time.
- That there will be one (or a small number) of physicians from the community supervising the medical monitoring program and performing the physical examinations. This is to ensure that the physician is familiar with the program, the diagnosis of the diseases of concern, and to ensure consistency.
- For the first cycle, the patients must have pre-testing access to a knowledgeable clinician (physician or nurse) be discuss the risks and benefits of the proposed testing
- That medical testing without physician interpretation of the results is inappropriate for the well being of the participant
- That the ideal is for a physician visit for results interpretation (and physical examination) following testing
- That without the physician examination, key portions of the evaluation will be missed, and that the physical examination is critical to identifying some of the diseases of concern.
- That any participant who fails to participate in the post-testing physician evaluation will receive a letter communicating their test results, and any recommendations for follow-up.
- In all cases, the evaluating physician shall have the freedom to repeat any test if there is evidence of a lab error or if no other clinical evidence is found to support the diagnosis suggested by the test result.
- If a patient has had any of the recommended tests within the past 6 months, and the written results these can be provided, those tests will not be repeated, and the patient-provided results used for the screening program.

- That following diagnosis with a disease of interest, the screening for that disease will cease, but other screenings will/could continue
- That some test results can be caused by multiple diseases. The interpreting physician will be charged with figuring these cases out.
- Despite targeted testing, it is possible conditions will be detected by the testing that are not related to the exposure. When that happens, the participant will be referred to their Primary Care Physician for follow-up and treatment.
- Workup of positive test results will continue until the determination of exposure-related or non-exposure-related can be made
- As soon as a non-exposure-related condition is identified, the patient will be referred to their PCP. The screening for the disease of interest will continue unmodified. This referral will occur each screening cycle. The patient can decline the referral if they deem it unnecessary.
- A patient with an abnormal finding related to the exposures will be referred to the appropriate specialist with each screening cycle. The patient can decline the referral if they deem it unnecessary.
- That a central repository of the screening, referrals, and outcomes data will be maintained, and depersonalized data made available for epidemiological evaluations. It is clear from my literature review in preparing this document that there is incomplete scientific evidence in the literature on screening programs, participation rates, referral rates, etc. This data could serve as the basis for answering many of these scientific questions.
- The screening program described here is based upon the best available medical knowledge in 2007. While I would not propose changing the diseases being monitored for, it is likely that in the future new technology or better understandings within medicine will require the updating of this protocol. This protocol should be reviewed periodically by the administering physician to ensure that the screenings and follow-up described here remain consistent with best medical practice.

Commentary on the differences between Dr. Komberg's proposal and this recommendation.

Overall, I concur with Dr. Komberg's assessment of the nature of the exposure as well as the diseases of concern associated with these exposures. My opinion differs from his only in the details.

1) The only disease caused by all three of the exposures is lung cancer. Dr Komberg recommended screening for lung cancer using chest x-rays. Unfortunately, by the time most lung cancers are large enough to be detected by chest x-ray they are incurable. Over the past several years there have been promising results from the use of low dose CT scans to screen for early lung cancers. This technology allows for the identification of much smaller tumors and the 3-D imaging makes it much easier to differentiate cancers from other lung lesions.

2) Some of the testing proposed by Dr Kornberg was aimed at biomonitoring (monitoring levels in blood, urine, or hair) to assess for the presence of the Arsenic, Lead, and Cadmium. I fully support monitoring whole blood lead since an elevated blood Lead is a disease in its own right. However, for arsenic and cadmium I do not believe biomonitoring would be useful clinically. There are two reasons.

   a. First, at this point the exposures are lower level chronic exposures, and the available biomonitoring tests are designed to monitor acute exposures, such as monitoring pre- and post-shift urinary cadmium for cadmium workers to assess the efficacy of employer control measures.
   b. The second reason is that the presence of the exposures has been established, and there could be a false sense of security (or even confusion) generated by low values on the biomonitoring tests. The risks of disease persist, whatever biomonitoring levels are found.

3) Dr Kornberg seemed to be offering options for the evaluating physician to add or subtract tests from the screening examination. To actually make this work, it would be necessary to have two visits with the physician, which would clearly add to the complexity of implementing the program. Efficiently looking for the diseases of interest is the key, but making the screening program practical to implement is also *quite* important. Thus, for the "general screening examination" my goal is to establish criteria that are very easy to implement (such as age) as the only differentiating factor for what tests each patient needs. A standardized testing regimen will allow the ordering of the tests to be handled by an administrative person, and allow the physician to focus on the interpretation of the tests and examining the patients. I would concur with Dr Kornberg's recommendation that current (< 6 months old) test results could be used in place of repeating the test.

4) There were several aspects of the screening examination proposed by Dr Kornberg that are good general medical surveillance, but not directly related to long term exposure to arsenic, cadmium, or lead. I have tried to focus the examination and eliminate these tests. For example, he includes an electrocardiogram (ECG), however, I am not able to directly associate ECG changes with the arsenic, cadmium, or lead at the levels likely to be found in this population.

In Summary, it is my recommendation that on the basis of their exposures in Spelter and the remaining class area that there is a significantly increased risk of developing disease, and that medical monitoring is necessary to look for these diseases.

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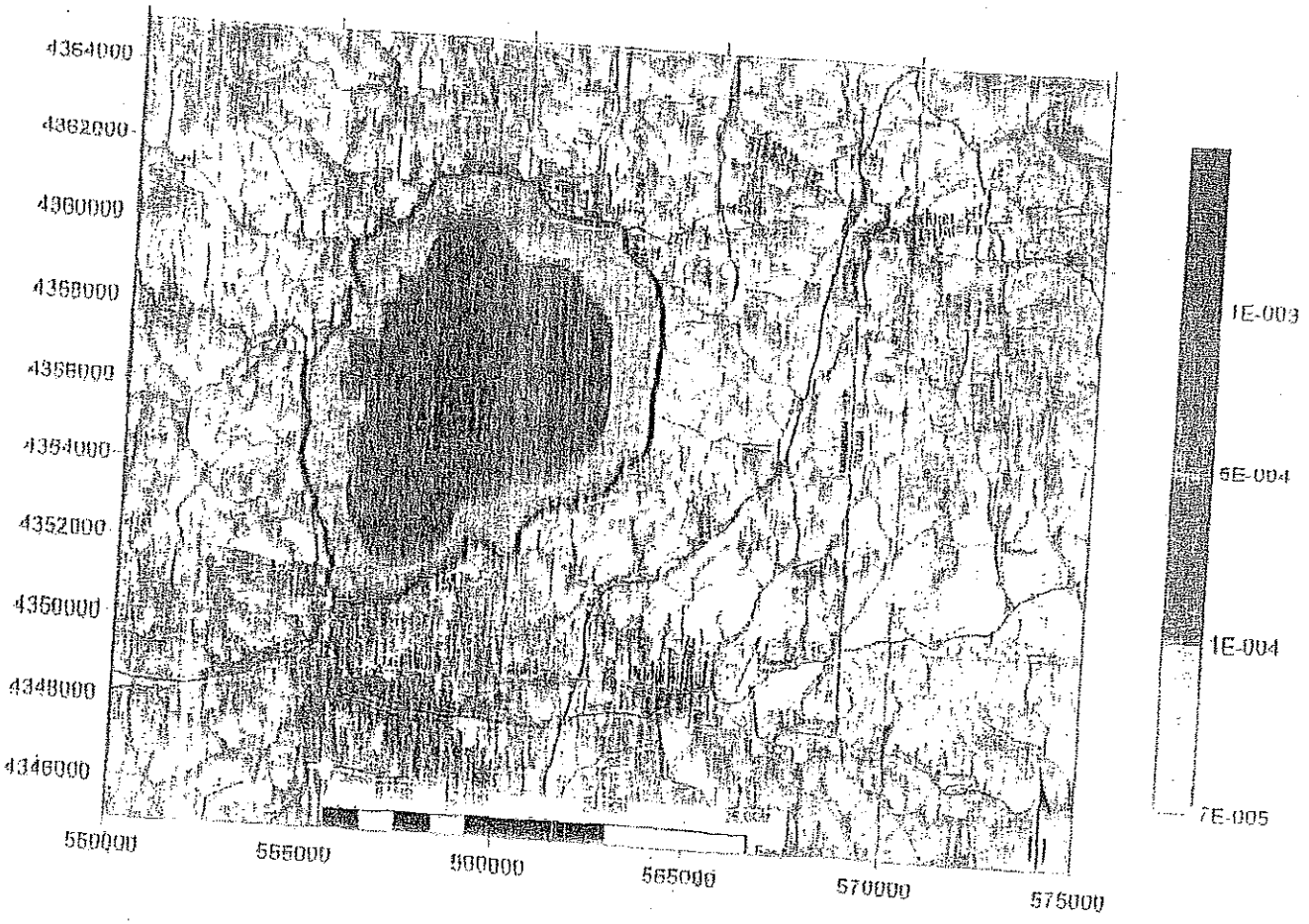
Incremental Total Cancer Risk for All Pathways



Appendix A - Modeling Monitoring

West Virginia University
SCHOOL OF MEDICINE

Proposed Medical Monitoring due to the contamination of Spelter, WV and surrounding communities with arsenic, cadmium, and lead.

Including estimations of participation rates and testing outcomes for economic purposes

March 30, 2007

A medical monitoring program has been prescribed for Spelter and the surrounding community (the class area) due to the contamination of the area with arsenic, cadmium, and lead, and the significantly increased risk of developing disease due to these exposures.

For the purposes of costing of this program, estimates are needed for the participation rates and the likely outcomes of the testing. This document is prepared for that purpose. The details of the monitoring program are the same as those contained in my main report, only quantification has been added for the various decision points within the surveillance program.

All of the details contained in this document are estimates, they are not evidence based, nor are they based upon prior experience in this sort of a program. I am not able to locate literature on these topics in the medical literature. On the basis of my best professional judgment I am offering anticipated participation and outcome estimates. *These estimates will be in italics and underlined.*

To facilitate the costing of this program, Appendix A shows the cost for the listed tests and medical procedures at West Virginia University Hospitals and University Health Associates, prepared by Melissa Mitchell, a certified professional coder in my office.

The monitoring program shall be the same for all participants, except:

- Chest CT scans only for participants with age greater than or equal to 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine Pregnancy test for potentially pregnant females 35-55 years old unless surgical sterility prior to scan.
- Below age 15, screen ONLY whole blood lead (capillary or veinous), and the physician visit

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General Estimates (evidence-based estimates welcome):

- *75% of eligible population will participate in initial screening. Of those:*
  - *85% will complete the testing and attend the physician visit*
  - *15% will not complete the testing and/or appear for the physician visit, and will require a letter reviewing their findings*
- *75% of those initially screened will appear for the second screening*
- *Thereafter (after the first two cycles of screening), there will be a 5% attrition rate each screening cycle*

- *5% of all blood and urine tests will need to be repeated due to suspicion of lab error or equivocal results*

- *2% of each test (except lead) in the initial screening battery will be unneeded due to the patient having had the same test within the past 6 months and being able to provide written results. 0% of the "follow-up" tests will not be needed for this reason.*

Medical Surveillance Program:

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
   a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
   b. Referral to PCP for findings not associated with the exposures

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Whole Blood Lead
- Stool Blood (Hemoccult)
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/interaction (Level 5 for adults, Level 4 for children < 15)
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)*
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards*

f. Review results of blood and urine* screening
g. Review CT scan results*
h. Order re-testing or make referrals based upon findings
* = Omit for children < 15 years old

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
  - *10% Positives overall*
    - *Blood 2% (Target disease – Needs follow-up with urologist)*
    - *Glucose 5% (Not target disease)*
    - *Infection 3% (Not target disease)*
- Urine Cytology
  - *1% Positive (Target disease – Needs follow-up with urologist)*
- Urine Beta-2 microglobulin
  - *5% Positive*
    - *2% (Target disease – Needs follow-up with nephrologist)*
    - *3% other known causes of kidney disease (i.e. diabetes)*
- BUN and Creatinine
  - *5% Positive*
    - *2% (Target disease – Needs follow-up with nephrologist)*
    - *3% other known causes of kidney disease (i.e. diabetes)*

Follow-up examination (Blood or Cytology positive)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy (Hospital and Professional Charge)
- CT scan of Abdomen (Hospital and Professional Charge)

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine positive)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis
- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Final Outcome

- *40%* go on to treatment
- *60%* return for next screening (diseases of interest not found)

Lungs

Medical Surveillance Examination (For persons >= age 35); Perform every 2 years

- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest (Hospital and Professional Charge)

First Cycle

- *30-50% will have a positive initial examination (per Harvard data), thus estimate 40% positives in our population*
  - Repeat same CT scan several months later (Hospital and Professional Charge)
  - Consultation with supervising physician to review changes over time and refer as appropriate

5% positives in all cycles

- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later (Hospital and Professional Charge)
- *25% of repeat CT scans positive*
  - *Refer to Pulmonologist*
    - Watch and repeat CT Scan *(50%)*
    - Decision to get Lung Biopsy *(50%),*
      - If Biopsy – specialist depends upon location of lesion
        - *35%* - Cardiothoracic surgeon
          - Office Visit
          - Biopsy
            - Hospital Charge
            - Professional Charge
            - Anesthesia Charge
            - Pathologist Charge
        - Pulmonologist *(65%),* depending upon the location of the lesion within the lungs
          - Biopsy
            - Hospital Charge
            - Professional Charge
            - Pathologist Charge

Final Outcome

- *25%* go on to treatment
- *75%* return for next screening (diseases of interest not found)

Plumbism (Lead Poisoning)

Screening Examination

- Whole Blood Lead

  Medical Action Level (above which additional investigation is needed):
  - Children (<18 Years Old): 10 µg/dl *(10% of tested)*
  - Adults (>18 years old): 30 µg/dl *(2% of tested)*

  Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
  - Children (<18 Years Old): 5 µg/dl *(20% of tested)*
  - Adults (>18 years old): 20 µg/dl *(5% of tested)*

  Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead *(Estimate this will mean that 75% of patients will NOT need re-evaluation with each cycle.)*

Medical Follow-up examination

- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (veinous) *(Children 15% Adults 15%)*
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin *(lab)*
- Complete Blood Count (Lab)
- Bone x-ray fluorescence testing to assess body burden (Hospital and Professional Charge, Travel (Pittsburgh for Children, New York City for Adults))

Neuropsychiatric follow-up

- Formal neuropsychiatric evaluation

Final Outcome

- Treatment does NOT preclude re-exposure or need for re-treatment
- *100%* return for next screening (diseases of interest not found)

Skin

Screening Examination

- Head-to-toe skin examination *Estimate 5% Positives from physician examination*

Follow-up Examination

- Refer to Dermatologist for evaluation
  - Office Visit – Level 5 initial
  - *50% Biopsy by dermatologist*
    - Procedure code
    - Supplies
    - Pathology
    - Follow-up visit with dermatologist (level 3 return)

Final Outcome

- *5%* go on to treatment
- *95%* return for next screening (diseases of interest not found, or treated)

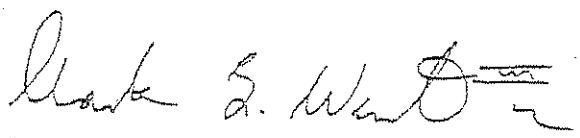
GI system (stomach, intestines, rectum)
Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination *Estimate 5% Positive hemoccult*
  Note: Most likely cause is colon disease, not a target disease
- Follow-up examination
  - Refer to PCP for evaluation for colon disease – *85% find colon disease (NOT target Disease)*
  - *15% will have negative colon disease workup* (and re-enter screening program to look for stomach cancer)
    - Refer to Gastroenterologist for stomach evaluation
    - EGD with biopsy
      - Procedure code
      - Supplies
      - Pathology

Final Outcome

- *25%* go on to treatment
- *75%* return for next screening (diseases of interest not found)

In Summary, the above is my prescription for the medical monitoring program for the community surrounding Spelter, along with estimates of participation and outcome rates based upon my professional judgment.



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ECONOMICS – APPENDIX A

DESCRIPTION	CPT CODE	PROF CHARGE	HOSPITAL CHARGE	PATH CHARGE (pro)	PATH CHARGE (tech)	CYTO TECH	PHARMACY	ANESTHESIA
							*** For the anesthesia medicine, rate is $5.59/minute. Time varies by procedure.	
CT Scan of Chest:								
w/o contrast	71250	$ 159.00	$ 1,030.50					
w/contrast	71260	$ 170.00	$ 1,156.00					
w/o contrast followed by w/contrast	71270	$ 189.00	$ 1,418.00					
CT scan of Abdomen:								
w/contrast	74160	$ 175.00	$ 1,011.50					
w/o contrast	74150	$ 163.00	$ 694.00					
w/o contrast followed by w/contrast	74170	$ 192.00	$ 1,156.50					
CT scan of Pelvis:								
w/contrast	72192	$ 150.00	$ 1,011.50					
w/o contrast	72193	$ 159.00	$ 694.00					
w/o contrast followed by w/contrast	72194	$ 167.00	$ 1,156.50					
Urinalysis:								
Dip	81002	$ 14.00						
Rapid Pregnancy	81025	$ 25.00						
Cytology	88108			$ 118.00	$ 93.00			
Beta -2 microglobulin	82043	$ 31.00						
Blood Collection:								
Venipuncture	36415	$ 15.00						
Creatinine	82565		$ 6.00					
BUN (Blood Urea Nitrogen)	84520							
Whole Blood Lead	83655		$ 13.00					
Blood Glucose	82947		$ 6.00					
SR - erythrocyte sedimentation rate	85651							
Zinc Protoporphyrin	84202		$ 21.00					
CBC-complete blood count	85027		$ 10.00					
Stool Blood (Hemoccult)	82270	$ 15.00	$ 10.00					
Vaticals - New Patients: (All specialities)								
<1 yr	99381	$ 151.00						
1-4 yrs	99382	$ 102.00						
5-11 yrs	99383	$ 159.00						

12-17 yrs	99384	$ 173.00							
18-39 yrs	99385	$ 173.00							
40-64 yrs	99386	$ 204.00							
>65 yrs	99387	$ 221.00							
Consult w/ Urologist	99245	$ 325.00							
Cystoscopy w/Biopsy	52354	$ 1,587.00	$ 8,500.00	$ 100.00	$ 151.00				
Consult w/Nephrologist	99245	$ 325.00						Est 45 Minutes $251.55	00800 - $80/15 minutes
Cardiothoracic Surgeon:									
Office Visit	99245	$ 325.00							
Lung Biopsy	32400	$ 399.00	$ 3,300.00	$ 163.00	$ 139.00	$ 139.50		Estimate 1.5 hours	
	32402	$ 1,374.00	$ 3,300.00		$ 100.00	$ 151.00	$	803.10	00522 - $80/15 minutes/Average $1,700.00
(Hospital charges for all, if done as outpatient)	32405	$ 271.00	$ 3,300.00				$	803.10	00522 - $80/15 minutes/Average $1,700.00
	32602	$ 935.00	$ 3,300.00	$ 300.00	$ 266.50		$	803.10	00522 - $80/15 minutes/Average $1,700.00
							$	803.10	00522 - $80/15 minutes/Average $1,700.00
Pulmonologist:									
Office Visit	99245	$ 325.00							
Lung Biopsy	31625	$ 937.00	$ 725.00	$ 100.00	$ 151.00				
Neuropsychiatric Evaluation	96118	$223/hr	Est 3 Hours = $669 // $1,011 total						
	96119	$114/hr	Est 3 Hours = $342 //						
Consult w/Medical Toxicologist or Environmental Medicine Specialist	99245	$ 325.00							
Consult w/Dermatologist:	99245	$ 325.00							
Biopsy	11100	$ 209.00	$ 1,500.00 *	$ 100.00	$ 151.00				* 00300 - $80/15 minutes (Est 30 Min = $160)
EGD	43239	$ 734.00	$ 1,200.00	$ 100.00	$ 151.00			Est 15 Minutes $83.85	00740 - $80/15 minutes
Bone x-ray - Fluorescence Testing		Not performed at WVU - Will need price from Columbia University in New York							

NOTES:

1. All prices reported here are current charges as of 3/29/2007 at West Virginia University Hospitals, Inc and WVU Medical Corporation, Inc.
2. For procedures: the prices shown are the average, with overall estimates (per Dr Wernz in *underlined italics*) in parentheses
3. Normally skin biopsy is an outpatient proceedure. A few ill patients may require a hospital biopsy *(estimate 3%) (Hosp Charge and Anes Charge)*

West Virginia University
School of Medicine

Anticipated health effects of the contamination of Spelter, WV and surrounding communities with arsenic, cadmium, and lead, and recommendations for medical monitoring.

March 30, 2007

The residents in the area around Spelter have been exposed to arsenic, cadmium, and lead an extended time. There are clear associations between arsenic, cadmium, and lead with significantly increased risks of developing disease, primarily cancers. IARC lists arsenic and cadmium in Group 1 (Carcinogenic to Humans). Lead is listed in Group 2A (Probably Carcinogenic to Humans). Additionally, there have been several studies documenting increased cancer risk around smelter sites[1,2,3,4] where similar exposures have occurred.

I have reviewed the Dr. Komberg's Initial report of November 11, 2005 as well as his rebuttal report of March 3, 2006. I concur with most of Dr. Komberg's conclusions and recommendations, however I have several updates to both focus the exams to those conditions associated with the arsenic, cadmium and lead exposures as well as to update the science to reflect new technology available for medical monitoring.

DEFINITION OF GEOGRAPHICAL TERMS

Dr Brown, in his incremental cancer risk map, shows the residual contamination across the class area. There are three distinct areas within the class area, separate in their degree of contamination, and thus the risk to the residents in those areas.

- Zone 1 ≡ The area delineated by Dr. Brown as within the $5x10^{-4}$ incremental risk contour for developing cancer.
- Zone 2 ≡ The area between the 5×10^{-4} incremental risk contour and the 1×10^{-4} incremental risk contour.
- Zone 3 ≡ The area within the class area but outside the 1×10^{-4} cumulative incremental risk contour.

The residents in all areas have a significantly increased risk of developing disease based upon their residence and exposures in the area. The toxic and carcinogenic effects of all

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[1] Brown LM, Pottern LM, Blot WJ, Lung Cancer in Relation to Environmental Pollutants Emitted from Industrial Sources. Environmental Research Vol 34, 250-261.
[2] Pershagen G, *Lung Cancer Mortality among Men Living near an Arsenic-Emitting Smelter*, American Journal of Epidemiology, Volume 122, Number 4, *Pp 684-694*
[3] ATSDR Public Health Assessment for National Zinc Company in Bartlesville, OK. Viewable at http://www.atsdr.cdc.gov/HAC/PHA/zinccraz_p2.html#PUBLIC
[4] Tokudome S, Kuratsune M, A cohort study on mortality from cancer and other causes among workers at a metal refinery, Int J Cancer, 1976 Mar 15;17(3):310-7.

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three of these agents are cumulative and additive[5]. As such, the longer one is exposed, and the more different toxins, the greater the likelihood of developing disease.

Arsenic is associated with cancers of the skin, lung, bladder, kidney, and liver. Cadmium accumulates in the kidney and can cause renal damage and ultimately renal failure. Cadmium is also a carcinogen, associated with cancer of the lung and kidney. There is also some evidence suggesting cancer of the prostate. Lead is associated with cancers of the lung, brain, stomach, and kidney. Additionally, elevated blood lead causes cognitive and behavioral difficulties and is a disease in its own right.

In response to these facts, I propose the following medical monitoring program for the residents of the affected area.

Residency Time Requirement

- For residents within Zone 1, an accumulation of one year of residence shall be required for entry into medical monitoring.
- For residents in the Zone 2, the accumulation of three years of residence in the class area shall be required for entry into medical monitoring.
- For residents in the Zone 3, the accumulation of five years of residence in the class area shall be required for entry into medical monitoring.
- Once a resident has qualified for entry into medical monitoring based upon their residence in the area, they shall remain in medical monitoring for 40 years past the remediation of their residence.

BASIS FOR THE RESIDENCY TIME RECOMMENDATIONS

My goal is to ensure that residents with a significantly increased risk are offered medical monitoring. However, reasonableness demands establishing a threshold for the minimum residency requirement. I also believe that it is appropriate to be moderate at each decision point.

In his report, Dr. Kornberg did calculations to estimate risk using the difference between the measured soil Arsenic levels to calculate the incremental risk, and concluded that 277 days of exposure would be required to reach an "action level". This was adequate to demonstrate the presence of increased risk, however more precise calculations of risk are now available on Dr. Brown's map titled "Incremental Total Cancer Risk for All Pathways" (copy attached as Appendix A), and these are the basis of the minimum residency time requirements for entry into the medical monitoring program delineated here.

General logic:

Based solely upon the risk of skin cancer from arsenic exposure via ingestion, and lung cancer from arsenic and cadmium inhalation, Dr. Brown has calculated the total cancer risk from the exposures in the class area. Clearly there are multiple additional cancer risks for the exposed population from the arsenic, cadmium, and lead that are not

[5] EPA Risk Assessment Guidance for Superfund Volume I Human Health Evaluation Manual (Part A), sections 8.2.2 and 8.3; viewable at http://www.epa.gov/oswer/riskassessment/ragsa/pdf/ch8.pdf

included in these calculations, which would only increase the calculated risk. Starting with the 30 year total risk from Dr Brown's model, I calculated the time duration that would expose a person to a 1:100,000 risk of developing these two cancers for each of the zones.

Calculations:
Using a simple proportion, with the goal of calculating the total risk then the proportion was solved for time (X)

$$\frac{\text{Total Risk}}{30\text{ Years}} = \frac{\text{Significant Risk}}{X}$$

$$X \times \text{Total Risk} = 30\text{ Years} \times \text{Significant Risk}$$

$$X = \frac{30\text{ Years} \times \text{Significant Risk}}{\text{Total Risk}}$$

Zone 1 (Inner)

$$X = \frac{30\text{ Years} \times 10^{-5}}{1 \times 10^{-3}} = \frac{30 \times 10^{-5}\text{ Years}}{1 \times 10^{-3}} = 0.3\text{ Years} = 109.5\text{ Days}$$

Zone 1 (Outer)

$$X = \frac{30\text{ Years} \times 10^{-5}}{5 \times 10^{-4}} = \frac{30 \times 10^{-5}\text{ Years}}{5 \times 10^{-4}} = 0.6\text{ Years} = 217\text{ Days}$$

Zone 2

$$X = \frac{30\text{ Years} \times 10^{-5}}{1 \times 10^{-4}} = \frac{30 \times 10^{-5}\text{ Years}}{1 \times 10^{-4}} = 3\text{ Years}$$

Zone 3

$$X = \frac{30\text{ Years} \times 10^{-5}}{7 \times 10^{-5}} = \frac{30 \times 10^{-5}\text{ Years}}{7 \times 10^{-5}} = 4.28\text{ Years}$$

Notes and codicils about residency time:

1. The contours on the map indicate that the area within the contour is at or above the listed risk. Thus, while a few residents just inside the contour line may have the risk level equal to the listed contour, most of the residents within the contour are exposed to a higher risk than that portrayed by the contour.

2. The exposure at individual residences will end only with the remediation of the contamination in the residences. Thus residence time calculations will end with the remediation of each individual residence.
3. The waste piles were capped in 2004, thus residence time in any home whose construction or installation was begun in 2005 or later would be excluded from the time calculations for medical monitoring, due to the much lower likelihood of the presence of large quantities of contaminated dust within the residence (although soil exposure risk remains).

I believe that it is appropriate to include moderating measures at each point in setting the minimum residency time.

Moderating measures used in calculating residency time included:

1. Using 1:100,000 as the threshold for "significant risk", rather than 1:1,000,000, which is a more common threshold.
2. The model discussed by Dr. Brown includes only skin cancer risk from arsenic and lung cancer risk from arsenic and cadmium. There are significant additional cancer risks that are not considered in this calculation. Thus, the actual cancer risk would be greater if these additional risks were considered.
3. The residence time was rounded up to the next reasonable interval (i.e. full year).
4. No cancer risk for lead was considered in the model

Moderating measures in medical surveillance program:

1. Only diseases clearly associated with arsenic, cadmium, and lead are monitored for.
2. Testing is limited to diseases and medical tests clearly supported by the literature or general medical practice.

GENERAL PRINCLPLES:

Once the entry criteria has been satisfied, the monitoring program shall be the same for all medical monitoring group members, except for differences by member age mentioned below.

Medical monitoring shall be conducted every 2 years for members of the medical monitoring group once entry criteria are met. While this spacing could miss some rapidly developing diseases, it will catch most diseases, and will not significantly increase the risk to the patients from the testing.

Medical monitoring shall continue until 40 years past the end of exposure. Generally this would be either 40 years beyond moving out of the class area or 40 years after their residence is remediated. This is based on the usual latencies of the diseases of interest.

Any resident whose residency within the class area ended more than 40 years ago, and has not resided within the class area within the past 40 years, shall be excluded from the medical monitoring eligibility.

Remediation

The residents in this community have been exposed to arsenic, cadmium, and Lead from the Spelter smelter site through breathing plant emissions during operations, soil contamination, exposure to fugitive emissions from the waste piles, living in houses contaminated with dust from the plant, soil contamination around their residence, incidental soil and dust ingestion, and consumption of contaminated vegetables, and perhaps drinking water contaminated by emissions from the plant site.

While clearly not of the magnitude as during smelter operations, exposure to arsenic, cadmium, and lead is ongoing for residents in the community. Several interventions have been undertaken to limit exposure, including extinguishing the fires in the piles, limiting access to the waste piles, and the capping of the piles to limit fugitive emissions, and establishment of municipal water for the affected area. I would encourage that additional interventions be undertaken to decrease or eliminate the exposure through the remaining routes. This would include remediating the homes to remove contaminated dust from the living spaces as well as the dust reservoir areas within the home (attic, basement, etc.), and remediating the soil around the residences.

Diseases considered to be related to the exposures from Spelter site. (Unfortunately, medical monitoring is not possible for all diseases associated with these exposures)

Arsenic[6,7]
Skin Cancer
Lung Cancer
Bladder Cancer
Kidney Cancer

Cadmium[8]
Lung Cancer
Kidney Cancer
Decreased Renal Function[9]
Renal Failure
Bone Fragility

Lead[10,11]
Plumbism (Lead Poisoning) – Having elevated whole blood lead is a disease in itself, causing mental retardation, poor school performance, and behavioral problems. In

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[6] Ferreccio C, Sancha AM. Arsenic exposure and its impact on health in Chile. J Health Popul Nutr. 2006 Jun;24(2):164-75
[7] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[8] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol58/volume58.pdf
[9] NIOSH Worker Notification Program; Cadmium Recovery Workers (Cadmium); Viewed at http://www.cdc.gov/niosh/pgms/worknotify/cadmium.html#estimated
[10] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[11] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol87/volume87.pdf

children, there is clear evidence of this effect at levels well below the CDC action level of 10 µg/dl.

Lung Cancer
Stomach Cancer[12]
Kidney Cancer
Decreased Renal Function[13]
Renal Failure[13]
Bone Fragility
Loss of teeth
Hypertension
Increased rates of criminal activity[14,15]

There are several additional cancers that have been proposed as due to lead exposure, but for which I do not yet find the literature compelling. At the present I would not recommend screening for these diseases, but I would recommend a review of the literature in several years to consider these conditions.

Brain Cancer
Stomach Cancer
Rectal Cancer
Prostate Cancer
Colon Cancer

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
    a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
    b. Referral to PCP for findings not associated with the exposures

The screening examination will be the same for all participants, except

- Start screening chest CT scans at age 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine pregnancy test for females age 35-55 prior to scan unless surgical sterilization.
- Below age 15, screen ONLY whole blood lead (capillary or veinous)

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[12] Steenland K, Boffetta P. Lead and cancer in humans: where are we now? Am J Ind Med. 2000 Sep;38(3):295-9.
[13] Ekong EB, Jaar BG, Weaver VM. Lead-related nephrotoxicity: a review of the epidemiologic evidence. Kidney Int. 2006 Dec;70(12):2074-84. Epub 2006 Oct 25
[14] Needleman HL, McFarland C, Ness RB, Fienberg SE, Tobin MJ. Bone lead levels in adjudicated delinquents. A case control study. Neurotoxicol Teratol. 2002 Nov-Dec;24(6):711-7
[15] Stretesky PB, Lynch MJ. The relationship between lead exposure and homicide. Arch Pediatr Adolesc Med. 2001 May;155(5):579-82.

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest[16] (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Calculated glomerular filtration rate (GFR)
  d. Whole Blood Lead
- Stool Blood (Hemoccult)
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/Interaction
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards
  f. Review results of blood and urine screening
  g. Review CT scan results
  h. Order re-testing or make referrals based upon findings

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
- Urine Cytology
- Urine Beta-2 microglobulin
- BUN and Creatinine
- Calculated Glomerular Filtration Rate

Follow-up examination (Blood on UA or positive cytology)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy
- CT scan of Abdomen

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine elevated)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis

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16 Bach PB, Jett JR, Pastorino U, Tockman MS, Swensen SJ, Begg CB. Computed tomography screening and lung cancer outcomes. JAMA. 2007 Mar 7;297(9):953-61.

- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Lungs

Medical Surveillance Examination (For persons >= age 35): Perform every 2 years
- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest

First Cycle Positives
- Repeat same CT scan several months later
- Consultation with ordering physician to review changes over time and refer as appropriate

Subsequent Cycle Positives
- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later
- Lung Biopsy
  - By Cardiothoracic surgeon or
  - Pulmonologist, depending upon the location of the lesion within the lungs

Plumbism (Lead Poisoning)

Screening Examination
- Whole Blood Lead
  - Medical Action Level (above which additional investigation is needed):
    - Children (<18 Years Old): 10 µg/dl
    - Adults (>18 years old): 30 µg/dl
  - Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
    - Children (<18 Years Old): 5 µg/dl
    - Adults (>18 years old): 20 µg/dl

    Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead

Medical Follow-up examination
- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (veinous) (Children 15%, Adults 15%)
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin
- Complete Blood Count
- Bone x-ray fluorescence testing to assess body burden

Neuropsychiatric follow-up
- Formal neuropsychiatric evaluation

Skin

Screening Examination

- Head-to-toe examination of the skin by the screening physician as part of the physical examination.

Follow-up examination

- Consultation with Dermatologist (1-2 visits)
- Biopsy by dermatologist if indicated

GI system (stomach, intestines, rectum)

Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination
- Follow-up examination
  - Refer to PCP for evaluation for colon disease
  - IF negative colon disease workup, then re-enter screening program to look for stomach cancer
    - Refer to Gastroenterologist for stomach evaluation
    - EGD (Endoscopic Gastroduodenoscopy)

Overall medical surveillance assumptions:

- Participation in the entire program is voluntary, and that a participant can choose to participate or discontinue participation at any time.
- That there will be one (or a small number) of physicians from the community supervising the medical monitoring program and performing the physical examinations. This is to ensure that the physician is familiar with the program, the diagnosis of the diseases of concern, and to ensure consistency.
- For the first cycle, the patients must have pre-testing access to a knowledgeable clinician (physician or nurse) be discuss the risks and benefits of the proposed testing
- That medical testing without physician interpretation of the results is inappropriate for the well being of the participant
- That the ideal is for a physician visit for results interpretation (and physical examination) following testing
- That without the physician examination, key portions of the evaluation will be missed, and that the physical examination is critical to identifying some of the diseases of concern.
- That any participant who fails to participate in the post-testing physician evaluation will receive a letter communicating their test results, and any recommendations for follow-up.
- In all cases, the evaluating physician shall have the freedom to repeat any test if there is evidence of a lab error or if no other clinical evidence is found to support the diagnosis suggested by the test result.
- If a patient has had any of the recommended tests within the past 6 months, and the written results these can be provided, those tests will not be repeated, and the patient-provided results used for the screening program.

- That following diagnosis with a disease of interest, the screening for that disease will cease, but other screenings will/could continue
- That some test results can be caused by multiple diseases. The interpreting physician will be charged with figuring these cases out.
- Despite targeted testing, it is possible conditions will be detected by the testing that are not related to the exposure. When that happens, the participant will be referred to their Primary Care Physician for follow-up and treatment.
- Workup of positive test results will continue until the determination of exposure-related or non-exposure-related can be made
- As soon as a non-exposure-related condition is identified, the patient will be referred to their PCP. The screening for the disease of interest will continue unmodified. This referral will occur each screening cycle. The patient can decline the referral if they deem it unnecessary.
- A patient with an abnormal finding related to the exposures will be referred to the appropriate specialist with each screening cycle. The patient can decline the referral if they deem it unnecessary.
- That a central repository of the screening, referrals, and outcomes data will be maintained, and depersonalized data made available for epidemiological evaluations. It is clear from my literature review in preparing this document that there is incomplete scientific evidence in the literature on screening programs, participation rates, referral rates, etc. This data could serve as the basis for answering many of these scientific questions.
- The screening program described here is based upon the best available medical knowledge in 2007. While I would not propose changing the diseases being monitored for, it is likely that in the future new technology or better understandings within medicine will require the updating of this protocol. This protocol should be reviewed periodically by the administering physician to ensure that the screenings and follow-up described here remain consistent with best medical practice.

Commentary on the differences between Dr. Kornberg's proposal and this recommendation.

Overall, I concur with Dr. Kornberg's assessment of the nature of the exposure as well as the diseases of concern associated with these exposures. My opinion differs from his only in the details.

1) The only disease caused by all three of the exposures is lung cancer. Dr Kornberg recommended screening for lung cancer using chest x-rays. Unfortunately, by the time most lung cancers are large enough to be detected by chest x-ray they are incurable. Over the past several years there have been promising results from the use of low dose CT scans to screen for early lung cancers. This technology allows for the identification of much smaller tumors and the 3-D imaging makes it much easier to differentiate cancers from other lung lesions.

2) Some of the testing proposed by Dr Kornberg was aimed at biomonitoring (monitoring levels in blood, urine, or hair) to assess for the presence of the Arsenic, Lead, and Cadmium. I fully support monitoring whole blood lead since an elevated blood Lead is a disease in its own right. However, for arsenic and cadmium I do not believe biomonitoring would be useful clinically. There are two reasons.

   a. First, at this point the exposures are lower level chronic exposures, and the available biomonitoring tests are designed to monitor acute exposures, such as monitoring pre- and post-shift urinary cadmium for cadmium workers to assess the efficacy of employer control measures.
   b. The second reason is that the presence of the exposures has been established, and there could be a false sense of security (or even confusion) generated by low values on the biomonitoring tests. The risks of disease persist, whatever biomonitoring levels are found.

3) Dr Kornberg seemed to be offering options for the evaluating physician to add or subtract tests from the screening examination. To actually make this work, it would be necessary to have two visits with the physician, which would clearly add to the complexity of implementing the program. Efficiently looking for the diseases of interest is the key, but making the screening program practical to implement is also quite important. Thus, for the "general screening examination" my goal is to establish criteria that are very easy to implement (such as age) as the only differentiating factor for what tests each patient needs. A standardized testing regimen will allow the ordering of the tests to be handled by an administrative person, and allow the physician to focus on the interpretation of the tests and examining the patients. I would concur with Dr Kornberg's recommendation that current (< 6 months old) test results could be used in place of repeating the test.

