PERRINE DUPONT SETTLEMENT CLAIMS OFFICE
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September 15, 2017

VIA HAND DELIVERY

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

Re: Class Member Medical Monitoring Testing Protocols Review and Update; Our File No. 4609-1{GG-13}

Dear Judge Bedell:

I hope this letter finds the Court well.

As ordered by the Court in its Order entered August 4, 2017, the purpose of this Report is to provide the Court a more detailed proposal regarding the proposed modifications of the Medical Monitoring Program design, as recommended by your Claims Administrator and the Medical Advisory Panel.

A. Recommended Health Study and Medical Monitoring Testing Protocol Modifications

The Panelists, who join in the submission of this Report, have first noted that there has been a significant drop in participation among registered claimants.

(i) Recommended Health Study

A Health Study may help tailor the Program testing protocols based on findings, help determine if there is a link between the heavy metals and Claimant disease, and help answer the common Claimant question of what happened health-wise in the Spelter Class Area. In our April 24, 2017 Report to the Court, in Exhibit A, the Panel and your Claims Administrator defended the need for an epidemiology or Health Study.

The Health Study would not be limited by the types of possible proposals that the Panel can now come up with, and is open to innovation and new ideas from applicants for a Health Study. Applicants would respond to the proposed Request for Applications in Exhibit B. For example,

psychological studies and testing could be enhanced. The study could help answer causation questions from mined data (e.g. comparing heavy metals in tested households with Health Study data). The study could also describe gaps in the data that need to be filled by additional studies or testing.

A Health Study is recommended. Contrary to DuPont's argument at our July 18, 2017, hearing, wherein DuPont argued that "there's nothing in Dr. Werntz's proposal that would authorize a study . . . and we submit there's nothing in the settlement that would authorize a study," the Court correctly questions "why have the Court remain involved for 30 years if it's a static document that's never going to be changed and can't be modified in any respect?" Hearing Regarding Distribution of the Surplus in the Property Remediation Fund, July 18, 2017, page 15, lines 11-18. See Exhibit C for the Hearing transcript. As the Court pointed out, and as the Panelists propose, the medical monitoring portion must "be subject to some tweaking, if nothing else, over the years as medical science advances." Id. "Some tests may be become obsolete and some tests may be more appropriate as suggested in limited fashion . . ." Id.

In the Court's August 24, 2011, Order Permitting the Establishment of a Program Database to Facilitate and Assist in Future Scientific and Medical Research, the Court ordered that, "after a claimant provides informed consent, that claimant's information may be placed into a research database and provided upon request to assist in a legitimate medical or scientific purpose." Relying upon the opinion of Dr. Werntz, to rebut Defendant's assertion "that the creation and maintenance of a medical monitoring program was not a part of the Perrine/Dupont settlement or part of the Medical Plan Order," the Court noted that its February 25, 2008 Final Order Regarding the Scope, Duration, and Cost of the Medical Monitoring Plan, adopted the medical monitoring plan envisioned by Dr. Werntz "in its entirety," and "the Defendant never made an objection or appeal to Dr. Werntz's idea of a database used for research."

In the August 24, 2011 Order, the Court concluded:

> Underlying this Court's current decision is the immense value that a database of this kind would provide to both the Plaintiffs and the scientific and medical community at large. Testimony in this case has already established that this field of study is barren of the kind of knowledge that the proposed database could provide. This data could be tremendously helpful in assessing the sorts of harms, if any, that prolonged exposure to arsenic, cadmium, and lead can incur. It would also assist in determining the interplay between these potential harms and the medical monitoring process. Furthermore, nay privacy concerns may be dealt with by a waiver. Because the benefits of such a database far outweigh the costs, it would be a mistake to neglect this opportunity.

Dr. Werntz provided, in his "Overall medical surveillance assumptions," "[t]hat a central respository 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." Werntz Report, page 10, March 10, 2007. The Court adopted

this Report in its entirety, and your Claims Administrator and Panelists submit that the proposed Health Study as proposed herein, and set out in Exhibit D, fits squarely within Dr. Werntz's report.

At this point, we estimate the cost of a Health Study for the initial year of study to be $333,333. See proposed budget in Exhibit E, August 30, 2017 Memorandum.

(ii) Recommended Medical Monitoring Testing Protocols Modifications

By its Order entered November 3, 2016, this Honorable Court approved the selection of a Medical Advisory Panel, as contemplated by the Court's Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, as entered by the Court on January 18, 2011.

In its previous Order of January 18, 2011, the Court "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 . . ." See Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, page 14, paragraph 6. As such, one of the assignments of the Medical Advisory Panel, as agreed to by the Finance Committee, is the consideration of the following question:

> Based upon scientific and medical developments since early 2011, do the existing medical monitoring protocols of the Perrine Medical Monitoring Program require updating?

As explained in the June 23, 2017 Report to the Court in Exhibit F, the Panel has carefully considered this question, and the unanimous answer is **"Yes."**

As Jim Arnold, DuPont's Counsel, argued at our July 18, 2017 hearing, "what the medical monitoring program was designed to do was to afford to this medical monitoring class the remedies and benefits under West Virginia's Medical Monitoring Law. And that was to provide diagnostic examinations and tests for people who could demonstrate exposure to certain toxic material and those tests have to be reasonable and necessary and what would – what a normal physician – a physician would normally prescribe to try to diagnose those particular illnesses." Hearing Regarding Distribution of the Surplus in the Property Remediation Fund, July 18, 2017, page 18, lines 8-17.

The Panel's recommended updated Medical Monitoring Testing Protocols regarding the tests for the toxic materials involved in our case were vetted with CTIA, the Settlement's Third-Party Administrator. CTIA's analysis of the suggested updated Medical Monitoring Testing Protocols is found in Exhibit G.

Given the scope of the recommended updates to the Medical Monitoring Testing Protocols, now testing for numerous additional maladies possibly associated with the heavy metals involved, the Panel recommends all 4,000 Class Members who originally registered for Program testing be invited again to participate in the Program.

As part of the Medical Monitoring Program, your Claims Administrator proposes that at least one of our Medical Panelists should speak with groups of people at local churches and the senior citizen center. At these meetings, we would propose that the Panelist explain the program described herein, which we believe would increase participation among our registered claimants.

One concern which may be presented is the safety and risks of such testing procedures. As the Court will recall, in the Court's October 21, 2011 Order, in Exhibit H, the Court addressed the risks of a CT Scan. The Court noted that "[t]he Parties have stipulated that the Medical Monitoring Program is a primary plan for medical testing benefits, with DuPont being responsible for all costs thereof." The Court went on to find that "CT Scans cannot be baseline or routine even at the commencement of Medical Monitoring." The approach suggested by your Claims Administrator best carries out the terms of the MOU, which provides:

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

Your Claims Administrator believes these estimates and costs are a fair and adequate representation of the cost of the proposed health study and protocol modifications. Thus, your Claims Administrator requests that this Court adopt and ratify these proposals and modifications.

(iii) Recommended Uniform Participant Wellness Exam Questionnaire

In carrying out its duties, the Panel was provided protected access to the confidential medical testing information compiled by CTIA, in conjunction with LabCorp, for participating Class Members who consented to make the information for research. This data is maintained in a uniform database, that may be sorted and analyzed. Also reviewed was a sample of the Claimant wellness exam results for the Program. The medical data so obtained from wellness exams by Program participating Physicians was not compiled in a uniform manner and is therefore not being compiled by CTIA into a database, so that its accessibility for a health study or other scientific research is limited.

The Panel recommends that a uniform wellness exam form substantially in the form of Exhibit I be utilized by the Program to facilitate compilation and study of the resulting medical records, but with the form to be modified from time to time as reasonable necessary.

B. Proposed Use of Settlement Automobile

As described in the April 24, 2017 Report to the Court in Exhibit A, the Settlement currently owns a vehicle, which was formerly used for the Remediation Program. However, the Settlement is no longer using the vehicle.

Your Claims Administrator and the Panel propose that the vehicle be donated to the Spelter Volunteer Fire Department, but the vehicle should be made available to be on loan from the Fire Department to the Settlement to use for transporting disabled Medical Monitoring Claimants or as otherwise necessary for the Settlement.

At our August 22, 2017, Quarterly Meeting, the Claimants' Committee recommended, when the vehicle is used to transport disabled Medical Monitoring Claimants, that the driver be trained in CPR and shall have passed a drug test within the preceding six (6) months.

Your Claims Administrator and the Panel find this to be a reasonable recommendation, and asks the Court to Order the transfer of the vehicle from the Settlement to the Fire Department with the stipulations set forth herein.

C. Proposed Claimant Participation Incentive Payments

Your Claims Administrator and the Panel propose that incentive payments be made to the participating claimants, as was initially proposed to the Court in their April 24, 2017 Report in Exhibit A.

A survey of incentives offered in similar programs found that the VA, for example, offers travel reimbursement for mileage from the patient's door to the facility. In some cases, the VA will reimburse food costs.

In some clinical trial programs, participants are paid only after they complete the process.

In a settlement in Mingo County, participants were given $10 in cash at testing and $10 in cash once the results were received. However, the Mingo program has been amended to give $20 in cash and a $25 Walmart gift card for participation.

Based upon the survey of other similar programs, for those registered participating claimants, your Claims Administrator and the Panelists propose that transportation be provided to those needing such. Moreover, each registered participating claimant would receive a $25 Walmart gift card at testing and a $25 Walmart gift card upon receiving testing result.

Assuming 3,000 participants, the cost of the Walmart gift card incentive program would be $150,000 for the next round of Program testing.

D. Suggested Supplement to Budget

As the Court knows, the proposed September 1, 2017 to August 31, 2018, Settlement Budget was submitted on August 8, 2017, and approved by Order dated August 14, 2017. The Budget Submission of the Settlement included a Supplement, which is needed to carry out the Program enhancements described in this Report. The Budget Supplement is described below.

As explained in Exhibit E, your Claims Administrator presents the following discussion of each Supplemental Budget expense category:

Health Study: The Medical Advisory Panel recommends a Health Study over time, rather than a one-time survey, to assist in identifying latent health effects on the Medical Monitoring Program ("MMP") Claimants. The Budget line item for a Health Study was estimated at $333,333, representing an anticipated three (3) year study at $1 Million. As shown in Attachment B to Exhibit E, we received two (2) Health Study cost estimates; one for a six (6) year study and additional biological testing at an estimated cost of $1.4 Million to $1.6 Million, with the other being a six (6) year study with questionnaires initially and every three (3) years and with no additional biological testing for an estimated cost of $750,000 to $850,000.

Medical Monitoring Incentive Payments: The Medical Advisory Panel and the Claims Administrator recommend that Claimants participating in the MMP be given a Walmart gift card valued at $25. For Budget purposes, we provided a Budget expense line item of $150,000 for the Budget year, representing the issuance of Walmart gift cards per Claimant of $50 ($25 at testing and $25 upon receiving testing results) for 3,000 Claimants.

Claims Administrator Legal Fees for Medical Monitoring Provisioning: The estimated Claims Administrator legal fees for additional Medical Monitoring Provisioning expenses is $120,000, or $10,000 per month, in connection with the additional MMP activities (Health Study, Medical Monitoring Incentive Payments, additional Medical Monitoring Participant interaction, etc.). As always, we pledge to continue to manage the MMP frugally, with the goal being for actual expenditures to continue to come in below the budgeted amount.

Additional Medical Provider Medical Monitoring Expenses: Additional Medical Provider expenses of $80,522 for the Budget year are provided for within the Budget, to provide funding should the number of active MMP Claimants increase due to the changes in the MMP.

Additional Third Party Administrator Fees and Expenses (CTIA): Please refer to Attachment C to Exhibit E, representing the Medical Monitoring Program Third Party Administrator's estimated budget should the Court approve the recommended changes to the MMP. If you remove the additional Medical Provider expenses of $80,522 from CTIA's budget, the additional estimated Third Party Administrator fees and expenses total $568,935, with these expenses including the following: Medical Provider fees for completing Claimant data forms, increases in MMP costs due to new laboratory tests, physician procedures, and specialty referrals (see Attachment D of Exhibit E, CTIA Analysis of Proposed Procedures with Estimated Fees), and CTIA service fees, consulting fees, and communication expenses.

Your Claims Administrator believes this Budget Supplement to be fair and reasonable, and should be approved by the Court.

A proposed Order granting the requests in this Report is in Exhibit J.

Thank you for the Court's consideration.

Yours very truly,

Ed Gentle, III
Claims Administrator

Joined by:

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Perrine Medical Monitoring Program Panel
Chair

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Internal Medicine Expert

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Mr. Don Brandt, CTIA

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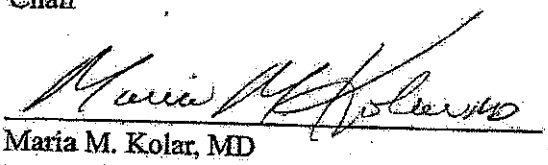

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Schedule of Exhibits to September 15, 2017 Report

Exhibit A:	**April 24, 2017 Report to the Court With Appendix A**
Exhibit B:	**Proposed Request for Health Study Applications**
Exhibit C:	**July 18, 2017 Hearing Transcript**
Exhibit D:	**Proposed Health Study Parameters**
Exhibit E:	**August 30, 2017 Memorandum re Supplemental Budget With Attachments A-D**
Exhibit F:	**June 23, 2017 Report to the Court Recommending Modifications to the Medical Monitoring Testing Protocols With Exhibits A-D**
Exhibit G:	**Analysis of Proposed Procedures Involved with Panel-Recommended Modifications to Medical Monitoring Testing Protocols with Estimated Costs**
Exhibit H:	**October 21, 2011, Order re CT Scans**
Exhibit I:	**Proposed Revised Wellness Exam Form**
Exhibit J:	**Proposed Order**

EXHIBIT A

April 24, 2017 Report to the Court

PERRINE DUPONT SETTLEMENT CLAIMS OFFICE
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April 24, 2017

VIA HAND DELIVERY

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

Re: The Perrine DuPont Settlement Remediation Program (the "Remediation Program") - Report Respecting Use of Remediation Program Second Surplus; Our File No. 4609-1 {DD-89}, 4609-1{GG-25} and 4609-1{GG-26}

Dear Judge Bedell:

I hope this letter finds the Court well.

As the Court may recall, your Settlement Administrator projects a surplus in the Remediation Program of approximately $600,000. The purpose of this Report is to present the detailed proposal of the Medical Advisory Panel and Settlement Administrator "on the possible uses of the remaining funds for medical monitoring, including possibly an epidemiological or health study and possible Claimant participation incentive payments, and disabled Claimant transportation, and to present it to the Court and the Parties," as ordered in the Court's Order entered March 9, 2017. In making this Report, we are aware that the Claimants voted in our town hall meetings to issue a second dividend from all of the surplus. With the recommendations below, we are sensitive to the recommendations of the Claimants as we suggest that half of the surplus go to the Claimants in the form of a dividend and half the surplus to help the Medical Monitoring Program to the benefit of the Claimants. This Report addresses the Court's instructions in two parts: claimant participation incentives and transportation; and scientific research, which might include a health study.

A. Recommended Incentive Payments and Transportation

The Panelists and your Settlement Administrator recommend that Claimants participating in the Medical Monitoring Program be given a Walmart gift card valued at $25 for each round of testing. Assuming 500 participants with 12 more rounds of testing, the cost of the Walmart gift card incentive program would be $150,000, which we recommend be paid from the remediation surplus.

The Panelists, who join in the submission of this report, first note that there has been a significant drop in participation among registered claimants. We believe an incentive program such as this might increase the claimant participation rate.

A survey of incentives offered in similar programs found that the VA, for example, offers travel reimbursement for mileage from the patient's door to the facility. In some cases, the VA will reimburse food costs.

In some clinical trial programs, participants are paid only after they complete the process, which may be the practice here.

In the administration of a settlement in the *Mingo County Coal Slurry Litigation*, in the Circuit Court of Mingo County, West Virginia, Case Number 10-C-5000, supervised by Mr. Gentle, as Settlement Administrator, participants were originally given $10 in cash at testing and $10 in cash once the results were received. However, the Mingo program has been amended to give a $20 Walmart gift card when tested and a $20 Walmart gift card when the Claimant returns for the results. In the Mingo County case, the Settlement's Medical Monitoring Plan provides free screenings once every two years during a thirty-year period, based upon the effects of the slurry contamination of the water supplies in Mingo County. An Environmental Protection Agency report stated that the main risks associated with "ingestion and exposure based upon contaminants found in Mingo County are liver damage, cancer, kidney problems, blood issues, reproductive disorders and problems with the nervous system."

Based upon the survey of other similar programs, for those registered participating claimants, your Settlement Administrator and the Panelists also propose that transportation be provided to those needing such. The Spelter Volunteer Fire Department is agreeable to accepting the contribution of the Settlement vehicle, in exchange for providing Medical Monitoring transportation for Claimants needing it.

The Settlement's suggested donation of its vehicle to the Spelter Fire Station with the understanding that it will be used to transport Claimants to their Medical Monitoring appointments as needed should provide needed transportation help for the Medical Monitoring Program.

B. Recommendations Concerning Scientific Research[1] Which May Include an Epidemiology[2] or Health Study

The Panelists and your Settlement Administrator recommend the use of some of the surplus for a seed scientific research grant in order to review Claimant and related data for scientific trends and findings, and the results of which may help in future Medical Monitoring testing protocol design. Using the current data in hand may be counterproductive given that more high-powered, detailed data is necessary for some scientific studies. Such scientific research may include the completion of an epidemiology study. We recommend a seed grant from the remediation surplus of $150,000 for this purpose, with research grant applications to the Settlement to be vetted by the Medical Advisory Panel and the Settlement Administrator and realizing that such research may be more costly, as shown by one estimate in Appendix A.