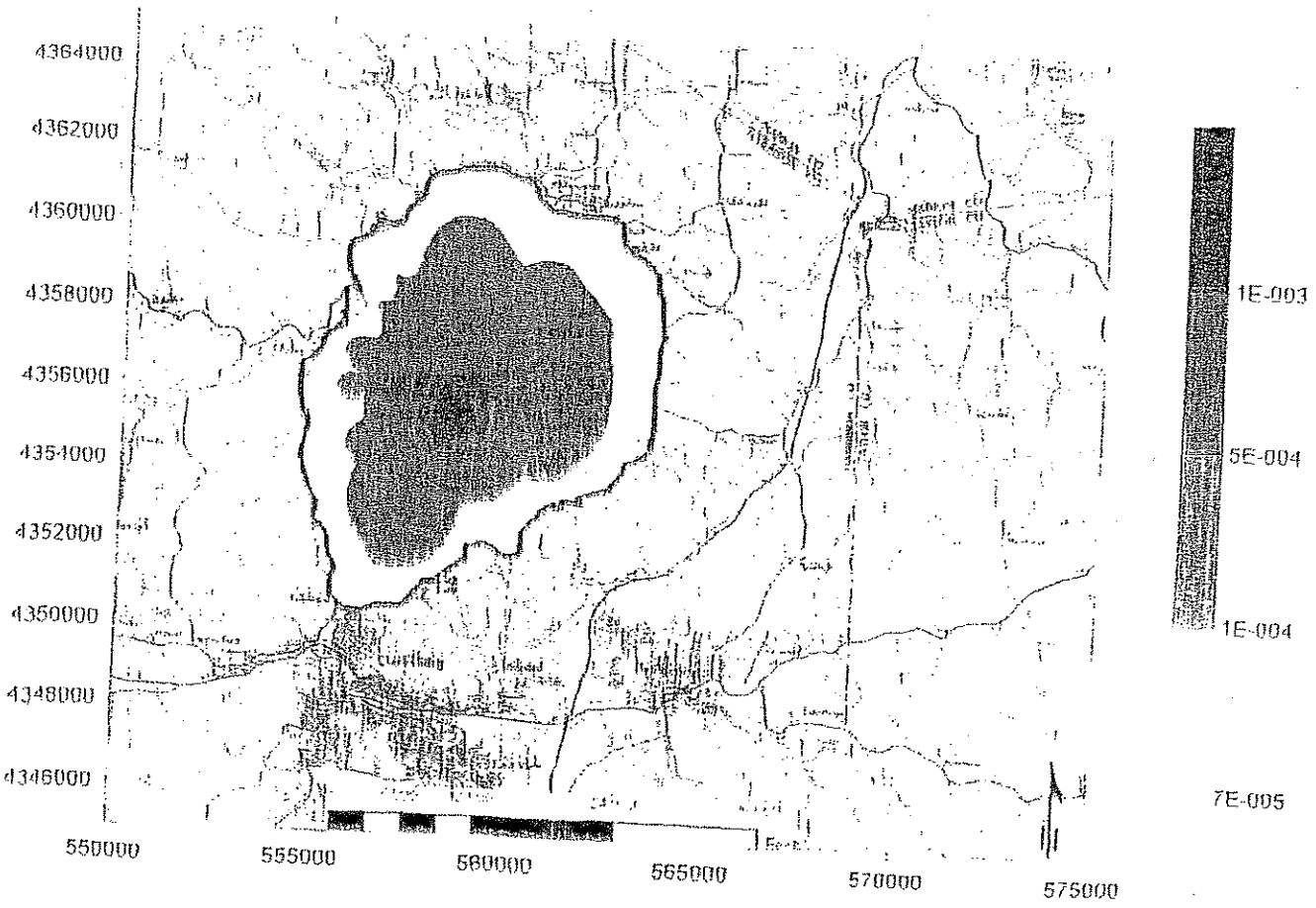
4) There were several aspects of the screening examination proposed by Dr Kornberg that are good general medical surveillance, but not directly related to long term exposure to arsenic, cadmium, or lead. I have tried to focus the examination and eliminate these tests. For example, he includes an electrocardiogram (ECG), however, I am not able to directly associate ECG changes with the arsenic, cadmium, or lead at the levels likely to be found in this population.

In Summary, it is my recommendation that on the basis of their exposures in Spelter and the remaining class area that there is a significantly increased risk of developing disease, and that medical monitoring is necessary to look for these diseases.

Charles L. Werntz III, D.O., MPH, FACOEM
Assistant Clinical Professor
Associate Residency Director
Institute for Occupational and Environmental Health
Department of Community Medicine
West Virginia University School of Medicine

Appendix A - Medical Monitoring

Incremental Total Cancer Risk for All Pathways



ECONOMICS – APPENDIX A

DESCRIPTION	CPT CODE	PROF CHARGE	HOSPITAL CHARGE	PATH CHARGE (pro)	PATH CHARGE (tech)	CYTO TECH	PHARMACY	ANESTHESIA
							**** For the anesthesia medicine, rate is $5.69/minute. Time varies by procedure.	
CT Scan of Chest:								
w/o contrast	71250	$ 159.00	$ 1,030.50					
w/contrast	71260	$ 170.00	$ 1,158.00					
w/o contrast followed by w/contrast	71270	$ 189.00	$ 1,418.00					
CT scan of Abdomen:								
w/contrast	74160	$ 175.00	$ 1,011.50					
w/o contrast	74150	$ 163.00	$ 694.00					
w/o contrast followed by w/contrast	74170	$ 192.00	$ 1,156.50					
CT scan of Pelvis:								
w/contrast	72192	$ 150.00	$ 1,011.50					
w/o contrast	72193	$ 159.00	$ 694.00					
w/o contrast followed by w/contrast	72194	$ 167.00	$ 1,156.50					
Urinalysis:								
Dip	81002	$ 14.00						
Rapid Pregnancy	81025	$ 25.00						
Cytology	88108			$ 118.00	$ 93.00			
Beta -2 microglobulin	82043	$ 31.00						
Blood Collection:								
Venipuncture	36415	$ 15.00						
Creatinine	82565		$ 8.00					
BUN (Blood Urea Nitrogen)	84520							
Whole Blood Lead	83655		$ 13.00					
Blood Glucose	82947		$ 8.00					
ESR - erythrocyte sedimentation rate	85651							
Zinc Protoporphyrin	84202		$ 21.00					
CBC-complete blood count	85027		$ 10.00					
Stool Blood (Hemoccult)	82270	$ 15.00	$ 10.00					
Physicals - New Patients: (All specialities)								
<1 yr	99381	$ 151.00						
1-4 yrs	99382	$ 182.00						
5-11 yrs	99383	$ 159.00						

12-17 yrs	99384	$ 173.00							
18-39 yrs	99385	$ 173.00							
40-64 yrs	99386	$ 204.00							
>65 yrs	99387	$ 221.00							
Consult w/ Urologist	99245	$ 325.00							
Cystoscopy w/Biopsy	52354	$ 1,567.00	$ 8,500.00	$ 100.00	$ 151.00				
								Est 45 Minutes $261.55	00800 - $80/15 minutes
Consult w/Nephrologist	99245	$ 325.00							
Cardiothoracic Surgeon:									
Office Visit	99245	$ 325.00							
Lung Biopsy	32400	$ 399.00	$ 3,300.00	$ 183.00	$ 139.00	$ 139.50	Estimate 1.5 hours		
	32402	$ 1,374.00	$ 3,300.00		$ 100.00	$ 151.00	$ 503.10		00522 - $80/15 minutes/Average $1,700.00
(Hospital charges for all, if done as outpatient)	32405	$ 271.00	$ 3,300.00				$ 503.10		00522 - $80/15 minutes/Average $1,700.00
	32602	$ 935.00	$ 3,300.00	$ 360.00	$ 266.50		$ 503.10		00522 - $80/15 minutes/Average $1,700.00
							$ 503.10		00522 - $80/15 minutes/Average $1,700.00
Pulmonologist:									
Office Visit	99245	$ 325.00							
Lung Biopsy	31625	$ 937.00	$ 725.00	$ 100.00	$ 151.00				
Neuropsychiatric Evaluation	96118	$223/hr	Est 3 Hours = $669 // $1,011 total						
	96119	$114/hr	Est 3 Hours = $342 //						
Consult w/Medical Toxicologist or Environmental Medicine Specialist	99245	$ 325.00							
Consult w/Dermatologist:	99245	$ 325.00							
Biopsy	11100	$ 209.00	$ 1,500.00 *	$ 100.00	$ 151.00				
									* 00400 - $80/15 minutes (Est 30 Min = $160)
EGD	43239	$ 734.00	$ 1,200.00	$ 100.00	$ 151.00				
							Est 15 Minutes $83.85		00740 - $80/15 minutes
Bone x-ray - Fluorescence Testing	Not performed at WVU - Will need price from Columbia University in New York								

NOTES:

1. All prices reported here are current charges as of 3/29/2007 at West Virginia University Hospitals, Inc and WVU Medical Corporation, Inc.
2. For procedures: the prices shown are the average, with overall estimates (per Dr Wernitz in *underlined italics*) in parentheses
3. Normally skin biopsy is an outpatient proceedure. A few ill patients may require a hospital biopsy *(estimate 3%) (Hosp Charge and Anes Charge)*

EXHIBIT H

GENTLE, TURNER & SEXTON
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*ALSO ADMITTED IN FLORIDA

January 28, 2011

VIA FEDERAL EXPRESS and
TELECOPIER

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)-
Initial Medical Monitoring and Property Remediation Time Lines and Punch Lists;
Our File No. 4609-1 (Z)

Dear Judge Bedell:

In accordance with the January 18, 2011 Order respecting medical monitoring, please find the initial time line and punch list for medical monitoring and the initial time line and punch list for property remediation. We are submitting these to you simultaneously, because the two time lines are interrelated. In accordance with the Order, and as reflected in the time lines, we are using our best efforts to share resources and expenditures of the Settlement in carrying out both medical monitoring and property remediation in tandem.

Thank you for the Court's consideration.

Yours very truly,

Edgar C. Gentle, III

ECGIII/kjm
Enclosures

cc: (with enclosures)(by e-mail)

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

cc: (with enclosures)(by fax)
Clerk of Court of Harrison County,
West Virginia, for filing (via telecopier: (304) 624-8710)

A. PREAMBLE TO SUGGESTED INITIAL MEDICAL MONITORING AND PROPERTY PROGRAM TIME LINES AND PUNCH LISTS

In accordance with the Court's January 18, 2011 Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, at decretal paragraphs 2 and 9, below are the initial Proposed Time Lines and Punch Lists for the Medical Monitoring and Property Programs developed by the Claims Administrator in collaboration with the Finance Committee. In carrying out the Settlement, the Claims Administrator and the Finance Committee have agreed to work by consensus to the fullest extent practicable. To this end, and to the extent practicable, the Claims Administrator, to the extent practicable, will provide the Finance Committee with draft submissions to the Court five business days before they are filed, in order to obtain comments and possible resolution. The Finance Committee has agreed not to make filings with the Court concerning the administration of the Settlement without likewise sharing them with the Claims Administrator and all members of the Finance Committee, to the extent practicable, five business days in advance for comment and possible resolution. In a similar vein, the schedule of proposed payment vouchering procedures to be filed with the Court shortly to provide the Finance Committee a reasonable time (at least two business days to the extent practicable) to review proposed Claims Administrator disbursements from either of the two qualified settlement funds before they are made.

THE BELOW COMPLETION DATES ARE PROJECTED. THEY COULD BE CHANGED DUE TO UNFORSEEN EVENTS.

B. SUGGESTED MEDICAL MONITORING PROGRAM INITIAL TIME LINE AND PUNCH LIST

Milestone	Suggested Completion Date
Court establishment of Settlement Finance Committee ("SFC")	January 18, 2011
Class Counsel and DuPont provide the Court and the Claims Administrator their nominees for SFC Representative	January 24, 2011
Claims Administrator submits to the SFC draft initial medical monitoring budget (through 6 month sign up period), and Medical Monitoring Fund payment vouchering procedures, written accounting internal controls, and written investment policy	January 24, 2011
Class Counsel provides Claims Administrator in soft medium the Class Area mail-out address list that was used in Settlement Notice, and to be used in noticing the below town meetings and a description of how it was generated, and Parties provide lists of ineligible Graselli properties	January 24, 2011

Claims Administrator and SFC select Claims Administrator office site and finalize lease for possible Court approval, and Claims Administrator submits the lease to the Court	January 26, 2011
Claims Administrator provides SFC with proposed town meeting Notice mailing list and a description of how it was generated, and lists received from the two sides of the case re property program ineligible Graselli properties	January 26, 2011
Claims Administrator provides SFC draft Class member Notice (for publication and mailing) and registration* forms and draft eligibility criteria for Class medical monitoring program	January 28, 2011
Claims Administrator creates and provides to SFC for review draft list of candidates for medical monitoring third party claims administrator and Claims Administrator provides to SFC for review draft medical monitoring third party claims administrator request for proposals	January 28, 2011
Claims Administrator files medical monitoring and property remediation initial time lines and punch lists with the Court	January 28, 2011
Claims Administrator's Office opens	February 1, 2011
Class Counsel and Claims Administrator nominate to the Court Claimants Advisory Committee for in-Class Area (5 members) after Claims Administrator meets with Class Representatives on February 1	February 4, 2011
Claimants Advisory Committee nominees convene	February 4, 2011
Claims Administrator and SFC finalize initial medical monitoring budget (through 6 month sign-up period), and Medical Monitoring Fund written accounting internal controls, payment vouchering procedures, and written investment policy, and subinit to the Court for review	February 4, 2011
The finalized Class Member Notice and registration* forms and eligibility criteria for the Class Medical Monitoring Program are finalized and submitted to the Court for review	February 7, 2011

*Registration means proving medical monitoring Class membership. It does not require participation in the medical monitoring testing program

The Court considers entering an Order approving: (a) the initial medical monitoring time line and punch list; (b) SFC Party Representatives; (c) Claimants Advisory Committee in-Class Area members; (d) the initial budget for the medical monitoring program (through 6 month sign up period); (e) the Medical Monitoring Fund written accounting internal controls, payment vouchering procedures and written investment policy; (f) the Class Member Notice and medical monitoring registration* forms and eligibility criteria; and (g) payment of $100 to medical monitoring Class Members after they register, with the balance to be paid at end of registration*	February 10, 2011
Medical Monitoring registration* Notice is published** and town meeting notice invitation letters and registration* forms are mailed to Class Area addresses	February 15, 2011
The medical monitoring third party claims administrator candidate list and request for proposals are finalized and submitted by the Claims Administrator to the Court for review	February 21, 2011
Class medical monitoring registration* begins on February 28, 2011 and ends August 31, 2011, inclusive (medical monitoring registration* will be available at the February 28 to March 12, 2011 town meetings)	February 28, 2011
The Court considers approving medical monitoring third party claims administrator candidate list and request for proposals	February 28, 2011
Medical monitoring registration* and property program design town meetings at Spelter Fire Station	Weekdays of February 28 to March 11, 2011 (morning 9 a.m. and afternoon 2 p.m. sessions)
RFP issued by Claims Administrator to third party claims administrator candidates	March 1, 2011
Claims Administrator submits to Court recommendations for out-of-Class Area Claimants Advisory Committee Members (4 persons)	March 17, 2011
The Court considers approving out-of-Class Area Claimants Advisory Committee Members	March 24, 2011

** In same newspapers as Class Settlement hearing notice.

Initial medical monitoring Class member cash payments begin as Class membership is proven (maybe $100/each)	March 31, 2011
Third party claims administrator bids received by Claims Administrator and shared with the SFC and the Court for review	April 1, 2011
Third party claims administrator candidates interviewed by Claims Administrator, Claimants Advisory Committee, and SFC. Claims Administrator, after consulting with the SFC, submits report to the Court recommending third party claims administrator selection	April 29, 2011
The Court considers approving medical monitoring third party claims administrator	May 16, 2011
Third party claims administrator interviews University of West Virginia and other area medical testing providers, surveys Class Area and out-of-Class Area medical monitoring physicians and laboratory prospects, for medical testing provisioning, and prepares for Claims Administrator and SFC for review: (A) medical monitoring implementation recommendations, based on a "retail model" of paying for medical monitoring building blocks; (B) list of in-Class Area and out-of-Class Area potential medical monitoring physicians and laboratories; and (C) draft medical monitoring roll out time line draft (collectively, the "Medical Monitoring Implementation Plan")	July 15, 2011
Claims Administrator prepares for review by SFC and third party claims administrator draft budget for year one (begins with Implementation Date)	July 15, 2011
Medical Monitoring Implementation Plan is finalized by the Claims Administrator, the SFC and the third party administrator and submitted to the Court for review	August 1, 2011
Third party claims administrator and Claims Administrator, after consulting with the SFC and Claimants Advisory Committee, submit medical monitoring implementation budget for year one (beginning with Implementation Date) to the Court for review	August 1, 2011
The Court considers approving the Medical Monitoring Implementation Plan and the year one (beginning with Implementation Date) medical monitoring budget	August 15, 2011
Class medical monitoring registration* ends	August 31, 2011
Medical monitoring testing begins (Implementation Date)	September 8, 2011

Final list of medical monitoring Class members is approved by the Court, and balance of medical monitoring class member cash is paid to registered* medical monitoring Class members	November 15, 2011

C. SUGGESTED PROPERTY PROGRAM INITIAL TIME LINE AND PUNCH LIST

Milestone	Suggested Completion Date after Effective Date
Court establishment of Settlement Finance Committee ("SFC")	January 18, 2011
Class Counsel and DuPont provide the Court and the Claims Administrator their nominees for SFC Representative	January 24, 2011
Claims Administrator submits to the SFC draft initial property program budget (pre-remediation start date), and Property Fund payment vouchering procedures, written accounting internal controls, and investment policy	January 24, 2011
Class Counsel provides Claims Administrator in soft medium the Class Area mail-out address list that was used in Settlement Notice, and to be used in noticing the below town meetings and a description of how it was generated, and Parties provide lists of ineligible properties	January 24, 2011
Claims Administrator and SFC select Claims Administrator Office site and finalize lease for possible Court approval, and Claims Administrator submits the lease to the Court	January 26, 2011
Claims Administrator provides SFC with proposed Notice mailing list and a description of how it was generated, and lists received from the two sides of the case re property program exempt Graselli properties	January 26, 2011
Claims Administrator provides SFC list of potential property remediation technical advisor candidates	January 28, 2011
Claims Administrator submits to the SFC proposed town meeting notice form for medical monitoring sign-up and claimant discussion of property program design	January 28, 2011
Claims Administrator files medical monitoring and property remediation initial time lines and punch lists with the Court	January 28, 2011

Claims Administrator's Office opens	February 1, 2011
Property remediation technical advisor candidates selected for review provide cost proposals	February 3, 2011
Class Counsel and Claims Administrator nominate to the Court Claimants Advisory Committee for in-Class Area (5 members) after Claims Administrator meets with Class Representatives on February 1	February 4, 2011
Claimants Advisory Committee nominees convene	February 4, 2011
Claims Administrator and SFC (a) finalize and submit to the Court for review proposed initial property program (pre-remediation start date) budget, and Property Fund payment vouchering procedures, accounting internal controls, and investment policy, and submit to the Court for review, and (b) nominate for the Court's consideration property remediation technical advisor	February 4, 2011
Property remediation technical advisor candidates selected for a telephone interview are interviewed by the Claims Administrator and SFC, and the Claims Administrator, after consultation with the SFC, provides report and remediation technical adviser nominee(s) to the Court	February 7, 2011
The Court considers issuing an Order approving (a) the initial property program time line and punch list; (b) the SFC Party Representatives; (c) Claimants Advisory Committee in-Class Area Members; and (d) the initial budget for the property program (pre-remediation start date), and Property Fund written accounting internal controls; payment vouchering procedures and written investment policy, (e) the town meeting notice and (f) the property remediation monitoring technical advisor	February 10, 2011
Notice of town meetings (11 meetings for about 250 households each based on alpha sort of tax record property owner last names) is published *** sent to property Class addresses to discuss property program and medical monitoring program	February 15, 2011

*** In same newspapers as Class Settlement hearing notice.

Medical monitoring registration* and property program design town meetings at Spelter Fire Station	Weekdays of February 28 to March 11, 2011 (morning 9 a.m. and afternoon 2 p.m. sessions)
Claims Administrator, in consultation with technical advisor and SFC, designs follow-up property program Class member questionnaire re property program design, and submits to the Court for review	March 29, 2011
The Court considers approving questionnaire	April 7, 2011
Questionnaires are mailed to property Class addresses	April 14, 2011
Questionnaire results are received and compiled by the Claims Administrator and submitted to the SFC and the Court for review	May 16, 2011
Property Program Fairness Hearing by the Court, with the Court and the Claims Administrator to obtain final Class member input on property program design	June 1-2, 2011
The Court considers determining in an Order the structure of the property program	June 15, 2011
Claims Administrator, after consulting with the technical advisor and SFC, provides the Court for approval draft property Class member registration forms and eligibility criteria for property program	July 1, 2011
Claims Administrator, technical advisor and SFC submit to the Court RFP for property remediation general contractor and proposed list of candidates for property remediation general contractor for review by the Court (to the extent applicable)	July 1, 2011
The Court considers issuing an Order approving (a) the proposed property program registration forms and (b) the RFP for property remediation general contractor and proposed candidates for property remediation general contractor (to the extent applicable)	July 8, 2011
Property Class Program notice by mail and publication is given, and registration begins, with registration being provided in-person at the Claims Administrator's office, and by mail	July 11, 2011
General contractor RFP issued (to the extent applicable)	July 18, 2011
Property Class cash payments (to the extent applicable) begin to be made on a rolling (as Class members register) basis	August 10, 2011

General contractor bids received, general contractor candidates interviewed by Claims Administrator and Technical Advisor and SFC. Claims Administrator and Technical Advisor, in collaboration with the SFC, submit report to Court recommending selection of property remediation general contractor (to the extent applicable)	August 18, 2011
Court considers approving hiring of property remediation general contractor(s) (to the extent applicable)	August 25, 2011
Property remediation year one implementation budget, time line and punch list (beginning with Implementation Date) (to the extent applicable) are prepared by Claims Administrator, property remediation technical advisor (if applicable), property remediation general contractor (to the extent applicable) and the SFC, and are submitted to the Court for review	September 7, 2011
Court considers approving of year one property remediation implementation budget, time line and punch list (to the extent applicable)	September 14, 2011
Remediation relief (to the extent applicable) for Class members in zones 1, 2 and 3 (to the extent applicable) begins	September 21, 2011
Following verification of Class Member eligibility and the achievement of sufficient remediation registrants to make remediation economical to begin, remediation begins (to the extent applicable) (Implementation Date)	November 1, 2011

EXHIBIT I

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 26428
(304) 622-7443
(800) 345-0837
www.perrinedupont.com
perrinedupont@standslaw.com

February 15, 2011

Re: Registration* for Medical Monitoring Program and Property Clean-Up Program

Dear Potential Medical Monitoring or Property Program Class Member,

THIS LETTER INVITES YOU TO A TOWN MEETING AT THE SPELTER, WEST VIRGINIA, FIRE STATION, WHERE WE WILL HELP YOU WITH YOUR PAPERWORK TO DETERMINE IF YOU ARE A MEMBER OF EITHER OF THESE CLASSES.

On January 4, 2011, a settlement between DuPont and members of two classes was approved by the Circuit Court of Harrison County. The approved settlement establishes two distinct plaintiff classes – a medical monitoring class and a property class. Ed Gentle has been appointed as the Claims Administrator for both classes. On January 18, 2011, the Court approved the medical monitoring program. Based upon information currently available to me, you may be a member of one or both of these classes. We will help you fill out your medical monitoring registration* form. Each Class Member must fill out a form. We will have extra copies at the town meeting or we can mail them to you. If you are a member of the property class, you will have an opportunity to discuss possible options available to address impacted properties within the class area. The Court Orders and a Class Area Map can be viewed at the settlement website at www.perrinedupont.com.

Here is the Town Meeting Schedule:

If Your Last Name Begins With	Your Town Meeting Is (You have the option to come to either the morning or the afternoon session. You are not required to attend both.)
A through B	February 28, 2011, 9:00 am or 2:00 pm
C through D	March 1, 2011, 9:00 am or 2:00 pm
E through G	March 2, 2011, 9:00 am or 2:00 pm
H through J	March 3, 2011, 9:00 am or 2:00 pm
J through L	March 4, 2011, 9:00 am or 2:00 pm
M through N	March 7, 2011, 9:00 am or 2:00 pm
O through R	March 8, 2011, 9:00 am or 2:00 pm
S	March 9, 2011, 9:00 am or 2:00 pm
T through Z	March 10, 2011, 9:00 am or 2:00 pm
Make Up Day (If you were unable to attend on your designated day, you may come on this day.)	March 11, 2011, 9:00 am or 2:00 pm

*Registration means proving medical monitoring Class membership. It does not require participation in the medical monitoring program.

If you cannot attend your scheduled town meeting, feel free to attend any other listed meeting. If you are disabled or otherwise unable to attend, please call us and we can review the Settlement with you over the phone or may be able to come visit you. It is not necessary that you attend one of these town meetings in order to complete the registration forms to determine whether or not you are eligible to participate in either the Medical Monitoring or Property Clean Up Classes. If you do not attend one of the town meetings, you can still complete the enclosed registration* form and mail it back to me at the above address or place it in the drop box at my office.

Below is a brief description of the Medical Monitoring Program and the Property Clean-Up Design town meeting.

A. THE MEDICAL MONITORING PROGRAM

Enclosed is your registration* form.

If you qualify as an eligible class member for medical monitoring you are entitled to receive two benefits: a cash payment and medical monitoring for a period of up to 30 years. In order to determine your eligibility, you must complete the enclosed eligibility registration form and you must choose whether you wish to receive both medical monitoring and cash benefits, or just the cash payment only. Once we have verified your eligibility, an initial cash payment of $200 will be given to you and you may receive an additional cash payment later this year, depending upon the total number of participants in this program. You do not need to sign up for medical monitoring in order to receive this additional cash payment. The amount of the cash payment will be the same regardless of whether you choose to participate in the Medical Monitoring program. Additionally, you will begin to receive free medical monitoring for a period of up to 30 years if you choose to receive this benefit. Please note that if you don't apply to receive the medical monitoring by filling out the enclosed form by August 31, 2011, you will forever waive your right to receive that benefit.

As you may know, under this Settlement, the Honorable Thomas A. Bedell, Circuit Judge of Harrison County, West Virginia, has approved a 30 year Medical Monitoring program for individuals who lived in Zone 1 of the Class Area (see enclosed map attached to form) for at least 1 year, Zone 2 for at least 3 years, or Zone 3 for at least 5 years.**

To register* for the Medical Monitoring Program, a Class Member needs to fill out the enclosed Registration Form and provide the requested supplemental documents proving residency if you have them.

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*Registration means proving medical monitoring Class membership. It does not require participation in the medical monitoring program.

** As long as the Class Member has continuously lived in the Class Area prior to reaching the minimum residence requirement, a Class Member's number of years of residence in each zone are added to determine if the number of years has been met. For example, if a Class Member lived ½ year in Zone 1 and 1 ½ years in Zone 2, he or she would qualify for Medical Monitoring, having spent 50% of the time required in each Zone.

At the town meeting, we will help you complete the form. You may bring the completed form to our office at the Perrine DuPont Settlement Claims Office, located at the Spelter Volunteer Fire Department, 55 B Street, Spelter, West Virginia, 26438 (a drop box is provided if we are closed), or mail it to The Perrine DuPont Settlement Claims Office, Attn: Edgar C. Gentle, Claims Administrator, c/o The Spelter Volunteer Fire Department Office, P.O. Box 257, Spelter, West Virginia, 26428, or e-mail the form to perrineduponi@gtandslaw.com. We must receive the completed form and the supplemental documents proving residency by August 31, 2011, or you will receive nothing.

If you are eligible and elect to participate in the Medical Monitoring program, then you can be medically tested free of charge shortly after registering*, and every 2 years thereafter, for a total monitoring period of 30 years. The voluntary screening exam for participants will involve only a whole blood test for those below age 15, and blood and urine monitoring for those from 15 to 35. In addition to blood and urine tests, class members age 35 or older may receive prescribed non-routine CT scans. All participants age 15 or less in the Medical Monitoring program will be tested for lead poisoning, skin cancer and gastrointestinal system problems.

No routine CT scans shall be performed as part of the Medical Monitoring program. CT scans shall be provided that are diagnostically medically necessary as determined by a competent physician as relevant to possible exposure to heavy metal contamination at issue in the Settlement.

After each screening, you will receive the confidential test results, and you will be entitled to a free physician office visit, where you will be allowed to discuss your medical history, have a physical exam, and review your test results with the physician.

If there is a positive finding of disease possibly associated with exposure to zinc, cadmium, arsenic or lead, you will be referred to a medical specialist for treatment. For other disease findings, the physician will also recommend treatment. The Settlement does not provide funding for actual medical treatment, and follow up treatment will not be paid for out of the Medical Monitoring program.

In the enclosed Medical Monitoring Registration* Form, we encourage you to recommend a Medical Clinic in the Class Area (with the major towns being Lumberport, Spelter, Arlington, Hepzibah, Shinston and Meadowbrook) in order to conduct the Medical Monitoring or provide the physician office visits.

Although it is not required, we also encourage you to provide the names and addresses of relatives and friends who have left the Class Area, so we can invite them to participate in this program.

*Registration means proving medical monitoring Class membership. It does not require participation in the medical monitoring program.

To efficiently carry out the Medical Monitoring process, which will involve reminders provided to you on your tests to be scheduled every two years, a confidential database protected by HIPAA and subject to a confidentiality agreement and other privacy laws will be maintained and will not be available to persons outside of the Medical Monitoring network without your prior permission. The Court will take the steps necessary to ensure that your private information stay private. The steps will include the use of confidentiality and protective orders and limitations on access to the database and/or identifying information. Refer to the January 18, 2011 Order at Paragraph 4.

B. PROPERTY CLEAN-UP PROGRAM DESIGN TOWN MEETING

Under the Settlement, $34 Million is to be used to help clean up impacted properties in the Class Area, which has 2,800 parcels, *except that the* ineligible Grasselli properties*** are not included. If you own a parcel in the Class Area other than a Grasselli property, you are a Property Class Member, and you will be encouraged to participate in the design of the property clean-up. The target contaminants are zinc, cadmium, arsenic and lead. At the town meetings, our clean-up expert, Marc Glass, will describe for you the impact of these metals on the Class Area, and we will welcome your suggestions on how to address the impacted properties in the area.

We will send you a follow-up property clean-up questionnaire after the town meetings. We will ask the Court to have a Fairness Hearing and decide how to design and carry out the property remediation program.

We look forward to meeting you and to your participation in this Settlement if you qualify as a Class Member.

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*Registration means proving medical monitoring Class membership. It does not require participation in the medical monitoring program.

** As long as the Class Member has continuously lived in the Class Area prior to reaching the minimum residence requirement, a Class Member's number of years of residence in each one are added to determine if the number of years has been met. For example, if a Class Member lived ½ year in Zone 1 and 1 ½ years in Zone 2, he or she would qualify for Medical monitoring, having spent 50% of the time required in each Zone.

***A list of these properties is on our website and will be available at the town meetings.

If you have any questions, please come by our office, call us, or send an email.

Yours very truly,

Ed Gentle,
Claims Administrator
(304) 622-7443
1-800-345-0837 (toll free)
Perrineduponti@gtandslaw.com

ECGIII/kjm
Enclosure

PERR...E 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

MEDICAL MONITORING REGISTRATION* FORM

FILL OUT A SEPARATE FORM FOR EACH PERSON REGISTERING*

This Medical Monitoring Program only applies to Class Members who lived in the Class Area (See Attached Map) for the minimum time, as explained in Paragraph A on Page 6 and 7 of the January 18, 2011 Order approving the Medical Monitoring program**, and as explained in the February 15, 2011 letter mailed to you with this form.

COMPLETE AND RETURN THIS FORM BY HAND DELIVERY, MAIL OR E-MAIL TO THE ADDRESS AT THE TOP OF THIS PAGE NO LATER THAN AUGUST 31, 2011

For HELP with this form, visit our Office in Spelter (office hours are 9 to 5, Monday through Friday), call (304) 622-7443 or 1-800-345-0837, view our website at www.perrinedupont.com, or email us at perrinedupont@gtandslaw.com.

I. REQUIRED PARTICIPATION DECISION: YOU CAN USE THE MEDICAL MONITORING PROGRAM AND GET YOUR CASH PAYMENT OR YOU CAN JUST REGISTER* AND GET YOUR CASH PAYMENT ANYWAY

CHECK ONE OF THE FOLLOWING TWO BOXES:

☐ YES, I wish to have Medical Monitoring available if I choose to use it, and want my cash payment.

☐ NO, I do not wish to use Medical Monitoring, and want my cash payment. If I check this box, I forever waive my right to be medically tested. The amount of the cash payment will be the same regardless of whether or not you choose to participate in the Medical Monitoring program.

II. REQUIRED CLASS MEMBER INFORMATION

LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

CURRENT ADDRESS ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CITY ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ STATE ☐☐ ZIP CODE ☐☐☐☐☐

* Registration means proving medical monitoring Class membership. It does not require participation in the Medical Monitoring program.

**The Court Order can be found on the Settlement website at www.perrinedupont.com.

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Birth Date ☐☐/☐☐/☐☐☐☐

III. REQUIRED PROOF OF LIVING IN THE CLASS AREA

PLEASE LIST ALL OF YOUR RESIDENCE ADDRESSES IN THE CLASS AREA (SEE ATTACHED MAP) WHERE YOU LIVED, TELL US WHEN YOU LIVED THERE, AND IF YOU WERE A CHILD AT THE TIME, PLEASE PROVIDE THE NAMES OF YOUR CUSTODIAL PARENT OR GUARDIAN AT THE TIME.

CLASS AREA ADDRESS:	DATES: FROM - UNTIL	CUSTODIAL PARENT OR GUARDIAN: (IF APPLICABLE)

Current Telephone Numbers: (___) _____ (Home) (___) _____ (Cell)

For additional addresses, attach a separate sheet of paper.

For each residence, to the extent you can, please attach proof that you lived there, and for how long, such as a school report card, medical bill, deed, lease, power bill, old check with the address, or the first page of income tax returns for each claimed year. Other documents you may use are in the attached table. We will also consider any other documents that show you lived in the Class Area.

We will also try to obtain the proof from outside sources that you lived in the class area to the extent possible. For adults, source documents will include class area voter registration rolls, Class Area ad valorem property tax records, Class Area Medical Clinic patient rolls, and Class Area utility billing records. For children, source documents will include Class Area school registration rolls and Class Area Medical Clinic patient rolls.

TO HELP US VERIFY THAT YOU LIVED IN THE CLASS AREA, PLEASE COMPLETE THE FOLLOWING TABLE:

Dates: From	Until	Class Area School Attended:

Dates: From	Until	Your Primary Care Doctor or Dentist:

IV. OPTIONAL ADDITIONAL REQUESTED INFORMATION- NOT NECESSARY TO RECEIVE CASH PAYMENT OR TO RECEIVE MEDICAL MONITORING

PLEASE LIST DOCTORS OR MEDICAL CLINICS IN OR NEAR THE CLASS AREA THAT YOU RECOMMEND TO CONDUCT MEDICAL MONITORING. WE WANT TO USE MEDICAL PROVIDERS THAT YOU TRUST.

Name	Address	Phone

PLEASE LIST BELOW THE NAMES AND ADDRESSES OF RELATIVES OR ACQUAINTANCES WHO HAVE LIVED IN THE CLASS AREA AND HAVE MOVED AWAY FROM THE CLASS AREA.

NAME: ADDRESS:

IF YOU NEED ADDITIONAL SPACE TO ANSWER ANY OF THE QUESTIONS ON THIS FORM, PLEASE USE ADDITIONAL SHEETS OF PAPER AND ATTACH TO THIS REGISTRATION FORM.

VERY IMPORTANT - THIS REGISTRATION FORM CONTINUES ON THE NEXT PAGE

V. REQUIRED CERTIFICATION AND SIGNATURE – MUST BE WITNESSED

The undersigned hereby swears under penalty of perjury that all of the information provided herein is true and accurate.

Adult claimants must sign unless incompetent.
For Minor Claimants, the Custodial Parent or Guardian must sign.
For Incompetent Adult Claimants, the Guardian or Conservator must sign.

CLASS MEMBER SIGNATURE Date: ___/___/_____

WITNESS SIGNATURE:

WITNESS NAME:

WITNESS ADDRESS:

DOCUMENTS THAT MAY BE USED TO PROVE HOW LONG YOU LIVED IN THE CLASS AREA

Children - Type of Documents for Proving Residency

Birth Certificate
School/Day Care Records
Medical Records
Parents/Guardians Tax Records Listing Dependants
Lease Agreements Listing Children as Occupants
Government Benefits/Public Assistance Documents
Insurance Documents
DHR/Guardianship/Other Government Program Documents Showing Residency
Police Records/Other Court Records
Church Enrollment Records
Passport
Employment Rolls if of Employment Age
Extracurricular Activities - Sports, Clubs, Library Cards, Etc.

Adults - Type of Documents for Proving Residency

Real Estate Tax Documents
Driver's License
Other DMV Records
Passport
Employment Rolls
Utility Bills
Insurance
Medical Records
Government Benefit/Public Assistance Documents
Deeds
Lease Agreements
Tax Records
Church Enrollment Records
Bank Records
DHR/DA Other Government Program Documents Showing Residency
Police Records/Other Court Records
Gym Membership

Simmston
Haywood
ZONE 3
Seminole
Lumberpon
Gypsy
ZONE 2
ZONE 1
Meadowbrook
Spelter
Lambert Run
Erie
Smelter
Repziban
Smith
Chapel
Dawmont
Gore
Arlington
Edgewood

EXHIBIT E

MEDICAL MONITORING PROPOSAL

FOR THE SPELTER CLAIMANTS

IN

PERRINE, ET AL., V. DUPONT, ET AL.,

IN

HARRISON COUNTY, WEST VIRGINIA

Presented to:
Edgar C. Gentle, III Esq.
Special Master and Claim Administrator

March 31, 2011

Presented by:
CTI Administrators, Inc.

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Table of Contents

Letter of Transmittal

Letter of Transmittal

Representative authorized to contractually obligate CTI Administrators, Inc.:

Donald Brandt
President
CTI Administrators, Inc.

Telephone: (515) 244-7322
Facsimile: (515) 244-8650
E-Mail: dbrandt@claimtechnologies.com

Person authorized to negotiate the contract on behalf of CTI Administrators, Inc.:

Donald Brandt
President
Telephone: (515) 244-7322

Persons to be contacted for clarification:

Donald Brandt
President
Telephone: (515) 244-7322
E-Mail: dbrandt@claimtechnologies.com

Daniel Montgomery
Vice President
Telephone: (515) 244-7322
E-Mail: dmontgomery@claimtechnologies.com

Proposal authorized by:

Donald Brandt

Date 3/31/2011

President
CTI Administrators, Inc.
100 Court Avenue – Suite 306
Des Moines IA 50309-2295

Proposal Summary

Proposal Summary

CTI Administrators, Inc. ("CTIA") has focused its practice for the past 20 years on meeting unique and/or specialized claims administration needs. As demonstrated in the following pages, we will bring proven expertise and a team of specialized professionals to the challenges of meeting our clients Claims Administration and Adjudication needs and quality standards.

Based in Des Moines, Iowa, CTIA has state-of-the-art claim processing hardware, software systems, and experienced adjudicators for the review of claims. These resources currently handle large volumes of claims and are readily expandable to accommodate the requirements of the Spelter Medical Monitoring Program (the Program) – a critical factor given the need for flexibility in managing the Claims Administration workflows that are anticipated. We also have the capabilities to develop and deliver direct mailings for the claimants in the Program in a cost effective and timely manner.

Our sister company, Claim Technologies Incorporated ("CTI") provides claims administration auditing and consulting services for over 200 large employers across the U.S. and will provide audit and control services required. CTI clients include corporations such as BAE Systems Inc., NEC Corporation; and numerous governmental entities including the States of Iowa, Kansas, Mississippi, Ohio, Vermont, and Wisconsin.

CTIA received a Request For Proposals (RFP) from Third Party Health Care Administrators for the Administration of a Medical Monitoring Program dated March 1, 2011. We relied on the information provided in the RFP to prepare our proposal. Several aspects of the RFP have direct bearing on our pricing and are itemized below:

- Participants have been found to have traces of Zinc, Lead, Cadmium, and Arsenic in their systems and have been awarded 30 years of medical monitoring. There are two classes of participants
  - Minors (approximately 1,600)
  - Adults (approximately 6,200)

- We further understand, based on the teleconference on March 14th, that the expected total enrollment will probably be closer to 5,000 participants, which is the enrollment we used to estimate our cost.

- The scope of the medical monitoring test to be performed has been derived from the report prepared by Dr. Charles L. Werntz III, D.O., MPH. Medical Monitoring will be provided to the Program participants (Participants) through seven testing protocols:
  1. Urinary System Tests
  2. Lung System Tests for Males
  3. Lung System Tests for Females

4. Plumbism Tests for Adults
5. Plumbism Tests for Children
6. Skin Tests
7. GI System Tests

The frequency of each of these tests has been forecasted by CTIA to develop the number of expected claims over the 30 years of medical monitoring. The expected volume of claims is very low averaging 1.1 claims per participant per year over the 30 years.

- Medical monitoring services assumed to be provided by a limited number of providers/clinics/hospitals in the geographic area within several hundred miles of Spelter West Virginia. We are assuming that the number of providers providing the seven tests is in the range of 15 – 20 and would include Lab Corp for laboratory services.

- We expect to use the University of West Virginia Hospital as the Clinical Research Facility.

- We assume that we will be able to establish EDI interface with all of the providers and that all of the providers will be able to submit their claims in standard formats and EDI protocols as set forth by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

- We understand that CTIA will not coordinate payment of benefits with Government and other insurance plans, including but not limited to, Medicare, Medicaid, and private health insurance Plan (collectively "Third Party Sources"). If Coordination of Benefits is required, our fees may have to be increased to cover the additional work.

- We have suggested that a series of system generated letters be used to remind participants to schedule their tests and to remind them to reschedule if they have missed their tests.

- We have also suggested the collection of the medical test results into a **Central Repository for Test Results** maintained for the Project. We propose to ask all providers to send test results directly to us. Since we are paying their claims, we will have the leverage to force them to provide the test results in a thorough and timely manner. We will then forward the test results to the clinicians assigned to monitor the test results.

CTIA will provide **Administrative Services and Consulting Services** which include, but are not limited to, the following:

Administrative Services

Enrollment Services:

- CTIA will interface with the Program on a consistent basis to accurately enroll each currently eligible Participant in the CTIA administration system.
- CTIA will update and maintain the enrollment records of eligible Participants in a timely manner.
- CTIA will prepare, print and distribute Booklets describing benefits of the Program for distribution to the Participants.
- CTIA will maintain Enrollment records for a minimum period of seven years after the individual Participants are no longer covered; and on-line history for no less than two years. Such records will be maintained in accordance with prudent standards of health insurance record keeping.
- CTIA will conduct correspondence as is necessary for the day-to-day enrollment of Participants in the Plan.

Claim Processing:

- CTIA will provide necessary facilities, Personnel, databases, software, procedures, forms, and instructions for the prompt processing of any Received Claims.
- CTIA will certify the eligibility of Participants to receive Benefits under the Plan.
- CTIA will examine each Received Claim for benefits under the Plan and take necessary steps to validate, compute the amount payable (if any), and disburse Payment or deny the claim in accordance with the administrative procedures set forth by the Project.
- CTIA will process Received Claims in accordance with procedures and Fee Schedules established by CTIA and the Project for the Providers.
- CTIA will provide each Provider submitting a claim with a written Explanation of Benefits (EOB) supporting payment or denial of such Received Claim.
- CTIA will take reasonable action to recoup any overpayments to Providers of covered service.
- CTIA will maintain Received Claim records for a minimum period of seven years and in accordance with state and federal law, and on-line claim payment history for no less than two years. Claim records will be maintained in accordance with prudent standards of insurance record keeping.

- Maintain capabilities to receive and transmit claims in electronic formats to and from Providers, Claim Clearinghouses and other vendors in formats specified by HIPAA and HITECH regulations.

Customer Service:

- CTIA will conduct such correspondence with Participants, Providers of covered services, and others as is necessary for the day-to-day administration of the Plan.
- CTIA will provide toll-free phone service numbers for Participants and Providers at all times during CTIA's usual and customary hours of operation
- CTIA will, upon written request of a Participant, Provider or the Project, review any previously denied claim in accordance with the Claims Appeal procedure set forth by the Program.
- CTIA will refer to the Program for consideration and final decision any questionable claim(s) with a written analysis of the issues to assist the Program in reaching a final decision.

Financial Services:

- With the aid of Project, establish a "Claim Fund Account", in the name of CTIA, as TPA for Program. (Interest earned on this account, if any, will accrue to the Program. Banking expenses incurred on this account will be borne by the Program.)
- CTIA will pay Providers from the Claim Fund Account, after CTIA verification and approval.
- CTIA will provide the Project with quarterly financial reports on the Plan, and other Reports as mutually agreed.
- CTIA will maintain records clearly showing the deposits and withdrawals from the Claim Fund Account. Copies of these records will be provided to the Project upon their request.
- CTIA will maintain all books and records for a minimum period of seven years and in accordance with state and federal law, and on-line claim payment history for no less than two years. Books and records will be maintained in accordance with prudent standards of insurance record keeping.
- The Program will retain ownership of the Claim Fund Account, with CTIA being an authorized signatory for purposes of carrying out payments as specified by the Project.
- CTIA will produce checks once each week drawn on the Claim Fund Account to Providers as specified by the Project.
- The Claim Fund Account bank statements will be sent to the Program for reconciliation. CTIA will provide a Claim Fund Account check register to

Program on a monthly basis. CTIA will maintain a complete record of all Claim Fund Account transactions for review by the Program if and when desired.

Reporting:

- CTIA will provide to Program the reports as mutually agreed. Claims data extracts will be provided at no cost to the Program.
- CTIA will assign an Account Manager who will manage Project's account, serve as the primary contact for Program and supervise the responsibilities of CTIA.
- CTIA will prepare and submit to Providers of Service and the Internal Revenue Service form 1099-MISC for claim payments made in conjunction with the Project.

Other Service and Obligations:

- CTIA will provide Project access to data as appropriate and reasonable for the purpose of auditing Administrative Services. CTIA will provide data necessary to conduct audits on electronic media (diskettes, tapes, etc.) at no additional charge to Project. The Project will have the right to select an independent audit firm to perform audits during the term of this agreement. Program must give forty-five (45) days advance written notice to CTIA to schedule an audit.
- CTIA will run back-up data of Program's data each day. Back-up data in electronic media will be stored in an off-site location, which is secure and environmentally suited for the storage of magnetic media.
- CTIA will maintain a fidelity bond in the amount as required by the State of Iowa covering CTIA and any of its agents or employees who may collect, disburse or otherwise handle or have possession of any funds of the Project or who may have authority to authorize or order disbursements of claims or other expenses on behalf of the Program.
- CTIA will maintain coverage for Errors and Omissions in the amount of no less than one million dollars ($1,000,000).
- CTIA will maintain a log of all complaints received from state insurance departments and attorneys representing Participants or Providers.

Consulting Services

Provider Negotiations:

- Providers CTIA will assist Project in selecting Providers.
- Provider Fees. CTIA will negotiate Provider fees on behalf of the Project.

- Laboratory Services. If Doctors and Clinics are not able to arrange for reasonably priced Plan laboratory services, CTIA will facilitate the Plan's engagement of a laboratory for this purpose.

Communications:

- CTIA will prepare communication materials, such as Plan change notices, benefit booklets, Newsletters, and other Participant communications. Use of the Program logos on communication materials and correspondence with participants to be in conformance with established standards of the Project.
- CTIA will obtain approval of Project and Providers for communication materials to include identification and relationships of CTIA, Project, and Providers.

Consulting:

- CTIA will assist Project in obtaining actuarial opinions relating to Plan design and fee schedules as necessary.
- CTIA will prepare and recommend claim administration procedures and practices for the administration of the Project and consult with Project on any changes thereto.
- Upon request of the Project, CTIA will provide Plan consulting and analytical services.

Optional Services:

- CTIA will assist Project in developing an automated letter writing system to **remind Participants of their need to schedule their tests**. The system is envisioned by CTIA to send a series of reminders and to ask participants to reschedule when they have missed their appointments.
- CTIA will collect all test results and maintain them in a **Central Repository for Test Results**. The Clinical Research Facility will have access to this data but the source data will be securely maintained by CTIA on behalf of the Project.

We thank you for the opportunity to compete for your business, and we pledge our professional staff, technical resources, and dedicated work ethic to help you meet your specialized requirements.

CTI Administrators, Inc.
March 31, 2011

Qualifications of Principals & Staff Members

Qualifications of Principals and Staff Members

Resumes of Key Staff can be found in the section "Other Supporting Materials".

Our response to the Proposal questionnaire/ Information Request section IV. e. Account Service highlights the qualifications of CTIA's principals and key staff. Following is a table from that section highlighting the experience of the staff recommended for this program:

CTIA Key Staff Summary of Experience

	Primary Role	Years Related Experience	Years with CTI Companies	Advanced Education / Industry Certifications	Benefit Consulting	Communications	Enrollment	Web Design & Maintenance	Auditing/Quality Assurance	Claims/Customer Service	Accounting Financial Controls	Number of Current Clients Served
Donald Brandt	Senior Mgmt., Provider Negotiations	37	21	●	●		●	●		●		5
Patricia Gagne	Account Manager	27	21	●	●			●	●			14
Daniel Montgomery	Acct Mgr. Contracts & Privacy Officer	25	4	●	●			●	●			5
David Bade	Claims, Customer Service	19	18	●				●	●			5
Jon White	Claims, Customer Service, Training	17	1	●				●	●			2
Donna Weber	Claims, Customer Service	30	2	●					●			2
Kelly Barnett	QA Audits, Training	20	5	●				●	●			6
Diane Wright	IT Manager, EDI	19	14	●	●	●	●	●				18
Judy Lucas	IT Support, QA Audits, Training	28	13	●		●	●	●	●			18
Rob Rater	Senior Management Accounting, Checks, 1099s	13	9	●				●			●	18
Randall Brandt	Senior Mgmt., Communications, Claim Support	9	10	●	●	●	●					9
Lynn Cozad	Manager Enrollment & Claim Support	15	9	●		●			●			9

Proposed Strategy
For Medical Monitoring
Administration

Proposed Strategy for Medical Monitoring Administration

CTIA's strategy for Medical Monitoring Administration is determined by consideration of the Program's strengths, weaknesses, opportunities, and threats.

The Strategic goals of the Program are to determine the impact of being exposed to lead, zinc, arsenic, and cadmium for persons living in and near to Spelter West Virginia.

The method (strategy) for achieving this goal is essentially the Project itself. CTIA's role in the project is critical because the Administrator is the link between Program Management, Participants, Providers, and the Clinical Research Team.

We have no concerns as to the capabilities of CTIA to deliver exceptional service in regards to the traditional claim paying and customer service of a TPA. We also believe that Provider Negotiations will not be difficult due to the limited number of test procedures recommended.

We further understand that Claim Payments are not the goal of the program; they are the means to getting test results for subsequent use by the Clinical Research team.

We understand that we must be Flexible and Responsive to the Projects needs as they will undoubtedly change over the next 30 years.

We understand that we must be Empathetic with the Program's Participants;

We believe the major **weakness/ threat** to the program is "how to get the participants to continue the recommended tests over the 30 year span of this project". Communications are the key to getting Participants to take their recommended tests. These are the action plans that will make the long term difference to the success of the Program. We have the personnel, the skills, the systems and the desire to make the Program a success.

Questionnaire
Response

Questionnaire Response/ Information Production

Company Information

Provider Experience Information

Medical Monitoring Experience

Account Service

Reporting Capabilities

Data and Systems

Medical Monitoring Plan Design and Implementation

Financial Proposal

Miscellaneous

[redacted]

Company
Information

[redacted]

Company Information

b.i. *Provide the complete name, address and federal tax identification number of the organization with whom the proposed third party administrator contract would be written. Indicate how many years the organization has been providing third party medical claims administration services.*

Response
CTI Administrators, Inc.
100 Court Avenue Suite 306
Des Moines, IA 50309

Tax ID: 42-1411305

Providing Claim Administration Services for 18 years.

b.ii. *Please provide the name of the primary contact for your organization that will be readily available to answer questions on the proposal, as well as his/her title, address email address, telephone and cell phone numbers, and fax numbers.*

Response
Donald Brandt
President
CTI Administrators, Inc.
100 Court Avenue Suite 306
Des Moines IA 50309

Telephone: (515) 244-7322
Cell Phone (515) 360-3491
Facsimile: (515) 244-8650
E-Mail: dbrandt@claimtechnologies.com

b.iii. *Explain the organization's ownership structure, listing all legal entities and their relationship within the structure.*

Response
CTI Administrators, Inc. (CTIA) and Claim Technologies Incorporated (CTI) are S Corporations incorporated in the State of Iowa. Both companies are wholly owned by CTI Holdings, also an S corporation formed in the State of Iowa. Owners of both corporations are Donald R. Brandt, Russell W. Calkins, III, and Patricia C. Gagne.

CTIA is the majority owner of Hot Claims, LLC, an electronic clearing house for medical and dental claims.

b.iv. *Describe recent (within the last 36 months) or planned changes in your organization, such as mergers, stock issues, acquisitions, spin-offs, etc..*

Response
CTI Holdings was formed in December 2009.

b.v. *Please provide an annual report for the past two years. If you do not provide an annual report specific to the TPA service business, please provide a balance sheet and income statement for the same period specific to the TPA business, and also include a synopsis of your company's history including length of time in the TPA business.*

Response
Audited annual reports for calendar years 2009 and 2010 are included in the "Other Supporting Material" section of this proposal.

CTIA has focused its practice for the past 20 years on meeting unique and/or specialized claims administration needs. We bring proven expertise and a team of specialized professionals to the challenges of meeting our clients claims administration and adjudication needs and quality standards.

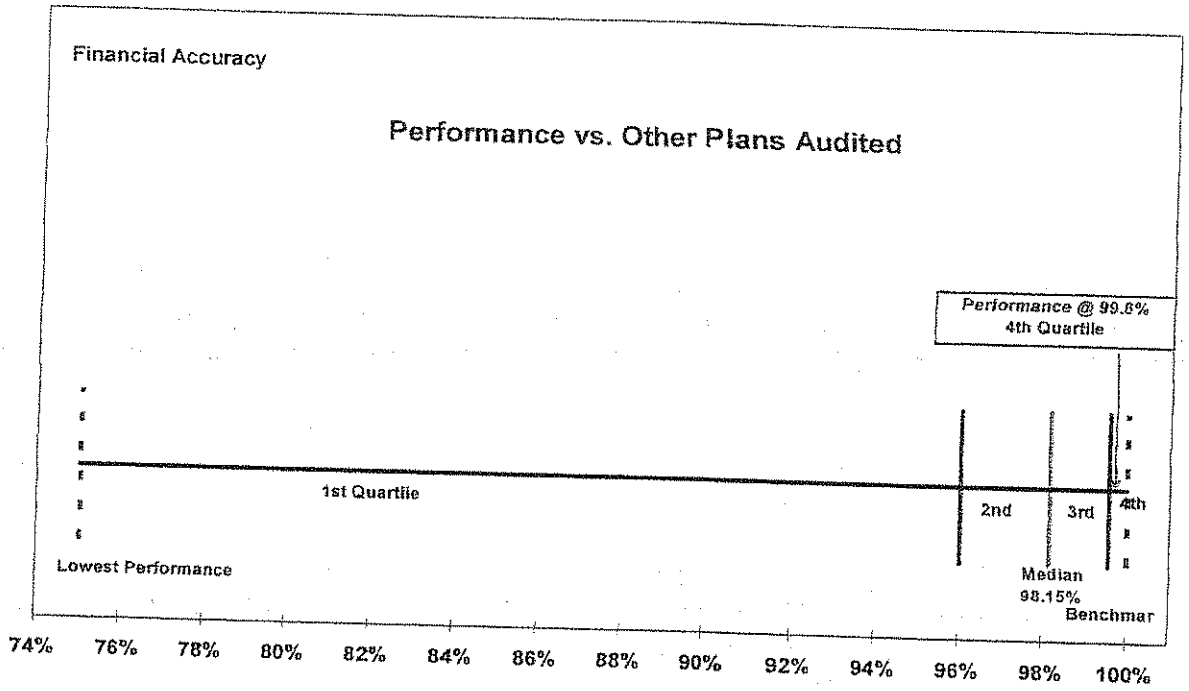
Based in Des Moines, Iowa, CTIA has state-of-the-art claim processing hardware, software systems, and experienced adjudicators for the review of claims. These resources currently handle large volumes of claims and are readily expandable to accommodate the requirements of the Spelter Medical Monitoring Program. We also have the capabilities to develop and deliver direct mailings for the claimants in the Program in a cost effective and timely manner.

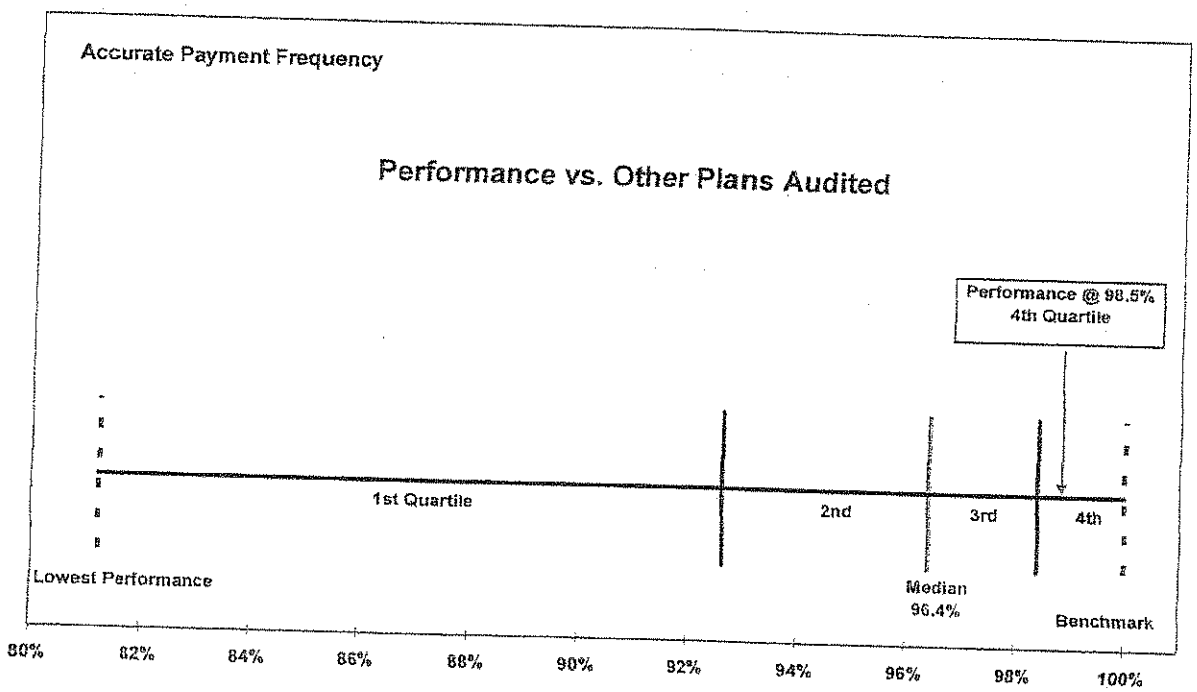
Our sister company, CTI provides claims administration auditing and consulting services for over 200 large employers across the U.S. and will provide audit and control services required. CTI clients include corporations such as BAE Systems Inc., Ingersoll Rand, Land O' Lakes, NEC Corporation; and numerous governmental entities including the States of Iowa, Kansas, Mississippi, Ohio, Vermont, and Wisconsin.

b.vi. *Please demonstrate and report on your organizations performance as a TPA against other competitors in the TPA service business.*

Response
Comparisons against other TPAs are an almost impossible task since there are few, if any, common metrics being monitored. The best response we can provide is to compare CTIA's internal audit results against the audit results of the 100 most recent audits performed by our sister company CTI.

The chart below shows the results of our internal audits against the results of the 100 most recent audits performed by the nations largest TPAs and insurance companies.





b.vii. *Are there any restrictions or pending reviews by state or federal authorities for non-compliance with state or federal regulations?* .

Response
No

b.viii. *Are there any legal, administrative, and/or regulatory investigations and/or inquiries currently pending?*

Response
No

b.ix. *Have there been any legal, administrative, and/or regulatory investigations and/or inquiries within the past 36 months?*

Response
No

b.x. *Please disclose any potential conflicts of interest in serving as the TPA for this project, including, but not limited to, any personal, business, and/or professional relationships with DuPont or any of its affiliates, Plaintiff's' Counsel, Defense Counsel, and/or the Special Master, including, but not limited to. Edgar C. Gentle, III, Esq.....Lightfoot Franklin & White, Alabama.*

Response
Since 2007, CTIA. has served as the third party administrator of the Tolbert Healthcare Project, pursuant to a Final Judgment and Order entered September 9, 2003 in *Tolbert, et al. v. Monsanto Company, et al. and Oliver, et al. v. Monsanto Company, et al.*, Civil Action Nos. 2:01-cv-1407-UWC and 2:02-cv-0836-UWC, in the United States District Court for the Northern District of Alabama, Southern Division. Mr. Edgar C. Gentle III serves as Claims Administrator for the Tolbert Healthcare Project. His associate, Ms. Diandra S. Debrosse, also assists in management of the Tolbert Healthcare Project. Various employees of CTIA make regular reports to Mr. Gentle and Ms. Debrosse regarding claims paid by and medical services used by participants in the Tolbert Healthcare Project.

CTIA is wholly owned by CTI Holdings, Inc., which also wholly owns Claim Technologies Incorporated CTI, a health plan claims administration auditing and consulting firm. Since 1994 CTI has provided claims audit services to E.I. du Pont de Nemours and Company and expects it will continue to do so. Direct communication between CTI and DuPont is limited respectively to audit staff and the managers who oversee the third party claims administrators of DuPont's employee health plans.

CTIA has performed preliminary analysis related to the Spelter medical monitoring project on behalf of Virginia Buchanan, Shareholder in the Levin, Papantonio law firm in Pensacola, Florida. No contract for ongoing services resulted from this engagement for limited services.

b.xi. *Is your organization HIPAA compliant?*

Response
Yes

b.xii. *Please provide proof of General Liability and Professional Liability coverage. The program is to be held harmless and fully indemnified in the event of any action arising out of the operation of the program by vendors or providers*

Response
A Certificate of Insurance can be found in the section "Other Supporting Material".

Provider Experience Information

Provider Experience Information

c.i. *Have you ever administered a plan focused solely on medical testing? If so please describe in detail.*

Response
No However, medical testing is a common provision in most employer based medical plans.

c.ii. *Is your primary medical care/ primary medical testing network nationwide? If not, who do you use for a secondary network and how are they reimbursed?*

Response
We use both LabCorp and Lab One for our clients otherwise we use the lab services provided by various clinics and provider offices.

c.iii. *If available, please provide a primary care medical provider/ primary care medical testing network directory for Harrison County, West Virginia.*

Response
We do not have a network in Harrison County. We do not believe a network is necessary for this project.

c.iv. *How do you monitor physician/ screening compliance with contract standards and protocols of care? What procedures will you follow to review a provider's standard of care?*

Response
CTIA relies on its selected PPO Networks to monitor their providers. We choose a PPO Network that will best serve the client from the perspective of access, cost and quality of care. However, our understanding of this program suggests that direct contraction with local providers and laboratories is a more cost effective and user friendly approach.

c.v. *Do you currently contract with any national laboratories on behalf of your clients for primary medical care or testing? If so, which?*

Response
Yes, we have direct contracts with LabCorp and contracts with Lab One through some of the PPO Networks that we use.

c.vi. *Have you ever performed client-specific contracting to establish specific rate levels for primary medical care or testing for a primary care client in Harrison County, West Virginia? If so, please describe*

Response
No

c.vii. *Have you ever performed client-specific contracting to establish specific rate levels for one client in Harrison County, West Virginia? If so, please describe*

Response
No

c.vii. *What type of plan material will be provided to registered claimants to guide them in using the primary medical care or testing network providers? Please provide an example, if available.*

Response
There are five methods of directing claimants to the primary care or testing network providers:

1. Plastic ID cards. See example in the section "Other Supporting Materials".
2. Schedule of Benefits. See example in the section "Other Supporting Materials".
3. Newsletters See example in the section "Other Supporting Materials".
4. On-line Coverage Verification. See example in the section "Other Supporting Materials".
5. Toll Free Customer Service

c.ix. *Please review your credentialing process for various primary medical care or testing providers. Do your credentialing requirements meet National Committee for Quality assurance (NCQA) standards? Do you make primary medical care or testing provider on-site visits? How often are credentialed primary medical providers reviewed?*

Response
CTIA relies on its selected PPO Networks to credential and review their providers. We choose a PPO Network that will best serve the client from the perspective of access, cost and quality of care. The PPO Networks we use are NCQA compliant. As stated previously, our understanding of this program suggests that direct contracting with local providers and laboratories are a more cost effective and claimant friendly approach.

c.ix. *What is your process for complaints on care or service issues?*

Response
First, we recommend that all complaints or appeals be submitted in writing so we have an accurate understanding of the issues. If the complaint is received via our toll free telephone service, we will note the complaint as accurately as possible but still ask the claimant to submit the complaint in writing.

All complaint are registered in our complaint log and submitted to the vice president of claims and account executive for review and follow-up.

We will try to resolve all complaints that are payment related or a result of inadequate customer service response.

All complaints will be forwarded to the Special Master/Claim Administrator along with an explanation as to its resolution or with a recommendation for resolution.

Experience

Medical Monitoring Experience Information

d.i. *Have you ever been part of a medical monitoring program?*

Response
No

d.ii. *Have you ever provided administrative services with regard to the large scale screening of a population or plan for zinc, arsenic, cadmium, or other metal or chemicals*

Response
The only experience related to chemicals for a large population is with the Tolbert HealthCare Plan. CTIA provides administrative services for the Tolbert HealthCare Plan. Services include Direct Contracting with Providers, EDI interface for claim submission, Customer Service, Claim Adjudication, Accounting, Reporting, Consulting, and Communications (direct mail & newsletters).

d.iii. *Have you ever worked with a university regarding screening of a population?*

Response
No,

d.iv. *If you have answered yes to either question IV(d)(i), IV(d)(ii), or IV(d)(iii) above, please provide a detailed explanation*

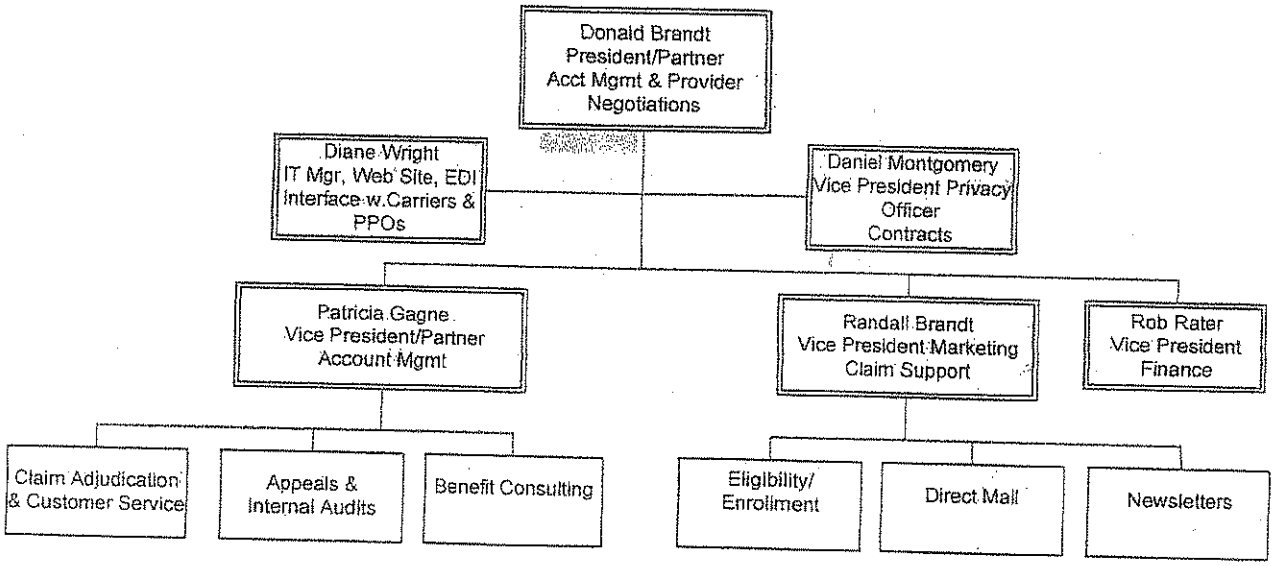
Response
N/A

Account Service

e.i. *Provide an organizational chart for the account service team proposed for this project with name, title, responsibility, and office location of each service team member. At a minimum, the proposed account team should consist of an Account Manager who is responsible for daily account issues.*

Response

All employees expected to service the program are located in Des Moines Iowa.



e.ii. *Supply the name and the following information for each member of the proposed account service team: education, experience, years with company, years in current position, and number of current clients.*

Response

Following is a table highlighting the experience of the staff recommended for this program:

CTIA Key Staff Summary of Experience

	Primary Role	Years Related Experience	Years with CTI Companies	Advanced Education / Industry Certifications	Benefit Consulting Communications	Enrollment	Web Design & Maintenance	Auditing/Quality Assurance	Claims/Customer Service	Accounting Financial Controls	Number of Current Clients Served
Donald Brandt	Senior Mgmt., Provider Negotiations	37	21	●	●		●	●		●	5
Patricia Gagne	Account Manager	27	21	●	●			●	●		14
Daniel Montgomery	Acct Mgr. Contracts & Privacy Officer	25	4	●	●			●	●		5
David Bade	Claims, Customer Service	19	18	●				●	●		5
Jon White	Claims, Customer Service, Training	17	1	●				●	●		2
Donna Weber	Claims, Customer Service	30	2	●					●		2
Kelly Barnett	QA Audits, Training	20	5	●				●	●		6
Diane Wright	IT Manager, EDI	19	14	●	●	●	●	●			18
Judy Lucas	IT Support, QA Audits, Training	28	13	●		●	●	●	●		18
Rob Rater	Senior Management Accounting, Checks, 1099s	13	9	●				●		●	18
Randall Brandt	Senior Mgmt., Communications, Claim Support	9	10	●	●	●	●				9
Lynn Cozad	Manager Enrollment & Claim Support	15	9	●		●			●		9

For additional detail please refer to the resumes in the section "Other Supporting Materials".

e.iii. *Identify which team member is responsible for day-to-day account issues and communications with the Special Master and staff. Please confirm that this person will respond to all account inquiries from the Special Master and/or his staff within one (1) business day. If this individual is unavailable to respond, please describe the process for escalating or delegating this responsibility to another account team member.*

Response

Patricia Gagne will be the designated Account Manager and responsible for day-to day claim, and customer service related issues.

Lynn Cozad will be the day-to-day person to contact for eligibility/enrollment issues. Both Ms. Gagne and Ms. Cozad will respond to all inquiries from the Special Master

and/or his staff within one (1) business day. If these individuals are unavailable to respond, either Randy Brandt or Dan Montgomery will take the inquiry and respond appropriately.

e.iv. *Please indicate the percentage of time that the assigned Account Manager will be dedicated to working with this project. Is your organization willing to guarantee this percentage?*

Response
Patricia Gagne will dedicate as much time as is required to service this program. We understand that the implementation phase of this program will be the most critical and will require that Ms. Gagne dedicate as much time as necessary to keep the program on schedule. We cannot guarantee a percentage of her time to be dedicated to this project other than to state that she will dedicate as much time as is necessary to satisfy the claimants, providers, and the Special Master.

e.v. *Confirm your willingness to meet with management and/or staff from this project quarterly and annually to review plan performance and utilization trends.*

Response
Yes, we are willing to meet with management and/or staff from this project quarterly and annually to review plan performance and utilization trends.

e.v. *Using the table below, provide at least three (3) references of current accounts with over 4,000 members that are similar to this project in demographics...*

Response

Client Name	Location	Length of Relationship	Number of Covered Lives	Contact Name, Title, and Phone
Boys & Girls Clubs Workers Association	Nationwide	31 years	8,800	Ron Rolett, Chair (979) 822-7516
Western Illinois University	Macomb Illinois	2 years	5,200	Mary Margaret Harris, M.S. Director (309) 298-1888 x222
Tolbert HealthCare Plan	Northeast Alabama	4 years	6,601	Diandra Debrosse, Esq. (205) 716-3000

Eligibility and Service

f.i. *Please describe how your organization maintains eligibility data.*

Response
Eligibility data is maintained as an integral part of our claim paying system. This means that we cannot process a claim if there is not a corresponding eligibility record for the claimant. We have the capability for online enrollment but don't think that it would be advantageous for this project.

All mail communications sent to claimants will utilize the "Address service requested" option provided through the postal service. This allows us to collect updated addresses from the post office and keep the eligibility records as current as possible.

f.ii. *Please indicate which personnel shall be responsible for the maintenance of eligibility data for the project.*

Response
Loading and maintaining eligibility data is segregated from Claim adjudication. This ensures that Claim Adjudicators cannot add or modify eligibility records or override the system edits regarding eligibility information. Only persons in the eligibility department with the appropriate permissions (system passwords) are allowed to add or change eligibility records.

f.iii. *Please describe your organization's ability to provide a toll-free telephone number during regular business hours (8:00 AM to 5:00PM EST) providing the following services:*

a. Answer questions concerning member's eligibility and Plan benefits;
b. Research questions;
c. Monitor complaints; and
d. Answer written correspondence regarding any of the issues necessary.

Response
We will provide toll free customer service from 8:00 AM to 5:00 PM on regular business days. We will also provide 24/7 online verification of eligibility for providers for circumstances when the claimants do not have their Plan ID cards. Please see the Online Verification of Coverage form in the "Other Supporting Material" section of this proposal.

Reporting Capabilities

g.i. *Please describe your organization's ability to report monthly and/or quarterly on claims volume, turnaround, accuracy by entity, and by demographic profile.*

Response
We prefer to provide management reports using charts and graphs as much as possible. We also prefer to provide reports using Power Point. Most importantly, we believe that the client should be satisfied with the thoroughness and timeliness of the reports. We will work with the Special Master to provide the reports necessary to manage the project. We can access all of the data maintained in our system. We are skilled at using the report generators provided with our claim system as well as through the use of Microsoft Access and/or SQL.

g.ii. *Please describe your organization's ability to report on utilization by service, by diagnosis and by demographic profiles.*

Response
We can report on utilization by service, by diagnosis, and by demographic profiles. Also see response to question g.i. above.

g.iii. *Please describe your organization's ability to report on Third Party Claims activity, including Medicare, Medicaid, and other Third Party insurers (if applicable in this context-which has yet to be determined).*

Response
We can report on coordination with Third Party insurers.

g.iv. *Please describe your ability to track claim payment errors, corrections and recovery of errors.*

Response
When necessary, we can track claim payment errors until they are recovered. We have system generated letters that are used to pursue recovery. All outstanding overpayments are managed and monitored through our claim paying system.

g.v. *Please describe your ability to track and report timely on large claims activity and case management status.*

Response

CTIA's claim processing system provides for tracking and timely reporting on large claims activity and case management status. However, we don't expect large claims or the need for case management on this project.

g.vi. *Please describe your ability to report on grievances/ appeals and appeals status and turnaround performance.*

Response
CTIA's standard appeals process follows the Department of Labor Guidelines for ERISA plans. However, we expect very few, if any, appeals on the medical tests performed since we assume that there will be no co-payments, deductibles, or coinsurance. Additionally, we expect that all providers will not be allowed to bill the claimants and will abide by direct contracted fee schedules.