Another case to consider is that of the Fernald, Ohio Uranium Plant Medical Monitoring Program. In this case, 11,000 people were exposed to radiation in uranium dust from a plant that converted uranium ore to metal for use in nuclear plants and for nuclear weapons. A $78 million settlement fund was established for a medical monitoring program and administered by the University of Cincinnati, with detailed testing being conducted annually to identify disease if present. The database and archived biospecimens represented a rich resource for future research of both health effects related to the environmental exposure, and a wide range of non-exposure questions. As suggested in the *Fernald* case, one purpose of medical monitoring is to determine if there is linkage between the toxic substance or the dangerous product and disease. Five grant-funded studies were completed at Fernald: (i) Estimation of radon exposures to workers at the Fernald Feed Materials Production Center 1952-1998 (2008); (ii) Retrospective smoking history data collection for deceased workers: completeness and accuracy of surrogate reports (2002); (iii) Mortality among a cohort of white male workers at a uranium processing plant: Fernald Feed Materials Production Center, 1951-1989 (1995); (iv) Uranium dust exposure and lung cancer risk in four uranium processing operations (1995); and (v) Mortality among workers exposed to external ionizing radiation at a nuclear facility in Ohio (1991).

The Medical Panel notes that an epidemiologic study of the existing Medical Monitoring data is unlikely to be informative. There is a significant risk the study is underpowered due to the high dropout rate and the seemingly high number of cancers needed to show a difference between controls. The control group may also be less than ideal. Thus, we recommend a grant from the Remediation surplus of $150,000 as seed money for a scientific research study related to the Settlement, instead, with the possible scientific research not being limited to data only collected through the Medical Monitoring Program.

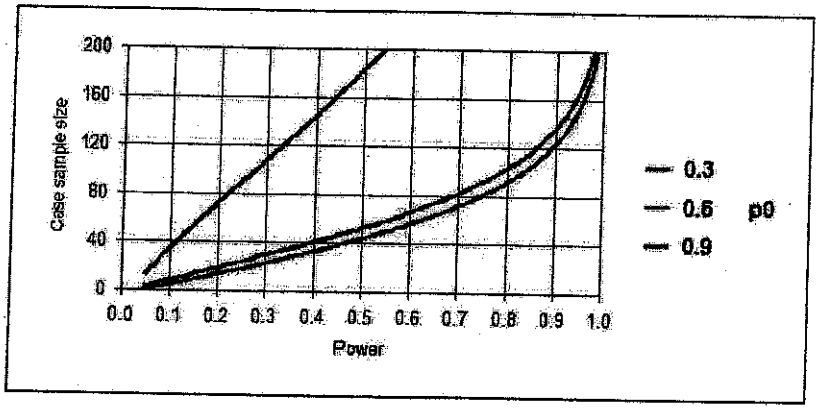
Although the Medical Advisory Panel and Settlement Administrator are sensitive to the

[1] Scientific research is the systematic investigation of scientific theories and hypotheses. A hypothesis is a single assertion, a proposed explanation of something based on available knowledge, for something yet to be explained. It is therefore more flexible than an epidemiology study.

[2] Epidemiology is the study and analysis of the patterns, causes, and effects of health and disease conditions in defined populations. It is the cornerstone of public health, and shapes policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare. Major areas of such studies include disease causation, transmission, outbreak investigation, disease surveillance, forensic epidemiology and screening, biomonitoring, and comparisons of treatment effects such as in clinical trials.

value of information gleaned from epidemiological studies utilizing the carefully constructed and interrogatable database (see B above), there was an overall sense that a one-time cross sectional retrospective study (as proposed by Translational Technologies International – see Appendix A – study objectives A,B) would not necessarily be informative for assuring that components of medical surveillance were focused on health outcomes of individuals of the claimant cohort (addressing their risk of disease from exposure to lead, arsenic and/or cadmium). A cross sectional observational health survey is not likely to replace reviewing emerging literature on harmful effects of these agents, individually or in combination, in situations where exposure is well documented and adjusting components of medical surveillance. Furthermore, the extensive drop off rate in participation (see A above) of the claimants will significantly detract from conclusions made in any longitudinal (Appendix A – study objective C) or case-control (Appendix A- Study objective D) studies. The latter will also be hampered by concerns of population size and statistical analyses. The Medical Advisory Panel and Settlement Administrator felt that determinants of clinical assessment (physical examination, laboratory tests including biomarkers, imaging and pathophysiological phenotypic measurements, etc) will continue to rely on evidence based epidemiological studies in peer reviewed medical journals depicting risks and modalities for early detection and potential prevention of disease in carefully controlled relevant cohorts. In particular:

A cross sectional study by nature is descriptive and provides data on entire population under study. Capturing health outcomes (and behaviors and risk factors) for variety of chronic diseases from original cohort of 4100 persons from Perrine WV who entered medical surveillance in 2011 will indeed quantify prevalence of any particular disease outcome (number of cases in this group normalized to these 4100 persons). Nonetheless the associative nature of the analysis and the uncertainty of exposure precludes cause and effect. A higher level observational study is required that includes a control group with similar demographic and potentially confounding features but void of the attribute (e.g. exposure to metal toxicants from zinc smelter plant). If we just consider cancer (combined lung, bladder and skin cancer), then in entire state of West Virginia, the average annual age-adjusted incidence (per 100,000) is 81, 21 and 24, respectively (2016 West Virginia Cancer Burden Report; http://dhhr.wv.gov/oeps/cancer/Documents/burdenreport2016.pdf) and thus there would be an expected 3 lung, 1 bladder and 1 skin cancer (in presumptive largely unexposed population). In the case of lung cancer, utilizing a case-control study in Chile on effect of ingesting arsenic (Smith AH et al, J Expos Sci Environ Epidemiol 2009) odds ratios ranged from 0.7-7.1 for developing lung cancer across increasing exposure to arsenic. A power analysis (http://biostat.mc.vanderbilt.edu/wiki/Main/PowerSampleSize) performed with assumption that the odds ratio for developing lung cancer with a moderate arsenic exposure is 2.0 and the probability of exposure among controls (p_0) was 0.3, we would need 60 cancer cases to have a study with a 60% power (See figure below). This number would increase if odds ratio for lung cancer was lower or the probability that the control group (p_0) was exposed was higher; conversely it would decrease if odds ratio was higher and probability of misassignment were lower.



Thus, this type of analysis could be done for a myriad of medical outcomes derived from the rich data accumulated in the initial cohort of 4100 in a reasonable period of time for a modest investment as described by Translational Technologies International. The difficulty in assuring the control group was not exposed may be challenging and the distinct likelihood that the study may be underpowered detracts from the likelihood of arriving at associations between disease endpoint and exposure that would be useful in medical surveillance.

Attempting to identify and describe disease trends in the community through the survey year (2017) is fraught with concerns about drop out of approximately 50% every two years. It is imperative and quite challenging to evaluate the diminishing cohort with respect to reasons for dropout that may confound such a longitudinal analysis and bias results of disease outcomes with time. There is nothing in the current design of such an epidemiological study that will identify a causal link between exposures to the community and identified outcomes. This requires a gradient of exposures over space and time that is not empirically apparent in the data potentially at hand although it is possible that remediation, per se, provides a point in time where exposure is abruptly decreased.

The Medical Advisory Panel is currently in the process of reviewing the breadth and specificity of the nature of surveillance for the members of the initial cohort of potentially exposed individuals and assuring best practices based on emerging medical and toxicological science is utilized.

It is possible that information gleaned from research grants described in section B above may be useful in designing interventional studies that may be of benefit in documenting exposure, identifying useful biomarkers and clinical assessments and help focus on a subgroup of original cohort that may be particularly at risk. A multicenter double blind placebo-controlled randomized 10 year long trial showed that among stable patients with a history of myocardial infarction, intravenous chelation therapy (with disodium EDTA) modestly reduced the risk of adverse cardiovascular outcomes (Lamas et al, J Am Med Assoc 309: 1241- 1250) that was reduced even more in subgroup of post myocardial infarction patients with diabetes mellitus (Escolar E et al, Circ Cardiovasc Qual Outcomes 7: 15-24, 2014). This latter observation is currently in a replicative phase that will attempt to establish whether removal of toxic metals (lead, cadmium) from the body as demonstrated by Waters et al (Biol Trace Elem Res 83:

207-221, 2001) is a plausible mechanism for the benefit of such therapy (Lamas et al, J Amer Coll Cardiol 67: 2411-2418).

Please let us know if the Court has any questions regarding our Report.

Thank you for the Court's consideration.

Yours very truly,

Ed Gentle, III
Claims Administrator

Joined by:

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Perrine Medical Monitoring Program Panel
Chair

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Claims Administrator

Joined by:

Bruce R. Pitt 21 Apr 2017

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Maria M. Kolar, MD (signed by ED Gentle with permission)
Maria M. Kolar, MD
Perrine Medical Monitoring Program Panel
Internal Medicine Expert

Peter L Perrotta MD
Peter L. Perrotta, MD
Perrine Medical Monitoring Program Panel
Pathology Expert

ECGIII/jcs

Amanda Williams

From: Ed Gentle <escrowagen@aol.com>
Sent: Monday, April 24, 2017 3:33 AM
To: Amanda Williams
Subject: Fwd: The Perrine Medical Monitoring Program

Pls print n out on my chair thanks ed

Ed Gentle
Gentle, Turner, Sexton & Harbison, LLC
501 Riverchase Parkway East, Ste. 100
Hoover, AL 35244
(205) 716-3000 phone
(205) 716-3010 fax
(205) 960-2533 cell

Sent from my iPhone

Begin forwarded message:

> **From:** Ed Gentle <escrowagen@aol.com>
> **Date:** April 24, 2017 at 3:31:00 AM CDT
> **To:** "Kolar, Maria" <mkolar@hsc.wvu.edu>
> **Subject: Re: The Perrine Medical Monitoring Program**
>
> Maria I will just sign for you no problem Ed
>
> Ed Gentle
> Gentle, Turner, Sexton & Harbison, LLC
> 501 Riverchase Parkway East, Ste. 100
> Hoover, AL 35244
> (205) 716-3000 phone
> (205) 716-3010 fax
> (205) 960-2533 cell
>
> Sent from my iPhone
>
> > On Apr 23, 2017, at 9:50 PM, Kolar, Maria <mkolar@hsc.wvu.edu> wrote:
> >
> > I'm sorry for the delay in getting this to you. I am having difficulty with my home computer. I should be able to sign and return to you in the morning. Or, if you think it would be better to sign for me, that would be fine too.
> >
> > Thanks.
> >
> > Maria

I hereby certify that I have served a copy of the foregoing upon the following individuals by email:

David B. Thomas
James S. Arnold
Thomas Combs & Spann, PLLC
P.O. Box 3824
Charleston, WV 25338-3824

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

Virginia Buchanan
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Pensacola, FL 32591

J. Farrest Taylor
The Cochran Firm-Dothan, PC
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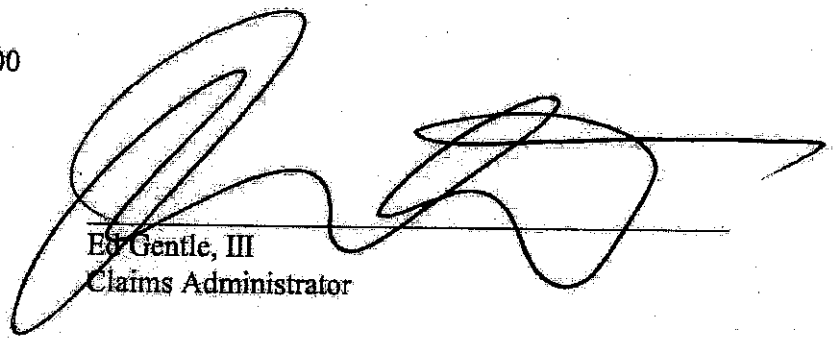
Dothan, AL 36301

Michael A. Jacks
Jacks Legal Group, P.L.L.C.
3467 University Ave, Suite 200
Morgantown, WV 26505



E. Gentle, III
Claims Administrator

APPENDIX A

Perrine, WV Preliminary Study Estimate

Study Rationale

Those who live near an environmental hazard site may suffer from harmful health effects linked to exposure to contaminants released into the environment. As is the case in this situation, oftentimes following a class-action litigation suit, monetary resources are set aside to provide the benefit of medical monitoring to the exposed community (Wones et al. 2009). The introduction of unsafe levels of heavy metal contaminants of lead, arsenic, cadmium, and zinc into the water supply has increased the risk of adverse health events such as cancer in those exposed to the metals. There is a strong relationship between exposure to lead, cadmium, mercury, and arsenic and serious health complications, in which high risks have been observed (Jarup 2003). Cadmium exposure is associated with kidney damage, bone fragility, and fractures (ATSDR, CDC 2012). Children are especially susceptible to lead exposure, as its toxicity prevents normal brain development, potentially causing permanent mental retardation. Adults experience suppressed immune systems and generalized increased mortality rates (Brown and Margolis 2012). Since mercury is a neurotoxin, exposure to it can cause brain damage, loss of peripheral vision, muscle weakness, and impairment of speech, hearing, and walking (EPA 2016).Exposure to arsenic in drinking water may lead to cancers, skin lesions, cardiovascular disease, and diabetes (WHO 2016). Early detection and intervention of any health outcomes the contaminants may be linked to is important for the individual patient, their families, and their community. This study will help identify markers and indications of any contaminant-related diseases to allow for early treatment and better final health outcomes for all those affected.

Study Objectives

A. To identify and recruit approximately 4100 persons from Perrine, WV for participation in a cross-sectional (one-time) epidemiology study;
B. To obtain medical data on participants as part of Medical Monitoring Program (MMP), including abstraction of medical records and administration of questionnaires to capture health outcomes, behaviors and risk factors for many chronic diseases;
C. To identify and describe disease trends in the community through the survey year (2017), using data obtained from patient medical records;
D. To conduct analyses examining the potential causal link between exposures to the community and identified outcomes;
E. To review and adjudicate medical information from hospital, physician and other records;
F. To develop innovative hypotheses, perform data analysis, and produce publications from this study;
G. To provide community education and feedback regarding information from the study itself; to provide information to improve the health of the community in general.

General Proposed Study Methodology / Protocol

*This is a draft skeleton for budgeting purposes only.

A. Questionnaires
   a. General health status and medical history
   b. Behavioral health and lifestyle factors
   c. Disability
   d. TBD
B. Abstraction of Records from Medical Examinations
   a. Extent TBD based on final budget
C. Survey administration – single survey in 2017

Cost Assumptions

- Assumes cost for exams is captured separately as part of medical monitoring plan.
- Estimated costs are based on knowledge and experience in conducting studies of similar size and complexity and factor in a margin of error for unknown protocol elements to be determined at a later time; estimates are subject to change once additional data becomes available.
- Protocols may be adapted to accommodate available funding.

Cost Estimate

- $300,000 for the 1-year study period

References

Agency for Toxic Substances and Disease Registry (ATSDR). 2012. Toxicological Profile for Cadmium. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service.

Brown, M.J., Margolis, S. (2012). Lead in Drinking Water and Human Blood Levels in the United States. Morbidity and Mortality Weekly Report (MMWR). Centers for Disease Control and Prevention.

Environmental Protection Agency (EPA), 2016. Health Effects of Exposures to Mercury.

Järup, L. (2003). Hazards of heavy metal contamination. British medical bulletin, 68(1), 167-182.

World Health Organization (WHO). 2016. Arsenic: Fact Sheet. http://www.who.int/mediacentre/factsheets/fs372/en/

Wones, R., Pinney, S. M., Buckholz, J. M., Deck-Tebbe, C., Freyberg, R., & Pesce, A. (2009). Medical monitoring: a beneficial remedy for residents living near an environmental hazard site. Journal of occupational and environmental medicine/American College of Occupational and Environmental Medicine, 51(12), 1374.

EXHIBIT B

Proposed Request for Health Study Applications

A Time Sensitive Request for Applications: Environmental epidemiologic studies of residents of Spelter WV exposed to arsenic, lead and/or cadmium: Medical surveillance of Perrine vs Dupont (Zinc smelter) settlement.

Purpose and Background: As a result of Perrine vs Dupont Settlement of 2011, individuals residing in regions in proximity to Dupont Zinc Smelter, Spelter, WV, became eligible for a medical surveillance program to provide early detection of a variety of potential disease endpoints that they may be at risk of developing due to exposure to lead, cadmium and/or arsenic. Approximately 4000 adult residents and 400 minors/incompetents became class members for medical surveillance. Exposure was quantified by environmental modeling from soil samples of Cd, Ar and Pb and geographic zones were established by estimating risk of developing certain forms of cancer based on existing scientific regulatory data. Biomonitoring was limited to voluntary blood lead levels only during medical surveillance (every two years). Endpoints of disease were linear with respect to metal exposure (for example, lung cancer and arsenic; cadmium and renal dysfunction; lead and neurodevelopment in minor class members). At the time of the settlement (2011), members were considered homogenous for risks of various endpoints (primarily cancer and renal dysfunction) with the exception of some cognitive/neurodevelopmental changes in underage minor group. Surveillance, every two years, was initiated in 2011 and medical records and test results have been accrued from providers in an agreed upon fashion making them available for investigation purposes. Separate from remediation (soil and attics, municipal water, that was completed in 2017), a liason was established with the community for medical surveillance resulting in enrollment of 4000 residents in 2011. According to submitted medical reimbursement requests, this has decreased by approximately 50%.