Our system records the date the claims are received in our office as well as all significant events during the processing cycle. Claim turnaround reports can be provided in minute detail or simply from the date received until the check is issued to the provider.

g.vii. *Please describe your ability to prepare an annual report of payments.*

Response
We can prepare claim payment reports for any time period requested.
See response to question g.i. above.

g.viii. *Please provide a sample copy of the reports you prepare for clients.*

Response
As mentioned before, we prefer to provide management reports using charts and graphs as much as possible. We also prefer to provide reports using Power Point. We can access all of the data maintained in our system. We are skilled at using the report generators provided with our claim system as well as through the use of Microsoft Access and/or SQL. We also can provide data extracts in excel.
Please see Sample Quarterly Reports in the "Other Supporting Material" section of this proposal.

g.ix. *Please describe your ability to provide a Plan Cash Flow Report on a Quarterly Basis.*

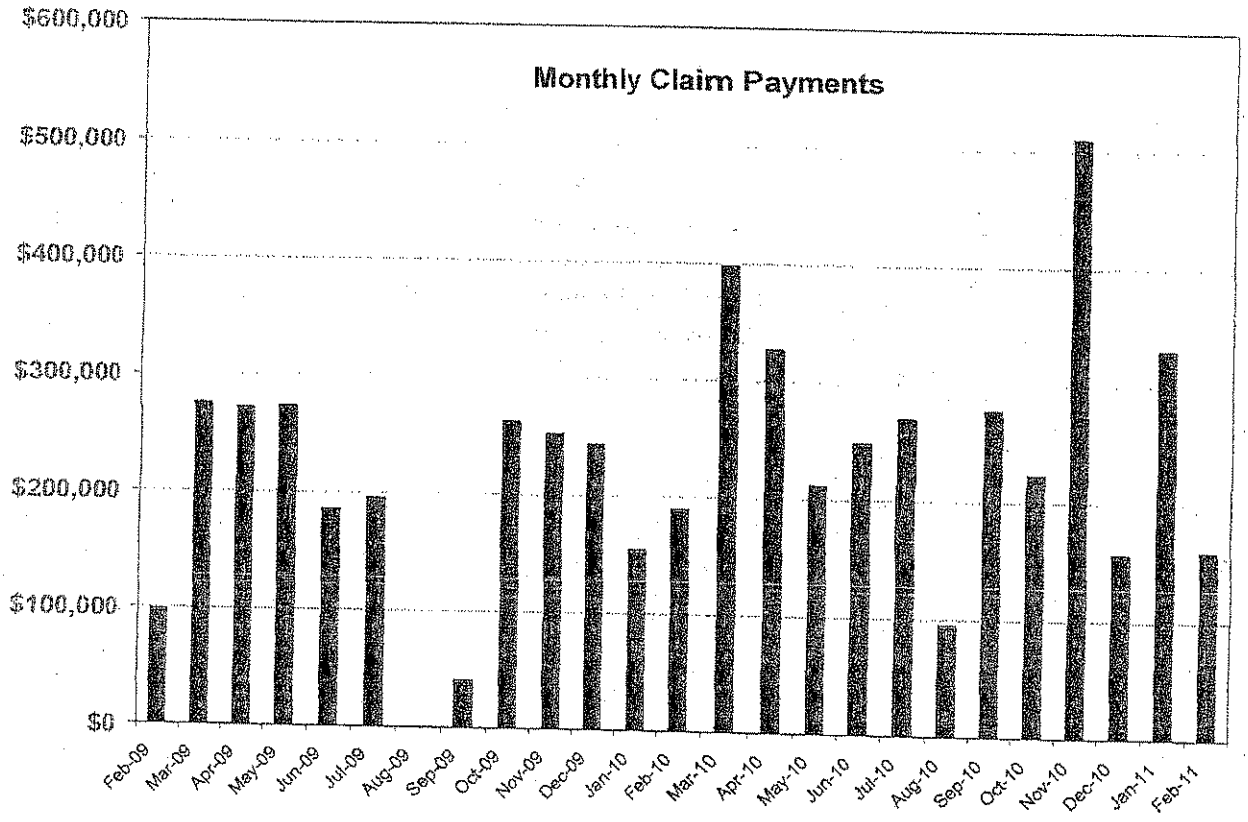
Response

The following report is an example of a Quarterly Cash Flow Report we prepare for another client:

SELF-FUNDED MEDICAL PLAN FINANCIAL SUMMARY August 1, 2009 - January 31, 2011		
	PLAN YEAR 8/1/09 7/31/2010	PLAN YEAR 8/1/2010 1/31/2011
I. GROSS PREMIUM		
A. Premium Received ($329.64 per enrollee)	$3,764,035	$2,011,114
B $125,000 Specific Stop Loss Premiums	($196,000)	($115,200)
C. MEDEX Evacuation & Repatriation Premiums	($19,800)	($9,900)
Net Premium	**$3,548,235**	**$1,886,014**
II. ADMINISTRATION EXPENSE		
A. CTIA Administration	($120,000)	($74,000)
Consulting	($7,200)	($6,500)
B. Plan Operating Expense	($414,800)	($207,400)
Total Administrative Expenses	**($542,000)**	**($287,900)**
% Net Premium Available for Claims	84.7%	84.7%
III. CLAIM EXPENSE		
A. Paid Claims	($2,602,964)	($1,488,252)
B. Reinsurance ($38,262 is pending reimbursement)	$135,466	$38,262
C. Large Claim Reserve subsidy (one claim over $100,000)		$25,000
D. PPO Network Fees (Health Link)	($127,030)	($44,693)
E. PPO Network Fees (GlobalCare)	($5,915)	$0
F. Case Mgmt.-Hines & Other Vendors	$0	$0
G. Bank Related Expenses	($955)	($403)
H. Incurred But Not Paid (IBNP):		
Beginning IBNP	$0	$400,000
Ending IBNP (per FSA recommendation)	$400,000	$440,000
Change to IBNP	($400,000)	($40,000)
Total Claim Expenses	($3,001,398)	($1,510,086)
IV. SURPLUS (deficit)	**$4,837**	**$88,028**

g.x. *Please describe your ability to provide a Paid Claims report for Screening Paid Claims on a Quarterly Basis.*

Response
The following report is an example of a Paid Claim Report.



Data and Systems

h.i. *Please describe the manner in which your organization assures claim payments.*

Response
CTIA uses a licensed state-of-the-art paperless claim system interfaces eligibility records, provider records, claim payments, correspondence, and management reporting of claims in process. The system also provides security protocols that restrict access to protected health information. Security protocols allow us to permit access by users to various components of our system based upon individual need.

We will supplement this system with an image management system that we will use as the **Central Repository** for all the test results. The image managements system will allow CTIA to maintain all the test results in one central location. More important than assuring claim payments is the collection of the test results. We will hold payments to providers until the test results have been forwarded to the **Central Repository**. We will develop automated letters to remind providers that they must provide test results before they will be paid.

h.ii. *Please describe the electronic methods of primary medical care or testing claims filing and adjudication including telecommunications and/or web applications.*

Response
CTIA can receive claims in paper format and in electronic format. We, of course, prefer to receive claims in an electronic format. To facilitate the receipt of electronic claims, we have contracted with Emdeon to act as a clearinghouse. Emdeon is the largest claim clearinghouse and will interface with most provider practice management systems.

We also have our own clearinghouse that we use for providers that have non-standard or proprietary practice management systems and prefer to send electronic claims directly to CTIA.

Lastly, we have a solution for very small provider offices where they have no practice management systems for routing electronic claims. We call our system "Hot Claims". Hot Claims is a web based data entry system for recording claims in the CMS 1500 format and routing them to CTIA.

We will work with providers to convert to electronic submissions on a continuous basis. There is no charge to providers for using any of the three methods we offer.

h.iii. *Please describe the manner in which network primary medical care or testing providers have access to your organizations systems.*

Response

We can provide access to our system by outside users but have chosen to restrict access by providers. CTIA does not believe that there is any reason that warrants the need for providers to access our systems. We have toll free customer service and 24/7 online verification of coverage. Claims are routinely paid in less than one week so we don't believe there is a demonstrated need by providers to access our system. We are very concerned about the security of the data we maintain and limit access to our system as much as possible.

We further recommend that we download test results to the selected research team on a weekly basis. Data will be transferred in an encrypted format.

h.iv. *Are network primary medical care or testing providers trained in the usage of your organization's systems. .*

Response
The only interface to our system is through the electronic submissions of claims. If the providers currently use Emdeon, which most do, no training is required. If they choose to use our proprietary clearinghouse, there is little training required since we use standard HIPAA data formats. For very small provider offices, where they have no capability for routing electronic claims we will set them up on Hot Claims. Again, little training is necessary since this is a web based data entry system for recording claims in the mandated CMS 1500 format.

h.v. *Explain your internet capabilities for providing reports to the Project and primary medical care or testing providers. .*

Response
Please see response to h.iii. above.

[redacted]

Medical Monitoring
Plan Design
Implementation

[redacted]

Medical Monitoring Plan Design and Implementation

i.i. *Currently, the project anticipates.....in this RFP and the attached exhibits, please provide an overview of the method your organization would develop a medical monitoring plan design.*

Response
CTIA suggestion for the overall design of the medical monitoring plan can best be described by phases.

Phase 1 Analysis of Enrollment Forms
By analyzing the enrollment applications we will be able to determine the providers currently being used by the claimants. We will then have to determine which providers would best serve the claimants. From there, we should be able to put together a list of providers that should be contacted to see if they would participate in the project.

Phase 2 Direct Contracting with Providers
Fee schedules will be developed for the recommended blood, urine and CT Scans. Providers would be contacted and contracts approved. Providers would include LabCorp which appears to be the best choice for laboratory services.

Phase 3 Setting-up EDI Claim Submissions from Providers
CTIA will work with the contracted providers to determine the best method for submitting claims and test results if they perform their own laboratory services.

Phase 4 Contracting with Clinical Research Facility
The project will need a clinical research facility to analyze the test results of the claimants. We believe that the University of West Virginia Hospital is the leading candidate for this job.

Phase 5 Loading the Eligible Claimants into the Claim System
The claimants must be loaded into the claim system.

Phase 6 Scheduling the Initial Battery of Tests
We suggest scheduling the initial battery of tests over a six month period. This will smooth the implementation process and smooth the testing schedules for the remaining years. We will contact all the claimants explaining the scheduling as well as **issuing plastic ID cards** that can be presented to the contracted providers.

Phase 7 Reminding Claimants of their Test Schedules
CTIA suggests contacting the claimants two months in advance of their scheduled test, again at one month, and again, one month after their scheduled test if the test wasn't performed. CTIA will perform this scheduling task using the system eligibility files and system generated letters.

Phase 8 Testing Begins

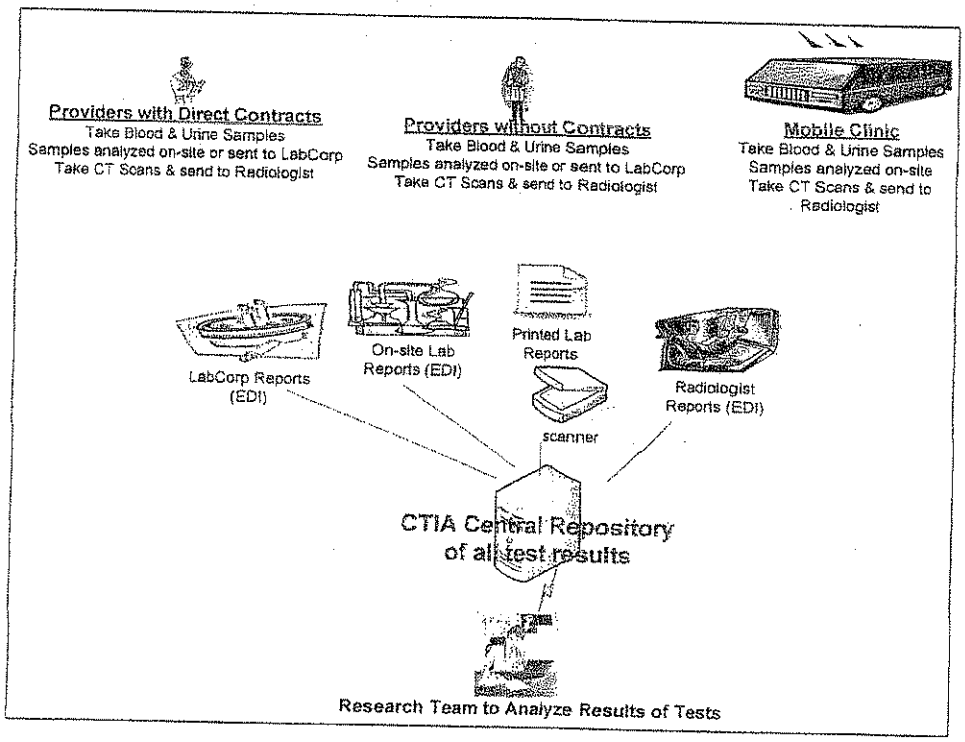
Providers will start the testing program and submit claims to CTIA for reimbursement.

Phase 9 Claim Processing
Claims will be submitted from the providers. We expect that there will be 10 – 20 contracted providers including a mobile clinic that can perform CT Scans. We also expect to receive a few claims from providers that have not contracted with the project. Before claims are paid to the providers, the claim adjudicators will check to see if the Test Results have been received. If not, a "payment pending" letter will be sent to the provider encouraging them to submit the test results.

Phase 10 Collection of Test Results
We expect the providers to take the blood and urine samples consistent with the tests recommended by Dr. Werntz. The blood and urine samples can be evaluated by a laboratory at the physician's office or by sending the samples to LabCorp. The results of the tests will be forwarded to CTIA where they will be entered into the **Central Repository for Test Results.**

We expect the providers to take CT Scans consistent with the tests recommended by Dr. Werntz. CT scans will be sent to a radiologist for evaluation. The evaluation of the CT Scan will be forwarded to CTIA from the radiologist where they will be entered into the **Central Repository for Test Results.**

Phase 11 Downloading Test Results to Clinical Researchers
CTIA will download the test results to the selected clinical research facility via encrypted transmission. We will work with the clinical research facility to determine the appropriate schedule for downloads. See the overview for collecting test results below:



i.ii. *Please describe your organizations experience with directly contracted or sub-leased primary care or testing provider networks. Provide examples and details.*

Response
CTIA has not directly contracted with any "provider networks". However, CTIA has negotiated direct contracts with several clinics in Northeast Alabama including a medical and dental clinic, pediatric clinic, and an orthodontist. Fees are scheduled and reviewed annually. Fee schedules are developed using Medicare, Medicaid, & various PPO Network fees for the geographic area. We believe these schedules have significantly reduced our clients claim costs and are accepted as fair reimbursements by the providers.

CTIA does not believe that the use of traditional "provider networks" is a cost effective for this program. We recommend direct contracting with individual providers and/or clinics.

i.iii. *Please provide the contact information for two of the directly contracted primary medical care or testing provider network and/or sub-leased provider network.*

Response
LabCorp, no others.

i.iv. *Please describe your organization's experience with developing a custom network. Please provide examples and details.*

Response
Please see response to question i.ii. above.

i.v. *Does your organization have a primary health care provider network established in Harrison County, West Virginia?*

Response
No.

i.vi. *Utilizing the information referenced above, the overview of the project, and your Organization's expertise, please indicate which model would be best for the project.*

Response
With the exception of LabCorp, CTIA does not believe that the use of traditional "provider networks" is a cost effective for this program. We recommend direct contracting with individual providers and/or clinics.

Financial Proposal

j.i. *Fee Pricing Schedule*

Response

Fee Pricing Schedule				
Description	Units	Fees		
		Year 1	Year 2	Year 3
Initial Fee to set-up CTIA Systems due at signing of Administration Agreement	Per Year	$6,500	$0	$0
Provider Negotiations of Fee Schedules Determine Fee Schedules Negotiate Contracts Set-up EDI Interface	Per Hour	Hourly Fees Travel, Lodging & Out-of-Pocket Expenses		
Communication Materials as coordinated with and authorized by the Special Master, including but not limited to: Letters and Envelopes Schedule of Benefits Newsletters Email Notifications		Design & materials cost + 10% surcharge Mail house charges + 10% surcharge Postage at actual cost Actual cost + 10%		
Production and Distribution of Plastic ID Cards	Per ID Card	$1.85	$1.90	$1.95
		Postage at actual Cost		
Administrative Services as defined in the Proposal Summary section of this proposal:	Per Claim	$12.50	$13.00	$14.00
Enrollment Services Financial Services Claim Processing EOBs Customer Service Toll Free Telephone Service On-line Verification of Coverage for Providers EDI Clearing house fees Record Maintenance Secure off-site Back-up of all records		Postage at actual Cost		
Scheduling/ Appointment Reminder Letters Up to three letters per Participant every other year	Per letter	$1.40	$1.45	$1.50
		Postage at actual Cost		
Central Repository for Test Results Follow-up letters to Providers to obtain test results Collection of test results Maintenance of test results Download of test results to clinical research facility Secure off-site Back-up of all records	Per Test	$5.10	$5.30	$5.50
Quarterly Meetings Reports Presentation	Per Meeting	$1,000 per meeting Travel, Lodging & Out-of-Pocket Expenses		
Consulting Services, other than those specifically identified by the Administrative Services Agreement, and authorized by the Special Master	Per Hour	Hourly Fees Travel, Lodging, & Out-of-Pocket Expenses		
Hourly Fees	Per Hour	Partner $220 Account Executive $175 Senior Consultant $175 IT Consultant $135 Consultant $130		
		Travel at 50% of normal hourly fees		

j.ii. *How are your fees computed? Please provide a detailed description of your fee structure? Are your fees based upon a percentage of the participants who participate?*

Response

Our fees are computed based upon expected cost to provide the required services. Since we process claims on a regular basis we have a good understanding of our per claim costs. For undefined requirements such as provider negotiations and communications, we must use hourly and reimbursement of incurred costs.

j.iii. *Please describe how your fee structure has been adjusted based upon the specific needs of this project.*

Response

As one can see from the table below, the claim volume is relatively light, averaging around one claim per Participant per year over the 30 year span of monitoring tests. The table is based upon the population of 1,000 Participants. CTIA expects the volume of claims to vary dramatically from month to month which is why we are suggesting that the initial testing be scheduled over a six month period to smooth the work load.

Estimated Number of Claims Per 1,000 Participants									
Test Period		Uninary System Test	Lung System Tests Males	Lung System Tests Females	Plumbism (lead poisoning) Adult Population	Plumbism (lead poisoning) Child Population	Skin Test	GI Test	Total Claim Counts
Year 1	Test 1	788	515	907	659	146	56	612	3,684
Year 3	Test 2	695	454	801	581	129	43	38	2,741
Year 5	Test 3	661	432	761	552	122	43	38	2,608
Year 7	Test 4	628	410	723	524	116	39	34	2,474
Year 9	Test 5	596	390	686	498	110	41	36	2,358
Year 11	Test 6	566	370	652	473	105	39	32	2,238
Year 13	Test 7	538	352	620	450	100	37	31	2,126
Year 15	Test 8	511	334	589	427	95	35	29	2,020
Year 17	Test 9	486	317	559	406	90	33	27	1,919
Year 19	Test 10	461	301	531	386	85	32	26	1,823
Year 21	Test 11	438	286	505	366	81	30	25	1,731
Year 23	Test 12	416	272	479	348	77	28	24	1,645
Year 25	Test 13	396	258	455	331	73	27	22	1,562
Year 27	Test 14	376	246	433	314	70	26	22	1,485
Year 29	Test 15	357	233	411	298	66	24	21	1,411
		7,914	5,171	9,112	6,613	1,466	532	1,017	31,825

We have estimated the cost of collecting the test results and maintaining them in the **Central Repository for Test Results** knowing that we will have to send follow-up letters to the providers. Additionally, the test result data will have to be secured and backed-up at a secured facility. We will also have to develop protocols with the Clinical Research Facility so they can securely download the data for their analysis.

We also see a need to remind the participants to schedule an appointment for their test. This reminder will also tell the participants what test to schedule. We recommend sending the first reminder two months in advance, the second; one month in advance, and a reminder; one month after they have missed their scheduled test.

j.iv. *Please describe how your organization shall set network discount and utilization goals over the next 36 months.*

Response
We do not expect to have a discounting arrangement with the providers. We intend to enter into an agreement with the providers for fixed payments depending on the procedure performed. There are relatively few procedures recommended by Dr.Werntz, so this is not an extremely difficult task. Our fee schedules will be set considering the prevailing Medicare, Medicaid, and PPO allowances for the Harrison County area. Our goals are to develop a fee structure that is fair and will be readily accepted by the Providers.

We don't expect to engage in a program to control/ reduce utilization. To the contrary, we expect that one of the most difficult tasks will be getting the participants to schedule their appointments and undergo the tests. That is why we recommend a letter campaign to encourage participants to schedule their appointments and take the appropriate tests.

j.v. *Please describe how your organization plans to meet these network discount and utilization goals over the next 36 months.*

Response
Please refer to the response to question j.iv. above.

j.vi. *Will you put a portion of your fees "at risk" to meet certain network discounts and utilization goals over the next 36 months?*

Response
No, as stated before, we do not think this is an appropriate objective. Please refer to the response to question j.iv. above.

j.vii. *Do your contracts have prompt pay stipulations with providers?*

Response
No, but if this becomes a point of negotiating with the providers, we can add such a provision.

j.viii. *Define a clean claim.*

Response
A clean claim is, in the context of this project, a claim that has all the required information to pay the claim plus having the test results forwarded to the **Central Repository for Test Results**.

j.ix. *An accurate accounting of a "clean claim" may require an audit of itemized statements requested of the providers. Please review and describe your contractual wording for this.*

Response
Claims expected for this project are blood, urine, and CT Scans. We don't expect any of the issues mentioned above to apply.

j.x. *Do the contracts have any wording that would give the projects TPA the authority to determine if the charges are properly payable under the developed Project Plan Document?*

Response
Yes

j.xi. *Are Total Eligible Charges defined as the charges from the primary healthcare and testing providers for covered services after the contracted discounts/pricing has been applied?*

Response
Yes

j.xiii. *Do your contracts have any guarantee that the primary health care provider/ tester will not be "balanced billed" for repayment of claim discounts for claims not paid in a timely manner.*

Response
We don't understand the question. Our provider agreements will not allow providers to balance bill the participants.

j.xiv. *Would you negotiate on behalf of this client amended language to your contracts with the primary healthcare providers/ testers for this project?.*

Response
Yes.

j.xv. *Utilizing your organization's proposed medical monitoring care plan design, please provide an overview of how your chosen fee pricing schedule would ensure that plan participants will receive services below or within the proposed budget.*

Response

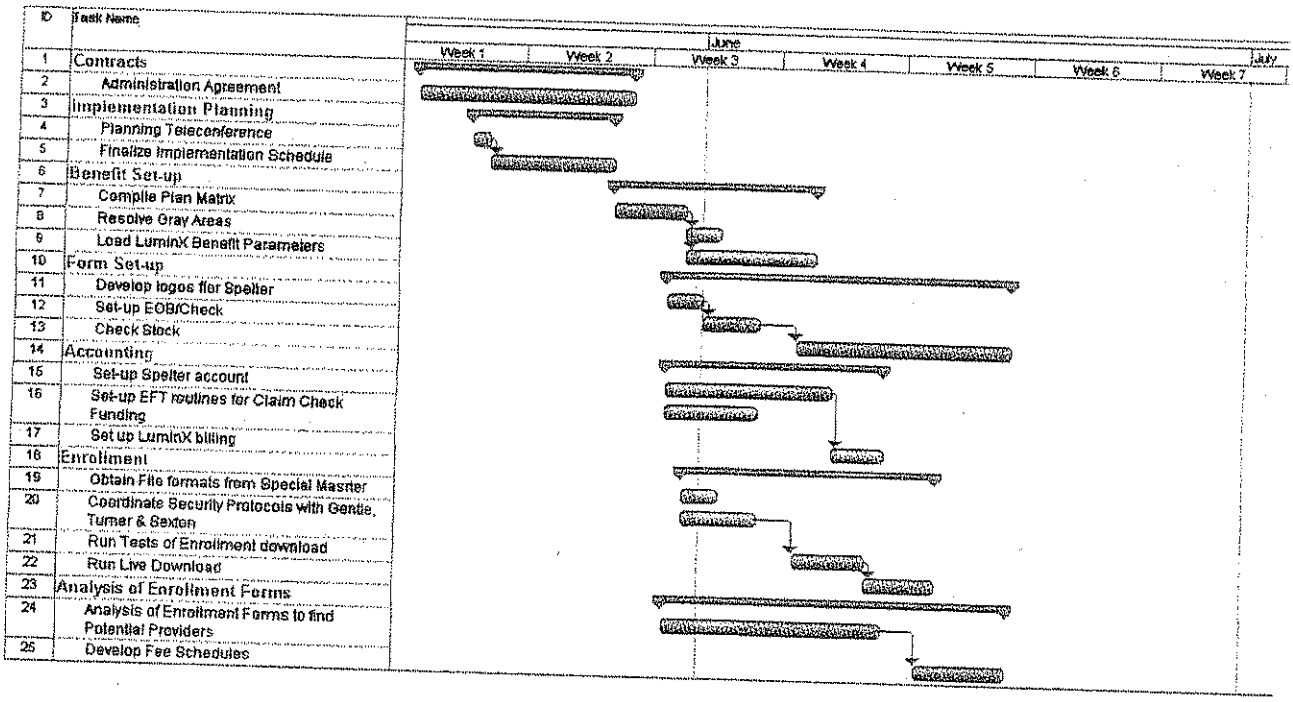
We did not consider the budget for this project when we determined our fees. Our fees were developed based upon our expected costs related to satisfying needs specified in this RFP. We did take considerable time and effort to develop the table in question j.iii. to determine the frequency of expected claim by type of test over 30 years.

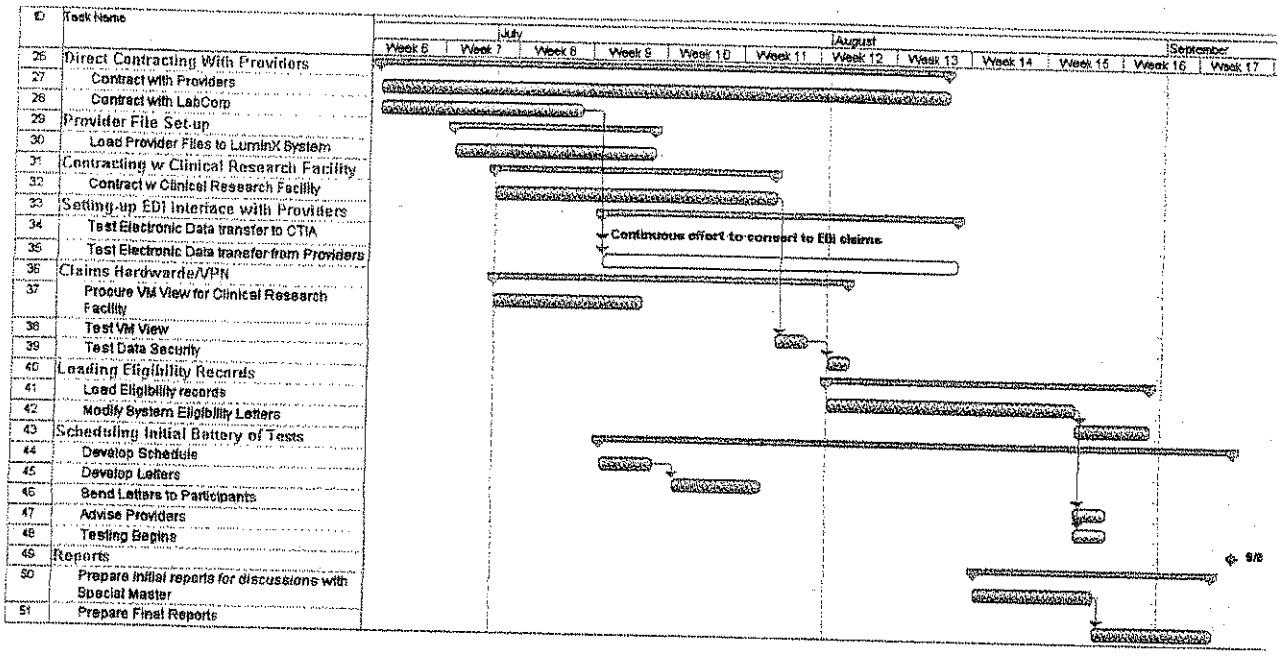
Miscellaneous

k.i. *Please provide your analysis of how you would be able to perform within the time frame for implementation set forth in the punch list in Exhibit H.*

Response

We have reviewed Exhibit H and have developed an implementation schedule for the tasks we feel are necessary as well as their projected time frames. Please see the following Gantt chart:




ID
Task Name
July
August
September
Week 6
Week 7
Week 8
Week 9
Week 10
Week 11
Week 12
Week 13
Week 14
Week 15
Week 16
Week 17
26 Direct Contracting With Providers
27 Contract with Providers
28 Contract with LabCorp
29 Provider File Set-up
30 Load Provider Files to LuminX System
31 Contracting w Clinical Research Facility
32 Contract w Clinical Research Facility
33 Setting-up EDI Interface with Providers
34 Test Electronic Data transfer to CTIA
35 Test Electronic Data transfer from Providers
36 Claims Hardware/VPN
37 Procure VM View for Clinical Research Facility
38 Test VM View
39 Test Data Security
40 Loading Eligibility Records
41 Load Eligibility records
42 Modify System Eligibility Letters
43 Scheduling Initial Battery of Tests
44 Develop Schedule
45 Develop Letters
46 Send Letters to Participants
47 Advise Providers
48 Testing Begins
49 Reports
50 Prepare initial reports for discussions with Special Master
51 Prepare Final Reports
Continuous effort to correct to EDI claims
9/8

k.ii. *Please provide samples of the informational brochures and or materials sent to participating members.*

Response
See Plastic ID Card, Schedule of Benefits, Newsletter, and On-line Coverage Verification in the "Other Supporting Materials section of this proposal.

k.iii. *Please state whether your organization currently provides a toll free number for customer assistance. Please provide your toll free number.*

Response
Yes, CTIA provides a toll free number for customer assistance. 888 220 2439

k.iv. *Are there any other matters which the Special Master and the Evaluation Committee should be aware of in reviewing your organizations proposal?.*

Response
Yes, the suggestions to **send letters to participants** reminding them to schedule their appointments and the suggestion to establish a **Central Repository** for the test results are not a mandatory part of our proposal.

[redacted]

Other Supporting Material

[redacted]

Other Supporting Material

Audited Financial Reports

Certificate of Insurance

Plastic ID cards

Schedule of Benefits

Newsletter

On-line Coverage Verification

Proposed Staff Resumes

Sample Quarterly Reports

Audited Financial Reports

ROTH & COMPANY, P.C.

Certified Public Accountants

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Tim Breitbach
Jerry Carlson
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INDEPENDENT AUDITORS' REPORT

To the Board of Directors
CTI Administrators, Inc.
Des Moines, Iowa

We have audited the accompanying consolidated balance sheets of CTI Administrators, Inc. and subsidiary as of December 31, 2010 and 2009, and the related consolidated statements of operations, stockholders' equity and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CTI Administrators, Inc. and subsidiary as of December 31, 2010 and 2009, and the results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Roth + Company, P.C.

March 2, 2011

CTI ADMINISTRATORS, INC.

CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2010 AND 2009

ASSETS	2010	2009
CURRENT ASSETS		
Cash and cash equivalents	$137,198	$113,885
Short-term investments	-	100,000
Trade receivables	200,918	72,504
Prepaid expenses and other assets	58,881	59,182
Total current assets	396,997	345,571
PROPERTY		
Office furniture and fixtures	66,824	74,542
Office equipment and software	719,103	694,239
	785,927	768,781
Less accumulated depreciation	(595,123)	(598,687)
Property, net	190,804	170,094
Receivable from affiliate	173,879	231,806
TOTAL ASSETS	$761,680	$747,471
LIABILITIES AND EQUITY		
CURRENT LIABILITIES		
Current maturities of long-term debt	$28,541	$32,214
Trade accounts payable and accrued expenses	46,269	65,780
Customer deposits	143,523	134,683
Total current liabilities	218,333	232,677
Long-term debt, less current maturities	51,836	34,267
Total liabilities	270,169	266,944
EQUITY		
CTI Administrators, Inc. stockholder's equity:		
Common stock, no par value; 100,000 shares authorized; 10,000 shares issued and outstanding	10,000	10,000
Additional paid-in capital	196,460	196,460
Retained earnings	288,789	279,104
Total CTI Administrators, Inc. stockholder's equity	495,249	485,564
Noncontrolling interests (deficit)	(3,738)	(5,037)
Total equity	491,511	480,527
TOTAL LIABILITIES AND EQUITY	$761,680	$747,471

See notes to consolidated financial statements.

CTI ADMINISTRATORS, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED DECEMBER 31, 2010 AND 2009

	2010	2009
REVENUES		
Third-party administration fees	$1,421,057	$1,370,511
Brokerage fees	275,441	294,876
Claim processing fees	24,308	17,153
Consulting fees	33,703	40,987
Total revenues	1,754,509	1,723,527
OPERATING EXPENSES		
Compensation and related payroll costs	1,059,489	927,951
Depreciation	47,866	41,672
Office rent	78,476	81,485
Other	476,407	493,382
Total operating expenses	1,662,238	1,544,490
INCOME FROM OPERATIONS	92,271	179,037
OTHER INCOME (EXPENSE)		
Interest income	1,613	3,474
Interest expense	(2,344)	(3,632)
Loss on disposal of assets	(2,556)	-
Other expense, net	(3,287)	(158)
NET INCOME	88,984	178,879
Less net income attributable to the noncontrolling interests	(1,299)	(881)
Net income attributable to CTI Administrators, Inc. stockholder	$87,685	$177,998

See notes to consolidated financial statements.

CTI ADMINISTRATORS, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDER'S EQUITY
YEARS ENDED DECEMBER 31, 2010 AND 2009

	CTI Administrators, Inc. Stockholder					
	Common Stock	Additional Paid-in Capital	Retained Earnings	Total	Non-Controlling Interests	Total Equity
Balances, December 31, 2008	$10,000	$196,460	$357,172	$563,632	($5,918)	$557,714
Net income			177,998	177,998	881	178,879
Distributions			(256,066)	(256,066)	-	(256,066)
Balances, December 31, 2009	10,000	196,460	279,104	485,564	(5,037)	480,527
Net income			87,685	87,685	1,299	88,984
Distributions			(78,000)	(78,000)	-	(78,000)
Balances, December 31, 2010	$10,000	$196,460	$288,789	$495,249	($3,738)	$491,511

See notes to consolidated financial statements.

CTI ADMINISTRATORS, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2010 AND 2009

	2010	2009
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$88,984	$178,879
Adjustments to reconcile net income to net cash from operating activities:		
Depreciation	47,866	41,672
Loss on disposal of assets	2,556	-
Change in operating assets and liabilities:		
(Increase) decrease in:		
Trade receivables	(128,414)	36,258
Prepaid expenses and other	301	(11,055)
Increase (decrease) in:		
Trade accounts payable and accrued expenses	(19,511)	11,536
Customer deposits	8,840	(90,621)
Total adjustments	(88,362)	(12,210)
Net cash provided by operating activities	622	166,669
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale of property	5,312	-
Purchase of property	(76,444)	(120,775)
Net decrease in receivable from affiliate	57,927	20,862
Net decrease in short-term investments	100,000	-
Net cash provided by (used in) investing activities	86,795	(99,913)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from issuance of long-term debt	50,000	50,000
Principal payments on long-term debt	(36,104)	(40,432)
Distributions to stockholders	(78,000)	(256,066)
Net cash used in financing activities	(64,104)	(246,498)
Net change in cash and cash equivalents	23,313	(179,742)
Cash and cash equivalents, beginning of year	113,885	293,627
Cash and cash equivalents, end of year	$137,198	$113,885
SUPPLEMENTAL DISCLOSURES		
Cash paid during the year for interest	$2,344	$3,632

See notes to consolidated financial statements.

CTI ADMINISTRATORS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2010 AND 2009

1. NATURE OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES

Nature of Business - The operations of CTI Administrators, Inc. (CTIA) consist primarily of providing third-party claims administration and marketing services for employee benefit plans. CTIA also brokers the sale of employee group benefit plans and provides employee benefits consulting services. CTIA owns 90% of the outstanding member units of Hot Claims, L.L.C. (Hot Claims). In July 2004, Hot Claims was organized to process claims electronically and commenced operations that consist primarily of providing health and dental claim processing services for third party administrators and PPO networks.

Reorganization - Effective December 1, 2009, the stockholders of CTIA and the stockholders of an affiliate, Claim Technologies Incorporated, exchanged their ownership interests in these entities for the ownership interests of CTI Holdings, Inc. As a result of the exchange, CTIA and the affiliate became wholly-owned subsidiaries of CTI Holdings, Inc. (the Parent).

Principles of Consolidation - The accompanying consolidated financial statements include the accounts of CTIA and its subsidiary, Hot Claims (collectively, the Company). All material intercompany balances and transactions have been eliminated in consolidation.

Cash and Cash Equivalents - The Company considers all cash accounts, which are not subject to withdrawal restrictions or penalties, and all highly liquid debt instruments with a maturity of three months or less when purchased to be cash equivalents.

Short-term Investments - Short-term investments are carried at cost, which approximates fair value. At December 31, 2009, short-term investments were comprised of certificates of deposit.

Trade Receivables - Trade receivables are carried at amounts billed less an estimate for doubtful receivables, if any. Management determines the allowance for doubtful accounts by regularly evaluating individual customer receivables and considering a customer's financial condition, credit history and current economic conditions. Trade receivables are written off when deemed uncollectible. No allowance for doubtful accounts was deemed necessary by management at December 31, 2010 and 2009.

Property - Property is depreciated using straight-line and accelerated methods over three to seven-year lives.

Income Taxes - Prior to the reorganization described above, CTIA and its stockholders elected to be taxed under the provisions of Subchapter S of the Internal Revenue Code. Accordingly, the stockholders of CTIA included taxable income or loss of the company in their individual income tax returns and the company generally was not subject to income tax. Subsequent to the reorganization, CTIA is included in the consolidated income tax returns of its Parent. The Parent and its stockholders have elected to be taxed under the provisions of Subchapter S of the Internal Revenue Code.

Hot Claims is organized as an Iowa Limited Liability Company. For federal and state income tax purposes, Hot Claims is treated as a partnership and, therefore, is not generally subject to income tax. Each member will report their share of the company's taxable income or loss and any separate tax items.

No provision for income taxes has been made in the accompanying financial statements. Management assesses the income tax positions of CTIA and Hot Claims based upon an evaluation of the facts, circumstances and information available at the reporting dates. The income tax returns of CTIA, Hot Claims and the Parent for the years 2007 through 2010 remain open for possible examination by Federal and state taxing authorities. Management does not expect any material adjustments to their income tax positions should these returns be examined.

Revenue Recognition - The Company recognizes revenues generally in the month the services are provided.

Retirement Plan - The Company sponsors a 401(k) plan covering substantially all of its employees. The plan permits participants to make voluntary salary deferral contributions and the Company matches a percentage of such contributions. The Company's expense for contributions to the plan for 2010 and 2009 was $22,092 and $22,437, respectively.

Use of Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Concentrations of Credit Risk - Financial instruments that potentially expose the Company to concentrations of credit risk consist primarily of cash and cash equivalents. The Company maintains its bank accounts in well-capitalized financial institutions and cash and cash equivalents on deposit may, at times, exceed federally insured limits. The Company has not experienced any losses in such accounts.

Subsequent Events - In the normal course of preparing the Company's financial statements, management reviews events that occur after the balance sheet date for potential recognition or disclosure in the financial statements. Management has evaluated subsequent events through March 2, 2011, which is the date the financial statements were available to be issued.

2. MAJOR CUSTOMER

CTIA has an agreement with the Boys & Girls Club Workers' Association Insurance Trust (BGCWA). CTIA provides administrative and marketing services for various employee benefit programs authorized by BGCWA. Under the terms of the agreement, CTIA bills and collects benefit plan premiums from participating Boys & Girls Clubs, remits insurance premiums to the respective insurance carriers and pays eligible claims under the plans.

As compensation for the above described services, CTIA earns administrative fees based on the number of participating employees of the Boys & Girls Clubs. The initial term of the agreement was effective through July 31, 2010 when the agreement automatically renewed for an additional term of three years through July 31, 2013. Third-party administration fee income under the agreement for the years ended December 31, 2010 and 2009 was $1,035,000 and $1,083,000, respectively. Accounts receivable from BGCWA at December 31, 2010 and 2009 was $143,182 and $47,308, respectively.

3. LINE OF CREDIT AND LONG-TERM DEBT

Line of Credit

CTIA has a $150,000 revolving line of credit with a financial institution that matures in October 2011. Interest at the lender's base rate plus .50% with a minimum rate of 4.00% (4.00% at December 31, 2010) is payable monthly. The line of credit is secured by substantially all corporate assets and personal guarantees of the Parent's stockholders. At December 31, 2010, there were no borrowings outstanding on this line of credit. At December 31, 2009, there were no borrowings outstanding under a similar line of credit.

Long-term Debt

CTIA's long-term debt at December 31, 2010 and 2009 consists of the following:

	2010	2009
Note payable, financial institution, collateralized by substantially all corporate assets and personal guarantees of the Parent's stockholders, due in monthly installments of $3,277 including interest at 6.65% through May 2010.	$ -	$20,280
Note payable, financial institution, collateralized by substantially all corporate assets and personal guarantees of the Parent's stockholders, due in monthly installments of $1,130 through August 2013. The interest rate, variable at lender's base rate plus .50% with a minimum rate of 4.0%, was 4.0% as of December 31, 2010.	34,266	46,201
Note payable, financial institution, collateralized by substantially all corporate assets and personal guarantees of the Parent's stockholders, due in monthly installments of $1,489 including interest at 4.50% through September 2013.	46,111	-
Total	80,377	66,481
Less current maturities	28,541	32,214
Long-term debt, less current maturities	$51,836	$34,267

Aggregate annual maturities of long-term debt as of December 31, 2010 are as follows: 2011, $28,541; 2012, $29,782; and 2013, $22,054.

4. CUSTOMER DEPOSITS

In connection with CTIA's third-party claims administration services, gross premiums are received from customers and held by CTIA until they are used to fund insurance premiums, insurance claims and administrative expenses. At December 31, 2010 and 2009, customer deposits were $143,523 and $134,683, respectively, related to employee benefit plans that the Company provides administration services.

5. OPERATING LEASES

The Company leases office space and automobiles under non-cancelable operating leases expiring July 2011 through October 2013. Rent expense for the years ended December 31, 2010 and 2009 was $108,270 and $111,015, respectively. At December 31, 2010, approximate future annual minimum lease payments under the operating leases are as follows: 2011, $56,400; 2012, $14,200; and 2013, $5,500.

6. RELATED PARTY TRANSACTIONS

The Company has transactions with an affiliate, Claim Technologies Incorporated, which provides employee benefit plan claims administration audit and consulting services. CTIA and the affiliate share common ownership and management and, subsequent to the reorganization described in Note 1, are both wholly-owned by the Parent. Additionally, the Company and the affiliate share certain employees and office facilities. Expenses for these items are allocated to the entities based on various criteria.

The Company has advanced funds to the affiliate which are unsecured. For the years ended December 31, 2010 and 2009, the Company received interest income of $1,216 and $2,637, respectively, from the affiliate. At December 31, 2010 and 2009, outstanding advances receivable from the affiliate were $173,879 and $231,806, respectively.

[redacted]

Certificate of
Insurance

[redacted]

Certificate of Insurance

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/28/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Bearence Management Group
1045 76th Street, Suite 4000

West Des Moines IA 50266

CONTACT NAME: Yukiko Collins
PHONE (A/C, No, Ext): (515) 327-8450 FAX (A/C, No): (515) 327-8457
E-MAIL ADDRESS: ycollins@bearence.com
PRODUCER CUSTOMER ID #: 00013135

INSURED
CTI Administrators, Inc
Claim Technologies Incorporate

100 Court Avenue, Ste. 306
Des Moines IA 50309

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: General Casualty Company of WI	24414
INSURER B: Westchester Fire Insurance Co.	
INSURER C: Hartford Fire Insurance Company	
INSURER D:	
INSURER E:	
INSURER F:	

COVERAGES CERTIFICATE NUMBER: CL113308881 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT X LOC			CCS0350129	2/13/2011	2/13/2012	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 1,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS X SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS COMP/COLL $500			CBA0350129	2/13/2011	2/13/2012	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE X RETENTION $ 10,000			CCU0350129	2/13/2011	2/13/2012	EACH OCCURRENCE AGGREGATE	$ 6,000,000 $ 6,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N N/A If yes, describe under DESCRIPTION OF OPERATIONS below			CWC0350129	2/13/2011	2/13/2012	WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
B	Professional Liability			G24191047001	2/13/2011	2/13/2012	$1,000,000 Each Claim Agg	$3,000,000
C	Crime			FA0232257511	2/13/2011	2/13/2012	Employee Dishonesty	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

Bidding Purposes Only

CANCELLATION

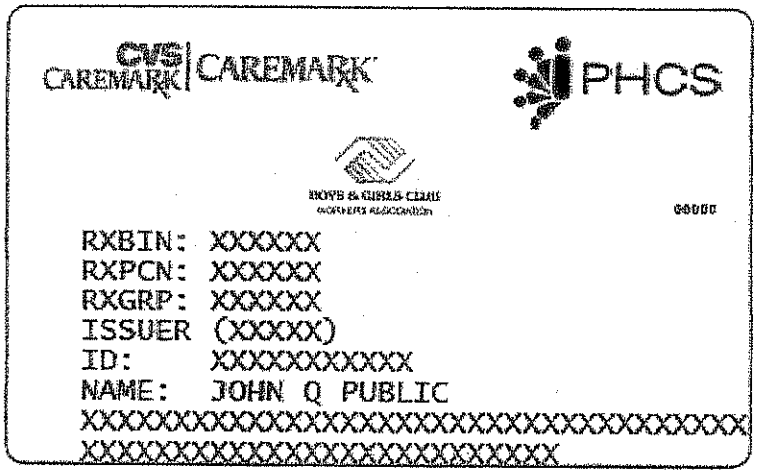
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

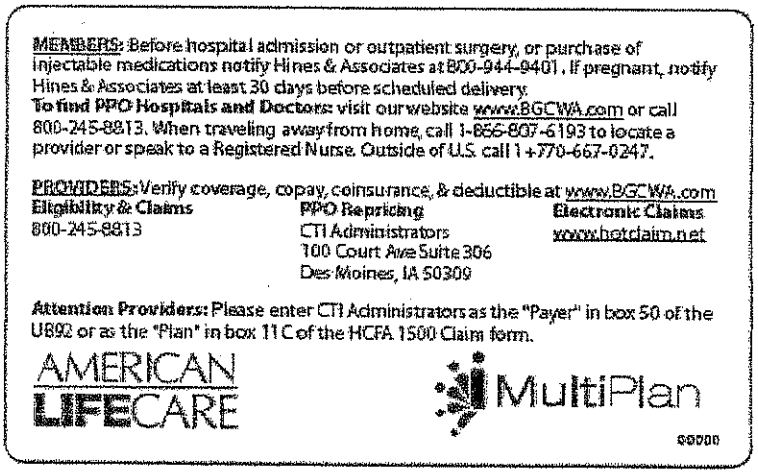
AUTHORIZED REPRESENTATIVE

Steve Schmidt/RHOMIL

ACORD 25 (2009/09)
INS025 (200909)

Plastic ID Card





SCHEDULE OF BENEFITS – CLUB SELECT

Benefits Effective January 1, 2011

The following Schedule of Benefits will apply to all medically necessary treatment of an illness or injury, or testing used to diagnose an illness or injury. These benefits are in compliance with the requirements of the Patient Protection and Affordable Care Act (PPACA) for a plan that is not Grandfathered.

Calendar Year Deductible
The Calendar Year Deductible applies to all covered services except

- Certain Preventive Care services (See the Preventive Care section of this Schedule of Benefits for a description of those services)
- Certain Office Services by a Network Provider (See the Co-payment section of this Schedule of Benefits for Co-payments applied to Office Services by a Network Provider).

For all other covered services the Deductible amount depends on whether a Network provider is used and is as follows:

Calendar Year Deductible - Services by a Network Provider*	Calendar Year Deductible - Services by a non-Network Provider*
Single $500 Family $1,000	An additional Deductible of $250 per individual not to Exceed $500 per Family

*An additional Calendar Year Deductible of $250 per Person, not to exceed an additional $500 for a Family will apply if services are performed by a non-Network Provider and the treatment was not within 48 hours of the onset of an Emergency.

Coinsurance is the share of covered expense paid by the Plan and will depend on the type of service and whether a Network provider or a non-Network provider is used.

- **Coinsurance for Preventive Services:**
  - **Coinsurance is 100%** of charges for Preventive Services performed by a Network Provider with the deductible being waived
  - **Coinsurance is 85%** of charges for a Preventive Services performed by a non-Network Provider
- **Coinsurance is 85% in the following situations:**
  - Covered medical service is performed by a Network Provider.
  - Covered medical service is performed by a non-Network Provider for Emergency Care rendered within 48 hours of the onset of an Emergency.
- **Coinsurance is 65%** if Covered medical service is performed by a non-Network Provider. (does not apply to Emergency care within 48 hours of the onset of an Emergency)
- **Coinsurance for Services rendered in the Office of a Network Provider other than Physical Therapy, Occupational Therapy and Speech Therapy:**
  - **The first $500 in Covered Services**
    - **Coinsurance is 100%** of the first $500 in charges for Services rendered in the office of a Network Provider after the Co-payment of $30 (See the section on Co-payment for more information on how this applies).
    - **Coinsurance is 85%** after the first $500 in charges for Services rendered in the office of a Network Provider
- ***Coinsurance on Prescription Drugs***
  Prescription Drug coverage for this Plan is administered by CVS/Caremark. There are three Prescription Drug programs. When you purchase a prescription through these programs you will pay a percent of the cost based upon the type of prescription and the program you are buying it through. The percent that you pay for each program, by drug category follows:

DRUG CATEGORY	RETAIL DRUG CARD PROGRAM	MAIL ORDER DRUG PROGRAM	SPECIALTY RX PROGRAM
Generic Drugs	10% with a minimum of $8.00 and a maximum of $16.00 for a 30 Day Supply	10% with a maximum of $20.00 for a 90 Day Supply	
Preferred Brand Name Drugs*	20% with a minimum of $20.00 and a maximum of $40 for a 30 Day Supply	20% with a maximum of $50.00 for a 90 Day Supply	
Other Brand Name Drugs**	30% with a minimum of $30.00 and a maximum of $60 for a 30 Day Supply	30% with a maximum of $100.00 for a 90 Day Supply	
Injectable and Oral Specialty Drugs			20% with a maximum of $250 for a 30 Day Supply

*The Plan will require the employee to pay the difference in cost between the brand name drug and the generic equivalent of that drug, even if a physician signs an order to dispense the brand name drug.

Important Notice for All Medicare Beneficiaries: The coverage provided through this Plan has been determined by CVS/Caremark to be creditable in accordance with guidance from the Centers for Medicare and Medicaid Services.

Co-Payment

The Co-Payment is the amount that you must pay before the plan will apply deductible or coinsurance. Co-Payment paid by you does not apply to the Deductible or the Calendar Year Out-of-Pocket Maximum.

- **Co-Payment on Certain Office Services by a Network Provider**
  Covered services provided in the office of a Network Provider will require a $30 Co-Payment for the first $500 of charges provided in the office on that day, this will not apply to Preventive Services provided in the office.

  Physical therapy performed by a licensed physical therapist or a physical therapy assistant, occupational therapy performed by a licensed occupational therapist, and speech therapy performed by a licensed speech therapist will not be subject to Co-Payment, but will be paid after the deductible is met and at the appropriate coinsurance level.

- **Co-Payment on Magnetic Resonance Imaging (MRI), Computerized Tomography Scan (CT Scan) & Positron Emission Tomography (PET Scan)**
  Covered MRI, CT scans, and PET Scans will require an additional 5% Co-Payment up to a maximum of $150 per occurrence before the Plan pays the covered expense at the appropriate deductible and coinsurance. The 5% Co-Payment will not apply toward your calendar year deductible or out-of-pocket maximum accumulations.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of Deductible and Coinsurance you must pay for Covered Expenses in a Calendar Year.

Services By a Network Provider or for Emergency Care within 48 hours of onset	Services By a Non-Network Provider
Single $3,000 Out-of-Pocket Maximum Family $6,000 Out-of-Pocket Maximum	An additional $4,000 per individual will be charged to the Out-of-Pocket Maximum

The Out-of-Pocket Maximum does not include any of the following expenses:

- Co-Payments for services rendered in a Network Provider's office or copayments for MRI, CT Scans, or Pet Scans;
- Coinsurance you pay for Prescription Drugs;
- Your share of payments for any Behavioral Health Care treatment;
- Penalties for not pre-certifying an inpatient hospital confinement, organ and/or tissue transplant, surgery, or specialty drugs; and

- Charges for expenses that the Plan does not cover.

Annual Benefit Maximums
The maximum amount payable under this Plan will be $2,000,000 in a calendar year.

Lifetime Benefit Maximums
The following services will have limited coverage under this Plan as follows:

- $3,000 in charges for treatment of any Temporomandibular Disorder
- $1,000 Lifetime Maximum Benefit for Psychological Testing
- Lifetime maximum number of Applied Behavioral Analysis (ABA) visits with a certified provider or a program manager per dependent: 60
- Lifetime maximum number of treatment Applied Behavioral Analysis (ABA) with a therapy assistant per dependent: 450

Preventive Care
With the enactment of health care reform, there has been more emphasis on preventive care services. This Plan intends to be fully compliant with health care reform's intent to encourage people to do what is necessary to prevent illness. The following Preventive Care is covered by this plan if performed on a routine basis and not because of any previous diagnosis of an illness or injury.

Covered Preventive Care Services	
Preventive Services over age two	The plan will cover routine, sports and school physicals
Well Baby Care under age two	Limited to be in keeping with prevailing medical standards
Immunization Vaccines: Children, Adolescents and Adults	Immunizations for routine use in children, adolescents and adults that are recommended by the Advisory Committee on Immunization Practices.
Mammograms – women age 35 or older or w/history of breast cancer in immediate family	Limited to One per Calendar Year
Prostate Exams	Limited to one Prostate Specific Antigen Blood Testing per Calendar Year
Preventive Colon Examination	Limited to: Proctosigmoidoscopy, Sigmoidoscopy, and Colonoscopy. Benefits are limited to participants age 50 or over, once every 10 years.
Oral Fluorides	At current recommended doses to preschool children older than 6 months.

Behavioral Health Benefits
This plan provides benefits for services necessary to treat Behavioral Health conditions such as mental and nervous disorders, drug addiction and substance abuse. For the Behavioral Health services listed below the Calendar Year Deductible and Coinsurance described in this Schedule of Benefits will apply. However, any Coinsurance amount paid by you will not accumulate to your Calendar Year Out of Pocket Maximum. The schedule of benefits for Behavioral Health Care is as follows:

Covered Behavioral Health Care Services	
Inpatient Care and Partial Hospitalization – Mental/ Nervous Condition	Pre-certification required
Inpatient Care – Drug/ Alcohol Addiction	Pre-certification required. Limited to one confinement of not more than 30 days per lifetime
Outpatient Care	Paid subject to the co-payment, deductible and coinsurance provisions described above.
Psychological Testing	Limited to Lifetime Benefit Maximum of $1,000

Brain Development Disorder Treatment Benefits for Dependent Children

This Plan provides benefits for behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) and/or related structured behavioral programs, when administered and supervised by the Autism Center at the University of Washington Center on Human Development and Disability (CHDD), or providers who have met the certification criteria established by the Autism Center at the CHDD, or those working under the direct supervision of the certified provider. This benefit will be available to dependent children whose primary diagnosis is Autistic Disorder, International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 299.0, Childhood Disintegrative Disorder (ICD-9-CM code 299.1), Asperger's Disorder (ICD-9-CM code 299.8), or Pervasive Developmental Disorder (ICD-9-CM code 299.8).

ABA services must be pre-authorized by Hines and Associates or no benefit will be payable. If pre-authorized, ABA services will be paid subject to the Calendar Year Deductible and Coinsurance described in this Schedule of Benefits. However, any Coinsurance amount paid by you will not accumulate to your Calendar Year Out of Pocket Maximum. Coverage of these services will be limited as follows:

- Lifetime maximum number of treatment visits with a certified provider or a program manager per dependent: 60
- Lifetime maximum number of treatment visits with a therapy assistant per dependent: 450

Organ and/or Tissue Transplant Benefits

Covered Organ and/or Tissue Transplants will be paid according to the following schedule of benefits:

Any organ or tissue transplant listed below will be covered subject to referral to and pre-authorization by the Utilization Review Coordinator, Hines and Associates. Failure to pre-authorize a transplant procedure with Hines and Associates will result in the application of a $5,000 Deductible to all Covered Expenses incurred as a result of the transplant. This Deductible is in addition to any other plan Deductible and will not be accumulated to the Participants Out of Pocket Maximum. All reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a maximum of $10,000 per transplant period.

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of $10,000 per Transplant Benefit Period when the transplant services are rendered by a non- Network Provider. This does not include the donor's transportation and lodging expenses.

For the Transplant Procedures listed below the Calendar Year Deductible will apply. Coinsurance for Network and non-Network Providers will be 100%, however if a non-Network provider is used the plan will apply an Overall Payment Maximum as shown below and any amount over the maximum will be paid by you and will not accumulate to your Calendar Year Out of Pocket Maximum.

Covered Transplant Procedures	Non-Network Provider Overall Payment Maximum
Heart	Limited to $110,000 including a Physician's maximum of $20,000.
Lung	Limited to $155,000 including a Physician's maximum of $20,000.
Bone Marrow	Limited to $130,000 including a Physician's maximum of $20,000.
Liver	Limited to $130,000 including a Physician's maximum of $20,000.
Heart/Lung	Limited to $150,000 including a Physician's maximum of $20,000.
Pancreas	Limited to $70,000 including a Physician's maximum of $20,000.
Kidney	Limited to $55,000 including a Physician's maximum of $20,000.

Diabetic Education
The Plan covers one diabetic educational session with a covered provider of service in a patient's lifetime subject to the co-payment, coinsurance and deductible provisions described above.

Dependent Eligibility
A Dependent is eligible to enroll for this Plan if he/she is related to the employee as one of the following:

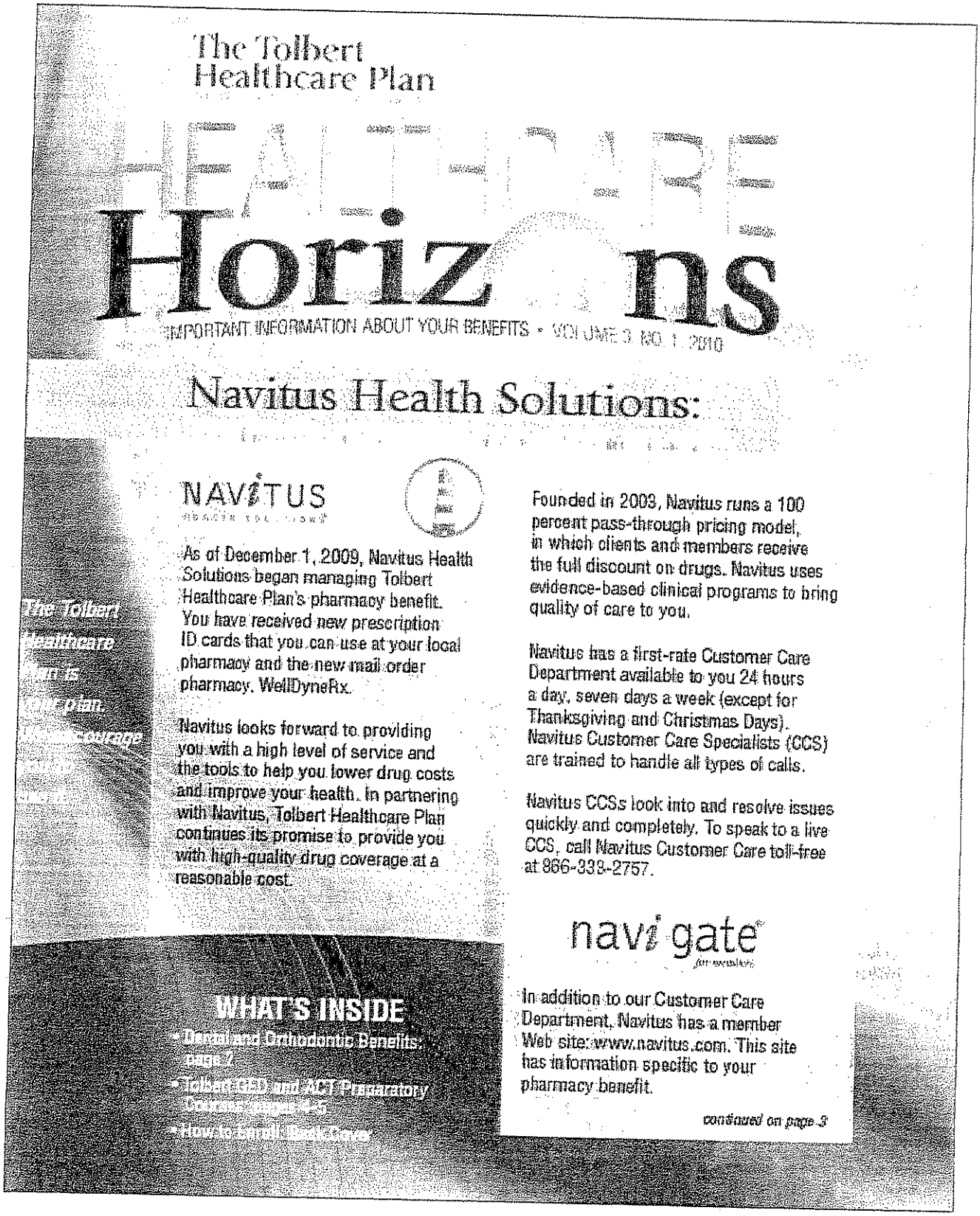
- A covered employee's or a covered retiree's Spouse,
- A covered employee's Child(ren) from birth until the 26th birthday,
- A covered employee's Handicapped Dependent Child(ren)* over age 26,
- A covered employee's Child(ren) who is given the right to enroll in this Plan through a Qualified Medical Child Support Order (QMCSO) and who satisfies all other eligibility standards of this Plan. Employees may obtain a copy of QMCSO procedures from the Claim Administrator at no cost.

Limitation on Pre-Existing Conditions
For an Eligible Employee enrolling as a Late Enrollee or Special Enrollee, benefits for pre-existing conditions are limited as described below. This limitation does not apply to newly hired employees that have enrolled as a Timely Enrollee or any dependent child enrolling who is under the age of 19.

No benefits will be paid for any expenses incurred as a result of or related to any Pre-existing Condition except in the following situations:

- The condition is pregnancy;
- This limitation will cease to apply 12 months after the Patient's Effective Date.

Newsletter



The Tolbert Healthcare Plan

HEALTHCARE

Horizons

IMPORTANT INFORMATION ABOUT YOUR BENEFITS • VOLUME 3, NO. 1, 2010

Navitus Health Solutions:

NAVITUS

As of December 1, 2009, Navitus Health Solutions began managing Tolbert Healthcare Plan's pharmacy benefit. You have received new prescription ID cards that you can use at your local pharmacy and the new mail order pharmacy, WellDyneRx.

Navitus looks forward to providing you with a high level of service and the tools to help you lower drug costs and improve your health. In partnering with Navitus, Tolbert Healthcare Plan continues its promise to provide you with high-quality drug coverage at a reasonable cost.

Founded in 2003, Navitus runs a 100 percent pass-through pricing model, in which clients and members receive the full discount on drugs. Navitus uses evidence-based clinical programs to bring quality of care to you.

Navitus has a first-rate Customer Care Department available to you 24 hours a day, seven days a week (except for Thanksgiving and Christmas Days). Navitus Customer Care Specialists (CCS) are trained to handle all types of calls.

Navitus CCSs look into and resolve issues quickly and completely. To speak to a live CCS, call Navitus Customer Care toll-free at 866-333-2757.

navigate

In addition to our Customer Care Department, Navitus has a member Web site: www.navitus.com. This site has information specific to your pharmacy benefit.

continued on page 3

WHAT'S INSIDE

Dental and Orthodontic Care

The Tolbert Healthcare Plan provides benefits for dental and orthodontic care for you and your family. Here's a summary of the plans and services included.

Dental Coverage —

- The Dental Plan Maximum Annual Benefit payable in a calendar year is $750 per eligible participant.
- There is no deductible that you must pay.
- Some services have a CoPayment that will be paid by the Plan's Surplus Fund and will not be collected from you at the time of service.

The Dental Plan benefits include:

Service	CoPayment from Surplus	Plan Limitations
Exams, Cleanings, Bitewing X-Rays		Twice in a calendar year
Sealants		For patients age 20 and under
Full Mouth X-Rays		Once every three years
Fluoride Treatment		Twice in a calendar year, for patients age 20 and under
Diagnostic Procedures	$5	
Basic Dental Procedures	$10	
Major Dental Procedures		Major dental procedures are not covered

CoPayments to Be Paid from Surplus Fund

Some Dental and Prescription Drug benefits are subject to CoPayments (an amount paid by you). Until further notice, all CoPayments will be paid on your behalf from the Surplus Fund.

This means that, until the Surplus Fun is depleted, you will not be required to pay the Dental and Prescription Drug CoPayments as described in your Tolbert Healthcare Plan Summary of Benefits.

Orthodontic benefits for participants under age 21 require Coinsurance (an amount paid by you). The Coinsurance for Orthodontic benefits must be paid by you and will not be paid by the Surplus Fund.

Navitus Health Solutions

continued from front page 1

Called Navi-Gate for Members, it provides you with online access to a wealth of information. This site will help you better understand your pharmacy benefit, add convenience to your life and show cost-saving options.

Navi-Gate for Members provides easy access to your specific:

- Benefit information
- Formulary listing
- Mail order service
- Forms
- FAQ
- Drug cost information
- Health information

Navitus is happy to be working with the Tolbert Healthcare Plan. They look forward to serving you.

Navitus Customer Care's toll-free number:
866-333-2757
www.navitus.com

Need a Mammogram?

The Tolbert Healthcare Plan provides benefits each year for one routine mammogram for patients age 35 and older. You must use the NE Alabama Regional Medical Center, and the results are sent to Anniston Quality Health Care.

To make an appointment, contact:

Anniston Quality Health Care
(256) 236-0221

Legacy Claimant Eligibility

If you are the child, grandchild, or legal ward of a Tolbert claimant, you are considered to be a "legacy claimant." As a "legacy claimant," you can enjoy all the benefits that other minor child claimants enjoy, including free primary care with the Pediatric Care Center of Northeast Alabama, prescription drugs, GED courses, ACT courses and the scholarship benefit.

New Orthodontia Benefit

New Orthodontia benefits became available to the Tolbert Healthcare Plan beginning December 1, 2009. These benefits are limited to Participants in the Plan beginning orthodontia treatment prior to age 21.

The proposed plan is significantly better than the typical plan design for Orthodontia benefits provided through most employer plans.

Under the Schedule of Orthodontic Benefits, the plan pays 70% and the participant pays 30%, with the following limitations:

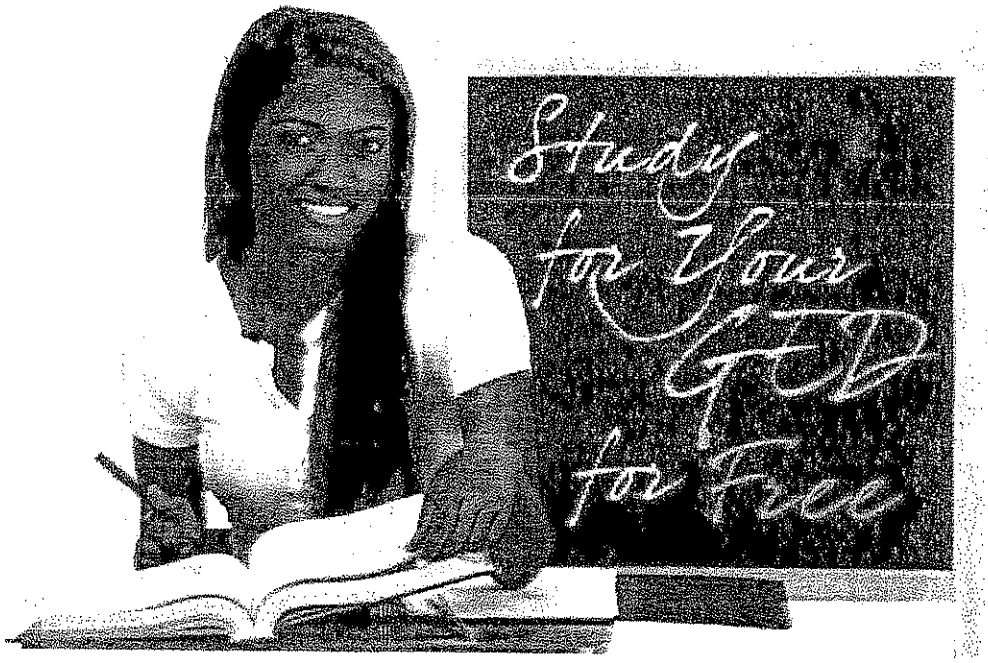
- Coverage for Participants age 20 and under.
- Maximum amount payable on a course of orthodontic treatment is $750 per calendar year.
- Orthodontia benefit payments will accrue toward annual maximum dental benefits of $750.
- Expenses will be paid over the course of time that the appliances are installed and remain in place.
- No more than 25% of the total cost of the course of treatment will be allowed for the initial placement of the appliance. The remaining cost will be considered on a monthly basis and payments will be pro-rated over the minimum expected course of orthodontic treatment.

Patients must be referred for Orthodontic Treatment by **Dr. Angela Martin, MD, FAAP**.

The Pediatric Care Center of Northeast Alabama
304 E 4th Street
Anniston, AL 36207
(256) 237-1184

Orthodontic Treatment is provided by
Dr. Joseph A. Walker, Jr., D.M.D., M.S.

630 Leighton Avenue
Anniston, AL 36207
(256) 236-1623



To help Tolbert children attain their General Equivalency Diploma (GED), Tolbert is pleased to offer a free Preparatory Course.

The course is open to claimants ages 16-21 who have not completed high school. They must meet some state requirements before they can take the GED exam, which covers the following five subject areas: Language Arts (Writing and Language Arts), Reading, Science, Social Studies and Math.

Claimants who take the Preparatory Course are first given a test to determine their grade level. Claimants then are taught the subject matter and take subject-based practice tests to master the material. Once a claimant scores 75% (or 720 or more) on each subject-based practice test, they may sit for the GED exam.

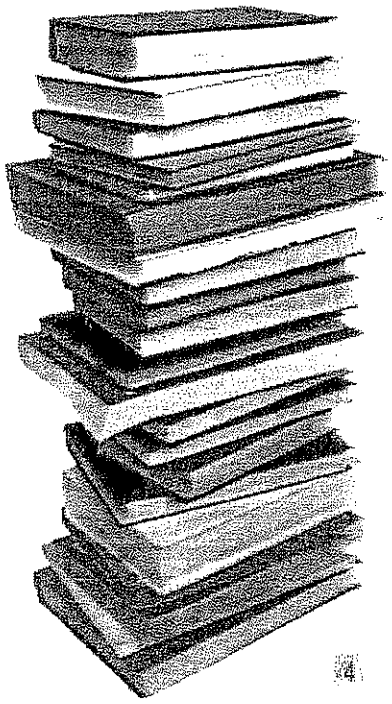
The GED Preparatory Course is currently taught on Tuesday and Wednesday evenings at the Carver Community Center in Anniston, AL.

The exam fee is $50, but for Tolbert claimants who take the GED Preparatory Course, the exam is free of charge.

To date, one claimant has taken and passed the GED exam. Three more claimants have taken the exam this year, and their test results are pending.

The GED exam is given several times a year. Also, students who do not pass all the subjects can be retested in the subjects they didn't pass for $10 per subject exam.

If your Tolbert child and/or legacy claimant is interested in the GED course, please contact our office at **1-800-345-0837.**



Study for the ACT for Free

To help Tolbert children perform well on their ACT test, Tolbert offers a free Preparatory Course through Kaplan Educational Services, the leading provider in ACT and AST test-taking services.

The Tolbert ACT Preparatory Course is open to claimants ages 16-19. It's a 13-week course designed to teach students how to analyze and interpret concepts in the following subjects: English, Math, Reading, Science and Writing (optional).

The classes usually meet from 5:30 p.m. to 8 p.m. on Thursday evenings, and from 9 a.m. to noon on some Saturdays. Classes are held at the Carver Community Center in Anniston, AL.

The ACT Preparatory Course typically costs $2,000, but Tolbert claimants can take it free of charge.

The ACT Preparatory Course has provided Tolbert child claimants with the rigorous academic assistance necessary to perform well on the ACT test. Since the Course's inception...

- We've conducted three 13-week courses with approximately 40 Tolbert child claimants participating.
- Of those, approximately 16 claimants have sat for the exam. Of the nine students who reported their scores, all increased their ACT scores on average by 2 or more points.

The ACT exam is given four times a year, usually at a college, university or local high school. The fee to take the exam varies year to year, but it's free of charge to claimants who participate in the Preparatory Course.

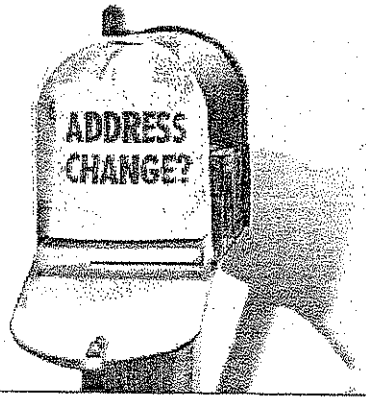
If your Tolbert child and/or legacy claimant is interested in the course, please contact our office at **1-800-345-0837**.

The Tolbert Healthcare Plan

CTI Administrators
100 Court Avenue, Ste. 306
Des Moines, IA 50309

Enrolling in the Tolbert Healthcare Plan is Easy!

Eligible participants age 21 and over may register at the Anniston Quality Health Care Clinic, and participants under age 21 may register at The Pediatric Care Center of Northeast AL. The clinics will notify CTI Administrators of your registration. As a new participant, you will receive an ID card which you can use for future visits to these facilities. Your ID card can also be used to fill prescriptions.



Please remember to notify CTI Administrators if your address changes so that we can stay in touch with important information about the Plan.

Just call us at **(888) 220-2439** and say you're reporting an address change for a Tolbert member.

VOL3 N01 6.0 2.10

On-line Coverage Verification

The Tolbert Healthcare Plan

Date of Request: 3/28/2011
Participant: PAT GAGNE
123 Name of Street
Des Moines, IA 50309
Plan: Age 21 and over

OTHER COVERAGE:
OTHER COVERAGE UNKNOWN

Designated Provider: **Anniston Quality Health Care**
1316 Noble Street
Anniston, AL 36201
(256) 236-0221 or Toll-free: (888) 490-0131

MEDICAL BENEFITS

Calendar Year Maximum on All Medical Expenses: $1,750 (Paid YTD: $0.00) Deductible: None

Service	Co-Pay	Limitations
Office Visits	none	
Newborn Care (Well Baby)	$10.00	Inpatient Care
Routine Physicals	none	1 per calendar year
Well Woman Exam	none	1 per calendar year
Routine Mammograms *	none	1 per calendar year, age 35 and over
Pap Smears	none	1 per calendar year
Prostate Exams	none	1 per calendar year
Bone Density	none	1 per calendar year
Well Child	none	Under age 2
Immunizations	none	Prevailing medical standards

DENTAL BENEFITS

Calendar Year Maximum on All Dental Expenses: $850 (Paid YTD: $0.00) Deductible: None

Service	Co-Pay	Limitations
Exams, Cleanings, Bitewing X-Rays	none	Twice in a calendar year
Full Mouth X-Rays	none	Once every three years
Diagnostic Procedures	$5.00	
Basic Dental Procedures	$10.00	
Major Dental Orthodontia		No coverage if over age 21

This Verification of Coverage is not a guarantee that benefits will be paid. All benefit determinations are subject to eligibility at the time of service and benefit provisions of the plan.
Laboratory Services must be performed by Dr. Angela Martin or Quality of Life Services; or by their referral to LabCorp of Anniston Alabama.
* Routine mammograms must be performed by NE Alabama Regional Medical Center. For an appointment, contact Anniston Quality Health Care. The results will be sent to Anniston Quality Health Care.
Prescription Drug coverage provided through **Navitus Health Solutions.**
The Tolbert Plan is a result of a mass tort settlement, and does not function as primary health coverage. The Tolbert Plan is a secondary payor for the pre-determined Tolbert-sponsored medical plan benefits. This plan does not replace your current benefits and is secondary to benefits for which you are eligible. As a member, your responsibility is to disclose all coverage you have or all coverage for which you believe you may be eligible.
Questions regarding eligibility and claims? Call CTI Administrators at (888)220-2439.

Proposed Staff Resumes

Donald R. Brandt, FLMI
President and Partner

CTIA President Donald R. Brandt has over 35 years of experience in system design and management of claim administration. As President, Mr. Brandt's duties include general management and product development. He has been with CTIA since founding it in 1990.

As founder and President of Benefit Administrators of America, Inc., Mr. Brandt was responsible for developing a Third Party Administration company generating over $5.6 million in revenue per year.

As Senior Vice President for Kirke-Van Orsdel, Inc. (KVI), Mr. Brandt was responsible for the design and implementation of KVI's automated enrollment and claim systems. His management responsibilities included information systems, marketing, and administration. He was responsible for the management of five departments with over 350 employees.

As Assistant Vice President for Marsh and McLennan at Smith-Sternau, he was responsible for the design and management of insurance systems.

As Technical Staff Member for Computer Sciences Corporation, he performed systems analysis and design for the Joint Chiefs of Staff, Reconnaissance Information and Electronic Warfare Information Systems.

Mr. Brandt has a Graduate Certificate in Computer Systems from American University and received a Bachelor's Degree (Business Major) from the University of Maryland. He is a licensed Life, Accident & Health agent and the FLMI designation from the Life Office Management Association.

Mr. Brandt is a member of the Self Insurance Institute of America, International Foundation of Employee Benefits and the FLMI Society of Greater Des Moines. Mr. Brandt is also active in numerous civic organizations. He served in the United States Navy from 1967-1969.

Patricia C. Gagne, FLMI
Vice President and Partner

Patricia C. Gagne, Vice President of CTIA, has 27 years of experience in administration, consulting, and brokerage of group benefit programs. As Vice President, Ms. Gagne's responsibilities include oversight of claims processing and customer service, product development and general administration of the firm's audit related activities. Ms. Gagne has been involved extensively in the development of CTIA's affiliated corporation, Claim Technologies Incorporated ("CTI"), program of continuous quality improvement for benefit plan administration. CTI's continuous quality improvement program includes electronic and statistical sample claim audits of medical, pharmacy, dental, vision, disability, and flexible benefits. Ms. Gagne manages the audit operations of CTI and is responsible for the on-going training and development of the CTI audit staff. She has 20 years of experience in managing programs for continuous quality improvement of group health insurance plans.

Prior to joining CTIA in its formative stages, Ms. Gagne's most recent position was as Director of Marketing for Benefit Administrators of America, Inc. (BAAI), a third party administrator of employer and association group benefit plans. In her tenure with BAAI, Ms. Gagne was responsible for customer service, consulting and plan design as well as the development and maintenance of relationships with insurance carriers, agents, and brokers. She was responsible for research of government regulations affecting the insurance industry including ERISA, COBRA, Section 125, and Section 89. She also provided consulting services to BAAI clients in the areas of cost containment and plan funding alternatives. Through her contributions, BAAI more than doubled its client base to become one of the nation's largest third party administrators.