A medical advisory committee (internist, pathologist and public health investigator) was established and charged by terms of original settlement to oversee contemporary nature of surveillance and assure it was within best practices as ascertained by accumulation of new information since 2011. The advisory committee has identified many such changes in 2017 and concomitantly suggested that a number of aspects were devoid of information and such information could only be obtained by de novo investigation of aspects of environmental health in Spelter. Examples of such deficiencies include refinement of assessment and quantification of **exposure, stratification** of individuals to better refine cause and effect, **retrospective cohort** study as assessment of population health **or** impact of exposure to **combination** of metals and are discussed below (research scope).

Research Scope

a. **Exposure studies**: Exposure was quantified by environmental modeling from soil samples of Cd, Ar and Pb and geographic zones were established by estimating risk of developing certain forms of cancer based on existing scientific regulatory data. Biomonitoring was limited to voluntary blood lead levels only during medical surveillance (every two years). This latter assessment is considered to only reflect recent lead exposure (10-30 day) leading to possible disconnect from: a) health effects of more chronic exposure; b) possible effects of combination of exposure to Cd, Ar and Pb: c) uncertainty and stress for individual without a more precise assessment of chronic exposure; and d) challenges in epidemiologic assessment of health of entire cohort.

   Support is available for exposure scientists and epidemiologists to utilize existing data as well as make new measurements on class members of medical monitoring program for the purpose of estimating individual levels of chronic exposure to lead, cadmium and if feasible, arsenic. Successful applications will: a) probe tissue compartments (bone, soft tissue, urine, etc) with measurements of burden to Cd, Pb and/or Ar at current baseline with or without provocation (for example, single dose chelation); b) apply toxicokinetic modeling to distinguish chronic and current burdens; c) detail mechanism to provide feedback to individual class member and health care providers in medical monitoring program; and d) provide timely peer reviewed descriptions of their efforts. Efforts may include:

   a. laser ablation inductively coupled plasma mass spectrometry of metal content of shed deciduous teeth in underage minor cohort.
   b. X-ray fluorescence of metal levels in tibia, knee and/or soft tissue.
   c. Simultaneous urine and blood metal measurements, with or without NaEDTA chelation
   d. metal adducts (metallothionein, protoporphyrin, albumin, hemoglobin, etc)
   e. other biological samples (hair, nails).

b. **Epidemiology studies with stratification:** Since 2011, considerable epidemiologic data suggests that these metals (Ar, Cd and/or Pb) may advance disease and mortality via augmentation or initiation of pathophysiological processes and thereby add to risk of various disease endpoints due to other risk factors (Cosselman, Navas-Acien and Schwartz, Nature Rev Cardiol 2015). Compelling evidence supporting a role for chronic low level exposure to metals and cardiovascular disease emerges from NIH Trial Assess Chelation Therapy I and II (Lamas et al, J Am Coll Cardiol 2016). As such, epidemiologic studies involving stratification of class members with confounding underlying disease (e.g. recent myocardial infarction and/or diabetes) and other risk factors (smoking, obesity) may greatly aid in the impact of the medical monitoring program.

   Support is available for environmental epidemiologists to perform retrospective and prospective health studies on class members in medical monitoring program

using existing medical electronic records and laboratory test results. Successful applicants will identify potential subgroups with contributing risk factors and contrast their incidence and prevalence of disease as well as their prospective outcomes following remediation. Types of proposals that address this RFA include:

a) comparing health endpoints in members with recent myocardial infarction with or without diabetes to experience of larger group and appropriate controls;
b) identifying the interaction of other risk factors (smoking, obesity, alcohol consumption) with Cd, Ar and/or Pb on cancer and non-cancer endpoints within the class membership and in contrast to appropriate control groups.
c) next generation whole exome sequencing for genetic risk factors towards progression of exposed group to disease endpoints (cancer, renal dysfunction, cardiovascular disease, diabetes, etc).

c. **Retrospective cohort study:** The origins of the original settlement and the basis of medical surveillance are in large part derived from a medical approach to individual patients. As such, considerable important information on population health of Smelter that may affect how to go forward in surveillance is missing. A carefully constructed retrospective cohort study would be a first step in revealing essential metrics of population health. Furthermore such a study could be performed within the constraints of time and fiscal concerns

From questionnaires, medical histories and laboratory records of entry of class members to medical surveillance in 2011, the prevalence of relevant diseases can be calculated and compared to appropriate cohort of controls. The latter may be derived by geocoding and identifying a range of exposures with data accumulated in 2011 or identification of a suitable cohort in comparable towns in West Virginia (but devoid of smelters).

d. **Effect of Combination of Exposure to Metals:** To the extent that the effect of residing near smelter was an unique experience for residents of Spelter (e.g. not readily predictable from literature depicting human effects of each individual metal), a significant component of such disparity may be the result of effects of exposure to combination of metals. Accordingly, competitive grants for epidemiological studies stratifying individual exposure (from geocoding and measurements of environmental metals in soil and/or attic; or individual biomonitoring as in (a) above) and retrospective cohort disease experience within Spelter may reveal relative contributions of individual metals and the impact of the magnitude of their various combinations.

Additional Considerations

Successful competition for funds and completion of proposed work is expected to occur in a timely fashion (e.g. two years) to inform ongoing medical surveillance. Accordingly, no preliminary data is anticipated and a realistic plan to bring accrued information to the attention of the residents and move it forward via peer reviewed mechanisms will be a component of review of applications.

All proposals will require well defined community based participatory research component including effective pathways to share results with individuals and the population. This should include the identification of a collaborator with credentials for such activity.

As health concerns at hand are for a local community in Harrison County within the State of West Virginia, arrangements including investigators within a reasonable distance from Spelter, WV, either by virtue of the principal investigators location or via a well documented arrangement of collaboration with such an entity is critical to the outcome of the award.

Award Budget: Two awards for $167,000 total costs/year (including 8% indirect costs) will be made. Renewal and/or a second round of competitive awards will await decisions on available funds.

Eligibility: Public/state controlled institutions of higher education, private institutes of higher education or nonprofits with 501(c)(3) IRS status.

Content and Form of Application Submission: A letter of intent with a descriptive title of proposed activity, name and addresses and email of Principal Investigator and participating institution should be sent to:

Edgar C. Gentle, III, Esq.
Claims Administrator
501 Riverchase Parkway East, Suite 100
Hoover, Alabama 35244

Submission requirements: We could refer to an NIH like grant or I have a couple of examples of things from pharmaceutical and/or foundation.

Application Review Information: Again, we could refer to an NIH like grant or I have a couple of examples of things from pharmaceutical and/or foundation. Familiar criteria like overall impact, significance, investigators, innovation, approach, environment, protection for human subjects can all be catered to our mechanism of funding.

Review and selection process: Like an NIH thing, we could indicate that applications will be evaluated for scientific and technical merit and the likelihood to benefit class members of the medical monitoring program by an appropriate Scientific Review group (it could include me, Pete and Maria and we could add two or three ad hoc experts to help)

EXHIBIT C

July 18, 2017 Hearing Transcript

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

* *

LENORA PERRINE, et al.,
Plaintiff,

The Honorable Thomas Bedell, Judge

v.

Case No. 04-C-296-2

E.I. DU PONT DE NEMOURS AND COMPANY,
a Delaware corporation doing business in
West Virginia
Defendants.

* *

HEARING REGARDING THE DISTRIBUTION OF THE SURPLUS IN THE PROPERTY REMEDIATION FUND

The following is a transcript of the proceedings held in the above-styled matter before the Honorable Thomas Bedell, in the Circuit Court of Harrison County, West Virginia, on the 18th day of July, 2017

LESLIE QUEEN-PRUITT
Court Reporter
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Claims Administrator
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Spelter, WV 26438
(appearing telephonically)

P R O C E E D I N G S

(The following proceedings were held on the 18th day of July, 2017, as follows, to-wit:)

THE COURT: Comes on for proceedings at the present time, civil matter encaptioned Lenora Perrine, et al, Plaintiffs, versus E.I. DuPont De Nemours and Company, et al, Defendants. This matter bears case number 04-C-296-2. The Court would further note that today is Tuesday, the 18th day of July, 2017 and these matters come on by way of further proceedings in the above-captioned civil action pursuant to the order of the Court heretofore entered herein.

Beginning with those counsel present in Harrison County, West Virginia, will counsel note their appearance for the record and further note the presence or absence of their respective clients or others whose attendance they care to note.

Mr. Gentle?

MR. GENTLE: Good afternoon, Your Honor. Ed Gentle, the Court Settlement Administrator. With me is our local counsel and the co-author of the settlement, Mike Jacks.

THE COURT: Okay.

MR. GENTLE: And Christy Mullens whose with our claims office.

THE COURT: Okay.

Ms. McCarthy?

MS. MCCARTHY: Thank you, Your Honor. Meredith McCarthy on behalf of the minor children and incompetent adults.

THE COURT: And Mr. Arnold?

MR. ARNOLD: Thank you, Your Honor. Jim Arnold on behalf of DuPont, and also on behalf of DuPont on the telephone are Niall Paul and Clifford Kinney from the Spilman law firm in Charleston.

THE COURT: Okay.

Will those remaining individuals who are participating by phone please note your appearances as well, please.

MS. BLANKENSHIP: Kip Hardeston, Chris Smith, and Jennifer Blankenship with Ed Gentle's office in Birmingham.

THE COURT: Anyone --

MR. TAYLOR: This is Farrest Taylor with the Cochran firm on behalf of the Plaintiffs.

THE COURT: Yes, sir.

Counsel, let me recognize the purpose today is primarily or -- although maybe not exclusively for the Court to make a determination on the distribution of the program surplus in these matters. And the Court has received the written submissions in no particular order, of the Guardian Ad Litem in response to settlement administrator's proposal for remediation program surplus. I've received the communication from the settlement administrator that was tendered to the Court by

letter of April 24th of 2017. DuPont's proposal for the distribution of surplus and the property remediation fund and its objections to other submitted proposals, as well as further communication concerning perhaps not directly on the surplus issue but -- that was tendered by the claims administrator by correspondence dated the 23rd day of June, 2017 concerning the updating, for lack of a better description, of the medical monitoring program.

Counsel, let me just give each or all of you an opportunity. I'll note I think this is the first hearing that we've not had any participation from the claimants here today. Maybe they've just given up on us as far as that goes or maybe nobody thought to tell them about it, perhaps. But I don't think that's the case since I believe these proceedings were set at the last proceedings.

But Mr. Gentle, anything? Certainly the Court is familiar with the issues and the respective positions, but anything you want to emphasize or anything that comes to mind in light of the other submissions to the Court?

MR. GENTLE: Yes, Your Honor. I'd be happy to. First of all, as a preliminary matter, the finance committee continues to work well with the settlement and we're -- I think we're vetting the proposed medical monitoring protocols and we're caucusing, I guess, is the fancy word, Jim, on August 22nd

with our medical panel. So I don't think that's ripe to bring to the Court yet. And again --

THE COURT: So --

MR. GENTLE: -- our goal is always to reach as much consensus as possible.

THE COURT: Okay.

MR. GENTLE: And that's my hope is that we can just resolve that.

On the --

THE COURT: So that would be a democratic process since it's a caucus? Isn't it a conference, if I remember my high school civics? If it was from those on the other side of the aisle?

MR. GENTLE: Could be, Judge.

THE COURT: So -- okay.

MR. GENTLE: I like -- I'd like to think we're on the same side of the aisle.

THE COURT: Okay.

MR. GENTLE: That is to help the settlement work. So I'm going to speak about the surplus. I also would like to note that Dr. Bruce Pitt has come into the room. He's the chairman of our medical panel. You can see from our August 24th submission that we have a brilliant and very able panel. And so they -- they laid out in this letter, which I co-authored with

them. They used me as a litmus and if an Auburn grad can understand it then perhaps everyone else can.

But basically, as the Court knows, we have this $600,000 problem. A good problem. That is money that's remaining after all the remediation is completed. We have about 1400 mediation claimants. 1400. So if you were to pay it all out it would be about $400 a head. If you pay them half or 300,000 it's about 200 a head and that sort of helps us look at what it means to the household, so to speak.

As the Court knows, we've tried to do this in a caucus like manner trying to get everybody's input. One thing we did do and reported it with our February 21 letter is we vetted the claimant population to see what they would like to do, as the Court knows. And the large percent, 92 percent, they wanted all of it as a dividend. And we're very sensitive to that, both the medical panel and I am, in the settlement. And that will be reflected in what we've proposed.

I've also pointed out in a previous submission to the Court that there is a provision in Section 2(b) of the settlement memo of understanding that remediation monies that are left can be used for medical monitoring costs if the Court considers those as the Court decides what to do with the surplus.

So what we did with the panel is we thought about this. I think, Dr. Pitt, we might have had three meetings on this. And

we were very sensitive to the claimants' request that they get all the money as a dividend. And so what we decided to recommend as a group, and it was unanimous, is that half would go as a dividend and then half the Court, in its consideration, might think about some other uses.

So the panel then decided to look at what would be good uses to advance the purposes of the medical monitoring program. And I defined the purposes as encouraging claimants who signed up to come be tested every two years to find disease and -- early so that they can -- they have a better chance of cure. And so one thing we thought about on page 2 of our report is to take half of the $300,000 that we're recommending not be used as a dividend and use that as an incentive payment to claimants. For example, this is done with VA when they do exams. We administered the Mingo County coal slurry litigation with Massey Energy. And we do something similar, Your Honor. Right now we're giving $20 Walmart gift cards. And so we're recommending that the Court think about that. I think that the process would be that the claimant would go through that round of medical monitoring testing and then come pick up their gift card or, excuse me, their incentive card.

We also thought about encouraging the sick and those unable to have transportation to be tested. And as the Court knows, earlier on we recommended that the settlement vehicle be donated

to the fire station in Spelter. And they're very happy to have that vehicle and to use it for that purpose as needed.

The other half of the $300,000 is addressed on page three of our report. And that deals with the question of a health study. The health study, I think, I would serve -- could serve different purposes. Dr. Pitt and the other two experts, Dr. Perrotta and Dr. Kolar, have outlined in those subsequent pages a detailed analysis of that. I'm sure Dr. Pitt is happy to discuss it further this afternoon. But basically, as it says here, it would help us to review claimant and related data for scientific trends and findings and the results of which may help in future medical monitoring testing protocol design. And that is we would get feedback from the actual medical monitoring population on what their health conditions are so that we can match the test with what the panel is finding in looking at a scientific study.

The recommendation, again, would be $150,000 from the remediation surplus to be used for that purpose. Where would the -- it could cost, though, as we've showed in this appendix A, a total of $300,000 and not just $150,000. And that's something I think the parties have their points of view about. I'll just speak to some history that I'm aware of. In the Mingo County settlement we are now doing a health study that the defendants are paying for. And so that's in precedent now in

the state of West Virginia.

I think, again, the parties disagree on how to do that. You might, though, just have a $150,000 grant and the applicant has to find matching funds. Or you might have that other money paid by somebody else. But I think that summarizes, Your Honor, the panel's position and the settlement's position. Thank you.

THE COURT: Okay.

Ms. McCarthy, what would you have to offer, please?

MS. MCCARTHY: Thank you, Your Honor. As a large statement, I generally agree with the Claims Administrator in his proposals. However, I do want to address the Court. In reading the objections from DuPont I think generally, to keep it simple, the major issues are one, who owns this surplus, whether it's just the property class or whether it's the medical monitoring class. I think both classes own the surplus together. And I think that the case cited by them, Klier versus Elf Autochem North America helps support that. That the class as a whole owns the surplus.

Next, can the surplus be used to do research with the medical monitoring people or as an incentive payment? And, again, I would argue yes per the prior orders of this Court. On January 4, 2011 this Court approved the agreement, the MOU. So it's still a very relevant document. It is still -- outlines the goals of the underlying litigation. And I think it's -- I

think it's the leading principal behind the order.

But, at any rate, I also want to say that the property classes have been made whole. They had their soil and homes remediated. They've received a significant inconvenient pay as well as a partial dividend already. So that particular class has received the windfall of the monies allowed in this litigation. So I think it would be fair and equitable and I believe that there is authority within the prior orders that this Court can allow that that money be used for medical monitoring or research. The research. And I also think that if the Court disallows the incentive payment, the whole 300,000 should go to the medical research. However, I'm a big advocate of allowing the matching funds. I think that it's important for these research people to go out and find their money to support this research. And I think WVU had an interest in this case from the get-go. And I think that we've been working with them since. So that's -- I think those are my statements and I've outlined it in a position previously submitted to the Court.

THE COURT: Okay.

Mr. Arnold, anything that you care to add for the Court's consideration today, sir?

MR. ARNOLD: Yes, Your Honor. Of course, DuPont's position is the money is -- should be distributed for the benefit of the property class. That's the class that has the

interest in it. From the arguments and the two proposals -- the other proposals submitted to the Court, it appears that there is a disagreement between the Claims Administrator and the Guardian Ad Litem and DuPont as to whether there are more than one class. There are clearly two classes here, Your Honor. And pointing simply to the MOU really doesn't give the whole picture, as the Court is aware. I mean, the Court in approving the settlement and entering orders, multiple orders, implementing the settlement, the Court has been scrupulous to keep the two classes separate. And, in fact, the Claims Administrator spends a great deal of time and effort maintaining the separateness of those two classes and the qualified funds that this Court set up. And we just simply say the law is that that fund, and specifically since it's a large enough sum that si-pru principals don't really apply, and I don't think there's an issue about that --

THE COURT: Sure.

MR. ARNOLD: -- here. It's got to stay with or be used for the benefit of the property class. And so we would urge that the Court order the distribution as it did the larger distribution back in 2016.