Prior to her experience at BAAI, Ms. Gagne was employed by Equitable Life Assurance Society of the U.S. She was Claims Manager there for four years following two years as a Claims Examiner of group insurance claims for self-insured plans.

Ms. Gagne attended Hofstra and Grand View Universities, achieved FLMI designation from the Life Office Management Association and is a member of the Iowa Society of Health Underwriters. She has testified before the United States Congress on issues related to self-funding of Association Health Plans.

Daniel L. Montgomery, FLMI, J.D., MHP, HCAFA
Vice President

Daniel L. Montgomery, Vice President of CTIA, has more than 25 years of experience in administration of individual and group benefit programs. As Vice President, Mr. Montgomery has primary responsibility for contract administration, regulatory relationships and compliance in support of the firm's general administration and audit activities.

Prior to joining CTI, Mr. Montgomery was Vice President of Claims and Professional Relations for ARAG, a legal insurance company. He also led the Claims and Provider Network Management departments for the American Enterprise companies of American Republic and World Insurance companies. In his tenure at American Enterprise, he was responsible for contracting with the preferred provider organizations through which health care services were provided to customers. He directly negotiated PPO contracts on behalf of the companies, integrating staff and processes to lower costs and improve efficiency. While leading the claims department at American Republic, he was responsible for both life and health claims and introduced process changes to improve claims financial quality, reduce inaccurate benefit payments, implement overpayment recovery programs and increase electronic data interchange of claims and auto-adjudication ratios. He provided leadership to ensure processes were in place to monitor state and federal legislative and regulatory changes and to coordinate administrative compliance with laws and regulations affecting claims payment and customer service. The cumulative effect of his contributions was a complete turnaround in the performance of the claims organization, with performance results that meet or exceed industry standards.

His professional experience also includes positions with Coventry Healthcare and Wellmark BlueCross BlueShield. While at Coventry, Mr. Montgomery led staff responsible for grievances and appeals, training and system support. At Wellmark, he followed six years as associate counsel with line leadership in claims, customer service and benefit administration. He has had extensive involvement with the developing law of subrogation under both state and federal laws and the implementation of procedures to ensure accurate coordination of benefits.

Mr. Montgomery holds B.A. and M.A. degrees from Iowa State University and received his law degree at Drake University. He is a member of the Iowa State Bar Association and the past chair of the Claims and Administrative Operations

Committee of the trade association, America's Health Insurance Plans (AHIP). He holds the FLMI and ACS designations from the Life Office Management Association and the Managed Healthcare Professional (MHP) and Health Care Anti Fraud Associate (HCAFA) designations from AHIP.

David M. Bade, HIA, HCAFA
Claims Adjudicator/ Customer Service

David M. Bade, Senior Auditor and Claims Processor of CTIA, has over 19 years experience in group health claims administration and over 13 years of medical, pharmacy, dental, pharmacy, flexible spending and COBRA plan audit experience.

Prior to joining CTIA, David was employed by CIGNA Healthcare as a Team Leader. In this capacity he was responsible for the day to day management of a group of claims examiners and customer service representatives as well as being the primary client contact regarding claims related issues. Previous to that he was a Technical Assistant, where he assisted claims examiners in the processing of claims that required in-depth analysis. In this capacity he was responsible for the initial training and continued development of the examiners assigned to him. He started at CIGNA as a claims examiner where he was exposed to many different types of policy and plan types.

Mr. Bade is a graduate of the University of Wisconsin, where he received a Bachelor of Arts Degree (Economics Major). He is a member of the Iowa Association of Life Underwriters and the Des Moines Life & Health Claim Association. He has continued his education while taking insurance related courses through HIAA and LOMA. He has continued his education through the America's Health Insurance Plans (AHIP) and has earned the HIA designation (Health Insurance Associate) and the HCAFA designation (Health Care Anti-fraud Associate).

Jon White
GHSU Project Role: Senior Claims Processor and Trainer

Jon R. White, Senior Claims Processor of CTIA, has over 17 years experience in group health claims administration, training, auditing and customer service.

Prior to joining CTI in 2010, Jon was employed by West Asset Management as a Learning Facilitator. His responsibilities included the hiring and training of new employees, where he would train new employees how to conduct an audit of medical claims on behalf of third party vendors. Previously, he was employed at Principal

Financial Group, where he was progressively promoted to the position of Lead Trainer. As a Lead Trainer his primary responsibility was to train new and existing employees how to process medical, dental, vision, pharmacy and flexible spending claims. He kept staff updated on new federal and state insurance regulations. While at Principal, Mr. White was a claims examiner and Team Lead for Fleetwood Enterprises, a group client whose members submitted more than 20,000 claims each month.

Mr. White has a diploma from Salt Lake Community College. He has been certified for his knowledge of HIPAA and ERISA, and has continued his education while taking insurance related courses through the America's Health Insurance Plans (AHIP).

Donna J. Weber
Senior Claims Processor

Donna J. Weber, Senior Claims Processor of CTI Administrators, Inc., has over 30 years experience in claims administration, auditing, and customer service.

Prior to joining CTIA in 2010, she was employed by West Asset Management, a firm which identifies and pursues recoveries on behalf of third-party payors. Previously, she was employed by Principal Financial Group, where she held numerous positions. Her most recent experience with Principal was as a Senior Quality Review Auditor where she managed team of employees who performed post-payment review of claims to ensure proper payment and to identify potential overpayments or fraud.

While at Principal, Ms. Weber was responsible for processing claims for the Iowa Association of School Boards, a group client whose members submitted more than 20,000 claims monthly.

Ms. Weber has continued her education while taking insurance related courses through the America's Health Insurance Plans (AHIP).

Diane M. Wright
IT Manager

Diane M. Wright, IT Manager of CTIA, has over 19 years of systems and procedural development experience. She has overall responsibility for development and management of the company's audit systems and computing resources for the company including the SQL Server database administration. She has extensive

experience in converting large medical, pharmacy, disability, and dental claim files to CTIA's proprietary audit database/system.

Prior to joining CTI, Diane was with the Iowa League of Cities as Controller. She was responsible for preparing all financial statements, budget and statistical information for the Iowa Municipalities Workers' Compensation Association. She was instrumental in bringing the outsourced services of underwriting, loss control, financial and claim administration under internal management. This included the development and implementation of automated systems and procedures. Among other duties, she managed relationships with agents, brokers, reinsurance carriers and third party administrators.

Prior to the League, Diane was with the Risk Management Department at Iowa Methodist Medical Center. Her responsibilities included processing workers' compensation claims and hospital incident occurrence reports.

Ms. Wright is a graduate of the University of Northern Iowa where she received a Bachelor of Fine Arts degree in education. She has attended numerous career-related courses through Drake University, Des Moines Area Community College, and numerous claim administration system courses. She has completed numerous IT courses including Visual Basic programming and SQL Server database administration.

Kelly L. Barnett, HIA
Senior Auditor and Trainer

Kelly L. Barnett joined CTIA, in 2006. She brings over 20 years experience t in the health insurance industry. Her expertise includes administration of large group HMO, TPA, PPO, fully-insured, and self-insured, Medical, Dental, Pharmacy, Vision, and Flexible Spending Products.

Prior to joining CTIA, Ms. Barnett was with Catalyst Rx and as a member of the Client Services Team, participated in the implementation of Catalysts Rx's largest client with a 2 million multi-product member base.

Prior to joining Catalyst Rx, Ms. Barnett held the position of Client Service Consultant with CIGNA HealthCare. She managed large group multi-product health accounts by working directly with clients, brokers, and matrix partners. She was responsible for consulting, training and advising on the administration of employee benefit claims. This included implementing plan changes and process improvements based on client requests and expectations. Ms. Barnett managed performance guarantee contracts representing $1.4 million at risk if guarantees were not met.

Ms. Barnett is a graduate of Upper Iowa University, where she received a Bachelor of Science Degree in Business Administration with honors. She has continued her education through America's Health Insurance Plans (AHIP) and has earned her Health Insurance Associate (HIA) designation. She is currently continuing her education in Certified Employee Benefit Specialist (CEBS) courses.

Judith A. Lucas, CFE, HIA

IT Special Projects

Judith A. Lucas has over 28 years experience in claims administration and auditing. She has been an IT Special Projects associate with CTIA for 6 years.

Prior to joining CTIA, Judy was employed at Norwest Financial as the Claims Supervisor in their personnel department for the administration of their self-funded medical, dental, vision, and long-term disability plans. In this capacity she was responsible for the day to day management of all phases of the claims administrations of these plans including claims examiners, eligibility administrators, claim computer operations and clerical staff.

Prior to this she worked at Benefit Administrators of America (BAAI) as a claims examiner and subsequently promoted to a unit leader. Before BAAI, she was the Vice President of Administration at American Administrators in Des Moines. She previously worked as a medical and dental claims examiner at American Trust Administrators in Kansas City, Employee Benefit Administrators, LaHood & Associates, and Washington National Insurance Company.

She is a member of the Iowa Association of Life Underwriters and the Des Moines Life & Health Claim Association. She is a member of the Iowa Association of Life Underwriters (ICA) and the Des Moines Life & Health Claim Association. A Certified Fraud Examiner (CFE), she has continued her education while taking insurance related courses through ICA and America's Health Insurance Plans (AHIP) and has earned the HIA designation (Health Insurance Associate), the Managed Healthcare Professional designation (MHP), the HCAFA designation (Health Care Anti-Fraud Associate), the HCSA designation (Health Care Customer Service Associate), the EHBA designation (Employee Healthcare Benefits Associate), the HIPAA designation (Health Insurance Portability and Accountability Act Associate), the HIPAAP designation (HIPAA Professional), the Business Process Advisor (BPA), the DIA (Disability Income Associate), and the DHP (Disability Healthcare Professional). She is also a Certified COBRA Administrator.

Robert A. Rater
Vice President Finance

Robert A. Rater, Vice President of CTI Administrators, Inc., has thirteen years of experience in accounting and a year in office management. As Accounting Manager, Mr. Rater's responsibilities include maintaining and preparing all financial statements and cash flow projections, and the development and implementation of accounting procedures and routines.

Mr. Rater is also responsible for the computation, processing, and reporting of carrier premiums for medical, dental, disability, and life insurance as well as preparation of statistical information regarding premiums, eligibility, benefit costs and claim trends.

Prior to employment with CTIA, he was Accounting Manager for Acsys, Inc. In that capacity, Mr. Rater was responsible for preparing and maintaining the accounting information for the Western Division of Acsys. Other areas of responsibility included supervision of support personnel.

Mr. Rater received his Bachelor's degree in Accounting from Iowa State University and graduated with honors.

Randall J. Brandt
Vice President

Randall Brandt, Vice President Administration and Marketing, has nine years experience in direct marketing and administration in the insurance industry.

Mr. Brandt's responsibilities at CTI Administrators include, overseeing the day to day marketing and administration of its clients fully insured and self-funded insurance plans. These plans include medical, dental, vision, life and short and long term disability. Mr. Brandt is also in charge of preparing proposals, performing plan comparisons, attending regional and national conferences, establishing and maintaining national PPO networks, assisting in plan design, creating benefit booklets, and recouping delinquent accounts. Mr. Brandt is also responsible for overseeing the COBRA and Retiree Billing Department and acting as an Account Executive between CTI Administrators and its COBRA clients.

Prior to working at CTI Administrators, Mr. Brandt worked for Allied Insurance Company (A member of Nationwide Insurance) in their property and casualty sales. Mr. Brandt also has 8 years of management and sales experience in the retail sector, and two

years of teaching Business Administration and Marketing in South America.

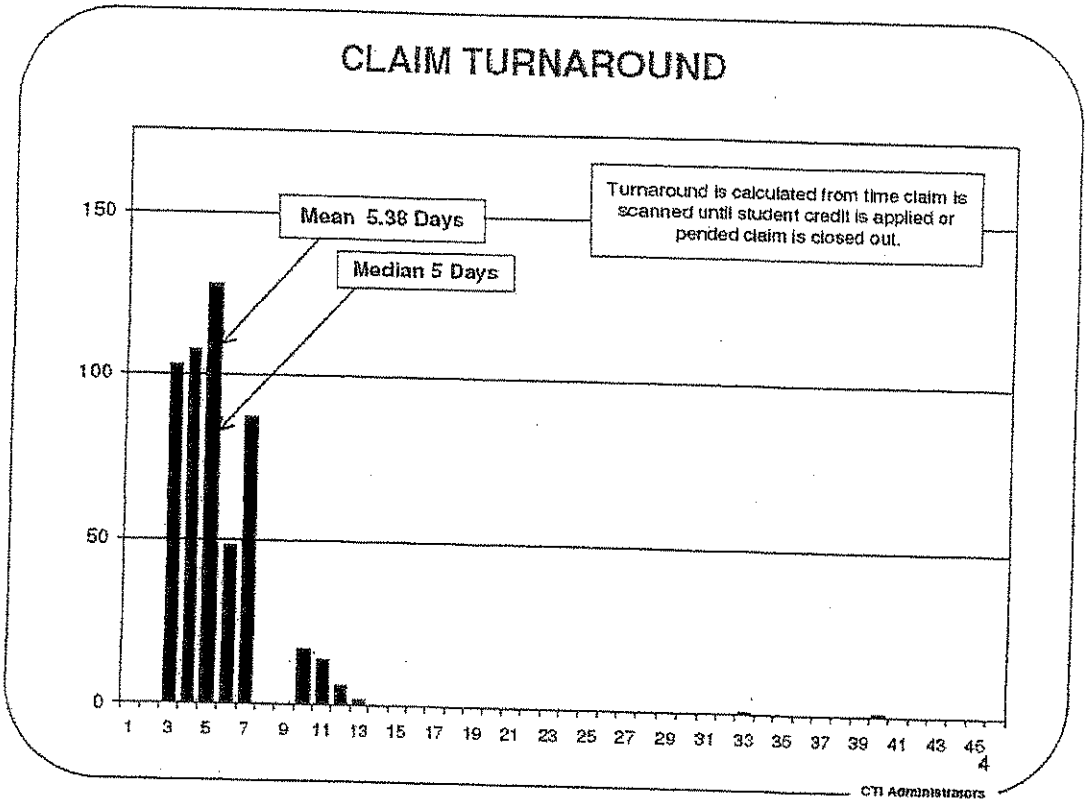
Mr. Brandt has a Bachelor's degree from the University of Louisiana, Lafayette with an emphasis on Business Administration and Marketing. Mr. Brandt is also licensed in 44 states as a Life, Accident, and Health Insurance Agent. Mr. Brandt is a Dale Carnegie graduate and a member of the Iowa Association of Health Underwriters, and the Iowa Association of Business and Industry. Mr. Brandt has earned a certificate in Benefit Plan Administration from the International Foundation of Employee Benefits.

J. Lynn Cozad, CCA, HIA, HCSA
Manager of Enrollment and Claim Support

J. Lynn Cozad, Manager of Enrollment and Claim Support at CTIA has over 15 years of experience in the health insurance industry. Her experience includes self-funded administration fee pricing, marketing, underwriting, and administration of group benefit programs. Ms. Cozad's responsibilities include overseeing the COBRA administration for national and local clients, and acts as the primary contact for these clients and their insurance carriers. In addition, she performs a broad range of administrative duties regarding membership, eligibility and customer service and oversees the daily operations of the enrollment department.

Prior to joining CTIA, Lynn was an Account Manager at Lamair-Mulock-Condon Co. In this position she acted as the liaison between employers and insurance carriers to assist with open enrollments, marketing reinsurance, and the renewal employee benefit plans. Prior to that, Ms. Cozad was a Marketing Coordinator with Wellmark Administrators, Inc., and a Group Life and Health Underwriter with Principal Financial Group. In these positions, she was responsible for determining self-funded group benefit plan administration fees, marketing reinsurance, issuing proposals for the third party administration, and new case implementation. In addition, she acted as the group primary account contact. Ms. Cozad also has three years of management experience with USG Annuity and Life Company as the Agent Licensing Manager.

Ms. Cozad has attended career related courses including business writing, customer service, and leadership training. She has continued her insurance education through AHIP and has earned the HIA and HCSA designations and a Customer Service Certificate. Lynn is also a Certified COBRA Administrator.


CLAIM TURNAROUND
Mean 5.38 Days
Median 5 Days
Turnaround is calculated from time claim is scanned until student credit is applied or pended claim is closed out.
150
100
50
0
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45
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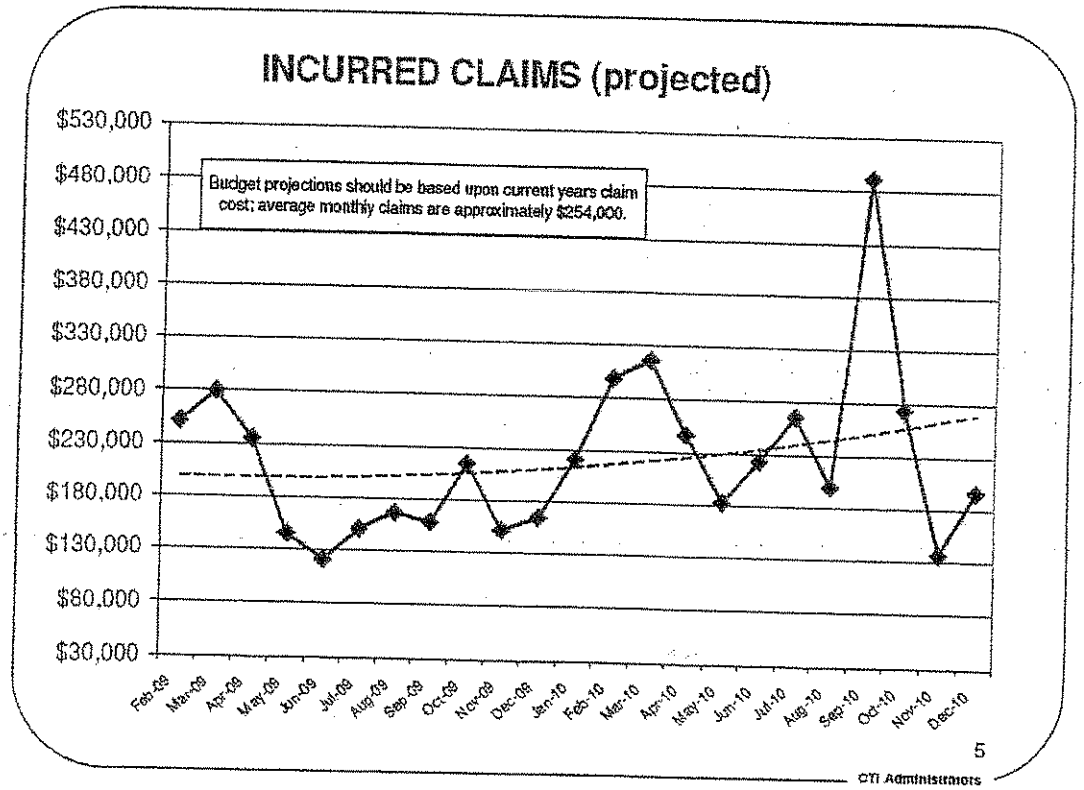
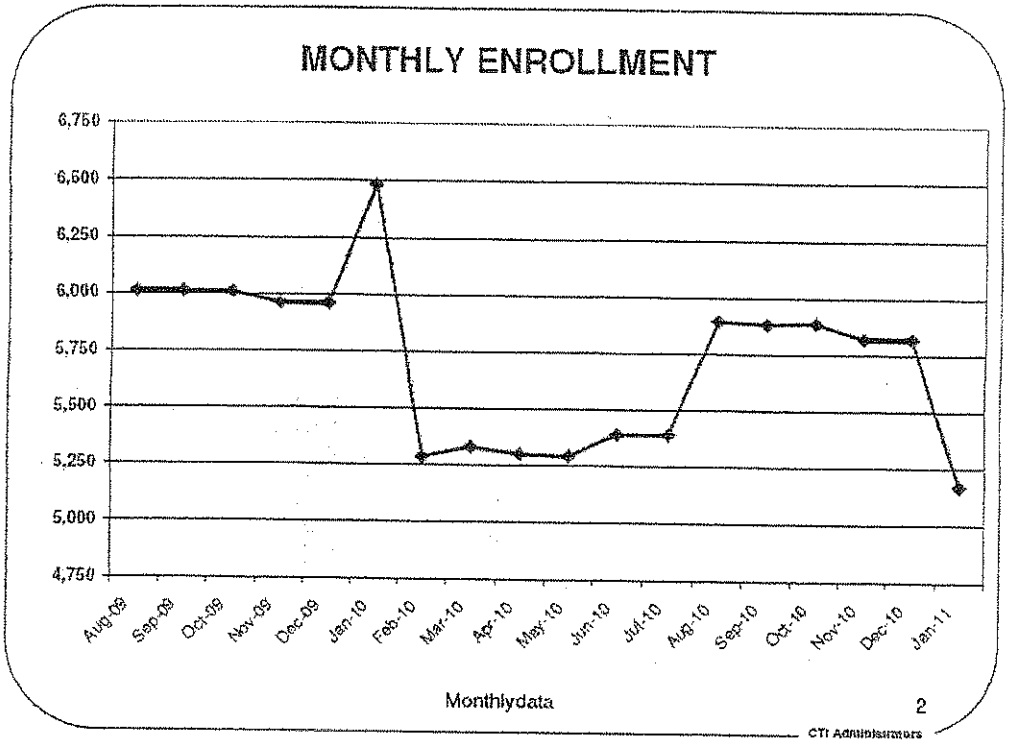
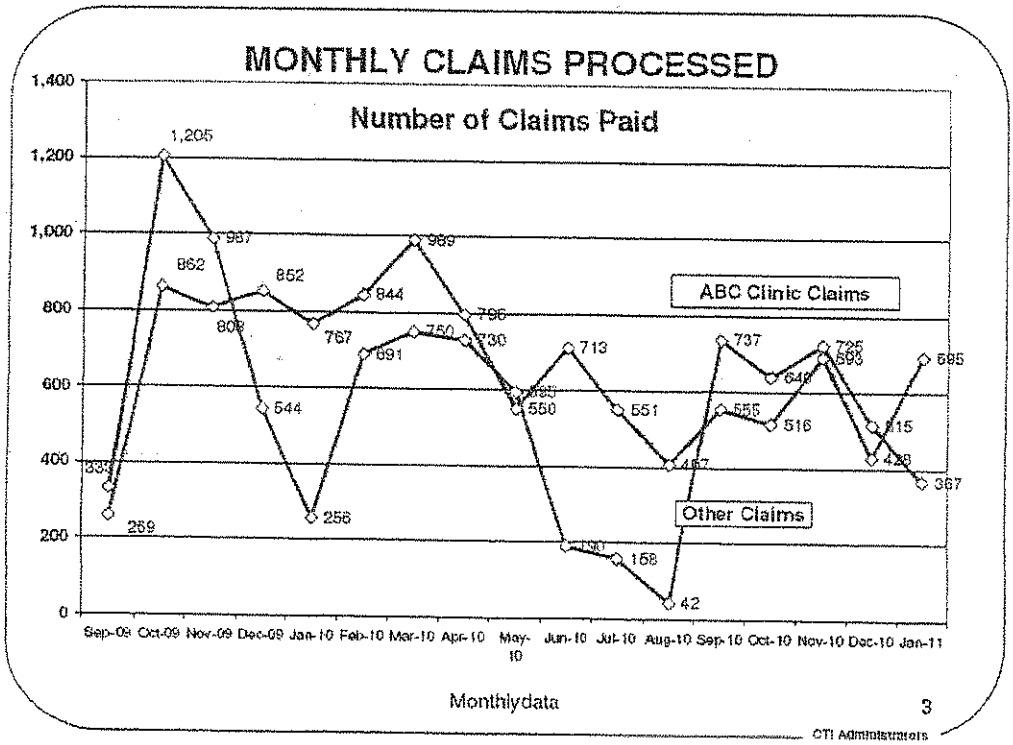
CTI Administrators


INCURRED CLAIMS (projected)
Budget projections should be based upon current years claim cost; average monthly claims are approximately $254,000.
$530,000
$480,000
$430,000
$380,000
$330,000
$280,000
$230,000
$180,000
$130,000
$80,000
$30,000
Feb-09 Mar-09 Apr-09 May-09 Jun-09 Jul-09 Aug-09 Sep-09 Oct-09 Nov-09 Dec-09 Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10
5
CTI Administrators

Sample Quarterly Reports





Mandatory Requirements – Appendix A

REQUEST FOR PROPOSALS FROM THIRD PARTY HEALTH CARE ADMINISTRATORS FOR THE ADMINISTRATION OF A MEDICAL MONITORING PROGRAM
IN THE MATTER OF
PERRINE, ET AL., v. E.I. DUPONT DE NEMOURS AND COMPANY, ET AL.

APPENDIX A
ACCEPTANCE OF MANDATORY RFP REQUIREMENTS

The following are the mandatory RFP requirements that shall be met by the successful bidder

General

1. Bidder agrees that the response to the RFP and any subsequent documentation (best and final offer, finalist presentation, or memo) shall be considered part of the final agreement and contract.

2. Bidder will report internal fraud unit findings on book-of-business on an annual basis

3. The initial TPA contract term shall be three (3) years, renewable in one-year extensions at the option of the Claims Administrator. However, bidder agrees to a termination without cause provision whereby the Special Master may terminate the agreement upon 30 days prior written notice to Bidder. Bidder will be allowed to terminate the agreement upon 180 days prior written notice to the Special Master.

Account Management

4. Bidder will provide a representative to attend the Project meetings on a quarterly basis in West Virginia.

5. Bidder will maintain claims data, including utilization at no additional charge to the Project.

6. Bidder will assign a team to work with the Claims Administrator/Special Master, Finance Committee, and Claimant Advisory Board to create the medical monitoring plan.

Plan Design

7. Bidder will provide the Special Master with relevant plan management decisions that lower cost trend.

Data, Systems, and Reporting

8. Bidder will accept electronic data transfer and administer claimant information in compliance with HIPAA standards for privacy, security and electronic data interchange

9. Bidder will provide claims data to the Project. Claims data extracts shall be provided at a reasonable fee to the Project.

10. Bidder will maintain complete records of all claims and payments for a minimum of seven (7) years or greater as required by law.

11. Bidder will provide comprehensive financial and utilization reports. Reports shall be provided on a monthly, quarterly and annual plan year basis via hard copy and by electronic mail.

Audit Rights

12. Bidder agrees to provide unrestricted operational and financial audit rights to the Project in relation to the provision of services to the Project claimants.

13. Bidder agrees to properly disclose any and all sources of revenue and other levels of funding aside from that provided by the Project with regard to the administration of services to the Project claimants.

Financial Proposal

14. Bidder agrees to review of the contracted pricing if it is determined to be uncompetitive with the market. An independent third party may be utilized to conduct the pricing review and submit a mutually agreeable methodology for evaluating competitiveness.

15. Bidder guarantees the financial elements of its proposal throughout the term of the contract.

Consent to Jurisdiction and Waiver of Objections

16. Bidder, by its execution of the Agreement, submits to the jurisdiction of the Circuit Court of Harrison County, West Virginia in Pauline, et al. v. E. I. DuPont De Nemours and Company, et al., Case No. 01-C-296-2 (the "DuPont Case") for all purposes related to or arising out of Bidder's proposal to provide, or, if Bidder is selected as a provider, Bidder's provision of medical monitoring administrative services to the Project. In addition, Bidder hereby waives any and all objections it might otherwise assert to the aforesaid jurisdiction, venue, or authority of the Court in the DuPont Case to hear and determine any and all disputes that might arise out of or be related to the Services, reserving its rights to be heard in connection therewith and to appeal, it may be advised, from any adverse determination of the Court in the DuPont Case.

Confidentiality Agreement

17. Bidder understands that the Court in the DuPont Case has ordered that the identity of claimants in the DuPont Case and the details of chemical exposure, medical conditions and histories, and payments for medical monitoring be kept confidential, and state that Bidder will not reveal this information to anyone outside of authorized personnel in my company unless Bidder has express

permission to do so from the Honorable Thomas A. Beddall or the Special Master Claims Administrator. Bidder further understands that if Bidder violates this pledge of confidentiality, Bidder is subject to being brought before the Honorable Thomas A. Beddall for investigation and possible sanctions for this breach.

Company Name:

CTI ADMINISTRATORS, INC.

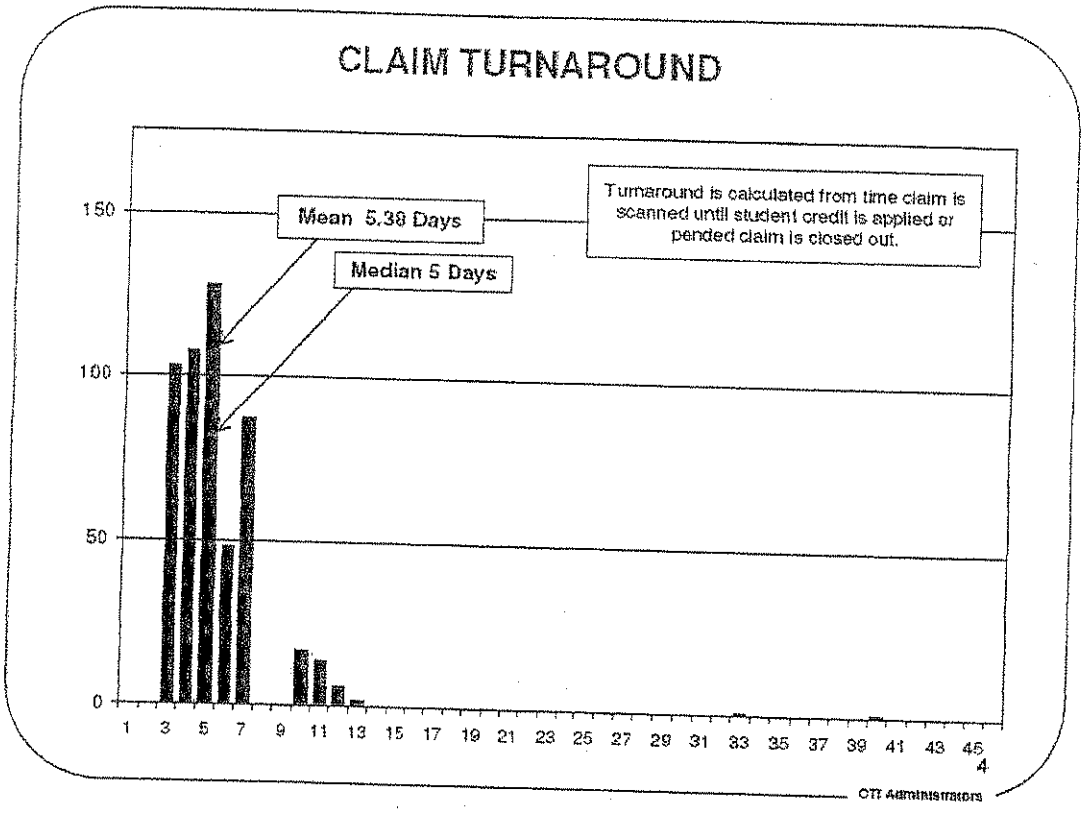
By: _____ 2/14/2011
Sign Name Date

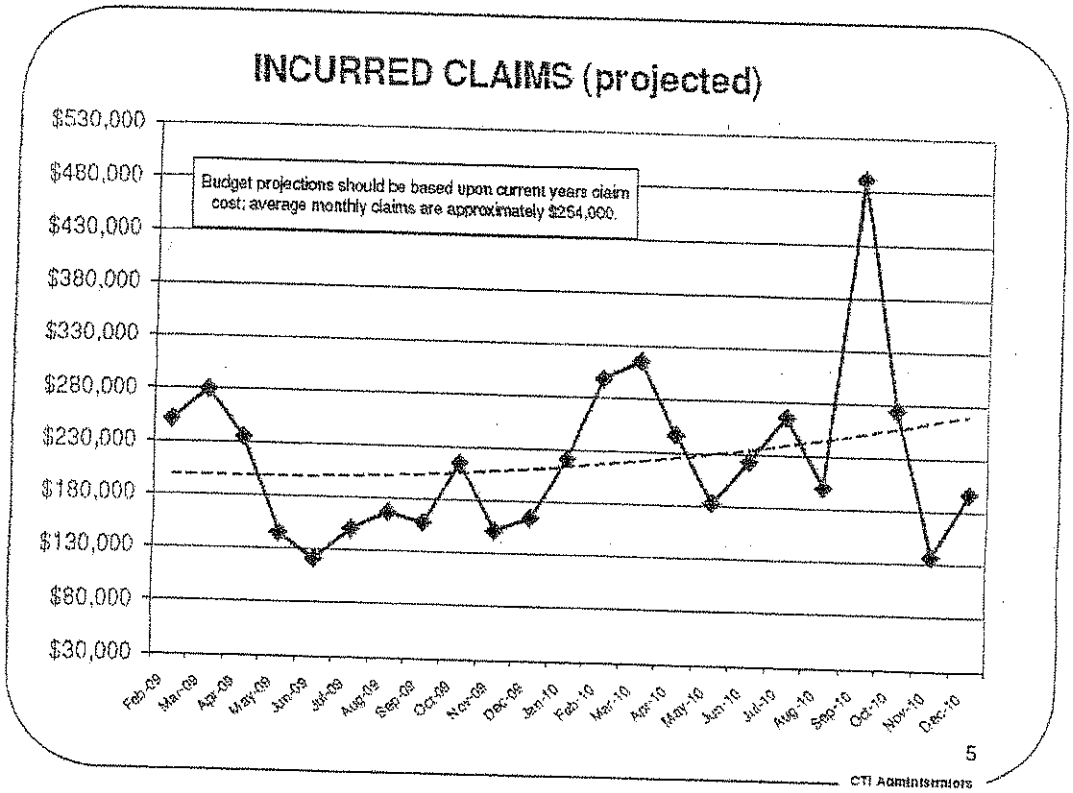
Donald R. Dorsey
Print Name of Signing Person

President
Title With the Company

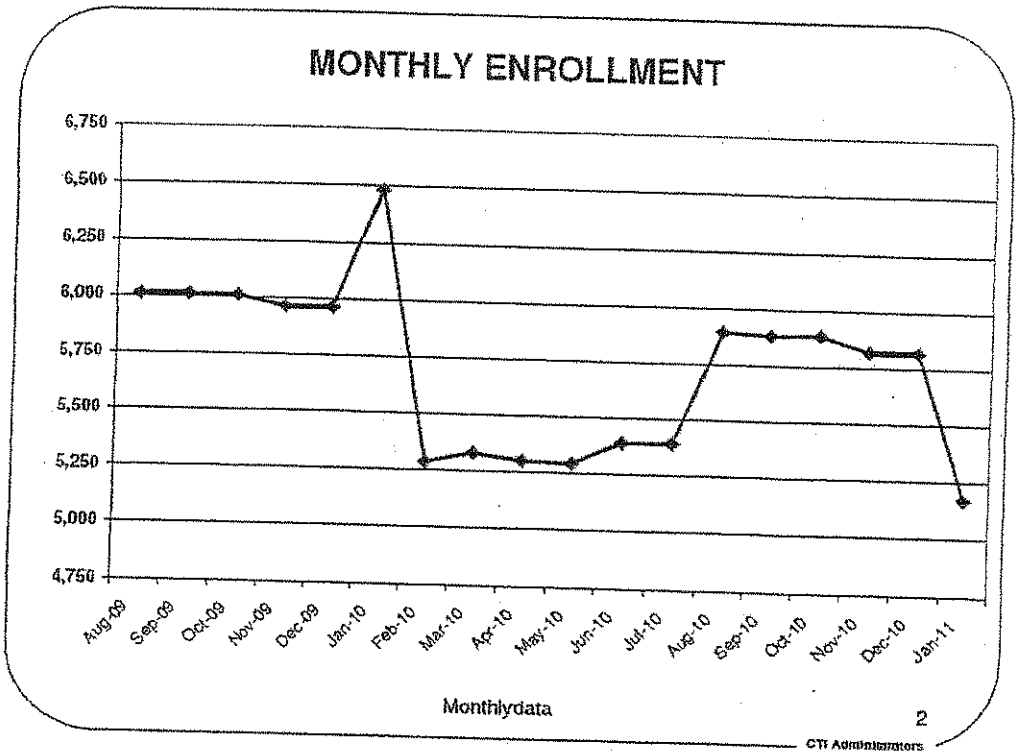
By signing the above, I, Donald R. Dorsey hereby represent that I have the authority and power to bind CTI Administrators, Inc. (company name) and that I will comply with all of the terms as set forth hereinabove.