What I find curious about the position of the other two proposals is that they do want to use some of the money, 50 percent of it, for the property class. What's curious about

that is that if they're right that this money could just be transferred to the medical monitoring class, then why waste the money in a smaller distribution to the property class because the administrative expense in making a distribution is probably going to be pretty close to being the same, whether all 600,000 of this surplus is distributed or whether only 50 percent of it is distributed to the property class. That administration expense is probably going to stay the same.

With respect to the incentive payments, there was an incentive payment agreed to as part of the settlement that was made very early on after the medical monitoring program was established and we were in that enrollment period. Our position with respect to further settlements or incentive payments, Your Honor, is simply that there's no provision in the settlement for that and that all monies that belong in the medical monitoring fund should be used for the diagnostic examination and testing of the participants in the program or for the incidental administrative expenses in connection with delivering those services.

With respect to the health study, I commented in our February hearing that I thought it would have been more helpful if we had a more specific understanding of what the study would really be. I don't think we've really moved that much forward since February with -- on -- with respect to any specificity of

the health study. The only thing that's been flushed out are some general comments about the general purposes that a health study could use as a goal. But I think a health study, Your Honor, is contrary to the legal principals in Bower. And this settlement, particularly the part of the settlement that relates to medical monitoring, was really a settlement of the claims that the Plaintiffs won at trial on medical monitoring and the Court in its evidentiary hearings after trial and in the orders since then has hewn very closely, as have the parties in their agreement, to the medical monitoring proposal of Dr. Wince and -- with some modifications. And, Your Honor, there's nothing in Dr. Wince's proposal that would authorize a study. And we submit there's nothing in the settlement that would authorize a study.

THE COURT: But on that issue, then, why have the Court remain involved for 30 years if it's a static document that's never going to be changed and can't be modified in any respect? I mean, why didn't I in 2011 go fishing or something on that -- you know, at that point as far as any monitoring or control or -- over the medical monitoring portion of things? It's got to be subject to some tweaking, if nothing else, over the years as medical science advances. Some tests may be become obsolete and some tests may be more appropriate as suggested in limited fashion as I understand up to this point.

MR. ARNOLD: But that's --

THE COURT: I mean, is it the position of DuPont that after 2011 the Court has no right to or no discretion to modify the medical monitoring portion of the settlement?

MR. ARNOLD: No, Your Honor. And that's not my argument at all. My argument is confined to a health study.

THE COURT: Okay.

MR. ARNOLD: I'm not talking about --

THE COURT: But you've suggested the incentive payments are inappropriate under all the orders and memorandum of understanding. You've suggested the -- that the health study is inappropriate for the same reasons. And I'm not sure that you've commented on any adjustment on types of evaluations or examinations or anything. But, I mean, what do you -- if that's the case do you believe that then only in the health -- the academic study, for lack of a better description, the Court just doesn't have jurisdiction to order that?

MR. ARNOLD: I do believe that with respect to the health study, yes, Your Honor.

THE COURT: Okay.

MR. ARNOLD: I think the Court certainly has a lot of other responsibilities during the 30 year life of this medical monitoring program. But as I pointed out in the papers that we filed, the one court that I could find that addressed

this issue said that, you know, generalized studies -- see, but --

THE COURT: But that was -- wasn't that a trial judge in federal court in Colorado? Is that the case --

MR. ARNOLD: Yes, Your Honor.

THE COURT: You know, --

MR. ARNOLD: It was.

THE COURT: -- I mean, there's a man or a woman -- I don't recall if it even commented on it -- I mean, that's, you know, at the trial court level struggling with the same issues that this court is. I mean, I'm not sure that that's very persuasive. I guess maybe since they're presidential appointment as opposed to being popular elected he's smarter or she's smarter than I am. But, I mean, is there -- other than the analysis that that judge went through, I mean, is really -- is that much help to this court?

MR. ARNOLD: Well, it's some help, Your Honor, or I would -- or at least I would hope it would be some help or I wouldn't have wasted the Court's time with making the reference.

THE COURT: I mean, then, do you believe that the incentive payments is within the discretion of the Court?

MR. ARNOLD: Well, the original one was, certainly.

THE COURT: Okay.

MR. ARNOLD: There was discussions and the parties

came together on it.

THE COURT: Well, that wouldn't be within the discretion. I mean, I don't know that I would have been -- I guess I would have had the authority to veto it, in essence, or whatever. But do you think that any current or future incentive payments are within the discretion of the court under the medical -- only on the medical monitoring side of things?

MR. ARNOLD: Well, Your Honor, I think what the medical monitoring program was designed to do was to afford to this medical monitoring class the remedies and benefits under West Virginia's Medical Monitoring law. And that was to provide diagnostic examinations and tests for people who could demonstrate exposure to certain toxic material and those tests have to be reasonable and necessary and what would -- what a normal physician -- or what a normal -- a physician would normally prescribe to try to diagnose those particular illnesses. And that's what the program is designed to do. It's not designed -- and Bowers is silent on doing health studies.

THE COURT: Well, if that health study would help direct the court to know what evaluations and examinations are appropriate, is that not an appropriate use of the medical monitoring portion of the proceedings? I mean, should I just -- again, is it static on what Wertz(phonetic) and them did way back in the '90s, presumably now, that -- you know, am I limited

to that? Or can I ask for outside assistance and say is there a better way to provide these evaluations and monitoring to this class of people?

MR. ARNOLD: Well, I think -- I think we are all constrained, Your Honor, by the evidence that the plaintiff class offered that would -- ended up being the basis for the settlement.

THE COURT: Okay.

MR. ARNOLD: In terms of the toxic chemicals to which they were exposed, to the diseases that were of concern. For example, I don't think we can expand those diseases.

THE COURT: But what if there's new scientific evidence that lead cadmium or arsenic causes some other ailment that we've not identified or --

MR. ARNOLD: I think --

THE COURT: -- then can we -- under your scenario is it not possible to conduct those tests to see if that further illness is caused by those chemicals?

MR. ARNOLD: Well, I think Bower and its progeny addressed that. And what they say is is that the claimant then can come back and with making the -- making -- meeting the necessary elements of proof can try to expand the relief. But I -- what I don't think can happen without that being litigated is for just us as the finance committee and the claims

administrator and the court to just rewrite that. I think the Plaintiff's class would have to come forward with proof and put on evidence that the -- there is a causal connection to this new disease and there are tests -- there are diagnostic tests or examinations that would help give early detection of that disease. That's the position I have, Your Honor.

THE COURT: Okay. And, quite frankly, I'll confess that I'm not sure that I recalled that part of Bowers because I've not looked at it in such -- probably -- I don't want to exaggerate, probably since 2011 as far as the last time I looked at Bowers specifically. But certainly I will review that as well. So anything else, Mr. Arnold?

MR. ARNOLD: I have nothing else at this time, Your Honor.

THE COURT: Okay.

Mr. Taylor, I'll start with you. Is there anything that you'd like to add for the Court's consideration, sir?

MR. TAYLOR: Yes, Your Honor. The first question is how this money can be used. How can this surplus be used. If you go back to the memorandum of understanding, if you look at paragraph 2(b), it takes the 66 million dollars, which is the fund that resulted in the surplus, and said it can be used for remediation, it can be used for medical monitoring costs and expenses. So the fund that created the surplus, it was clearly

anticipated that any surplus could be used as directed by the Court.

Now, the Court did allocate the 66 million to a settlement -- a qualified settlement fund for property remediation. But in that same order the Court retained jurisdiction and retained power to modify the terms of that order, as do most courts in class action settlements, especially settlements that go on for as long as this one does.

So clearly the MOU contemplated that this money could be used for medical monitoring and this court did reserve power to make modifications in how this money could be used. And that's especially relevant since the very purpose that this court allocated the 66 million into that settlement fund has been achieved. The property has been remediated and there's a surplus. So we believe that this fund is available for both medical monitoring and property remediation.

Now, we disagree with DuPont that this money could only be used for medical testing. Because the Court ordered a pay as you go provision for the testing. So that's already taken care of. And this 66 million was available -- the only way you can read it would be available for other costs and expenses on top of the testing. So because there is a pay as you go provision, the only way that you could read the settlement MOU is that there was contemplation that there would be costs and expenses

on top of this testing and claims administration.

Now, the other question is if this money can be used for medical monitoring, are there any restrictions that should be imposed. The Court in its January 8, 2011 order, in paragraph 5, relied upon the February 25, 2008 order on the scope, duration, and cost of the medical monitoring plan. That was an order entered by the Court. In that February 2008 the Court discusses taking data collected by the medical monitoring and using that data or allowing that data to be used in studies and also for academic research. So this was -- using this money to do research has been contemplated since 2008.

And with respect to incentive payment for the medical monitoring class, we think that there's clearly precedent for this in this case. There's been incentive payments made or, you know, various cash payments to the property class. And if that was permissible then certainly this Court has discretion to allow some of this money as an incentive payment to the property class.

And just one last thing, the only money that was earmarked in the settlement was four million dollars and that was earmarked solely to the medical monitoring class. So this money that resulted in the surplus was never earmarked for one specific purpose. It clearly states in the MOU that it can be used for medical monitoring and/or remediation.

And so we believe that the Court does have discretion and is within the bounds of its discretion to make this money available either as an incentive payment and/or fund a study based on the data generated and collected in the medical monitoring.

THE COURT: Thank you, sir.

Anyone else participating telephonically like to address the Court?

(No response)

THE COURT: Okay. Hearing no such request.

Counsel, this is kind of a unique situation, at least during the administration process of the case, because usually by the time matters come before the Court to make a final determination there's a consensus that's been reached by everyone here. That's -- and that's not the case, and that's the role of the Court in these matters. And, quite frankly, I agree with much of what each counsel has offered to the Court. And I've -- and, again, perhaps contrary to the administration -- prior administration, I don't know that I disagree with -- or that I don't disagree with a portion of everyone's presentation to the Court.

But I guess broad strokes, I don't know that I would find that there's different classes. It's one -- it's one class. It was one lawsuit and we broke it down into subclasses for the

administration of the property settlement portion of it. I don't know that the fact that there different lines, perhaps, and I certainly don't recall on the verdict form -- and I suspect that there was -- is of much consequence.

But I think the Court does have discretion with this remaining $600,000 that brings us together today. And I understand the bulk of what's left over, the medical monitoring portion, we're going to address hopefully in the very near future so a final determination can be made for that. And, you know, probably the first thing I've ever disagreed with Ms. McCarty on in this case or any other matter is I'm not so sure that the property claimants have been made whole in these matters. Certainly the evidence at the original proceedings were -- was -- that the defendants in these matters very seriously and very strongly impacted the lives of these folks and their real property. And certainly that's something that we West Virginians treasure very dearly to our hearts is our property. It's our little -- it may be 120 foot by 40 foot lot, but that's our property. That's our home, figuratively speaking. And the Court feels very -- also feels very strongly that those feelings should be recognized and taken into consideration by the Court.

But the Court does believe that it has the authority to allocate half or whatever percentage it would deem fair and

reasonable from those monies that are remaining to, in essence as we've treated it, the medical monitoring side of things. But having considered all the submissions and certainly the Court understands the February submissions on all the town hall meetings and all the surveys and everything and what the feelings of the claimants are. But it seems to me that the Court would choose not to exercise its discretion in allocating any portion of the 600,000 to the -- anything other than the payment to the claimants as to -- again, as we've made the dichotomy. The property remediation program.

It would be the first -- accordingly, it would be the order of the Court that those remaining monies be distributed pursuant -- consistent and pursuant to the last distribution on multiple lot owners and owners in the different subclasses with regards to class 1A and so on. It seems to me that those monies belong to the people. And that that's the appropriate distribution of the entire amount that's before the Court.

Now, having said that, the Court believes that it, however, does have discretion and continuing jurisdiction over the implementation of the medical monitoring portion of things, the side of the settlement. Excuse me. I shouldn't be in-artful. And that to the extent that the Court should or should not exercise that discretion, that I'm indicating I believe I have such discretion and weather it's an appropriate exercise, the

Court is not addressing today. I'd like to have all the information from -- and all of the parties and their counsel in these matters. And if the Court is going to approve an academic study I would like the specifics on that. And if I'm going to approve the incentive payments -- and I think we can extrapolate to the -- what's been presented to the Court today. So we don't have to re-plow a lot of that ground.

But it seems to me that the Court needs -- since we've conducted multiple hearings on it, we've had multiple briefs, considerable -- we've made a considerable record in this matter, it seems to me that one last shot, if anybody wishes to address any of the -- their respective positions on the discretion of the Court to order these additional items of relief should be included and the Court, making a very detailed order with findings of facts and conclusions of law, so if the Defendant disagrees with the Court ordering incentive payments out of the medical monitoring side of things, the ongoing budget, annual budget, that that can be brought the appellate court and they can make a determination on what -- on whether it's under Bowers or the existing statutes. Whether those are -- whether the Court has exceeded its jurisdiction in so ordering. And, quite frankly, if it has, all I need is someone to tell me -- the five justices tell me that I'm wrong and tell me how to do it better and then I can implement whatever they would believe appropriate

if they were called upon to review the Court's decision making.

Counsel, what is a -- I guess my concerning is we started this process in February and here we are in July before we -- before the Court has made at least what it deems is the easier determination as a matter of law and fact in this matter. I mean, can we bring -- can we make ripe the remaining issue in 60 days? Is that reasonable to have all the information before the Court?

MR. GENTLE: Your Honor, Ed Gentle. I think it is. And I think another timeframe we need to keep in mind is that the next round of testing is scheduled to begin November 1st. We have an August 22 meeting, like I mentioned. And you'll see with the June report we've submitted to the Court what we think that Dr. Wentz had in mind when he talks about epidemiological studies in his paper. And that is we asked our two experts, Dr. Perrotta and Dr. Pitt, to look at the scientific world now, and they found some new linkage with new diseases with these metals. And we have test. We're going to vet that with DuPont. They may disagree with that analysis but, again, the goal is consensus.

I'm hoping that certainly by mid-September, Jim, that should be ripe for the Court to be heard. We have a caucus August 22nd. I'd like to get that resolved in time to get those protocols in place to test our claimants, Your Honor. That's my

big concern. Likewise, we'd like to have the incentive payments known so we can get that going. I think this is very helpful today. And Dr. Pitt and Dr. Perrotta, and Dr. Kolar, I will get with them quickly and try to put some meat on the bones for a scientific study in the same sort of timeframe.

THE COURT: Okay.

Ms. McCarthy, just going around the room and giving everybody, is -- is the 60 days a reasonable timeframe? I mean, I think that still fits with the August and the November timeframes that Mr. Gentle detailed. If I have all the information to make final determination, whether it's one -- and I believe that I have -- that I have some discretion -- ongoing discretion in the implementation of the medical monitoring program and, two, whether the Court should exercise that in that case. Is that a reasonable timeframe from your perspective?

MS. MCCARTHY: Yes it is, Your Honor. Thank you.

THE COURT: Okay.

Mr. Arnold, what are your thoughts, sir?

MR. ARNOLD: That will be fine, Your Honor.

THE COURT: Okay.

Mr. Taylor, is that reasonable as busy as a counsel as you are, sir?

MR. TAYLOR: Yes, Your Honor. That's reasonable.

THE COURT: Okay.

So, counsel, again, is there a way to -- I'm not sure that I was very artful. I mean, what I -- any further submissions on -- in support of either the remaining issues of the incentive payments or the implementation of an academic study. I apologize. I lost my train of thought. Or any other modification to the program. My thoughts are submit it and if anything is going to be submitted by September 15th --

MR. GENTLE: Yes, sir.

THE COURT: -- of 2017. That it's done simultaneously by all counsel and then the Court will review it and generate an order addressing the issues then presently before it.

Let me volunteer young Mr. Jacks again to prepare an order from today's proceeding.

MR. JACKS: Yes, Your Honor.

THE COURT: Showing we came and the counsel made their presentations or renewed presentations to the Court with regards to the $600,000 approximately left in the property remediation fund and that we set the timeframes for any modifications to the medical monitoring portion of the case as we've described. And then I'll be glad to enter it promptly and then we'll go from there.

MR. ARNOLD: Yes, sir.

THE COURT: So hearing nothing further, then, we'll

stand in recess. Thank you-all.

(End of proceeding)

STATE OF WEST VIRGINIA,

COUNTY OF HARRISON, TO-WIT:

I, Leslie Queen-Pruitt, Official Reporter of the Circuit Court of Harrison County, West Virginia, Certified Court Reporter, do hereby certify that the foregoing is a true and correct transcript of the proceedings had and testimony taken in the matter of Lenora Perrine, et al., Plaintiffs, v. E.I. DuPont De Nemours and Company, et al, Case No. 04-C-296-2, on the 18th day of July, 2017 as reported by me in voice writing.

When spellings are in question, the words are spelled phonetically and marked with an asterisk (*).

I hereby certify that the transcript within meets the requirements of the Code of the State of West Virginia, 51-7-4, and all rules pertaining thereto as promulgated by the Supreme Court of Appeals.

Given under my hand this 1st day of September, 2017.

_____

Official Reporter, Circuit Court of
Harrison County, West Virginia

* * *

EXHIBIT D

Proposed Health Study Parameters

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
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(304) 622-7443 / (304) 622-7447 (fax)
(800) 345-0837
www.perrinedupont.com
perrinedupont@gtandslaw.com

Proposal for a Health Study for the Perrine Medical Monitoring Program

A. Principal Investigator and Research Team:

Principal Investigator and contact information: [to be selected by competitive bid]

Research team and contact information: [to be selected by competitive bid]

B. Proposed Research Synopsis

Study Title:

Perrine Heavy Metals Study

Study Population:

The study will be conducted with Medical Monitoring Program participants and other Class Members[1] willing to participate.