EXHIBIT F


CLAIM TURNAROUND
Mean 5.38 Days
Median 5 Days
Turnaround is calculated from time claim is scanned until student credit is applied or pended claim is closed out.
150
100
50
0
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45
4
CTI Administrators


INCURRED CLAIMS (projected)
Budget projections should be based upon current years claim cost; average monthly claims are approximately $264,000.
$530,000
$480,000
$430,000
$380,000
$330,000
$280,000
$230,000
$180,000
$130,000
$80,000
$30,000
Feb-09 Mar-09 Apr-09 May-09 Jun-09 Jul-09 Aug-09 Sep-09 Oct-09 Nov-09 Dec-09 Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10
5
CTI Administrators

Sample Quarterly Reports



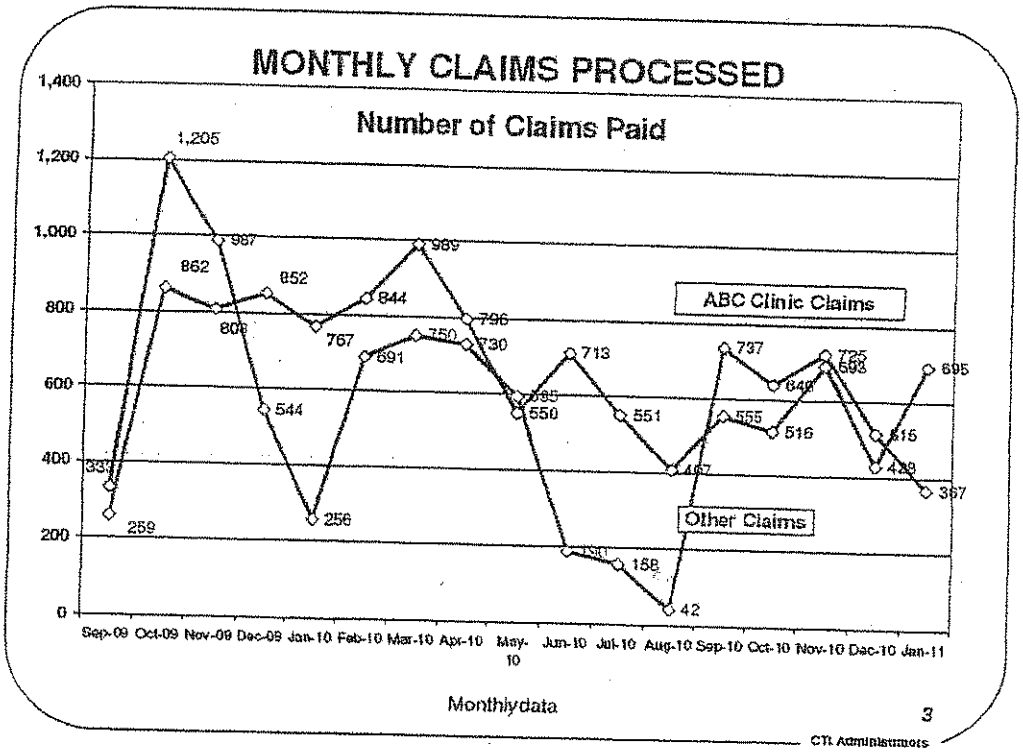


EXHIBIT G

Fee Pricing Schedule

Description	Units	Fees		
		Year 1	Year 2	Year 3
Initial Fee to set-up CTIA Systems due at signing of Administration Agreement	Per Year	$6,500	$0	$0
Provider Negotiations of Fee Schedules Determine Fee Schedules Negotiate Contracts Set-up EDI Interface	Per Hour	Hourly Fees Travel, Lodging & Out-of-Pocket Expenses		
Communication Materials as coordinated with and authorized by the Special Master, including but not limited to: Letters and Envelopes Schedule of Benefits Newsletters Email Notifications		Design & materials cost + 10% surcharge Mail house charges + 10% surcharge Postage at actual cost Actual cost + 10%		
Production and Distribution of Plastic ID Cards	Per ID Card	$1.85	$1.90	$1.95
		Postage at actual Cost		
Administrative Services as defined in the Proposal Summary including the following: Enrollment Services, Financial Services, Claim Processing, EOBs, Customer Service, Toll Free Telephone Service, On-line Verification of Coverage for Providers, EDI Clearing House Fees, Record Maintenance, Secure Off-site Back-up of Records		Per Active Claimant Fee per Month		
	Number of Active Claimants	Year 1	Year 2	Year 3
	1,000-1,500	$5.80	$6.03	$6.27
	1,501-2,000	$4.14	$4.31	$4.48
	2,001-2,500	$3.22	$3.35	$3.49
	2,501-3,000	$2.64	$2.74	$2.85
	3,001-3,500	$2.23	$2.32	$2.41
	3,501-4,000	$1.93	$2.01	$2.09
	4,001-4,500	$1.71	$1.77	$1.85
	4,501-5,000	$1.53	$1.59	$1.65
	Postage to be Reimbursed at Actual Cost			
Scheduling/ Appointment Reminder Letters Up to three letters per Participant every other year	Per letter	$1.40	$1.45	$1.50
		Postage at actual Cost		
Central Repository for Test Results Follow-up letters to Providers to obtain test results Collection of test results Maintenance of test results Download of test results to clinical research facility Secure off-site Back-up of all records	Per Test	$5.10	$5.30	$5.50
Quarterly Meetings Reports Presentation	Per Meeting	$1,000 per meeting Travel, Lodging & Out-of-Pocket Expenses		
Consulting Services, other than those specifically identified by the Administrative Services Agreement, and authorized by the Special Master	Per Hour	Hourly Fees Travel, Lodging, & Out-of-Pocket Expenses		
Hourly Fees	Per Hour	Partner $220 Account Executive $175 Senior Consultant $175 IT Consultant $135 Consultant $130 Travel at 50% of normal hourly fees		

EXHIBIT H

REQUEST FOR PROPOSALS FROM THIRD PARTY HEALTH CARE ADMINISTRATORS FOR THE ADMINISTRATION OF A MEDICAL MONITORING PROGRAM
IN THE MATTER OF
PERRINE, ET AL., v. E.I. DUPONT DE NEMOURS AND COMPANY, ET AL.

APPENDIX A
ACCEPTANCE OF MANDATORY RFP REQUIREMENTS

The following are the mandatory RFP requirements that shall be met by the successful bidder:

General

1. Bidder agrees that the response to the RFP and any subsequent documentation (best and final offer, finalist presentation, or memo) shall be considered part of the final agreement and contract.

2. Bidder will report internal fraud unit findings on book-of-business on an annual basis.

3. The initial TPA contract term shall be three (3) years, renewable in one-year extensions at the option of the Claims Administrator. However, bidder agrees to a termination without cause provision whereby the Special Master may terminate the agreement upon 30 days prior written notice to Bidder. Bidder will be allowed to terminate the agreement upon 180 days prior written notice to the Special Master.

Account Management

4. Bidder will provide a representative to attend the Project meetings on a quarterly basis in West Virginia.

5. Bidder will maintain claims data, including utilization at no additional charge to the Project.

6. Bidder will assign a team to work with the Claims Administrator/Special Master, Finance Committee, and Claimant Advisory Board to create the medical monitoring plan.

Plan Design

7. Bidder will provide the Special Master with relevant plan management decisions that lower cost trend.

Data, Systems, and Reporting

8. Bidder will accept electronic data transfer and administer claimant information in compliance with HIPAA standards for privacy, security and electronic data interchange.

4609-1-GG-1

9. Bidder will provide claims data to the Project. Claims data extracts shall be provided at a reasonable fee to the Project.

10. Bidder will maintain complete records of all claims and payments for a minimum of seven (7) years or greater as required by law.

11. Bidder will provide comprehensive financial and utilization reports. Reports shall be provided on a monthly, quarterly and annual plan year basis via hard copy and by electronic mail.

Audit Rights

12. Bidder agrees to provide unrestricted operational and financial audit rights to the Project in relation to the provision of services to the Project claimants.

13. Bidder agrees to properly disclose any and all sources of revenue and other levels of funding aside from that provided by the Project with regard to the administration of services to the Project claimants.

Financial Proposal

14. Bidder agrees to review of the contracted pricing if it is determined to be uncompetitive with the market. An independent third party may be utilized to conduct the pricing review and submit a mutually agreeable methodology for evaluating competitiveness.

15. Bidder guarantees the financial elements of its proposal throughout the term of the contract.

Consent to Jurisdiction and Waiver of Objections

16. Bidder, by its execution of the Agreement, submits to the jurisdiction of the Circuit Court of Harrison County, West Virginia in Perrine, et al., v. E. I. DuPont De Nemours and Company, et al., Case No. 04-C-296-2, (the "DuPont Case") for all purposes related to or arising out of Bidder's proposal to provide, or, if Bidder is selected as a provider, Bidder's provision of medical monitoring administrative services to the Project. In addition, Bidder hereby waives any and all objections it might otherwise assert to the aforesaid jurisdiction, venue, or authority of the Court in the DuPont Case to hear and determine any and all disputes that might arise out of or be related to the Services, reserving its rights to be heard in connection therewith and to appeal, it may be advised, from any adverse determination of the Court in the DuPont Case.

Confidentiality Agreement

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permission to do so from the Honorable Thomas A. Beddell or the Special Master/ Claims Administrator. Bidder further understands that if Bidder violates this pledge of confidentiality, Bidder is subject to being brought before the Honorable Thomas A. Beddell for investigation and possible sanctions for this breach.

Company Name:

CTI ADMINISTRATORS, INC.

By: [signature]
Sign Name

3/14/2011
Date

DONALD R. BRANDT
Print Name of Signing Person

PRESIDENT
Title With the Company

By signing the above, I, DONALD R. BRANDT hereby represent that I have the authority and power to bind CTI ADMINISTRATORS, INC (company name), and that I will comply with all of the terms as set forth hereinabove.

EXHIBIT I

West Virginia University
SCHOOL OF MEDICINE

Anticipated health effects of the contamination of Speiter, WV and surrounding communities with arsenic, cadmium, and lead, and recommendations for medical monitoring.

March 30, 2007

The residents in the area around Speiter have been exposed to arsenic, cadmium, and lead an extended time. There are clear associations between arsenic, cadmium, and lead with significantly increased risks of developing disease, primarily cancers. IARC lists arsenic and cadmium in Group 1 (Carcinogenic to Humans). Lead is listed in Group 2A (Probably Carcinogenic to Humans). Additionally, there have been several studies documenting increased cancer risk around smelter sites[1,2,3,4] where similar exposures have occurred.

I have reviewed the Dr. Kornberg's Initial report of November 11, 2005 as well as his rebuttal report of March 3, 2006. I concur with most of Dr. Kornberg's conclusions and recommendations, however I have several updates to both focus the exams to those conditions associated with the arsenic, cadmium and lead exposures as well as to update the science to reflect new technology available for medical monitoring.

DEFINITION OF GEOGRAPHICAL TERMS

Dr Brown, in his incremental cancer risk map, shows the residual contamination across the class area. There are three distinct areas within the class area, separate in their degree of contamination, and thus the risk to the residents in those areas.

- Zone 1 ≡ The area delineated by Dr. Brown as within the $5x10^{-4}$ incremental risk contour for developing cancer.
- Zone 2 ≡ The area between the 5×10^{-4} incremental risk contour and the 1×10^{-4} incremental risk contour.
- Zone 3 ≡ The area within the class area but outside the 1×10^{-4} cumulative incremental risk contour.

The residents in all areas have a significantly increased risk of developing disease based upon their residence and exposures in the area. The toxic and carcinogenic effects of all

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[1] Brown LM, Pottern LM, Blot WJ. Lung Cancer in Relation to Environmental Pollutants Emitted from Industrial Sources. *Environmental Research* Vol 34, 250-261.

[2] Pershagen G. *Lung Cancer Mortality among Men Living near an Arsenic-Emitting Smelter*. American Journal of Epidemiology. Volume 122, Number 4, *Pp. 684-694*

[3] ATSDR Public Health Assessment for National Zinc Company in Bartlesville, OK. Viewable at http://www.atsdr.cdc.gov/HAC/PHA/zinc/nzc_p2.html#PUBLIC

[4] Tokudome S, Kuratsune M. A cohort study on mortality from cancer and other causes among workers at a metal refinery. Int J Cancer. 1976 Mar 15;17(3):310-7.

Department of Community Medicine
Institute of Occupational and Environmental Health

3559 Robert C. Byrd Health Sciences Center
PO Box 9190
Morgantown, WV 26506-9190

Phone: 304-293-3693
Fax: 304-293-2629

three of these agents are cumulative and additive[5]. As such, the longer one is exposed, and the more different toxins, the greater the likelihood of developing disease.

Arsenic is associated with cancers of the skin, lung, bladder, kidney, and liver. Cadmium accumulates in the kidney and can cause renal damage and ultimately renal failure. Cadmium is also a carcinogen, associated with cancer of the lung and kidney. There is also some evidence suggesting cancer of the prostate. Lead is associated with cancers of the lung, brain, stomach, and kidney. Additionally, elevated blood lead causes cognitive and behavioral difficulties and is a disease in its own right.

In response to these facts, I propose the following medical monitoring program for the residents of the affected area.

Residency Time Requirement

- For residents within Zone 1, an accumulation of one year of residence shall be required for entry into medical monitoring.
- For residents in the Zone 2, the accumulation of three years of residence in the class area shall be required for entry into medical monitoring.
- For residents in the Zone 3, the accumulation of five years of residence in the class area shall be required for entry into medical monitoring.
- Once a resident has qualified for entry into medical monitoring based upon their residence in the area, they shall remain in medical monitoring for 40 years past the remediation of their residence.

BASIS FOR THE RESIDENCY TIME RECOMMENDATIONS

My goal is to ensure that residents with a significantly increased risk are offered medical monitoring. However, reasonableness demands establishing a threshold for the minimum residency requirement. I also believe that it is appropriate to be moderate at each decision point.

In his report, Dr. Kornberg did calculations to estimate risk using the difference between the measured soil Arsenic levels to calculate the incremental risk, and concluded that 277 days of exposure would be required to reach an "action level". This was adequate to demonstrate the presence of increased risk, however more precise calculations of risk are now available on Dr. Brown's map titled "Incremental Total Cancer Risk for All Pathways" (copy attached as Appendix A), and these are the basis of the minimum residency time requirements for entry into the medical monitoring program delineated here.

General logic:

Based solely upon the risk of skin cancer from arsenic exposure via ingestion, and lung cancer from arsenic and cadmium inhalation, Dr. Brown has calculated the total cancer risk from the exposures in the class area. Clearly there are multiple additional cancer risks for the exposed population from the arsenic, cadmium, and lead that are not

[5] EPA Risk Assessment Guidance for Superfund Volume I Human Health Evaluation Manual (Part A), sections 8.2.2 and 8.3; viewable at http://www.epa.gov/oswer/riskassessment/ragsa/pdf/ch8.pdf

included in these calculations, which would only increase the calculated risk. Starting with the 30 year total risk from Dr Brown's model, I calculated the time duration that would expose a person to a 1:100,000 risk of developing these two cancers for each of the zones.

Calculations:
Using a simple proportion, with the goal of calculating the total risk then the proportion was solved for time (X)

$$\frac{\text{Total Risk}}{\text{30 Years}} = \frac{\text{Significant Risk}}{X}$$

$$X \times \text{Total Risk} = \text{30 Years} \times \text{Significant Risk}$$

$$X = \frac{\text{30 Years} \times \text{Significant Risk}}{\text{Total Risk}}$$

Zone 1 (Inner)

$$X = \frac{30 \text{ Years} \times 10^{-5}}{1 \times 10^{-3}} = \frac{30 \times 10^{-5} \text{ Years}}{1 \times 10^{-3}} = 0.3 \text{ Years} = 109.5 \text{ Days}$$

Zone 1 (Outer)

$$X = \frac{30 \text{ Years} \times 10^{-5}}{5 \times 10^{-4}} = \frac{30 \times 10^{-5} \text{ Years}}{5 \times 10^{-4}} = 0.6 \text{ Years} = 217 \text{ Days}$$

Zone 2

$$X = \frac{30 \text{ Years} \times 10^{-5}}{1 \times 10^{-4}} = \frac{30 \times 10^{-5} \text{ Years}}{1 \times 10^{-4}} = 3 \text{ Years}$$

Zone 3

$$X = \frac{30 \text{ Years} \times 10^{-5}}{7 \times 10^{-5}} = \frac{30 \times 10^{-5} \text{ Years}}{7 \times 10^{-5}} = 4.28 \text{ Years}$$

Notes and codicils about residency time:

1. The contours on the map indicate that the area within the contour is at or above the listed risk. Thus, while a few residents just inside the contour line may have the risk level equal to the listed contour, most of the residents within the contour are exposed to a higher risk than that portrayed by the contour.

2. The exposure at individual residences will end only with the remediation of the contamination in the residences. Thus residence time calculations will end with the remediation of each individual residence.
3. The waste piles were capped in 2004, thus residence time in any home whose construction or installation was begun in 2005 or later would be excluded from the time calculations for medical monitoring, due to the much lower likelihood of the presence of large quantities of contaminated dust within the residence (although soil exposure risk remains).

I believe that it is appropriate to include moderating measures at each point in setting the minimum residency time.

Moderating measures used in calculating residency time included:

1. Using 1:100,000 as the threshold for "significant risk", rather than 1:1,000,000, which is a more common threshold.
2. The model discussed by Dr. Brown includes only skin cancer risk from arsenic and lung cancer risk from arsenic and cadmium. There are significant additional cancer risks that are not considered in this calculation. Thus, the actual cancer risk would be greater if these additional risks were considered.
3. The residence time was rounded up to the next reasonable interval (i.e. full year).
4. No cancer risk for lead was considered in the model

Moderating measures in medical surveillance program:

1. Only diseases clearly associated with arsenic, cadmium, and lead are monitored for.
2. Testing is limited to diseases and medical tests clearly supported by the literature or general medical practice.

GENERAL PRINCLPLES:

Once the entry criteria has been satisfied, the monitoring program shall be the same for all medical monitoring group members, except for differences by member age mentioned below.

Medical monitoring shall be conducted every 2 years for members of the medical monitoring group once entry criteria are met. While this spacing could miss some rapidly developing diseases, it will catch most diseases, and will not significantly increase the risk to the patients from the testing.

Medical monitoring shall continue until 40 years past the end of exposure. Generally this would be either 40 years beyond moving out of the class area or 40 years after their residence is remediated. This is based on the usual latencies of the diseases of interest.

Any resident whose residency within the class area ended more than 40 years ago, and has not resided within the class area within the past 40 years, shall be excluded from the medical monitoring eligibility.

Remediation

The residents in this community have been exposed to arsenic, cadmium, and Lead from the Spelter smelter site through breathing plant emissions during operations, soil contamination, exposure to fugitive emissions from the waste piles, living in houses contaminated with dust from the plant, soil contamination around their residence, incidental soil and dust ingestion, and consumption of contaminated vegetables, and perhaps drinking water contaminated by emissions from the plant site.

While clearly not of the magnitude as during smelter operations, exposure to arsenic, cadmium, and lead is ongoing for residents in the community. Several interventions have been undertaken to limit exposure, including extinguishing the fires in the piles, limiting access to the waste piles, and the capping of the piles to limit fugitive emissions, and establishment of municipal water for the affected area. I would encourage that additional interventions be undertaken to decrease or eliminate the exposure through the remaining routes. This would include remediating the homes to remove contaminated dust from the living spaces as well as the dust reservoir areas within the home (attic, basement, etc.), and remediating the soil around the residences.

Diseases considered to be related to the exposures from Spelter site. (Unfortunately, medical monitoring is not possible for all diseases associated with these exposures)

Arsenic[6,7]
Skin Cancer
Lung Cancer
Bladder Cancer
Kidney Cancer

Cadmium[8]
Lung Cancer
Kidney Cancer
Decreased Renal Function[9]
Renal Failure
Bone Fragility

Lead[10,11]
Plumbism (Lead Poisoning) – Having elevated whole blood lead is a disease in itself, causing mental retardation, poor school performance, and behavioral problems. In

[6] Ferreccio C, Sancha AM. Arsenic exposure and its impact on health in Chile. J Health Popul Nutr. 2006 Jun;24(2):164-75
[7] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[8] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol58/volume58.pdf
[9] NIOSH Worker Notification Program; Cadmium Recovery Workers (Cadmium); Viewed at http://www.cdc.gov/niosh/pgms/worknotify/cadmium.html#estimated
[10] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[11] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol87/volume87.pdf

children, there is clear evidence of this effect at levels well below the CDC action level of 10 µg/dl.

Lung Cancer
Stomach Cancer[12]
Kidney Cancer
Decreased Renal Function[13]
Renal Failure[13]
Bone Fragility
Loss of teeth
Hypertension
Increased rates of criminal activity[14,15]

There are several additional cancers that have been proposed as due to lead exposure, but for which I do not yet find the literature compelling. At the present I would not recommend screening for these diseases, but I would recommend a review of the literature in several years to consider these conditions.

Brain Cancer
Stomach Cancer
Rectal Cancer
Prostate Cancer
Colon Cancer

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
    a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
    b. Referral to PCP for findings not associated with the exposures

The screening examination will be the same for all participants, except

- Start screening chest CT scans at age 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine pregnancy test for females age 35-55 prior to scan unless surgical sterilization.
- Below age 15, screen ONLY whole blood lead (capillary or veinous)

[12] Steenland K, Boffetta P. Lead and cancer in humans: where are we now? Am J Ind Med. 2000 Sep;38(3):295-9.
[13] Ekong EB, Jaar BG, Weaver VM. Lead-related nephrotoxicity: a review of the epidemiologic evidence. Kidney Int. 2006 Dec;70(12):2074-84. Epub 2006 Oct 25
[14] Needleman HL, McFarland C, Ness RB, Fienberg SE, Tobin MJ. Bone lead levels in adjudicated delinquents. A case control study. Neurotoxicol Teratol. 2002 Nov-Dec;24(6):711-7
[15] Stretesky PB, Lynch MJ. The relationship between lead exposure and homicide. Arch Pediatr Adolesc Med. 2001 May;155(5):579-82.

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest[16] (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Calculated glomerular filtration rate (GFR)
  d. Whole Blood Lead
- Stool Blood (Hemoccult)
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/interaction
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards
  f. Review results of blood and urine screening
  g. Review CT scan results
  h. Order re-testing or make referrals based upon findings

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
- Urine Cytology
- Urine Beta-2 microglobulin
- BUN and Creatinine
- Calculated Glomerular Filtration Rate

Follow-up examination (Blood on UA or positive cytology)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy
- CT scan of Abdomen

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine elevated)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis

---

16 Bach PB, Jett JR, Pastorino U, Tockman MS, Swensen SJ, Begg CB. Computed tomography screening and lung cancer outcomes. JAMA. 2007 Mar 7;297(9):953-61.

- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Lungs

Medical Surveillance Examination (For persons >= age 35); Perform every 2 years
- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest

First Cycle Positives
- Repeat same CT scan several months later
- Consultation with ordering physician to review changes over time and refer as appropriate

Subsequent Cycle Positives
- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later
- Lung Biopsy
  - By Cardiothoracic surgeon or
  - Pulmonologist, depending upon the location of the lesion within the lungs

Plumbism (Lead Poisoning)

Screening Examination
- Whole Blood Lead
  - Medical Action Level (above which additional investigation is needed):
    - Children (<18 Years Old): 10 µg/dl
    - Adults (>18 years old): 30 µg/dl
  - Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
    - Children (<18 Years Old): 5 µg/dl
    - Adults (>18 years old): 20 µg/dl

  Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead

Medical Follow-up examination
- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (veinous) (Children 15%, Adults 15%)
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin
- Complete Blood Count
- Bone x-ray fluorescence testing to assess body burden

Neuropsychiatric follow-up
- Formal neuropsychiatric evaluation

Skin

Screening Examination

- Head-to-toe examination of the skin by the screening physician as part of the physical examination.

Follow-up examination

- Consultation with Dermatologist (1-2 visits)
- Biopsy by dermatologist if indicated

GI system (stomach, intestines, rectum)

Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination
- Follow-up examination
  - Refer to PCP for evaluation for colon disease
  - IF negative colon disease workup, then re-enter screening program to look for stomach cancer
    - Refer to Gastroenterologist for stomach evaluation
    - EGD (Endoscopic Gastroduodenoscopy)

Overall medical surveillance assumptions:

- Participation in the entire program is voluntary, and that a participant can choose to participate or discontinue participation at any time.
- That there will be one (or a small number) of physicians from the community supervising the medical monitoring program and performing the physical examinations. This is to ensure that the physician is familiar with the program, the diagnosis of the diseases of concern, and to ensure consistency.
- For the first cycle, the patients must have pre-testing access to a knowledgeable clinician (physician or nurse) be discuss the risks and benefits of the proposed testing
- That medical testing without physician interpretation of the results is inappropriate for the well being of the participant
- That the ideal is for a physician visit for results interpretation (and physical examination) following testing
- That without the physician examination, key portions of the evaluation will be missed, and that the physical examination is critical to identifying some of the diseases of concern.
- That any participant who fails to participate in the post-testing physician evaluation will receive a letter communicating their test results, and any recommendations for follow-up.
- In all cases, the evaluating physician shall have the freedom to repeat any test if there is evidence of a lab error or if no other clinical evidence is found to support the diagnosis suggested by the test result.
- If a patient has had any of the recommended tests within the past 6 months, and the written results these can be provided, those tests will not be repeated, and the patient-provided results used for the screening program.

- That following diagnosis with a disease of interest, the screening for that disease will cease, but other screenings will/could continue
- That some test results can be caused by multiple diseases. The interpreting physician will be charged with figuring these cases out.
- Despite targeted testing, it is possible conditions will be detected by the testing that are not related to the exposure. When that happens, the participant will be referred to their Primary Care Physician for follow-up and treatment.
- Workup of positive test results will continue until the determination of exposure-related or non-exposure-related can be made
- As soon as a non-exposure-related condition is identified, the patient will be referred to their PCP. The screening for the disease of interest will continue unmodified. This referral will occur each screening cycle. The patient can decline the referral if they deem it unnecessary.
- A patient with an abnormal finding related to the exposures will be referred to the appropriate specialist with each screening cycle. The patient can decline the referral if they deem it unnecessary.
- That a central repository of the screening, referrals, and outcomes data will be maintained, and depersonalized data made available for epidemiological evaluations. It is clear from my literature review in preparing this document that there is incomplete scientific evidence in the literature on screening programs, participation rates, referral rates, etc. This data could serve as the basis for answering many of these scientific questions.
- The screening program described here is based upon the best available medical knowledge in 2007. While I would not propose changing the diseases being monitored for, it is likely that in the future new technology or better understandings within medicine will require the updating of this protocol. This protocol should be reviewed periodically by the administering physician to ensure that the screenings and follow-up described here remain consistent with best medical practice.

Commentary on the differences between Dr. Komberg's proposal and this recommendation.

Overall, I concur with Dr. Komberg's assessment of the nature of the exposure as well as the diseases of concern associated with these exposures. My opinion differs from his only in the details.

1) The only disease caused by all three of the exposures is lung cancer. Dr Komberg recommended screening for lung cancer using chest x-rays. Unfortunately, by the time most lung cancers are large enough to be detected by chest x-ray they are incurable. Over the past several years there have been promising results from the use of low dose CT scans to screen for early lung cancers. This technology allows for the identification of much smaller tumors and the 3-D imaging makes it much easier to differentiate cancers from other lung lesions.

2) Some of the testing proposed by Dr Kornberg was aimed at biomonitoring (monitoring levels in blood, urine, or hair) to assess for the presence of the Arsenic, Lead, and Cadmium. I fully support monitoring whole blood lead since an elevated blood Lead is a disease in its own right. However, for arsenic and cadmium I do not believe biomonitoring would be useful clinically. There are two reasons.

   a. First, at this point the exposures are lower level chronic exposures, and the available biomonitoring tests are designed to monitor acute exposures, such as monitoring pre- and post-shift urinary cadmium for cadmium workers to assess the efficacy of employer control measures.
   b. The second reason is that the presence of the exposures has been established, and there could be a false sense of security (or even confusion) generated by low values on the biomonitoring tests. The risks of disease persist, whatever biomonitoring levels are found.

3) Dr Kornberg seemed to be offering options for the evaluating physician to add or subtract tests from the screening examination. To actually make this work, it would be necessary to have two visits with the physician, which would clearly add to the complexity of implementing the program. Efficiently looking for the diseases of interest is the key, but making the screening program practical to implement is also quite important. Thus, for the "general screening examination" my goal is to establish criteria that are very easy to implement (such as age) as the only differentiating factor for what tests each patient needs. A standardized testing regimen will allow the ordering of the tests to be handled by an administrative person, and allow the physician to focus on the interpretation of the tests and examining the patients. I would concur with Dr Kornberg's recommendation that current (< 6 months old) test results could be used in place of repeating the test.

4) There were several aspects of the screening examination proposed by Dr Kornberg that are good general medical surveillance, but not directly related to long term exposure to arsenic, cadmium, or lead. I have tried to focus the examination and eliminate these tests. For example, he includes an electrocardiogram (ECG), however, I am not able to directly associate ECG changes with the arsenic, cadmium, or lead at the levels likely to be found in this population.

In Summary, it is my recommendation that on the basis of their exposures in Spelter and the remaining class area that there is a significantly increased risk of developing disease, and that medical monitoring is necessary to look for these diseases.

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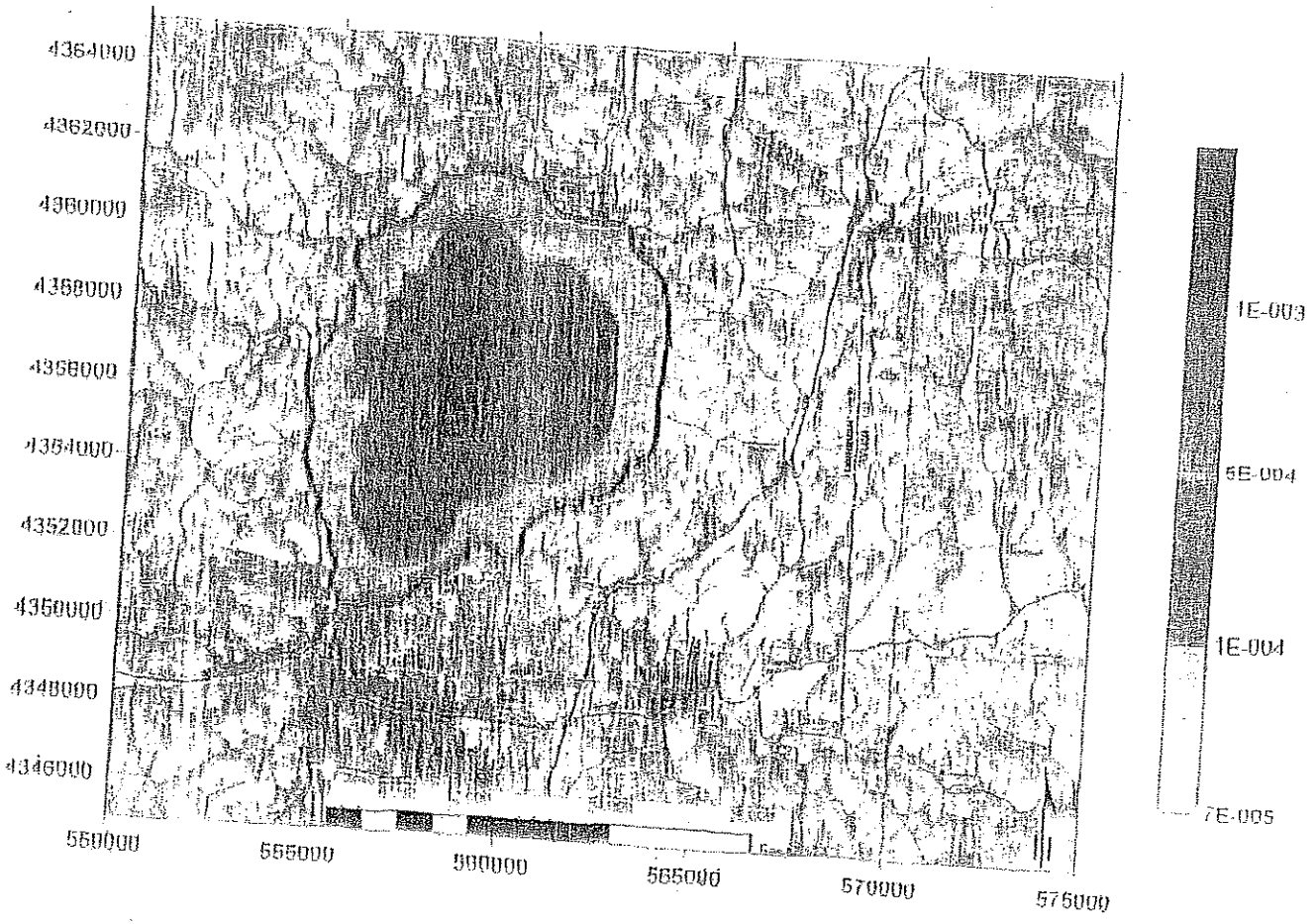
Incremental Total Cancer Risk for All Pathways



Appendix A - Mercury Monitoring

West Virginia University
SCHOOL OF MEDICINE

Proposed Medical Monitoring due to the contamination of Spelter, WV and surrounding communities with arsenic, cadmium, and lead.

Including estimations of participation rates and testing outcomes for economic purposes

March 30, 2007

A medical monitoring program has been prescribed for Spelter and the surrounding community (the class area) due to the contamination of the area with arsenic, cadmium, and lead, and the significantly increased risk of developing disease due to these exposures.

For the purposes of costing of this program, estimates are needed for the participation rates and the likely outcomes of the testing. This document is prepared for that purpose. The details of the monitoring program are the same as those contained in my main report, only quantification has been added for the various decision points within the surveillance program.

All of the details contained in this document are estimates, they are not evidence based, nor are they based upon prior experience in this sort of a program. I am not able to locate literature on these topics in the medical literature. On the basis of my best professional judgment I am offering anticipated participation and outcome estimates. *These estimates will be in italics and underlined.*

To facilitate the costing of this program, Appendix A shows the cost for the listed tests and medical procedures at West Virginia University Hospitals and University Health Associates, prepared by Melissa Mitchell, a certified professional coder in my office.

The monitoring program shall be the same for all participants, except:

- Chest CT scans only for participants with age greater than or equal to 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine Pregnancy test for potentially pregnant females 35-55 years old unless surgical sterility prior to scan.
- Below age 15, screen ONLY whole blood lead (capillary or veinous), and the physician visit

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General Estimates (evidence-based estimates welcome):

- *75% of eligible population will participate in initial screening. Of those:*
  - *85% will complete the testing and attend the physician visit*
  - *15% will not complete the testing and/or appear for the physician visit, and will require a letter reviewing their findings*
- *75% of those initially screened will appear for the second screening*
- *Thereafter (after the first two cycles of screening), there will be a 5% attrition rate each screening cycle*

- *5% of all blood and urine tests will need to be repeated due to suspicion of lab error or equivocal results*

- *2% of each test (except lead) in the initial screening battery will be unneeded due to the patient having had the same test within the past 6 months and being able to provide written results. 0% of the "follow-up" tests will not be needed for this reason.*

Medical Surveillance Program:

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
   a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
   b. Referral to PCP for findings not associated with the exposures

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Whole Blood Lead
- Stool Blood (Hemoccult) .
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/interaction (Level 5 for adults, Level 4 for children < 15)
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)*
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards*

f. Review results of blood and urine* screening
g. Review CT scan results*
h. Order re-testing or make referrals based upon findings
* = Omit for children < 15 years old

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
  - *10% Positives overall*
    - *Blood 2% (Target disease – Needs follow-up with urologist)*
    - *Glucose 5% (Not target disease)*
    - *Infection 3% (Not target disease)*
- Urine Cytology
  - *1% Positive (Target disease – Needs follow-up with urologist)*
- Urine Beta-2 microglobulin
  - *5% Positive*
    - *2% (Target disease – Needs follow-up with nephrologist)*
    - *3% other known causes of kidney disease (i.e. diabetes)*
- BUN and Creatinine
  - *5% Positive*
    - *2% (Target disease – Needs follow-up with nephrologist)*
    - *3% other known causes of kidney disease (i.e. diabetes)*

Follow-up examination (Blood or Cytology positive)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy (Hospital and Professional Charge)
- CT scan of Abdomen (Hospital and Professional Charge)

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine positive)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis
- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Final Outcome

- *40%* go on to treatment
- *60%* return for next screening (diseases of interest not found)

Lungs

Medical Surveillance Examination (For persons >= age 35); Perform every 2 years

- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest (Hospital and Professional Charge)

First Cycle

- *30-50% will have a positive initial examination (per Harvard data), thus estimate 40% positives in our population*
  - Repeat same CT scan several months later (Hospital and Professional Charge)
  - Consultation with supervising physician to review changes over time and refer as appropriate

5% positives in all cycles

- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later (Hospital and Professional Charge)
- *25% of repeat CT scans positive*
  - *Refer to Pulmonologist*
    - Watch and repeat CT Scan *(50%)*
    - Decision to get Lung Biopsy *(50%),*
      - If Biopsy – specialist depends upon location of lesion
        - *35%* - Cardiothoracic surgeon
          - Office Visit
          - Biopsy
            - Hospital Charge
            - Professional Charge
            - Anesthesia Charge
            - Pathologist Charge
        - Pulmonologist *(65%),* depending upon the location of the lesion within the lungs
          - Biopsy
            - Hospital Charge
            - Professional Charge
            - Pathologist Charge

Final Outcome

- *25%* go on to treatment
- *75%* return for next screening (diseases of interest not found)

Plumbism (Lead Poisoning)

Screening Examination

- Whole Blood Lead

  Medical Action Level (above which additional investigation is needed):
  - Children (<18 Years Old): 10 µg/dl *(10% of tested)*
  - Adults (>18 years old): 30 µg/dl *(2% of tested)*

  Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
  - Children (<18 Years Old): 5 µg/dl *(20% of tested)*
  - Adults (>18 years old): 20 µg/dl *(5% of tested)*

  Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead *(Estimate this will mean that 75% of patients will NOT need re-evaluation with each cycle.)*

Medical Follow-up examination

- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (venous) *(Children 15%, Adults 15%)*
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin (lab)
- Complete Blood Count (Lab)
- Bone x-ray fluorescence testing to assess body burden (Hospital and Professional Charge, Travel (Pittsburgh for Children, New York City for Adults))

Neuropsychiatric follow-up

- Formal neuropsychiatric evaluation

Final Outcome

- Treatment does NOT preclude re-exposure or need for re-treatment
- *100%* return for next screening (diseases of interest not found)

Skin

Screening Examination

- Head-to-toe skin examination *Estimate 5% Positives from physician examination*

Follow-up Examination

- Refer to Dermatologist for evaluation
  - Office Visit – Level 5 initial
  - *50% Biopsy by dermatologist*
    - Procedure code
    - Supplies
    - Pathology
    - Follow-up visit with dermatologist (level 3 return)

Final Outcome

- *5%* go on to treatment
- *95%* return for next screening (diseases of interest not found, or treated)

GI system (stomach, intestines, rectum)
Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination *Estimate 5% Positive hemoccult*
  Note: Most likely cause is colon disease, not a target disease
- Follow-up examination
  - Refer to PCP for evaluation for colon disease – *85% find colon disease (NOT target Disease)*
  - *15% will have negative colon disease workup* (and re-enter screening program to look for stomach cancer)
    - Refer to Gastroenterologist for stomach evaluation
    - EGD with biopsy
      - Procedure code
      - Supplies
      - Pathology

Final Outcome

- *25%* go on to treatment
- *75%* return for next screening (diseases of interest not found)

In Summary, the above is my prescription for the medical monitoring program for the community surrounding Spelter, along with estimates of participation and outcome rates based upon my professional judgment.