Study Design:

Review Medical Monitoring Program participant medical records, study medical monitoring test results, and develop and conduct a Class Member epidemiological health survey.

Sample Size:

The sample will include the Medical Monitoring Program participants medical records and medical testing results in addition to a health survey of Medical Monitoring Program participants and other Class Members willing to participate. All 4,000 Class Members who originally registered

[1]Defined as Medical Monitoring Program Class Members who checked the "yes" box for the Medical Monitoring Program whether they have remained active in the Program or not.

for the Medical Monitoring Program shall be invited to participate in the study.

We would encourage a review of the data being collected on the Claimants being medically monitored for trends, and this would be supplemented by a further health study. The epidemiologist will review our archived medical records and medical monitoring test results. Additionally, we will have the epidemiologist design and oversee an "epidemiological health survey" of the health status of the entire community. By doing this, the epidemic study may be thoroughly analyzed to study the common diseases/illnesses of participants in comparison to the health status of the entire community as a whole. Records indicate that we have zinc, cadmium, arsenic or lead in 816 houses in the Class Area, and in 166 soil properties in the Class Area. Thus, a study will attempt to correlate this data with the health symptoms.

Another approach to take may be the strata find approach. Under this approach, we would examine the data and find the 500 to 600 Class Members who had a heart attack within the last six (6) to twelve (12) months. We would study these Class Members in detail to determine if they were medically monitored and, if so, what the monitoring showed. We would also review the data with respect to the contamination levels of zinc, cadmium, arsenic or lead in their houses and/or soil.

We would also look to utilize seed money for further epidemiological studies with awards that do not pay for the entire cost of the study. Part of the costs would be favored.

The Medical Program would not be limited by the types of possible proposals that the Panel can now come up with, and is open to innovation and new ideas from applicants for a Health Study. For example, psychological studies and testing could be enhanced. The study could answer causation questions from mined data (e.g. comparing heavy metals in tested households with Health Study data). The study could describe gaps in the data that need to be filled by additional studies or testing.

Study Duration:

[to be determined]

Primary Objective:

The primary objective is to provide Medical Monitoring Program participants and other Class Members with the opportunity to have an early diagnosis of any diseases, possibly associated with exposure to zinc, cadmium, arsenic or lead, when treatment is more efficacious.

Secondary Objectives:

The secondary objective is to provide the Class Members with health risk trends, which will alert Class Members and medical providers to signs of diseases in those that may be identified to be at the highest risk; and to provide a peer review study and article for the Class.

C. Background and Significance:

The Medical Monitoring Program provides medical testing services that are designed to help detect and diagnose diseases/illnesses that could be related to exposure to heavy metals such as zinc, cadmium, arsenic or lead. The epidemiologist would review, investigate and try to determine possible and probable causal links between the heavy metals and the most commonly found diseases and illnesses. The epidemiologist would review the archived participant medical records and medical monitoring test results.

The purpose of this study is for the epidemiologist to (i) design and oversee an epidemiological health survey of the health status of Medical Monitoring Program participants and other Class Members willing to participate; (ii) thoroughly analyze the common diseases/illnesses of Medical Monitoring Program participants in comparison to the health status of other Class Members willing to participate as a whole; and (iii) a peer review study and article to be published for the Class.

Those who live near an environmental hazard site may suffer from harmful health effects linked to exposure to contaminants released into the environment. The introduction of unsafe levels of heavy metal contaminants of lead, arsenic, cadmium, and zinc into the water supply has increased the risk of adverse health events such as cancer in those exposed to the metals. There is a strong relationship between exposure to lead, cadmium, mercury, and arsenic and serious health complications, in which high risks have been observed. Cadmium exposure is associated with kidney damage, bone fragility, and fractures. Children are especially susceptible to lead exposure, as its toxicity prevents normal brain development, potentially causing permanent mental retardation. Adults experience suppressed immune systems and generalized increased mortality rates.

D. Objectives:

Primary Objective:

To determine the most common diseases/illnesses.

Secondary Objectives:

To determine the possible and probable causal links between the exposure to heavy metals such as zinc, cadmium, arsenic or lead and the most common diseases and illnesses. A peer review study and article are to be published for the Class.

E. Study design/methodology:

This will be a data review of medical records and Medical Monitoring Program test results of participants to determine the most common diseases/illnesses and any probable and possible causal links between the exposure to heavy metals such as zinc, cadmium, arsenic or lead and associated health risks.

A survey of participants and the other Class Members willing to participate will be

completed. This survey will include questions pertaining to the Class Member's general health status, medical history, behavioral health factors, lifestyle factors, and disability.

A peer review study and article will be developed and published for the Class' reference and knowledge.

In reviewing the existing data, a chelation study of cadmium and lead levels in the bones could be completed. Chelation is a treatment used in conventional medicine for removing heavy metals from the blood. It involves intravenous injections of a chelating agent, EDTA (ethylene diamine tetra-acetic acid), a synthetic amino acid.

In one metal toxicology chelation study, seventeen hundred (1,700) people participated in the study, whereby 850 were tested and 850 were placebos. The study found that chelation had a positive result of 18%. However, the plausibility of the study was in doubt as it would cause cardiodecalcification.

Lead, as in the *Perrine* case, goes from the blood to bone where it can be stored in the bones for up to 30 years, with a 30 to 35 percent reduction rate.

Registered participating claimants who are diabetic or have suffered a cardio infarction could be identified. Those Claimants would be treated with chelation in order to determine if they have cadmium and lead in their body. Doing this is in contrast to just medical monitoring; this would serve as a detection device. A one-time chelation would detect cadmium and lead but not arsenic.

The bones of participating claimants could be x-rayed for lead. Participating claimants could also be screened with an EKG.

In another Settlement administered by your Claims Administrator, blood tests cost approximately $225 per Claimant. Furthermore, in that Settlement, the Parties had included a long-term provision for a medical clinic through a grant. In order to efficiently utilize that grant, existing clinics were used by the 4,000 adults and 1,000 children involved in that case. In order to take full advantage of available third party payments from private insurance and government, and to maximize the value of clinic resources, a "retail model" was used with a third party administrator for medical care and a pharmacy benefit manager for the area pharmacies providing prescriptions. The $25-million-earmarked-grant was projected to last about fifteen years. On average, the annual cost per participating claimant was approximately $335.

F. Study Population:

Medical Monitoring participants and the other Class Members willing to participate.

G. Study Duration/Study Timeline:

Stage 1, review of Medical Monitoring Program participant medical records
Stage 2, review of Medical Monitoring Program participant test results

Stage 3, Class Member health survey
Stage 4, peer review study and article and publication

H. Informed Consent Process:

Privacy and Confidentiality:

Participants names will be kept on a password protected database and will be linked only with a study identification number for this research. There will be no personal identifiers. All data will be password protected. Data will be stored in a locked office during the survey and maintained for [time period] after the completion of the study.

I. Risks/Benefits:

Risks to Medical Monitoring Program Participants:

This study does not present any direct risks to the participants.

Benefits to Medical Monitoring Program Participants and the Class:

This study presents a benefit to the participants and the Class by providing an opportunity to gain a better understanding of the common diseases/illnesses and any probable and possible casual links between the exposure to heavy metals such as zinc, cadmium, arsenic or lead and associated health risks.

J. Data Safety Monitoring:

Data safety will be monitored on an ongoing basis throughout the duration of the study. The Principal Investigator will be responsible for reporting any data breaches or violations of the planned study data safety protocols.

K. Publication and Presentation Plans:

We will develop a peer review study and article for publication for the Class' reference.

L. References to be Utilized:

1. Medical Records
2. Medical Monitoring Plan
3. Medical Monitoring Program participant test results
4. Health Survey

EXHIBIT E

August 30, 2017 Memorandum re Supplemental Budget

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
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(800) 345-0837
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perrinedupont@gtandslaw.com

MEMORANDUM

VIA E-MAIL
CONFIDENTIAL

TO: **James S. Arnold, Esq.**
Virginia Buchanan, Esq.
Clifford F. Kinney, Jr., Esq.
Farrest Taylor, Esq.
Meredith McCarthy, Esq.

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

DATE: **August 30, 2017**

RE: **Perrine - DuPont Settlement - Supplement to Eighth Administration Budget; Our File No. 4609-1 {NN}**

Dear All:

At Jim's request, here is more detail respecting the proposed Supplemental Budget.

Thank you for the opportunity to work with you.

Yours very truly,

Edgar C. Gentle, III

ECGIII/mg
Attachment

cc: (via email)(confidential)(with attachment)
Terry D. Turner, Jr., Esq.
Katherine A. Harbison, Esq.
J. Christopher Smith, Esq.
Ms. Christy Mullins
Mr. Donald Brandt
Mr. Randy Brandt
Bruce R. Pitt, Ph.D.
Peter Perrotta, MD
Maria Kolar, MD

MEMORANDUM

TO: Edgar C. Gentle, III, Esq.

FROM: Terry D. Turner, Jr., Esq.

DATE: August 30, 2017

RE: Perrine-DuPont Settlement - Supplement to Eighth Administration Budget; Our File No. 4609-1 {NN}

The purpose of this memorandum is to provide you with further detail concerning the Supplement to Eighth Administration Budget (see Attachment A)(the "Budget") for the Settlement, as requested by Dupont's Counsel, Jim Arnold.

A discussion of each Budget expense category follows:

Health Study: The Medical Advisory Panel recommends a Health Study over time, rather than a one-time survey, to assist in identifying latent health effects on the Medical Monitoring Program ("MMP") Claimants. The Budget line item for a Health Study was estimated at $333,333, representing an anticipated three (3) year study at $1 Million. As shown in Attachment B, we received two (2) Health Study cost estimates; one for a six (6) year study and additional biological testing at an estimated cost of $1.4 Million to $1.6 Million, with the other being a six (6) year study with questionnaires initially and every three (3) years and with no additional biological testing for an estimated cost of $750,000 to $850,000.

Medical Monitoring Incentive Payments: The Medical Advisory Panel and the Settlement Administrator recommended that Claimants participating in the MMP be given a Walmart gift card valued at $25. For Budget purposes, we provided a Budget expense line item of $150,000 for the Budget year, representing the issuance of Walmart gift cards per Claimant of $50 ($25 at testing and $25 upon receiving testing results) for 3,000 Claimants.

Claims Administrator Legal Fees for Medical Monitoring Provisioning: The estimated Claims Administrator legal fees for additional Medical Monitoring Provisioning expenses is $120,000, or $10,000 per month, in connection with the additional MMP activities (Health Study, Medical Monitoring Incentive Payments, additional Medical Monitoring Participant interaction, etc.). As always, we pledge to continue to manage the MMP frugally, with the goal being for actual expenditures to continue to come in below the budgeted amount.

Additional Medical Provider Medical Monitoring Expenses: Additional Medical Provider expenses of $80,522 for the Budget year are provided for within the Budget, to provide funding should the number of active MMP Claimants increase due to the changes in the MMP.

Additional Third Party Administrator Fees and Expenses (CTIA): Please refer to Attachment C, representing the Medical Monitoring Program Third Party Administrator's estimated budget should the Court approve the recommended changes to the MMP. If you remove the additional Medical Provider expenses of $80,522 from CTIA's budget, the additional estimated Third Party Administrator fees and expenses total $568,935, with these expenses including the following: Medical Provider fees for completing Claimant data forms, increases in MMP costs due to new laboratory tests, physician procedures, and specialty referrals (see Attachment D, CTIA Analysis of Proposed Procedures with Estimated Fees), and CTIA service fees, consulting fees, and communication expenses.

Fasb 5 Contingency Reserve: This expense line item is simply 5% of all of the above supplemental budget line items, representing a reserve should projected supplemental budget expenses exceed projected amounts.

Should you need anything further considering this matter, please let me know.

TDTjr/
Attachments

cc: (with attachments)
J. Christopher Smith, Esq.

ATTACHMENT A

Perrine-DuPont Medical Monitoring Fund
Supplement to Eighth Administration Budget

Expense Category	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Total
Health Study									$333,333				$333,333
Medical Monitoring Incentive Payments	$0	$0	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$150,000
Claims Administrator Legal Fees for Medical Monitoring Provisioning	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$120,000
Additional Medical Provider Medical Monitoring Expenses [1]	$0	$40	$2,234	$6,274	$16,910	$12,710	$14,480	$9,699	$11,194	$4,324	$1,105	$1,552	$80,522
Additional Third Party Administrator Fees and Expenses [1]	$3,993	$9,583	$69,886	$67,209	$69,663	$72,463	$67,797	$74,745	$65,235	$59,790	$4,458	$4,113	$568,935
	$13,993	$19,623	$97,120	$98,483	$111,573	$110,173	$107,277	$109,444	$434,762	$89,114	$30,563	$30,665	$1,252,790
FASB 5 Contingency Reserve (5% of above amounts)	$700	$981	$4,856	$4,924	$5,579	$5,509	$5,364	$5,472	$21,738	$4,456	$1,528	$1,533	$62,640
													$0
Totals	$14,693	$20,604	$101,976	$103,407	$117,152	$115,682	$112,641	$114,916	$456,500	$93,570	$32,091	$32,198	$1,315,430

[1] See Exhibit A to the Budget and the attached Exhibit C – Medical Monitoring Program Medical Providers and Third Party Administration Budget Based on 4,053 Active Claimants and Developed by the Third Party Administrator.

ATTACHMENT B

TTI
Building Bridges in Health™

Perrine, WV Preliminary Study Estimate

Study Objectives

A. To identify and recruit approximately 4100 persons from Perrine, WV for participation in a six year longitudinal epidemiology study;
B. To collect data on participants as part of Medical Monitoring Program (MMP) including through abstraction of medical records and administration of questionnaires to capture health outcomes, behaviors and risk factors for many chronic diseases;
C. To conduct an annual contact, consisting of a brief questionnaire, of these persons following the initial examination with more in-depth questionnaires every two years;
D. To identify new disease events that have occurred following the initial examination and to describe disease trends in the community using data obtained from patient medical records (assuming follow-up exams every 2 years);
E. To conduct studies and analyses examining the potential causal link between exposures to the community and identified outcomes;
F. To review and adjudicate medical information from hospital, physician and other records;
G. To develop innovative hypotheses, perform data analysis, and produce publications from this study;
H. To provide community education and feedback regarding information from the study itself; to provide information to improve the health of the community in general.

General Proposed Study Methodology / Protocol

*This is a draft skeleton for budgeting purposes only.

A. Questionnaires
    a. General health status and medical history
    b. Behavioral health and lifestyle factors
    c. Disability
    d. TBD
B. Components of Medical Examinations
    a. TBD
C. Components of Lab Measurements
    a. Venipuncture
    b. Spot Urine
    c. Additional blood
    d. Lab Measurements – TBD
D. Record linkage with other sources
    a. Death certificates
    b. TBD

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E. Creation of family relationship database to construct pedigrees and to facilitate robust statistical analyses (accounting for relatedness) as well as genetic analyses, including gene-environment interactions

- Survey administration – full scale every 2 years
  - Baseline (2017)
  - 2019
  - 2021
  - 2023
- Assumes re-examinations as part of MMP– every 2 years

Cost Assumptions

- Assumes cost for exams is captured separately as part of medical monitoring plan.
- Assumes that an array of additional tests will be conducted on a subsample of subjects; examples include genetic markers and biomarkers of both exposure and disease.
- Estimated costs are based on knowledge and experience in conducting studies of similar size and complexity and factor in a margin of error for unknown protocol elements to be determined at a later time; estimates are subject to change once additional data becomes available.
- Protocols may be adapted to accommodate available funding.

Cost Estimate

- $1.4-1.6M for the 6 year study period

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Perrine, WV Preliminary Study Estimate

Study Objectives

A. To identify and recruit approximately 4100 persons from Perrine, WV for participation in a six year longitudinal epidemiology study;
B. To collect data on participants as part of Medical Monitoring Program (MMP) including through abstraction of medical records and administration of questionnaires to capture health outcomes, behaviors and risk factors for many chronic diseases;
C. To conduct an annual contact, consisting of a brief questionnaire, of these persons following the initial examination with more in-depth questionnaires every three years;
D. To identify new disease events that have occurred following the initial examination and to describe disease trends in the community using data obtained from patient medical records (assuming follow-up exams every 2 years);
E. To conduct studies and analyses examining the potential causal link between exposures to the community and identified outcomes;
F. To review and adjudicate medical information from hospital, physician and other records;
G. To develop innovative hypotheses, perform data analysis, and produce publications from this study;
H. To provide community education and feedback regarding information from the study itself; to provide information to improve the health of the community in general.

General Proposed Study Methodology / Protocol

*This is a draft skeleton for budgeting purposes only.

A. Questionnaires
    a. General health status and medical history
    b. Behavioral health and lifestyle factors
    c. Disability
    d. TBD
B. Abstraction of Records from Medical Examinations
    a. Extent TBD based on final budget

- Survey administration – full scale every 3 years
    - Baseline (2017)
    - 2020
    - 2023
- Assumes re-examinations as part of MMP– every 2 years

Cost Assumptions

- Assumes cost for exams is captured separately as part of medical monitoring plan.

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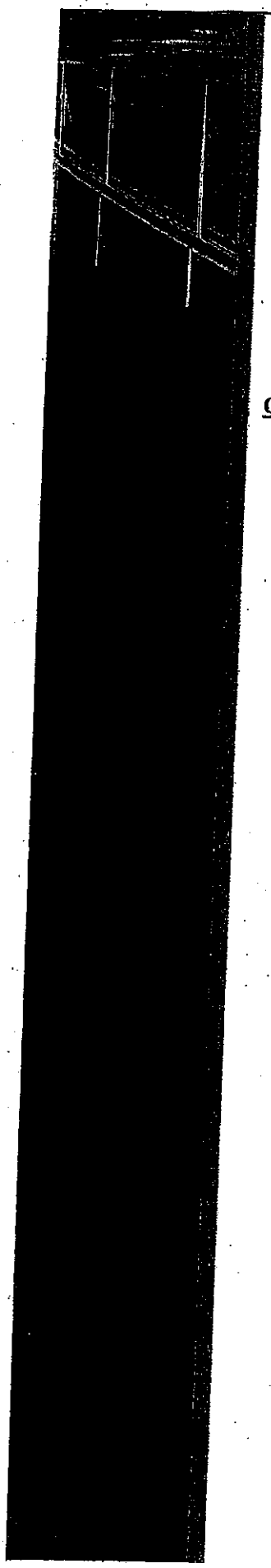

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- Estimated costs are based on knowledge and experience in conducting studies of similar size and complexity and factor in a margin of error for unknown protocol elements to be determined at a later time; estimates are subject to change once additional data becomes available.
- Protocols may be adapted to accommodate available funding.

Cost Estimate

- $750,000-$850,000 for the 6 year study period

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ATTACHMENT C

CLAIM TECHNOLOGIES INCORPORATED

?errina Budget Sep 2014 - Jul 2016

[redacted]

Category	9/12-8/13	9/14-8/15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	[redacted]
Service Fee	$89,101	$58,106	$4,739	$4,739	$4,734	$4,725	$4,930	$4,916	$4,914	$4,895	$4,879	$4,879	$4,879	$4,879	
Consulting	$62,380	$11,499	$1,375	$2,109	$1,656	$1,313	$568	$1,418	$1,094	$438	$0	$0	$0	$1,529	
Scheduling		$53,717	$0	$281	$4,463	$4,856	$9,221	$10,838	$6,025	$9,879	$5,414	$893	$285	$562	
Travel Expense		$1,435	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,435	
Communication Materials	$840	$4,596	$0	$435	$3,721	$0	$0	$400	$0	$0	$0	$0	$0	$0	
Letters	$1,268	$6,412	$0	$0	$276	$443	$1,048	$1,742	$721	$1,190	$941	$28	$6	$14	
Postage		$4,394	$2	$1,869	$105	$175	$341	$518	$392	$441	$368	$139	$0	$44	
ID Cards	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	
Report Fee	$2,800	$7,100	$350	$1,000	$1,000	$350	$350	$1,000	$350	$0	$1,000	$350	$350	$1,000	
Central Repository	$49,009	$14,674	$0	$0	$0	$0	$0	$0	$0	$10,912	$2,063	$1,238	$270	$193	
Total	$205,398	$161,892	$6,465	$10,432	$15,954	$11,861	$16,461	$20,833	$13,496	$27,755	$15,664	$7,528	$5,789	$9,655	
Claims Expense	$70,475	$95,373	$0	$50	$2,754	$7,737	$19,221	$15,371	$17,333	$11,140	$13,803	$5,331	$1,362	$1,270	[redacted]
Claims Expense for CT Scans		$3,915	$0	$0	$0	$0	$1,630	$300	$510	$820				$645	
Total		$99,288	$0	$50	$2,754	$7,737	$20,851	$15,671	$17,853	$11,960	$13,803	$5,331	$1,362	$1,915	

CATEGORIES

NEW BUDGET ESTIMATES

Calculations	Expense Categories	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	TOTAL
(# of active Claimants) x (Monthly fee per claimant)	Service Fee	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$8,917	$106,999
(2016 fees) plus we will need new fee schedules and web portal to enter physician's data form	Consulting	$3,925	$4,952	$4,319	$3,838	$796	$1,985	$1,531	$613	$0	$0	$0	$2,140	$24,098
(2016 fees) x (# active Claimants this round / # of active claimants round 3) x (increase in scheduling hourly rate)	Scheduling	$0	$543	$8,610	$9,381	$17,812	$20,936	$21,639	$19,084	$11,390	$1,725	$550	$1,086	$103,767
Airfare & lodging for 3 meeting @$1,600	Travel Expense	$0	$1,600	$0	$0	$1,600	$0	$0	$0	$1,600	$0	$0	$0	$4,800
(2016 fees) x (# active Claimants this round / # of active claimants round 3)	Communication Materials	$0	$787	$6,738	$0	$0	$724	$0	$0	$0	$0	$0	$0	$8,250
(# of active claimants this round) x (historical number of letters per active claimant) x (fee per letter) spread over 6 months	Letters		$8,538	$8,538	$8,538	$8,538	$8,538	$8,538						$51,230
(49/160) x letter fee above	Postage	$0	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$0	$0	$0	$0	$0	$15,689
none anticipated	ID Cards	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
per agreement	Monthly Status Report Fee	$350	$350	$350	$350	$350	$350	$350	$350	$350	$350	$350	$350	$4,200
(2016 fees) x (# active Claimants this round / # of active claimants round 3)	Central Repository per Lab Test	$0	$0	$0	$0	$0	$0	$0	$19,762	$3,735	$2,241	$488	$349	$26,574
(CTI fee for recording data on provider's form) x (# active Claimants this round) x (participation rate) spread over 8 months	Central Repository per Physician's Form			$975	$975	$975	$975	$975	$975	$975	$975			$7,802
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
(2016 fees) x (# active Claimants this round / # of active claimants round 3)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Total	$13,192	$28,383	$105,522	$106,076	$133,864	$130,328	$123,407	$127,325	$110,416	$81,315	$12,772	$15,140	$985,739

ASSUMPTIONS

# of Active Claimants Round 3	2,238	
# of Active Claimants This Round	4,053	
Monthly Fee per Claimant	$2.20	per Agreement
Fee per letter	$1.60	per Agreement
Postage per letter	$0.49	per Agreement
Scheduling calls per hourly rate 2016	$75.00	per Agreement
Scheduling calls per hourly rate	$80.00	per Agreement
Increase in scheduling hourly rate	6.67%	per Agreement
Maximum number of calls per person	2	per Round 3 guidelines
One Time Central Repository Fee per Lab Test	$5.50	per Agreement
Providers Fee for Recording Data per participating Claimant	$25.00	new fee
CTI Fee for Recording Data per participating Claimant and maintaining on Access database	$5.50	new fee
Fee per ID card	$2.05	per Agreement
Estimated rate of participation	35.00%	49.2% rnd 1, 24.3% rnd 2, & 12.9% rnd 3
Historical number of letters per entire population	7.90	actual based upon Round 3
Fee to Develop Web site for recording Physician's Form	$11,000.00	new fee (included in the first 4 mos of consulting)
Increase cost of Physicians initial visit per participating claimant	$184	We have added three new procedures to the initial physician's visit
Increase cost of additional lab tests	$110	We have added 15 new lab tests and eliminated three to the initial physician's visit. average cost per test has been $9.19. still waiting for labcorp response
Average cost of Speciality Referral per participant	$30	For the first three rounds the average was $15. we have doubled because we have added 11 new speciality procedures

8/31/2017

S:\Documents\4609-1\Administration Budget\Number 8 Sep 17 Thru Aug 18\Revised CTIA Budget 07-28-17

ATTACHMENT D

ANALYSIS OF PROPOSED PROCEDURES WITH ESTIMATED FEES

Xray fluoroscopy lead	76498 Facility	$225.00	YES		YES	YES		YES	Primary Care or Specialist	Hospital & Radiologist	Regularly performed by physician specializing in osteoporosis treatment (additional charge office visit). Need to update the radiologists on proposed procedures.	
	Radiologist	$78.00										
Abdominal Aortic Ultrasound	76770 Facility or	$265.00	YES	Males age 65-75 & used tobacco		YES		YES	Primary Care or Gastroenterologist	Hospital & Radiologist		
	76775 Facility	$140.00										
	76770 Radiologist or	$85.00										
	76775 Radiologist	$50.00										
Biopsy of Prostate-	55700	$329.00	YES		YES	YES	YES	YES	Urologist	Urologist, Hospital & Radiologist		
	Facility	$575.00										
	Anesthesiologist	$350.00										
	Radiologist	$180.00										
Colonoscopy	45378	$416.00	YES	Age 40 and over	YES	YES	YES	YES	Gastroenterologists	Gastroenterologists, Hospital & Radiologist		
	Facility	$725.00										
	Anesthesiologist	$450.00										
	Radiologist	$230.00										
CT Scan Brain	70450 Facility or	$275.00	YES			YES		YES	Primary Care or Specialist	Hospital & Radiologist	Use same administrative requirements that are currently in place for CT scans. Renew agreement with hospital and radiologist to verify fees.	
	70460 Facility or	$375.00										
	70470 Facility	$440.00										
	70450 Radiologist or	$85.00										
	70460 Radiologist or	$115.00										
	70470 Radiologist	$140.00										

ANALYSIS OF PROPOSED PROCEDURES WITH ESTIMATED FEES

Esophagogastroduodenoscopy	43235 Facility Anesthesiologist Radiologist	$940.00 $600.00 $325.00 $190.00	YES		YES	YES	YES	YES	Gastroenterologist	Gastroenterologist, Hospital & Radiologist		
Ultrasound (Abdomen-Liver)	76700 Facility Radiologist	$285.00 $90.00	YES			YES		YES	Primary Care or Gastroenterologist	Hospital & Radiologist		
Behavioral			YES								Recommendation is for diagnostic test (survey) to be done for Psych = body system for element = lead. A psychiatric specialist would need to administer if they want psychiatric testing done, with interpretation and evaluation. The attending Physician would complete the survey and refer to either a Psychologist or Psychiatrist for the initial diagnosis. The first treatment would be paid for as a diagnosis. We will need to find these specialist to work with the plan.	YES

** Facility, Radiologists, Anesthesiologist fees are estimated from current agreements, the remainder of fees are 130% of Medicare allowance.*

PROPOSED LAB FEES

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Primary Care Physician	80061	Lipid panel	$5.00	ADD	
Primary Care Physician	80076	Liver Function Test	$7.00	ADD	
Primary Care Physician	82947	Glucose	$2.63	ADD	
Primary Care Physician	83036	Hgb A1c	$8.00	ADD	
Primary Care Physician	82043/82570	Urine Micro albumin/creatine ratio	$24.00	ADD	
Primary Care Physician	82565	Glomerular Filtration Rate	$2.63	ADD	
Primary Care Physician	84153	Prostate Specific Antigen	$10.00	ADD	Males over age 50
Primary Care Physician	82340	Urine Calcium	$5.00	ADD	
Primary Care Physician	84550	Uric Acid	$2.63	ADD	
Primary Care Physician	85025	CBC/Diff	$4.20	ADD	
Primary Care Physician	86803	Hep C Screen	$10.00	ADD	Born between 1945-1965
Primary Care Physician	87389	HIV	$20.00	ADD	
Primary Care Physician	86701/86702	HIV (confirmation if positive)	$84.00	ADD	

*Allowable Fees provided by LabCorp

EXHIBIT F

June 23, 2017 Report to the Court Recommending Modifications to the Medical Monitoring Testing Protocols

PERRINE DUPONT SETTLEMENT CLAIMS OFFICE
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June 23, 2017

VIA HAND DELIVERY

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

Re: Class Member Medical Monitoring Testing Protocols Review and Update; Our File No. 4609-1{GG-13}

Dear Judge Bedell:

I hope this letter finds the Court well.

The purpose of this Report is to present the findings and recommendations of the Medical Advisory Panel and Claims Administrator with respect to the testing protocols of the Perrine Medical Monitoring Program, regarding the need to update the current Medical Monitoring Testing Program, and to provide the rationale and details of the recommended update.

By its Order entered November 3, 2016, this Honorable Court approved the selection of a Medical Advisory Panel, as contemplated by the Court's Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, as entered by the Court on January 18, 2011.

In its previous Order of January 18, 2011, the Court "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 . . ." See Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, page 14, paragraph 6. As such, one of the assignments of the Medical Advisory Panel, as agreed to by the Finance Committee, is the consideration of the following question:

> Based upon scientific and medical developments since early 2011, do the existing medical monitoring protocols of the Perrine Medical

Monitoring Program require updating?

The Panel has carefully considered this question, and the unanimous answer is **"Yes."**

The supporting reasoning for this decision is contained in the submissions of Doctors Pitt and Perrotta, in Exhibits A and B[1], respectively. The current testing protocols are in Exhibit C, and the current tests the Panel does not recommend at this time have a line through them. The recommended updated Medical Monitoring Testing Protocols are detailed in Exhibit D, prepared by Dr. Kolar. The Panel notes that some of the monitoring may be tailored based on the participant's age and sex.

Given the scope of the recommended updates to the Medical Monitoring Testing Protocols, now testing for numerous additional maladies possibly associated with the heavy metals involved, the Panel recommends all 4,000 Class Members who originally registered for Program testing be invited again to participate in the Program.

In carrying out its duties, the Panel was provided protected access to the confidential medical testing information compiled by CTIA, in conjunction with LabCorp, for participating Class Members who consented to make the information for research. This data is maintained in a uniform database, that may be sorted and analyzed. However, the medical data obtained by Program participating Physicians sampled by the Panel on a confidential basis was not compiled in a uniform manner and is not being compiled by CTIA, so that it's accessibility for a health study or other scientific research is limited. The Panel recommends that uniform procedures and forms be developed to obtain and compile this additional participating Class Member medical testing information to facilitate its future use.

The Panel understands that the details for carrying out the findings and recommendations in this Report need to be developed in conjunction with the Settlement Administrator, the Finance Committee and CTIA, and encourages their input in responding to this Report and suggestions on how to carry it out.

Thank you for the Court's consideration.

Yours very truly,

Ed Gentle, III
Claims Administrator

[1]Following his submission, Dr. Perrotta further clarified his position by stating that PSA is not recommended for men as part of routine monitoring.

Joined by:

Bruce R. Pitt, PhD
Perrine Medical Monitoring Program Panel
Chair

Maria M. Kolar, MD
Perrine Medical Monitoring Program Panel
Internal Medicine Expert

Peter L. Perrotta, MD
Perrine Medical Monitoring Program Panel
Pathology Expert

ECGIII/jcs

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David B. Thomas, Esq.
Katherine A. Harbison, Esq.
J. Christopher Smith, Esq.
Jennifer L. Blankenship, Esq.
Ms. Christy Mullins
Mr. Randy Brandt, CTIA
Mr. Don Brandt, CTIA

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Ms. Christy Mullins
Mr. Randy Brandt, CTIA
Mr. Don Brandt, CTIA

EXHIBIT A

Overall assessment:

a) An effective system was put in place to identify and recruit class members, employ general flow of proposed medical surveillance, maintain useful electronic records and histories, provide feedback to class members, provide secure HIPPA compatible records, interact with professional health care providers and be fiscally responsible as well as establish governance at multiple levels including medical surveillance program and its oversight.

b) Exposure to be eligible for surveillance based on time in residence within zones of various risks of cancer based on environmental (soil) determinants of Cd, Ar and Pb. At the time, biomonitoring (blood, urine, bone, hair for Ar, Cd or Pb) considered inadequate to identify chronic low level exposures and thus may provide false sense of security. An exception being that blood Pb screening would include potential follow up via XRF for cohort of class members who were minors

c) In the 2011 settlement, only diseases clearly associated with Ar, Cd and Pb were monitored:

Ar: skin, lung, bladder and kidney cancer

Cd: lung and kidney cancer; decreased renal function and failure

Pb: Lung , stomach and kidney CA; decreased renal function and failure; neurodevelopment in minor class member.

d) Homogeneous monitoring program for all medical monitoring group members (with exception of class members who are minors).

Potential areas to update Perrine Medical Monitoring Program:

1) Progress in biomonitoring suggest that body burdens of Cd and Pb (less so for Arsenic) can be usefully quantified. The utility of these approaches in epidemiological studies suggests that biomonitoring can provide useful medical insight at an individual level. This should address essential personal levels of stress among the class members as well as critical elements of early detection and potential therapy. Accordingly, adding urinary analysis of Cd (and perhaps lead; with or without metal

mobilization by chelating agents) and direct bone measurements of lead (XRF) can be added to overall surveillance.

2) Since 2011, a number of definitive prospective epidemiological studies including some with sufficient lag time for latent effects of chronic low level metal exposure (Strong Heart in Native Americans, HEALS in Bangladesh, Taiwan, Chile, Argentina) and prospective interventional trials (NIH TACT, NIH TACTII) have identified numerous non-cancerous endpoints not previously considered in 2011 in the context of Cd, Ar or Pb including cardiovascular, non-cancer pulmonary endpoints, metabolic and endocrine effects and neurodevelopmental, neurodegeneration and cognition.
3) In light of (1) and (2), modifying and contemporizing a number of laboratory and medical tests and assessments is in order. The net effect is to: a) incorporate contemporary clinical pathology and medicine; b) expand the 2011 focus on disorders that had a presumptive linearity with exposure to Ar, Cd and/or Pb to a more general view that such exposures are important contributors, as well, to common disorders; and c) have medical surveillance incorporate tenets of overall wellness.