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MEDICAL MONITORING ECONOMICS – APPENDIX A

DESCRIPTION	CPT CODE	PROF CHARGE	HOSPITAL CHARGE	PATH CHARGE (pro)	PATH CHARGE (tech)	CYTO TECH	PHARMACY	ANESTHESIA
							*** For the anesthesia medicine, rate is $5.69/minute. Time varies by procedure.	
CT Scan of Chest:								
w/o contrast	71260	$ 159.00	$ 1,030.50					
w/contrast	71260	$ 170.00	$ 1,168.00					
w/o contrast followed by w/contrast	71270	$ 159.00	$ 1,418.00					
CT scan of Abdomen:								
w/contrast	74160	$ 175.00	$ 1,011.50					
w/o contrast	74150	$ 163.00	$ 694.00					
w/o contrast followed by w/contrast	74170	$ 192.00	$ 1,156.50					
CT scan of Pelvis:								
w/contrast	72192	$ 150.00	$ 1,011.50					
w/o contrast	72193	$ 159.00	$ 694.00					
w/o contrast followed by w/contrast	72194	$ 167.00	$ 1,156.50					
Urinalysis:								
Dip	81002	$ 14.00						
Rapid Pregnancy	81025	$ 25.00						
Cytology	88108			$ 118.00	$ 93.00			
Beta -2 microglobulin	82043	$ 31.00						
Blood Collection:								
Venipuncture	36415	$ 15.00						
Creatinine	82565		$ 8.00					
BUN (Blood Urea Nitrogen)	84520							
Whole Blood Lead	83655		$ 13.00					
Blood Glucose	82947		$ 6.00					
ESR - erythrocyte sedimentation rate	85651							
Zinc Protoporphyrin	84202		$ 21.00					
CBC-complete blood count	85027		$ 10.00					
Stool Blood (Hemoccult)	82270	$ 15.00	$ 10.00					
ysicals - New Patients: (All specialities)								
< 1 yr	99381	$ 151.00						
1-4 yrs	99382	$ 162.00						
5-11 yrs	99383	$ 159.00						

12-17 yrs	99384	$ 173.00						
18-39 yrs	99385	$ 173.00						
40-64 yrs	99386	$ 204.00						
>65 yrs	99387	$ 221.00						
Consult w/ Urologist	99245	$ 325.00						
Cystoscopy w/Biopsy	52354	$ 1,587.00	$ 8,500.00	$ 100.00	$ 151.00		Est 45 Minutes $261.65	00800 - $80/15 minutes
Consult w/Nephrologist	99245	$ 325.00						
Cardiothoracic Surgeon:								
Office Visit	99245	$ 325.00						
Lung Biopsy	32400	$ 999.00	$ 3,300.00	$ 183.00	$ 139.00	$ 139.50	Estimate 1.5 hours	
	32402	$ 1,374.00	$ 3,300.00		$ 100.00	$ 151.00	$ 603.10	00522 - $80/15 minutes/Average $1,700.00
(Hospital charges for all, if done as outpatient)	32405	$ 271.00	$ 3,300.00				$ 603.10	00522 - $80/15 minutes/Average $1,700.00
	32602	$ 935.00	$ 3,300.00	$ 300.00	$ 266.50		$ 603.10	00522 - $80/15 minutes/Average $1,700.00
							$ 603.10	00522 - $80/15 minutes/Average $1,700.00
Pulmonologist:								
Office Visit	99245	$ 325.00						
Lung Biopsy	31625	$ 937.00	$ 725.00	$ 100.00	$ 151.00			
Neuropsychiatric Evaluation	96118	$223/hr	Est 3 Hours = $669 \\ $1,011 total					
	96119	$114/hr	Est 3 Hours = $342 //					
Consult w/Medical Toxicologist or Environmental Medicine Specialist	99245	$ 325.00						
Consult w/Dermatologist:	99245	$ 325.00						
Biopsy	11100	$ 209.00	$ 1,500.00	$ 100.00	$ 151.00			
EGD	43239	$ 734.00	$ 1,200.00	$ 100.00	$ 151.00			00400 - $80/15 minutes (Est 30 Min - $160)
							Est 15 Minutes $83.85	00740 - $80/15 minutes
Bone x-ray - Fluorescence Testing		Not performed at WVU - Will need price from Columbia University in New York						

NOTES:

1. All prices reported here are current charges as of 3/29/2007 at West Virginia University Hospitals, Inc and WVU Medical Corporation, Inc.
2. For procedures: the prices shown are the average, with overall estimates (per Dr Wernz in *underlined italics*) in parentheses
3. Normally skin biopsy is an outpatient procedure. A few ill patients may require a hospital biopsy *(estimate 3%) (Hosp Charge and Anes Charge)*

West Virginia University
School of Medicine

Anticipated health effects of the contamination of Spelter, WV and surrounding communities with arsenic, cadmium, and lead, and recommendations for medical monitoring.

March 30, 2007

The residents in the area around Spelter have been exposed to arsenic, cadmium, and lead an extended time. There are clear associations between arsenic, cadmium, and lead with significantly increased risks of developing disease, primarily cancers. IARC lists arsenic and cadmium in Group 1 (Carcinogenic to Humans). Lead is listed in Group 2A (Probably Carcinogenic to Humans). Additionally, there have been several studies documenting increased cancer risk around smelter sites[1,2,3,4] where similar exposures have occurred.

I have reviewed the Dr. Komberg's initial report of November 11, 2005 as well as his rebuttal report of March 3, 2006. I concur with most of Dr. Komberg's conclusions and recommendations, however I have several updates to both focus the exams to those conditions associated with the arsenic, cadmium and lead exposures as well as to update the science to reflect new technology available for medical monitoring.

DEFINITION OF GEOGRAPHICAL TERMS

Dr Brown, in his incremental cancer risk map, shows the residual contamination across the class area. There are three distinct areas within the class area, separate in their degree of contamination, and thus the risk to the residents in those areas.

- **Zone 1 ≡** The area delineated by Dr. Brown as within the $5x10^{-4}$ incremental risk contour for developing cancer.
- **Zone 2 ≡** The area between the 5×10^{-4} incremental risk contour and the 1×10^{-4} incremental risk contour.
- **Zone 3 ≡** The area within the class area but outside the 1×10^{-4} cumulative incremental risk contour.

The residents in all areas have a significantly increased risk of developing disease based upon their residence and exposures in the area. The toxic and carcinogenic effects of all

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[1] Brown LM, Pottern LM, Blot WJ. Lung Cancer in Relation to Environmental Pollutants Emitted from Industrial Sources. Environmental Research Vol 34, 250-261.

[2] Pershagen G. *Lung Cancer Mortality among Men Living near an Arsenic-Emitting Smelter*. American Journal of Epidemiology. Volume 122, Number 4. *Pp. 684-694*

[3] ATSDR Public Health Assessment for National Zinc Company in Bartlesville, OK. Viewable at http://www.atsdr.cdc.gov/HAC/PHA/zinc/nzc_p2.html#PUBLIC

[4] Tokudome S, Kuratsune M. A cohort study on mortality from cancer and other causes among workers at a metal refinery. Int J Cancer. 1976 Mar 15;17(3):310-7.

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three of these agents are cumulative and additive[5]. As such, the longer one is exposed, and the more different toxins, the greater the likelihood of developing disease.

Arsenic is associated with cancers of the skin, lung, bladder, kidney, and liver. Cadmium accumulates in the kidney and can cause renal damage and ultimately renal failure. Cadmium is also a carcinogen, associated with cancer of the lung and kidney. There is also some evidence suggesting cancer of the prostate. Lead is associated with cancers of the lung, brain, stomach, and kidney. Additionally, elevated blood lead causes cognitive and behavioral difficulties and is a disease in its own right.

In response to these facts, I propose the following medical monitoring program for the residents of the affected area.

Residency Time Requirement

- For residents within Zone 1, an accumulation of one year of residence shall be required for entry into medical monitoring.
- For residents in the Zone 2, the accumulation of three years of residence in the class area shall be required for entry into medical monitoring.
- For residents in the Zone 3, the accumulation of five years of residence in the class area shall be required for entry into medical monitoring.
- Once a resident has qualified for entry into medical monitoring based upon their residence in the area, they shall remain in medical monitoring for 40 years past the remediation of their residence.

BASIS FOR THE RESIDENCY TIME RECOMMENDATIONS

My goal is to ensure that residents with a significantly increased risk are offered medical monitoring. However, reasonableness demands establishing a threshold for the minimum residency requirement. I also believe that it is appropriate to be moderate at each decision point.

In his report, Dr. Kornberg did calculations to estimate risk using the difference between the measured soil Arsenic levels to calculate the incremental risk, and concluded that 277 days of exposure would be required to reach an "action level". This was adequate to demonstrate the presence of increased risk, however more precise calculations of risk are now available on Dr. Brown's map titled "Incremental Total Cancer Risk for All Pathways" (copy attached as Appendix A), and these are the basis of the minimum residency time requirements for entry into the medical monitoring program delineated here.

General logic:

Based solely upon the risk of skin cancer from arsenic exposure via ingestion, and lung cancer from arsenic and cadmium inhalation, Dr. Brown has calculated the total cancer risk from the exposures in the class area. Clearly there are multiple additional cancer risks for the exposed population from the arsenic, cadmium, and lead that are not

[5] EPA Risk Assessment Guidance for Superfund Volume I Human Health Evaluation Manual (Part A), sections 8.2.2 and 8.3; viewable at http://www.epa.gov/oswer/riskassessment/ragsa/pdf/ch8.pdf

included in these calculations, which would only increase the calculated risk. Starting with the 30 year total risk from Dr Brown's model, I calculated the time duration that would expose a person to a 1:100,000 risk of developing these two cancers for each of the zones.

Calculations:
Using a simple proportion, with the goal of calculating the total risk then the proportion was solved for time (X)

$$\frac{\text{Total Risk}}{30\ \text{Years}} = \frac{\text{Significant Risk}}{X}$$

$$X \times \text{Total Risk} = 30\ \text{Years} \times \text{Significant Risk}$$

$$X = \frac{30\ \text{Years} \times \text{Significant Risk}}{\text{Total Risk}}$$

Zone 1 (Inner)

$$X = \frac{30\ \text{Years} \times 10^{-5}}{1 \times 10^{-3}} = \frac{30 \times 10^{-5}\ \text{Years}}{1 \times 10^{-3}} = 0.3\ \text{Years} = 109.5\ \text{Days}$$

Zone 1 (Outer)

$$X = \frac{30\ \text{Years} \times 10^{-5}}{5 \times 10^{-4}} = \frac{30 \times 10^{-5}\ \text{Years}}{5 \times 10^{-4}} = 0.6\ \text{Years} = 217\ \text{Days}$$

Zone 2

$$X = \frac{30\ \text{Years} \times 10^{-5}}{1 \times 10^{-4}} = \frac{30 \times 10^{-5}\ \text{Years}}{1 \times 10^{-4}} = 3\ \text{Years}$$

Zone 3

$$X = \frac{30\ \text{Years} \times 10^{-5}}{7 \times 10^{-5}} = \frac{30 \times 10^{-5}\ \text{Years}}{7 \times 10^{-5}} = 4.28\ \text{Years}$$

Notes and codicils about residency time:

1. The contours on the map indicate that the area within the contour is at or above the listed risk. Thus, while a few residents just inside the contour line may have the risk level equal to the listed contour, most of the residents within the contour are exposed to a higher risk than that portrayed by the contour.

2. The exposure at individual residences will end only with the remediation of the contamination in the residences. Thus residence time calculations will end with the remediation of each individual residence.
3. The waste piles were capped in 2004, thus residence time in any home whose construction or installation was begun in 2005 or later would be excluded from the time calculations for medical monitoring, due to the much lower likelihood of the presence of large quantities of contaminated dust within the residence (although soil exposure risk remains).

I believe that it is appropriate to include moderating measures at each point in setting the minimum residency time.

Moderating measures used in calculating residency time included:

1. Using 1:100,000 as the threshold for "significant risk", rather than 1:1,000,000, which is a more common threshold.
2. The model discussed by Dr. Brown includes only skin cancer risk from arsenic and lung cancer risk from arsenic and cadmium. There are significant additional cancer risks that are not considered in this calculation. Thus, the actual cancer risk would be greater if these additional risks were considered.
3. The residence time was rounded up to the next reasonable interval (i.e. full year).
4. No cancer risk for lead was considered in the model

Moderating measures in medical surveillance program:

1. Only diseases clearly associated with arsenic, cadmium, and lead are monitored for.
2. Testing is limited to diseases and medical tests clearly supported by the literature or general medical practice.

GENERAL PRINCLPLES:

Once the entry criteria has been satisfied, the monitoring program shall be the same for all medical monitoring group members, except for differences by member age mentioned below.

Medical monitoring shall be conducted every 2 years for members of the medical monitoring group once entry criteria are met. While this spacing could miss some rapidly developing diseases, it will catch most diseases, and will not significantly increase the risk to the patients from the testing.

Medical monitoring shall continue until 40 years past the end of exposure. Generally this would be either 40 years beyond moving out of the class area or 40 years after their residence is remediated. This is based on the usual latencies of the diseases of interest.

Any resident whose residency within the class area ended more than 40 years ago, and has not resided within the class area within the past 40 years, shall be excluded from the medical monitoring eligibility.

Remediation

The residents in this community have been exposed to arsenic, cadmium, and Lead from the Spelter smelter site through breathing plant emissions during operations, soil contamination, exposure to fugitive emissions from the waste piles, living in houses contaminated with dust from the plant, soil contamination around their residence, incidental soil and dust ingestion, and consumption of contaminated vegetables, and perhaps drinking water contaminated by emissions from the plant site.

While clearly not of the magnitude as during smelter operations, exposure to arsenic, cadmium, and lead is ongoing for residents in the community. Several interventions have been undertaken to limit exposure, including extinguishing the fires in the piles, limiting access to the waste piles, and the capping of the piles to limit fugitive emissions, and establishment of municipal water for the affected area. I would encourage that additional interventions be undertaken to decrease or eliminate the exposure through the remaining routes. This would include remediating the homes to remove contaminated dust from the living spaces as well as the dust reservoir areas within the home (attic, basement, etc.), and remediating the soil around the residences.

Diseases considered to be related to the exposures from Spelter site. (Unfortunately, medical monitoring is not possible for all diseases associated with these exposures)

Arsenic[6,7]
Skin Cancer
Lung Cancer
Bladder Cancer
Kidney Cancer

Cadmium[8]
Lung Cancer
Kidney Cancer
Decreased Renal Function[9]
Renal Failure
Bone Fragility

Lead[10,11]
Plumbism (Lead Poisoning) – Having elevated whole blood lead is a disease in itself, causing mental retardation, poor school performance, and behavioral problems. In

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[6] Ferreccio C, Sancha AM. Arsenic exposure and its impact on health in Chile. J Health Popul Nutr. 2006 Jun;24(2):164-75
[7] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[8] IARC Monograph on Cadmium, viewed at http://monographs.iarc.fr/ENG/Monographs/vol58/volume58.pdf
[9] NIOSH Worker Notification Program; Cadmium Recovery Workers (Cadmium); Viewed at http://www.cdc.gov/niosh/pgms/worknotify/cadmium.html#estimated
[10] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol23/volume23.pdf
[11] IARC Monograph on Lead, viewed at http://monographs.iarc.fr/ENG/Monographs/vol87/volume87.pdf

children, there is clear evidence of this effect at levels well below the CDC action level of 10 µg/dl.

Lung Cancer
Stomach Cancer[12]
Kidney Cancer
Decreased Renal Function[13]
Renal Failure[13]
Bone Fragility
Loss of teeth
Hypertension
Increased rates of criminal activity[14,15]

There are several additional cancers that have been proposed as due to lead exposure, but for which I do not yet find the literature compelling. At the present I would not recommend screening for these diseases, but I would recommend a review of the literature in several years to consider these conditions.

Brain Cancer
Stomach Cancer
Rectal Cancer
Prostate Cancer
Colon Cancer

General flow for each surveillance exam:

1. Laboratory (Blood and Urine) and Chest CT obtained
2. Await results from studies (likely < 2 weeks)
3. Brief history, physical examination, and review of the results by a Physician
   a. Referral to specialist for positive findings in diseases associated with the exposures (paid for by screening program)
   b. Referral to PCP for findings not associated with the exposures

The screening examination will be the same for all participants, except

- Start screening chest CT scans at age 35 (none below age 35)
- No CT scans of anyone who is pregnant or possibly pregnant. Urine pregnancy test for females age 35-55 prior to scan unless surgical sterilization.
- Below age 15, screen ONLY whole blood lead (capillary or venous)

[12] Steenland K, Boffetta P. Lead and cancer in humans: where are we now? Am J Ind Med. 2000 Sep;38(3):295-9.
[13] Ekong EB, Jaar BG, Weaver VM. Lead-related nephrotoxicity: a review of the epidemiologic evidence. Kidney Int. 2006 Dec;70(12):2074-84. Epub 2006 Oct 25
[14] Needleman HL, McFarland C, Ness RB, Fienberg SE, Tobin MJ. Bone lead levels in adjudicated delinquents. A case control study. Neurotoxicol Teratol. 2002 Nov-Dec;24(6):711-7
[15] Stretesky PB, Lynch MJ. The relationship between lead exposure and homicide. Arch Pediatr Adolesc Med. 2001 May;155(5):579-82.

General Screening Examination:

- Single Breath Hold High Resolution Low Dose CT scan of the Chest[16] (>= age 35)
- Urine Collection for:
  a. Urinalysis (Dip)
  b. Urine Rapid Pregnancy (Females age 35 – 55, unless surgical sterilization)
  c. Urine Cytology
  d. Urine Beta-2-microglobulin
- Blood collection for:
  a. Creatinine
  b. BUN (Blood Urea Nitrogen)
  c. Calculated glomerular filtration rate (GFR)
  d. Whole Blood Lead
- Stool Blood (Hemoccult)
  a. Dispense Hemoccult cards at time of blood/urine collection
  b. Patient to return cards at physician exam
- Physician examination/interaction
  a. Record vital signs, including Blood Pressure
  b. Skin examination (head to toe, for skin cancer)
  c. HEENT exam, focus on dentition and mucosa
  d. Peripheral motor function (wrist & ankle extensors)
  e. Develop and review Hemoccult cards
  f. Review results of blood and urine screening
  g. Review CT scan results
  h. Order re-testing or make referrals based upon findings

Urinary System (Kidney & Bladder)

Screening exam:

- Urinalysis (dip stick)
- Urine Cytology
- Urine Beta-2 microglobulin
- BUN and Creatinine
- Calculated Glomerular Filtration Rate

Follow-up examination (Blood on UA or positive cytology)

- Consultation with Urologist (2 office visits)
- Repeat Urinalysis
- Cystoscopy with biopsy
- CT scan of Abdomen

Follow-up examination (Beta-2 microglobulin or BUN/Creatinine elevated)

- Consultation with a nephrologists (2 office visits)
- Repeat Urinalysis

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16 Bach PB, Jett JR, Pastorino U, Tockman MS, Swensen SJ, Begg CB. Computed tomography screening and lung cancer outcomes. JAMA. 2007 Mar 7;297(9):953–61.

- Repeat BUN/Creatinine
- Labwork to look for other causes of kidney failure
  - Blood Glucose
  - ESR

Lungs

Medical Surveillance Examination (For persons >= age 35): Perform every 2 years
- Single-breath-hold, high-resolution, low-exposure, CT scan of the chest

First Cycle Positives
- Repeat same CT scan several months later
- Consultation with ordering physician to review changes over time and refer as appropriate

Subsequent Cycle Positives
- Consultation with a pulmonologist (2-3 office visits)
- Repeat CT scan several Months later
- Lung Biopsy
  - By Cardiothoracic surgeon or
  - Pulmonologist, depending upon the location of the lesion within the lungs

Plumbism (Lead Poisoning)

Screening Examination
- Whole Blood Lead
  - Medical Action Level (above which additional investigation is needed):
    - Children (<18 Years Old): 10 µg/dl
    - Adults (>18 years old): 30 µg/dl
  - Neuropsychiatric Action Level (above which neuropsychiatric evaluation is needed):
    - Children (<18 Years Old): 5 µg/dl
    - Adults (>18 years old): 20 µg/dl

    Note: Repeat neuropsychiatric evaluation is not needed unless >25% increase in measured whole blood lead

Medical Follow-up examination
- Consultation with medical toxicologist/Environmental Medicine Specialist (4 office visits)
- Repeat whole blood lead (veinous) (Children 15%, Adults 15%)
  - If elevated, refer for evaluation and possible treatment
- Zinc Protoporphyrin
- Complete Blood Count
- Bone x-ray fluorescence testing to assess body burden

Neuropsychiatric follow-up
- Formal neuropsychiatric evaluation

Skin

Screening Examination

- Head-to-toe examination of the skin by the screening physician as part of the physical examination.

Follow-up examination

- Consultation with Dermatologist (1-2 visits)
- Biopsy by dermatologist if indicated

GI system (stomach, intestines, rectum)

Screening Examination

- Stool Hemoccult, cards distributed at blood/urine collection, developed at physician follow examination
- Follow-up examination
  - Refer to PCP for evaluation for colon disease
  - IF negative colon disease workup, then re-enter screening program to look for stomach cancer
    - Refer to Gastroenterologist for stomach evaluation
    - EGD (Endoscopic Gastroduodenoscopy)

Overall medical surveillance assumptions:

- Participation in the entire program is voluntary, and that a participant can choose to participate or discontinue participation at any time.
- That there will be one (or a small number) of physicians from the community supervising the medical monitoring program and performing the physical examinations. This is to ensure that the physician is familiar with the program, the diagnosis of the diseases of concern, and to ensure consistency.
- For the first cycle, the patients must have pre-testing access to a knowledgeable clinician (physician or nurse) be discuss the risks and benefits of the proposed testing
- That medical testing without physician interpretation of the results is inappropriate for the well being of the participant
- That the ideal is for a physician visit for results interpretation (and physical examination) following testing
- That without the physician examination, key portions of the evaluation will be missed, and that the physical examination is critical to identifying some of the diseases of concern.
- That any participant who fails to participate in the post-testing physician evaluation will receive a letter communicating their test results, and any recommendations for follow-up.
- In all cases, the evaluating physician shall have the freedom to repeat any test if there is evidence of a lab error or if no other clinical evidence is found to support the diagnosis suggested by the test result.
- If a patient has had any of the recommended tests within the past 6 months, and the written results these can be provided, those tests will not be repeated, and the patient-provided results used for the screening program.

- That following diagnosis with a disease of interest, the screening for that disease will cease, but other screenings will/could continue
- That some test results can be caused by multiple diseases. The interpreting physician will be charged with figuring these cases out.
- Despite targeted testing, it is possible conditions will be detected by the testing that are not related to the exposure. When that happens, the participant will be referred to their Primary Care Physician for follow-up and treatment.
- Workup of positive test results will continue until the determination of exposure-related or non-exposure-related can be made
- As soon as a non-exposure-related condition is identified, the patient will be referred to their PCP. The screening for the disease of interest will continue unmodified. This referral will occur each screening cycle. The patient can decline the referral if they deem it unnecessary.
- A patient with an abnormal finding related to the exposures will be referred to the appropriate specialist with each screening cycle. The patient can decline the referral if they deem it unnecessary.
- That a central repository of the screening, referrals, and outcomes data will be maintained, and depersonalized data made available for epidemiological evaluations. It is clear from my literature review in preparing this document that there is incomplete scientific evidence in the literature on screening programs, participation rates, referral rates, etc. This data could serve as the basis for answering many of these scientific questions.
- The screening program described here is based upon the best available medical knowledge in 2007. While I would not propose changing the diseases being monitored for, it is likely that in the future new technology or better understandings within medicine will require the updating of this protocol. This protocol should be reviewed periodically by the administering physician to ensure that the screenings and follow-up described here remain consistent with best medical practice.

Commentary on the differences between Dr. Kornberg's proposal and this recommendation.

Overall, I concur with Dr. Kornberg's assessment of the nature of the exposure as well as the diseases of concern associated with these exposures. My opinion differs from his only in the details.

1) The only disease caused by all three of the exposures is lung cancer. Dr Kornberg recommended screening for lung cancer using chest x-rays. Unfortunately, by the time most lung cancers are large enough to be detected by chest x-ray they are incurable. Over the past several years there have been promising results from the use of low dose CT scans to screen for early lung cancers. This technology allows for the identification of much smaller tumors and the 3-D imaging makes it much easier to differentiate cancers from other lung lesions.

2) Some of the testing proposed by Dr Kornberg was aimed at biomonitoring (monitoring levels in blood, urine, or hair) to assess for the presence of the Arsenic, Lead, and Cadmium. I fully support monitoring whole blood lead since an elevated blood Lead is a disease in its own right. However, for arsenic and cadmium I do not believe biomonitoring would be useful clinically. There are two reasons.

   a. First, at this point the exposures are lower level chronic exposures, and the available biomonitoring tests are designed to monitor acute exposures, such as monitoring pre- and post-shift urinary cadmium for cadmium workers to assess the efficacy of employer control measures.
   b. The second reason is that the presence of the exposures has been established, and there could be a false sense of security (or even confusion) generated by low values on the biomonitoring tests. The risks of disease persist, whatever biomonitoring levels are found.

3) Dr Kornberg seemed to be offering options for the evaluating physician to add or subtract tests from the screening examination. To actually make this work, it would be necessary to have two visits with the physician, which would clearly add to the complexity of implementing the program. Efficiently looking for the diseases of interest is the key, but making the screening program practical to implement is also quite important. Thus, for the "general screening examination" my goal is to establish criteria that are very easy to implement (such as age) as the only differentiating factor for what tests each patient needs. A standardized testing regimen will allow the ordering of the tests to be handled by an administrative person, and allow the physician to focus on the interpretation of the tests and examining the patients. I would concur with Dr Kornberg's recommendation that current (< 6 months old) test results could be used in place of repeating the test.

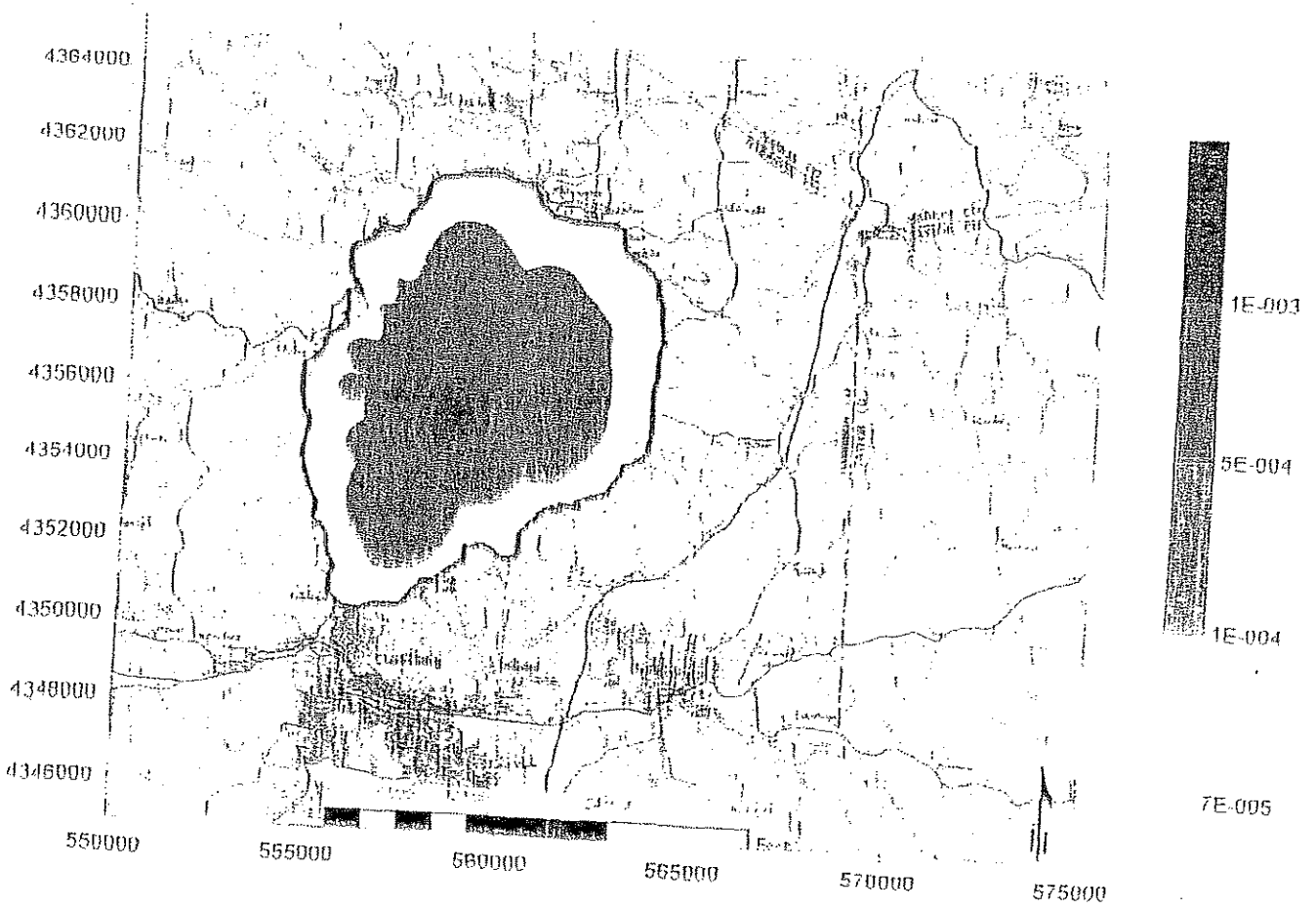
4) There were several aspects of the screening examination proposed by Dr Kornberg that are good general medical surveillance, but not directly related to long term exposure to arsenic, cadmium, or lead. I have tried to focus the examination and eliminate these tests. For example, he includes an electrocardiogram (ECG), however, I am not able to directly associate ECG changes with the arsenic, cadmium, or lead at the levels likely to be found in this population.

In Summary, it is my recommendation that on the basis of their exposures in Spelter and the remaining class area that there is a significantly increased risk of developing disease, and that medical monitoring is necessary to look for these diseases.

Charles L. Werntz III, D.O., MPH, FACOEM
Assistant Clinical Professor
Associate Residency Director
Institute for Occupational and Environmental Health
Department of Community Medicine
West Virginia University School of Medicine

Appendix A - Megsite Monitoring

Incremental Total Cancer Risk for All Pathways



MEDICAL MONITORING ECONOMICS – APPENDIX A

DESCRIPTION	CPT CODE	PROF CHARGE	HOSPITAL CHARGE	PATH CHARGE (pro)	PATH CHARGE (tech)	CYTO TECH	PHARMACY	ANESTHESIA
							**** For the anesthesia medicine, rate is $5.69/minute. Time varies by procedure.	
CT Scan of Chest:								
w/o contrast	71250	$ 159.00	$ 1,030.50					
w/contrast	71260	$ 170.00	$ 1,158.00					
w/o contrast followed by w/contrast	71270	$ 189.00	$ 1,418.00					
CT scan of Abdomen:								
w/contrast	74160	$ 175.00	$ 1,011.50					
w/o contrast	74150	$ 163.00	$ 694.00					
w/o contrast followed by w/contrast	74170	$ 192.00	$ 1,158.50					
CT scan of Pelvis:								
w/contrast	72192	$ 150.00	$ 1,011.50					
w/o contrast	72193	$ 159.00	$ 694.00					
w/o contrast followed by w/contrast	72194	$ 167.00	$ 1,156.50					
Urinalysis:								
Dip	81002	$ 14.00						
Rapid Pregnancy	81025	$ 25.00						
Cytology	88108			$ 118.00	$ 93.00			
Beta -2 microglobulin	82043	$ 31.00						
Blood Collection:								
Venipuncture	36415	$ 15.00						
Creatinine	82565		$ 8.00					
BUN (Blood Urea Nitrogen)	84520							
Whole Blood Lead	83655		$ 13.00					
Blood Glucose	82947		$ 6.00					
ESR - erythrocyte sedimentation rate	85651							
Zinc Protoporphyrin	84202		$ 21.00					
CBC-complete blood count	85027		$ 10.00					
Stool Blood (Hemoccult)	82270	$ 15.00	$ 10.00					
Physicals - New Patients: (All specialities)								
<1 yr	99381	$ 151.00						
1-4 yrs	99382	$ 182.00						
5-11 yrs	99383	$ 159.00						

12-17 yrs	99384	$ 173.00							
18-39 yrs	99385	$ 173.00							
40-64 yrs	99386	$ 204.00							
>65 yrs	99387	$ 221.00							
Consult w/ Urologist	99245	$ 325.00							
Cystoscopy w/Biopsy	52354	$ 1,567.00	$ 8,500.00	$ 100.00	$ 151.00			Est 45 Minutes $251.55	00800 - $80/15 minutes
Consult w/Nephrologist	99245	$ 325.00							
Cardiothoracic Surgeon:									
Office Visit	99245	$ 325.00							
Lung Biopsy	32400	$ 399.00	$ 3,300.00	$ 183.00	$ 139.00	$ 139.50		Estimate 1.5 hours	
	32402	$ 1,374.00	$ 3,300.00		$ 100.00	$ 151.00	$	693.10	00522 - $80/15 minutes/Averages $1,700.00
(Hospital charges for all, if done at outpatient)	32405	$ 271.00	$ 3,300.00				$	693.10	00522 - $80/15 minutes/Average $1,700.00
	32602	$ 935.00	$ 3,300.00	$ 300.00	$ 266.50		$	693.10	00522 - $80/15 minutes/Average $1,700.00
							$	693.10	00522 - $80/15 minutes/Average $1,700.00
Pulmonologist:									
Office Visit	99245	$ 325.00							
Lung Biopsy	31625	$ 937.00	$ 725.00	$ 100.00	$ 151.00				
Neuropsychiatric Evaluation	96118	$223/hr	Est 3 Hours = $669 // $1,011 total						
	96119	$114/hr	Est 3 Hours = $342 //						
Consult w/Medical Toxicologist or Environmental Medicine Specialist	99245	$ 325.00							
Consult w/Dermatologist:	99245	$ 325.00							
Biopsy	11100	$ 209.00	$ 1,500.00	$ 100.00	$ 151.00				00400 - $80/15 minutes (Est 30 Min = $160)
EGD	43239	$ 734.00	$ 1,200.00	$ 100.00	$ 151.00			Est 15 Minutes $93.85	00740 - $80/15 minutes
Bone x-ray - Fluorescence Testing		Not performed at WVU - Will need price from Columbia University in New York							

NOTES:

1. All prices reported here are current charges as of 3/29/2007 at West Virginia University Hospitals, Inc and WVU Medical Corporation, Inc.
2. For procedures: the prices shown are the average, with overall estimates (per Dr Wemtz in *underlined italics*) in parentheses
3. Normally skin biopsy is an outpatient procedure. A few ill patients may require a hospital biopsy *(estimate 3%) (Hosp Charge and Anes Charge)*

MEMORANDUM OF UNDERSTANDING

Lenora Perrine et. al. v. E.I. du Pont de Nemours and Company, et. al., Civil Action No. 04-C-296-2 (Cir. Ct. of Harrison County, W. Va.)

Comes now this 19th day of November 2010 the Plaintiffs in the above-captioned matter by Ed Hill, Esq. and comes the Defendant E.I. du Pont de Nemours and Company ("Defendant")in the above-captioned matter by James B. Lees Jr., Esq. and hereby set forth the terms and conditions of a proposed global resolution of this pending litigation as between these parties:

1. Plaintiffs shall dismiss any and all pending claims against Defendant with prejudice and shall release Defendant from any and all liability in this litigation, except as provided by this agreement.

2. The Defendant shall pay to the Plaintiffs the sum of $70,000,000.00 plus medical monitoring consistent with the Court Order dated February 25, 2008, as only modified by this agreement, under the following terms and conditions:

a. Although the parties understand that the final date of payment by Defendant to Plaintiffs depends on a number of factors and cannot be guaranteed, the parties agree to make all reasonable efforts to accomplish payment of the $70,000,000.00 from Defendant to a Qualified Settlement Fund on or before December 31, 2010.

b. $66,000,000.00 of the total $70,000,000.00 payment shall be available to the Plaintiffs as directed by the Court for the purposes of paying for remediation services, medical monitoring costs and expenses, and attorney fees and expenses.

c. The remaining $4,000,000.00 of the total $70,000,000.00 payment shall be made available only for a cash payment program for the medical monitoring sub-class of Plaintiffs as directed by the Court. Said sum shall not be used for any purpose other than for the sole benefit of the medical monitoring sub-class.

3. In addition to the above, Defendant shall provide on a pay-as-you-go basis a medical monitoring program for all enrolled Plaintiffs consistent with the previous referenced Court Order as only modified by this agreement, under the following terms and conditions:

a. There shall be an initial enrollment period of six (6) months beginning at a time reasonably determined by the Settlement Administrator for all Plaintiffs at which time any Plaintiff may enroll in the medical monitoring program to avail themselves of the future monitoring benefits of the program. No Plaintiff shall be entitled to participate in said program unless they have enrolled during the initial six (6) month enrollment period.

b. After said enrollment period has expired, a Finance Committee comprised of representatives from class counsel, DuPont, and the Settlement Administrator shall be created for purposes of advising the Court on the structure and execution of the medical monitoring program. On an annual basis the Court, with the recommendation of the Finance Committee, shall direct DuPont to pay a sum certain that will be set aside for each such calendar year that reasonably secures such expenditures for each such calendar year. In each subsequent year after year one DuPont shall be credited with any amounts remaining from the prior year in determining the amount of payment for the subsequent year.

c. 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.

d. Additionally, after the initial six (6) month sign-up period has concluded and the number of participating Plaintiffs, be they adults or minors, is known, the Defendant in the ordinary course of their business shall set aside reasonable reserves as required by applicable law which shall cover the estimated cost of such medical monitoring program.

e. Public notice to class members to notify them of the initial six (6) month sign-up period shall be deemed sufficient if done on a state-wide basis. All advertising and other costs associated with any and all notice requirements under this agreement shall be paid from the $1,000,000.00 start-up expenses referenced above. Notice of this settlement and court costs shall be paid by the defendant.

f. It is contemplated by the parties that a Finance Committee shall exist for purposes of helping provide guidance and advice for the operation of this medical monitoring program with each party hereto having one (1) representative on said Committee. In the event any decision is reached with respect to the payment for services or costs in the medical monitoring program to which the Defendant takes exception, the Defendant shall have the right to have such objection or exception reviewed by the Court and,

if necessary, appealed within the West Virginia judicial system.

4. Defendant reserves the right to reasonably challenge the enrollment of any Plaintiff in the medical monitoring program and/or property remediation class. With respect to any challenge relevant to the issue of eligibility for enrollment the challenger shall pay reasonable costs and attorney fees if the challenge is not successful.

5. It shall be expressly understood by the parties that Defendant shall not be responsible for the payment of any other monies for any purposes associated with the execution of this agreement and that any and all Plaintiff attorney fees and Plaintiff expenses associated with the execution of this agreement shall come from the $70,000,000.00 paid by the Defendant pursuant to this agreement.

6. It is expressly understood by the parties that no part or portion of the payments agreed to by the Defendant pursuant to this agreement are or should be considered a compromise or settlement of any punitive damage award returned against the Defendant, which shall now be vacated.

7. The parties agree that pursuant to any final settlement of this matter the Court, if at the conclusion of the Fairness Hearing approves the final settlement of this matter, will vacate any and all prior judgments relevant to this matter and enter a new judgment order accurately reflecting the terms and conditions of the final settlement of this matter.

8. Any and all pending motions and/or unresolved issues shall be deemed moot by this agreement, including, but not limited to, the pending motion for sanctions filed by the Plaintiffs in this action.

9. Plaintiffs shall maintain any and all copies, including electronic copies, of discovery which has been produced by Defendant to Plaintiffs in this litigation in a manner consistent with all Protective Orders entered in this case, and any and all Protective Orders are understood to continue in effect.

10. In the event members of the Plaintiff class are legally permitted to opt-out of this settlement at the discretion of the Court, the participation rate of the Plaintiffs participating in a final settlement of this matter, consistent with the terms and conditions set forth herein, must equal or exceed 90%. If this 90% participation rate is not achieved, Defendant shall have the option to void the settlement. However op-outs totaling 10% or less shall not reduce DuPont's obligations under this agreement.

11. Defendant understands and agrees that this proposed agreement must be approved by the Plaintiffs' class representatives and the Court pursuant to a Fairness Hearing and that counsel for the Plaintiffs shall strive to obtain such approval of the class representatives by the close of business on Monday November 22, 2010. Plaintiffs understand and agree that this proposed agreement must be approved by certain officers within the Defendant organization and that Defendant shall strive to obtain that approval by the close of business on Monday November 22, 2010. It is understood that neither party currently has legal authority to bind their respective clients today, but does agree to make a good faith effort to obtain the approval of the terms and conditions of this Memorandum of Understanding by their respective clients by the close of business on Monday November 22, 2010.

Agreed to:

Lenora Perrine, et al. by

B. Edison Hill

E.I. du Pont dee Nemours and Company et al. by

Dated: NOVEMBER 19, 2010