1) ***Biomonitoring of Cd and Pb:*** Biomonitoring of arsenic remains beyond the scope of interrogating chronic low level exposures (due to intrinsic short half life of arsenic). Alternatively, body burdens of relevant long half life compartments of Cd (renal accumulation as reflected in urinary Cd) and Pb (bone accumulation) have been utilized in epidemiologic studies for many years and post 2011 reports (including some technologic and physiologic modifications) suggest consideration of incorporating biomonitoring of Pb and Cd (including some new technologies) in both adult and minor class members.

a) ***Cadmium:*** Considerable use of urinary Cd levels (normalized to creatinine; either single spot or first morning void) as a biomarker of chronic low level Cd exposure (rather than a determinant of acute Cd exposure as described in an occupational setting in settlement of 2011) is now suggested as a common approach in prospective epidemiological studies (Vacchi-Suzzi et al, 2017). It has been employed in prospective study of native Americans (Garcia-Esquinas et al, 2014) including measurements of urinary Cd fifteen years after sample was procured, Canadian Health Measures Survey (Garner and Levallois, 2017), Mae Sot District of Thailand (Nishijo et al, 2014), World Trade Center-Health Program (Vacchi-Suzzi et al, 2017) and Third National Health and Nutrition Examination Survey (Adams et al, 2012). Care must be taken to account for confounding sources (tobacco products; diet) and concurrent renal disease.

b) ***Lead:*** Although blood lead levels remain important criteria in the pathophysiological spectrum of lead intoxication (plumbism), their short half life (<30 d) and their uncertain equilibrium with larger more stable (half lives >10-30 yrs) in bone has prompted more direct quantitation of the latter. In particular, blood lead captures recent exposure as well as lead that has been mobilized from bone; lead levels in bone (tibia and patella) are an indicator of chronic cumulative exposure and are the source of lead that is mobilized to blood (Hu, Shi, Rothenberg and Schwartz, 2007). Since the 1990's, epidemiologic studies have shown that the most important standard for predicting adverse health outcomes is not recent lead exposure but rather cumulative exposure over many years with or without the additional dimension of latency (Hu H and Shih R et al, 2007). This has resulted in large number of studies utilizing XRF (X-ray fluorescence) that suggest that: a) bone lead measurements may be useful indicator of prior exposure to lead; and b) bone lead stores, themselves, are a risk factor for future toxicity (Hu et al, 1995; Hu 1998). Indeed XRF was proposed as a followup to detection of potentially elevated levels of blood lead in the cohort of minors in 2011 settlement. The physical principles, limitations and subtleties of various X-ray fluorescence techniques is the subject of considerable longstanding interest

(Todd and Chettle, 1994). The feasibllity of a portable x-ray tube based KXRF system to measure lead in bone has been proposed by Weisskopf and colleagues (Nie LH et al, 2011) and a device manufactured by Thermo Fisher was employed in exposure study in children in China (Specht et al, 2016) and recently refined further by these authors (Specht et al, 2017). A number of these efforts include comparison of bone lead with blood lead and conclude (Specht et al, 2016) that bone Pb, at least in children, may be a better marker for determination of chelation efficiency.

c) ***Future determinations of Cd and Pb in class members who are minors; tooth exposome.*** The most recent efforts in measuring body burden of metals in children is the use of laser ablation inductively coupled plasma mass spectrometry (LA-ICP) in shed deciduous teeth (Modabbernia eet al, 2016). The technology facilitates reconstructing environmental exposures, including Cd and Pb, longitudinally from second trimester through first year of life and was most recently reported in a new study on fetal and postnatal metal dysregulation and autism in a study on twins in Sweden (Arora M et al, 2017).

2) ***Potential non-cancer endpoints to add to medical surveillance:***

a) ***Cardiovascular disease***: As noted by Cosselman et al (2015), arsenic, cadmium and lead advance disease and mortality via augmentation or initiation of pathophysiological processes associated with cardiovascular disease (blood pressure control, carbohydrate and lipid metabolism, vascular function and atherogenesis). As such metal exposure adds significantly to the risk of cardiovascular disease from traditional factors (smoking, diabetes, dyslipidemia, etc). Chronic exposure to **arsenic** (Naujokas MF et al, 2013) is now associated with increases in ischemic heart disease and (systolic) hypertension (Chen Y et al, 2011: Gong and OBryant 2012; Abhyankar et al, 2012) and prolongation of Q-T interval (Wu et al, 2014). Epidemiological studies have also associated **cadmium** levels in blood or urine with the incidence of and mortality from cardiovascular disease, stroke, coronary heart disease, heart failure, carotid plaque development, peripheral arterial disease and renal dysfunction (Cosselman et al, 2015; Tellez-Plaza et al, 2012; Tellez-Plaza et al, 2013; Fagerberg et al, 2015; Myong et al, 2014; Chung et al, 2014; Franceschini N et al, 2017). **Lead** has been long known to be associated with adverse cardiovascular outcomes (Navas-Acien et al, 2007; Kim et al, 2015)

b) ***Diabetes:*** Although an association has long been suspected between **arsenic** exposure and type 2 diabetes (Maull et al, 2012), improved exposure and outcome metrics (Beck, Styblo and Sethupathy, 2017) have secured this association (Kuo C-C et al, 2015).

c) ***Pulmonary (non-cancer):*** Although Ar and Cd have well documented associations with lung cancer (as outlined in settlement in 2011), recent epidemiological studies have associated exposure to heavy metals and non-cancer pulmonary endpoints including: a) blood levels of **Cd** and **Pb** and obstructive lung function in Korean (Leem At et al 2015) and US (Rokaida and Agarwal, 2013) National Health Surveys; b) urinary **Cd** and asthma in Wuhan China (Huang et al, 2016); c) urinary arsenic and impaired lung function (decrements in FEV1 and FVC) in Health Effects of Arsenic Longitudinal study (HEALS) in Bangladesh (Parvez et al, 2013); and d) **arsenic** and respiratory symptoms in children (Smith AH et al, 2013).

d) ***Nervous system:*** The impact of **lead** on neurodevelopment and behavior is well established and is a foundation in environmental and public health. As such, it was incorporated in the 2011 settlement for assessment and follow-up in the class members that are minors. Recent evidence has expanded the disease and syndrome endpoints of concern with lead including autism spectrum disorder (Arora et al, 2017) and early life exposure to lead and adult schizophrenia (Modabbernia et al, 2016). A critical review of cadmium toxicity literature suggests there is little support for **Cd** affecting cognition or attention deficit hyperactivity (Sanders, Henn and Wright, 2015). In contrast, **arsenic** may impair cognitive function in pre-school girls, but not boys (Hamadani et al, 2011) and motor function (Parvez et al, 2011).

e) ***Bone and mineral metabolism:*** Bone fragility is well known consequence of **cadmium** and **lead**. As such, it was mentioned in the 2011 settlement although precise medical and laboratory assessment was not outlined.

f) ***Kidney:*** As with bone changes, both **cadmium** and **lead** are known to cause acute tubular and chronic glomerular changes. These assessments were described in 2011 settlement and refinements are now outlined for future surveillance of kidney function.

3) *Other Considerations*

a) ***Metal mixtures:*** As noted above, an essential challenge in the design of medical surveillance is useful quantitative assessment of exposure. The likelihood that an individual may have been exposed to all three metals or combinations and permutations of exposure to Cd, Ar and Pb, greatly exacerbates potential concerns. Attempts to approach this are appearing in literature (Sanders et al, 2015; Bizon et al, 2016; Yang WY et al, 2017). The likelihood of incorporating developing understanding for this important issue in the context of medical surveillance requires confirmatory and new studies in the future. As such, the assumption that all individuals may have been exposed to all three metals appears pragmatic and identifying potential adverse outcomes as an accumulation of potential effects of each single metal appears to be the only practical way to address concerns in 2017.

b) ***Chelation:***

i) ***one time provocative Cd (or lead) mobilization to urine for exposure:*** The potential to enhance the sensitivity of urinary measures of Cd or Pb by a one time chelation approach (2,3 dimercaprol, dimercaptosuccinic acid or disodium EDTA (Waters et al, 2001; Kalia and Flora, 2005; Hoet et al, 2006) might be considered.

ii) ***interventional – TACT and TACT II.*** The biomedical fundamental principles of medical surveillance comprise value of early detection and prevention for potential therapies. In this regard, recent outcomes of NIH sponsored Trial to Assess Chelation Therapy; TACT) has significant relevance for the health outcomes of class members. In a prospective, large, randomized placebo control study, EDTA chelation therapy significantly reduced cardiac events in stable post-myocardial infarction patients (Lamas et al, 2013). This therapeutic benefit was exacerbated in patients with diabetes mellilitus and prior myocardial infarction (Escolar et al, 2013). This unexpected outcome has prompted a second TACT trial for replicative purposes focused on the later cohort and also suggested the mechanism underlying efficacy of EDTA chelation may have been removal of toxic metal stores in the body (Lamas et al, 2016).

c) ***Stratification (susceptibilities) – gender, age, genetics, smoking, obesity, confounding disease, etc*** The 2011 settlement provides for a homogenous medical surveillance plan (with the exception of the class members that are minors). Although this is of significant pragmatic value, it is apparent that the health effects of individual and collective metals may be specific as a function of gender, age, genetics, confounding disease, lifestyle (drugs, exercise, diet).

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EXHIBIT B

Summary of Recommendations for Changes to Medical Monitoring Program
Peter Perrotta 06/06/2017

Additions to the Program

Smoking cessation program: This is suggested as the risks of heavy metal exposure are likely more than cumulative when combined with other risk factors like smoking.

Add education in self-skin exam to regular skin checks every 2 years: A simple pamphlet showing how to perform a self-skin exam would complement the current screening every 2 years.

Complete Blood Count w/differential to assess long-term bone marrow effects.

Add hemoglobin A1c for diagnosis and monitoring of serum glucose for diabetes mellitus (DM). The fasting blood glucose level can be maintained.

Serum uric acid testing is indicated: Pb & Cd exposures causing renal damage have been associated with increased uric acid and gout.

Regular cognitive, neurological, and depression screenings: This is part of the monitoring, however, this could be more standardized and documented better.

Substitute Fecal Immunochemical Test (FIT) for the Fecal Occult Blood Test (FOBT)

- FIT removes the pre-collection dietary restrictions necessary for accurate test results. This alone decreases the risk of false-negative results.
- FIT allows a slightly larger sampling of specimen in some cases and better stability. This provides better sensitivity than the FOBT test..
- Colonoscopy is indicated if FIT testing is positive

Hepatic (liver) function testing (total protein, albumin, total bilirubin, alkaline phosphatase (ALP), LDH, AST/ALT) is recommended with the associated caveats:

- DM can cause mild to moderate changes in liver function tests.
- Metal toxicity tends to cause cirrhosis with an initial hepatitis pattern, with low enzyme markers in end-stage cirrhosis.
- Arsenic can inhibit osteoblastic activity to reduce bone turnover. This reduces bone ALP, which is a prominent component of circulating ALP.

Although creatinine clearance is best for assessing renal damage, we recommend serum creatinine with an estimated glomerular filtration rate (eGFR) as acceptable for screening & monitoring. Also, add a random urine microalbumin/creatinine ratio and a random urine protein for monitoring. Note:

- If renal disease is diagnosed, follow-up studies to consider include measures of serum vs urine calcium and phosphorus, which would be more useful (and less expensive) as direct indicators of damage rather than indirect ones (eg, beta-2-microglobulin in urine)

Urinalysis: We recommend continuing routine urinalysis with microscopic, recognizing the limited utility of this testing. Serum-based assessments and urine microalbumin & protein are better screens for renal damage. Metals don't make crystals, and any casts found on urinalysis would not be specific to heavy metal exposure.

One time urine measurements for all 3 metals is recommended, recognizing that this testing is most useful for As & Cd exposure.

Urine pregnancy/hCG screening prior to any imaging in females of childbearing age. This is standard procedure.

Periodic imaging, long bones: This is a preliminary suggestion and should be limited to children.

- There are different influences of the mentioned metals on bone function.
- Cadmium and Arsenic exposures tend to associate with osteonecrosis, osteomalacia, and osteoporosis.
- X-ray fluorescence of long bones is suggested in children for assessment of growth retardation in exposed children per CDC but no recommendation was made for utility in adults.
- While this test could provide a burden assessment, there are conflicting data in PubMed about whether Cd & As co-exposures interfere with the Pb burden assessment. This may be relevant in this case as co-exposures are possible and may complicate this means of monitoring.

Ultrasound of liver rather than CT if cirrhosis is not already present

- Could be a useful, inexpensive, and non-invasive/low-risk means of assessment if CT is not really deemed necessary by other assessments.
- CT could then be performed only if ultrasound demonstrates changes, if biopsy isn't yet favored to diagnose and stage the cirrhosis.

We also recommend that a data collection form/template be provided to participating providers so that data collection can be more standardized.

Consider bone densitometry for woman.

Testing that can be stopped or should not be considered: Some testing has questionable clinical utility and/or is now discouraged by CDC (https://www.atsdr.cdc.gov/):

- Blood-based metals measurements: Metals have short circulation half-lives, making them more appropriate for acute exposure than chronic testing. Urine testing is generally more useful for chronic burden & clearance assessment.

- Zinc & free RBC protoporphyrin: These tests are now considered obsolete in most applications, including toxic metal exposures.

- "Assay of beta-2 protein in urine": This is an indirect assessment of tubular damage. CDC sources note that both the glomerulus and tubule are damaged in these metal exposures. There is more evidence that urine testing for other analytes (eg, glucose, calcium, phosphate) might be more useful, although we do not recommend this at this time.

- Sedimentation rate: Now considered obsolete in all but an isolated few clinical applications, and only when considered with other clinical and lab-based data. This test lacks specificity.

- PSA is not recommended for men for this monitoring

- Vitamin D testing is not recommended

EXHIBIT C

CLAIM TECHNOLOGIES INCORPORATED

Procedure	Description	Age	Sex
32096	BIOPSY THROUGH CHEST WALL	All ages	Both
32097	BIOPSY LUNG, PERCUTANEOUS NEEDLE	All ages	Both
32098	BRONCHOSCOPY	All ages	Both
43239	UPPER GI ENDOSCOPY, BIOPSY	All ages	Both
71250	CT THORAX W/O DYE	Age 35 and over	Both
71260	CT THORAX WITH CONTRAST	Age 35 and over	Both
74150	CT SCAN ABDOMEN WITH CONTRAST	Age 35 and over	Both
74160	CT SCAN ABDOMEN WITH CONTRAST	Age 35 and over	Both
74176	CT SCAN ABDOMEN & PELVIS WITH CONTRAST	Age 35 and over	Both
74177	CT SCAN ABDOMEN & PELVIS WITH CONTRAST	Age 35 and over	Both
74178	CT SCAN ABDOMEN & PELVIS W/O CONTRAST IN ONE OR BOTH BODY REGIONS FOLLOWED BY CONTRAST MATERIALS IN ONE OR BOTH BODY REGIONS	Age 35 and over	Both
96118	NEUROPSYCH TST BY PSYCH/PHYS	All ages	Both
81001	003772- URINALYSIS, COMPLETE WITH MICROSCOPIC EXAMINATION	Age 15 and over	Both
81025	004038- URINE PREGNANCY TEST (age 35 - 55)	Age 35 and over	Female
~~82232~~	~~010173- ASSAY OF BETA-2 PROTEIN URINE~~	~~Age 15 and over~~	~~Both~~
82274	182949- OCCULT BLOOD, by FECAL HEMOGLOBIN	Age 18 and over	Both
82565	001370- CREATININE SERUM	Age 15 and over	Both
82947	001032- GLUCOSE SERUM	All ages	Both
83655	007825- LEAD BLOOD	All ages	Both
~~84202~~	~~010165- ZINC & FREE ERYTHROCYTE PROTOPORPHYRIN~~	~~All ages~~	~~Both~~
84520	001040- BLOOD UREA NITROGEN (BUN)	Age 15 and over	Both
85025	005009- COMPLETE BLOOD COUNT (CBC) WITH DIFFERENTIAL	All ages	Both
~~85652~~	~~005215- SEDIMENTATION RATE (ESR)~~	~~All ages~~	~~Both~~
88304	883040- TISSUE EXAM BY PATHOLOGIST	All ages	Both
88305	883050- Level IV SURGICAL PATHOLOGY, GROSS & MICROSCOPIC EXAMINATION	All ages	Both

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EXHIBIT D

	A	B	C	D	E	F	G
1	Element	Body System	Disease By System	Currently in Medical Monitoring Program Protocols?	Diagnostic Test	By Referral?	Qualifications (None where none shown)
2	Arsenic	Resp	Lung Cancer	Yes	CT Scan Lungs	Yes	
3			Decreased Lung Function	No	PFTs	Yes	
4		CV	CVD/CAD	No	Lipid Panel		
5				No	Abdominal Aortic Ultrasound (U/S)	Yes	Men 65-75 and used tobacco
6				No	Tobacco hx/Cessation pamphlet		
7			prolonged QTc	No	EKG		
8		GI	Hepatic angiosarcoma	No	U/S	Yes	
9			Hepatomegaly	No	U/S	Yes	
10			Elevated bilirubin/alkaline phosphatase	No	LFTs		
11		GU	Bladder Cancer	Yes	U/A		
12				Yes	Urine Cytology		
13			Renal Cell Cancer	Yes	U/A		
14				Yes	Cr		
15		Neuro	Peripheral Neuropathy	No	EMG	Yes	
16			CVA	No	CT Scan Brain	Yes	
17				No	Carotid U/S	Yes	
18		Endo	DM	No	Glucose		
19				No	Hgb A1c		
20				No	Urine Micro albumin/creatinine ratio		
21							
22	Cadmium	Resp	Lung Cancer	Yes	CT Scan Lungs	Yes	
23			COPD/ emphysema	No	PFTs		
24		GU	Kidney Damage/failure	Yes	Cr		
25				No	GFR		
26			Renal Cell Cancer	Yes	U/A		
27			Prostate Cancer	No	PSA	Yes	
28			Prostate Bioposy Follow-Up	No		Yes	
29			Kidney Stones	Yes	U/A		
30				No	Urine Calcium	Yes	
31		MS	Bone Fragility	No	X-ray	Yes	
32			Osteoporosis	No	DexaScan		Females aged 65 and over
33			Gout	No	Uric Acid		
34		All/Immun	Immunosupression	No	CBC/ Diff		
35				No	Hep C Screen		Born between 1945-1965
36				No	HIV		
37	Lead	Head/Neck	Tooth Loss	No	Exam		
38			Hearing Loss	No	Audiogram	Yes	
39		Resp	Lung Cancer	Yes	CT Scan Lungs	Yes	
40		CV	HTN	Yes	Exam		
41			CVD	No	Lipid Panel		
42				No	Tobacco hx/Cessation pamphlet		
43		GI	Stomach Cancer	No	EGD	Yes	

	A	B	C	D	E	F	G
1	Element	Body System	Disease By System	Currently In Medical Monitoring Program Protocols?	Diagnostic Test	By Referral?	Qualifications (None where none shown)
44				No	CT Scan Abdomen	Yes	
45			Rectal/ Colon Cancer	No	Colonoscopy	Yes	Age 40; one time every two years
46		GU	Renal Cell Cancer	Yes	U/A		
47			Renal Damage/ Failure	Yes	U/A		
48				Yes	CR		
49				Yes	GFR		
50			Prostate Cancer	No	PSA		Males over 50
51		Hematologic	Anemia	Yes	CBC/ Diff		
52		MS	Bone Fragility	No	X-ray		
53			Bone Lead	No	X-ray flourescence		
54			Gout	No	Uric Acid		
55		Neuro	Brain Cancer	No	CT Scan Brain	Yes	
56			Neuropathy	No	EMG	Yes	
57		Pysch	Cognitive	No	Survey		
58			Behavioral	No	Survey		

EXHIBIT G

Analysis of Proposed Procedures Involved with Panel-Recommended Modifications to Medical Monitoring Testing Protocols with Estimated Costs

ANALYSIS OF PROPOSED PROCEDURES WITH ESTIMATED FEES

Description	CPT Code	Fees *	Referral Required	Qualifications	Physician	Facility	Anesesthesia	Radiologist	Specialty (ordered by)	Performed by	Comments/Risks	Need new Specialist
DexaScan	77080 Facility	$100.00	YES	Females aged 65 and over	YES	YES		YES	Primary Care or Specialist	Hospital & Radiologist	Regularly performed by physician specializing in osteoporosis treatment (additional charge office visit). Need to update the radiologists on proposed procedures.	
	Radiologist	$55.00										
Xray fluoroscopy lead	76496 Facility	$225.00	YES		YES	YES		YES	Primary Care or Specialist	Hospital & Radiologist	Regularly performed by physician specializing in osteoporosis treatment (additional charge office visit). Need to update the radiologists on proposed procedures.	
	Radiologist	$75.00										
Xray for bone fragility (Dual X-ray Absorptiometry - DXA)	76499 (unlisted procedure code) 77085	$74.00	YES			YES		YES	Primary Care or Specialist	Specialist or Hospital & Radiologist	Regularly performed by physician specializing in osteoporosis treatment (additional charge office visit)	
Abdominal Aortic Ultrasound	76770 Facility or	$265.00	YES	Males age 65-75 & used tobacco		YES		YES	Primary Care or Gastroenterologist	Hospital & Radiologist		
	76775 Facility	$140.00										
	76770 Radiologist or	$85.00										
	76775 Radiologist	$50.00										
Audiogram	92550 or	$27.00	YES		YES				Audiologist	Audiologist	Hearing tests regularly performed by audiologist (additional fee for office visit). Need to find an audiologist	YES
	92551 or	$41.00										
	92552 or	$49.00										
	92553	$33.00										
Biopsy of Prostate	55700	$329.00	YES		YES	YES	YES	YES	Urologist	Urologist, Hospital & Radiologist		
	Facility	$575.00										
	Anesthesiologist	$350.00										
	Radiologist	$180.00										
Carotid Ultrasound	93880 Facility	$360.00	YES			YES		YES	Primary Care or Specialist	Hospital & Radiologist		
	Radiologist	$135.00										
Colonoscopy	45378	$416.00	YES	Age 40 and over	YES	YES	YES	YES	Gastroenterologists	Gastroenterologists, Hospital & Radiologist		
	Facility	$725.00										
	Anesthesiologist	$450.00										
	Radiologist	$230.00										
CT Scan Abdomen	74150 Facility or	$345.00	YES			YES		YES	Primary Care or Specialist	Hospital & Radiologist	Use same administrative requirements that are currently in place for CT scans. Renew agreement with hospital and radiologist to verify fees.	
	74160 Facility	$535.00										
	74150 Radiologist or	$110.00										
	74160 Radiologist	$170.00										
CT Scan Brain	70450 Facility or	$275.00	YES			YES		YES	Primary Care or Specialist	Hospital & Radiologist	Use same administrative requirements that are currently in place for CT scans. Renew agreement with hospital and radiologist to verify fees.	
	70460 Facility or	$375.00										
	70470 Facility	$440.00										
	70450 Radiologist or	$85.00										
	70460 Radiologist or	$115.00										
	70470 Radiologist	$140.00										

ANALYSIS OF PROPOSED PROCEDURES WITH ESTIMATED FEES

EMG	95885 or	$78.00	YES			YES		YES	Neurologist	Neurologist, Hospital & Radiologist	This is regularly performed by a neurologist (at times in their office). We would need to find a Neurologist to work with the plan.	YES
	95886	$119.00										
	95885 Facility or	$140.00										
	95886 Facility	$210.00										
	95885 Radiologist or	$50.00										
	95886 Radiologist	$65.00										
Esophagogastroduodenoscopy	43235	$340.00	YES		YES	YES	YES	YES	Gastroenterologist	Gastroenterologist, Hospital & Radiologist		
	Facility	$600.00										
	Anesthesiologist	$325.00										
	Radiologist	$190.00										
Pulmonary Function Test	94060	$84.00	YES		YES				Pulmonologist	Pulmonologist	This is regularly performed in a specialist's (pulmonologist) office (additional fee for office visit). We will need to find a Pulmonologist to work with the plan.	YES
Ultrasound (Abdomen-Liver)	76700 Facility	$285.00	YES			YES		YES	Primary Care or Gastroenterologist	Hospital & Radiologist		
	Radiologist	$90.00										
Cognitive			YES						Psychologist and Psychiatrist			YES
Behavioral			YES						Psychologist and Psychiatrist		Recommendation is for diagnostic test (survey) to be done for Psych = body system for element = lead. A psychiatric specialist would need to administer if they want psychiatric testing done, with interpretation and evaluation. The attending Physcian would complete the survey and refer to either a Psychologist or Psychiatrist for the initial diagnosis. The first treatment would be paid for as a diagnosis. We will need to find these specialist to work with the plan.	YES

** Facility, Radiologists, Anesthesiologist fees are estimated from current agreements, the remainder of fees are 130% of Medicare allowance.*

PROPOSED LAB FEES

Physician Type	Procedure Code	Description	Allowable Fee*	PROPOSED ADD / REMOVE	QUALIFICATION
Primary Care Physician	80061	Lipid panel	$5.00	ADD	
Primary Care Physician	80076	Liver Function Test	$7.00	ADD	
Primary Care Physician	82947	Glucose	$2.63	ADD	
Primary Care Physician	83036	Hgb A1c	$8.00	ADD	
Primary Care Physician	82043/82570	Urine Micro albumin/creatine ratio	$24.00	ADD	
Primary Care Physician	82565	Glomerular Filtration Rate	$2.63	ADD	
Primary Care Physician	84153	Prostate Specific Antigen	$10.00	ADD	Males over age 50
Primary Care Physician	82340	Urine Calcium	$5.00	ADD	
Primary Care Physician	84550	Uric Acid	$2.63	ADD	
Primary Care Physician	85025	CBC/Diff	$4.20	ADD	
Primary Care Physician	86803	Hep C Screen	$10.00	ADD	Born between 1945-1965
Primary Care Physician	87389	HIV	$20.00	ADD	
Primary Care Physician	86701/86702	HIV (confirmation if positive)	$84.00	ADD	
Primary Care Physician	82232/010173	ASSAY OF BETA-2 PROTEIN URINE	$25.20	REMOVE	
Nephrologist	85652/005215	SEDIMENTATION RATE (ESR)	$3.15	REMOVE	
Toxicologist	84202/010165	010165: ZINC & FREE ERYTHROCYTE PROTOPORPHYRIN	$10.50	REMOVE	

** Allowable Fees provided by LabCorp*

EXHIBIT H

October 21, 2011, Order re CT Scans

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

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

Plaintiffs,

v.

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

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

Defendants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT IS SO ORDERED.

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

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

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

Virginia Buchanan
Levin, Papantonio, Thomas, Mitchell,
Eshner & Proctor, P.A.
316 South Baylen St., Suite 600
Pensacola, FL 32591

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

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

ENTER: October 21, 2011

Thomas A. Bedell, Circuit Judge

EXHIBIT I

Proposed Revised Wellness Exam Form

Patient Name (Last, First, MI)_____
Date _____

New Patient History and Physical
Wellness Exam Form

Patient Demographic and Insurance Intake Form

Date: _____

Last Name: _____ First Name: _____ MI: ___

DOB: _____ SS#: _____ Sex:_____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Referred by: _____

Primary Care Physician Name and Number: _____

Pharmacy Name and Phone No.: _____

Insurance Information

Primary Insurance Co: _____ ID#: _____ Grp#: _____

Secondary Insurance Co: _____ ID#: _____ Grp#:_____

Policy Holder Name: _____ ID#: _____

Policy Holder DOB: _____ Policy Holder Address: _____

Policy Holder SS#: _____ Policy Holder Sex: _____ Copay Amount: _____

History of Present Illness

. Any Complaints Today?

_____
_____
_____
_____
_____
_____

Patient Name (Last, First, MI)_____
Date _____

Past Medical History

Past Medical History:

Diagnosis	Date
• Allergic rhinitis	
• Anxiety	
• Asthma	
• Atrial fibrillation (HCC)	
• Chronic obstructive airway disease (HCC)	
• Congestive heart failure (HCC)	
• Convulsions (HCC)	
• Coronary artery disease	
• CVA (cerebrovascular accident) (HCC)	
• Depression	
• Diabetes mellitus type 1 (HCC)	
• Diabetes mellitus, type 2 (HCC)	
• Esophageal reflux	
• Hx of breast cancer	
• Hypercholesterolemia	
• Hypertension	
• Hypothyroidism	
• MI (myocardial infarction) (HCC)	
• Migraine	
• Osteoarthritis	
• Osteoporosis	
• Other acne	
• Peptic ulcer	
• Pneumonia	
• Rheumatoid arthritis (HCC)	
• Blood in Stools or Urine	
• Liver Disease	
• Kidney Stones	

Past Surgical History:

Procedure	Laterality	Date
• CORONARY ARTERY ANGIOPLASTY		
• HX APPENDECTOMY		
• HX BACK SURGERY		
• HX CAROTID ENDARTERECTOMY		
• HX CATARACT REMOVAL		
• HX CESAREAN SECTION		
• HX CHOLECYSTECTOMY		
• HX COLECTOMY		
• HX CORONARY ARTERY BYPASS GRAFT		
• HX GASTRIC BYPASS		
• HX HEART VALVE SURGERY		
• HX HEMICOLECTOMY		
• HX HERNIA REPAIR		
• HX HIP REPLACEMENT		
• HX HYSTERECTOMY		
• HX KNEE REPLACMENT		
• HX MASTECTOMY, SIMPLE		
• HX TAH AND BSO		
• HX THYROID BIOPSY		
• HX TONSILLECTOMY		
• HX WISDOM TEETH EXTRACTION		
• INJECT ANESTHETIC AGENT;GREAT OCCIPITAL NRV (AMB ONLY)		

Prescription Medications, including dosage and when prescribed:_____
_____

Allergies:_____
_____

Are you pregnant or nursing? (if applicable) _____

Patient Name (Last, First, MI)_____
Date _____

Family History

Problem	Relation	Age of Onset
• Alzheimer's/Dementia		
• Anesth Problems		
• Arthritis-rheumatoid		
• Arthritis-osteo		
• Asthma		
• Blood Clots		
• Cancer		
• Congestive Heart Failure		
• Coronary Artery Disease		
• Diabetes		
• Fibromyalgia		
• Heart Attack		
• High Cholesterol		
• Hypertension		
• Melanoma		
• Migraines		
• Non-Melanoma Skin Cancer		
• Parkinsons Disease		
• Peripheral Vascular Disease		
• Seizures		
• Sleep disorders		
• Stroke		
• Sudden Death no cause		
• Thyroid Disease		

Social History

Social History

- Marital status:
  Spouse name:
- Number of children:
- Years of education:

Occupational History

-

Social History Main Topics

- Smoking status:
- Smokeless tobacco:
- Alcohol use

- Drug use:
- Sexual activity
  Partners:

Patient Name (Last, First, MI)_____
Date _____

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered. I authorize the use of any medical data for the purposes of a health study.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

EXHIBIT J

Proposed Order

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.

ORDER RESPECTING MODIFICATION OF THE PERRINE MEDICAL MONITORING PROGRAM

Presently pending before the Court is the September 15, 2017, Report of the Claims Administrator and the Court-Appointed Medical Monitoring Advisory Panel (the "Panel"), along with the submissions of the Parties with their respective positions, regarding the possible modifications of the Medical Monitoring Program design, as contemplated by the Court's Order of August 4, 2017.

A. Proposed Health Study

The Court finds that the Claims Administrator and the Panel propose that a Health Study be carried out as set out in Exhibit D to the Claims Administrator's September 15, 2017 Report.

As noted by the Panelists, a Health Study may help tailor the Program testing protocols based on findings, help determine if there is a link between the heavy metals in the Class Area and Claimant disease, and help answer the common Claimant question of what happened health-wise in the Class Area.

The proposed Health Study would not be limited by the types of possible proposals that the Panel can now come up with, and is open to innovation and new ideas from applicants for a

Health Study. If a Health Study is approved by the Court, applicants would respond to the Panel's Request for Applications in Exhibit B to the Claims Administrator's September 15, 2017 Report. For example, psychological studies and testing could be enhanced. The study could help answer causation questions from mined data (e.g. comparing heavy metals in tested households with Health Study data). The study could also define gaps in the medical data that need to be filled by additional studies or testing.

The Court hereby agrees with the Health Study recommendation, and Orders that a Health Study be implemented. Contrary to DuPont's argument at our July 18, 2017, hearing, wherein DuPont argued that "there's nothing in Dr. Werntz's proposal that would authorize a study . . . and we submit there's nothing in the settlement that would authorize a study," the Court questioned "why have the Court remain involved for 30 years if it's a *static document that's never going to be changed and can't be modified in any respect*?" Hearing Regarding Distribution of the Surplus in the Property Remediation Fund, July 18, 2017, page 15, lines 11-18 (emphasis added). As the Court pointed out, and as the Panelists proposed, ***the medical monitoring portion must "be subject to some tweaking, if nothing else, over the years as medical science advances.***" Id. (emphasis added). "Some tests may be become obsolete and some tests may be more appropriate as suggested in limited fashion . . ." Id.

In the Court's August 24, 2011, Order Permitting the Establishment of a Program Database to Facilitate and Assist in Future Scientific and Medical Research, the Court ordered that, "after a claimant provides informed consent, that claimant's information may be placed into a research database and provided upon request to assist in a legitimate medical or scientific purpose." Relying upon the opinion of Dr. Werntz, to rebut Defendant's assertion "that the creation and maintenance of a medical monitoring program was not a part of the Perrine/Dupont

settlement or part of the Medical Plan Order," the Court noted that its February 25, 2008 Final Order Regarding the Scope, Duration, and Cost of the Medical Monitoring Plan, adopted the medical monitoring plan envisioned by Dr. Werntz "in its entirety," and "the Defendant never made an objection or appeal to Dr. Werntz's idea of a database used for research."

In the August 24, 2011 Order, the Court concluded:

> Underlying this Court's current decision is the immense value that a database of this kind would provide to both the Plaintiffs and the scientific and medical community at large. Testimony in this case has already established that this field of study is barren of the kind of knowledge that the proposed database could provide. This data could be tremendously helpful in assessing the sorts of harms, if any, that prolonged exposure to arsenic, cadmium, and lead can incur. It would also assist in determining the interplay between these potential harms and the medical monitoring process. Furthermore, nay privacy concerns may be dealt with by a waiver. Because the benefits of such a database far outweigh the costs, it would be a mistake to neglect this opportunity.

Dr. Werntz contemplated that a Health Study would be part of the Settlement Medical Monitoring Program when he stated, in his "Overall medical surveillance assumptions," "[t]hat a central respository 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.**" Werntz Report, page 10, March 10, 2007 (emphasis added). The Court adopted this Report in its entirety, and the Court hereby find that the proposed Health Study fits squarely within Dr. Werntz's report, and the Court hereby ORDERS that the proposed Health Study be implemented, at the expense of DuPont.

The Settlement Administrator has estimated the cost of a Health Study for the initial year of study to be $333,333. The Court finds this to be a reasonable and fair expense to be undertaken by DuPont.

B. Recommended Medical Monitoring Testing Protocols Modifications

By the Order entered November 3, 2016, this Court approved the selection of the Panel, as contemplated by the Court's Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, as entered by the Court on January 18, 2011.

In the previous Order of January 18, 2011, the Court "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 . . ." See Final Order Setting Forth the Scope and Operation of the Medical Monitoring Plan, page 14, paragraph 6.

As such, one of the assignments of the Medical Advisory Panel, as agreed to by the Finance Committee, was the consideration of the following question:

> Based upon scientific and medical developments since early 2011, do the existing medical monitoring protocols of the Perrine Medical Monitoring Program require updating?

As explained in the June 23, 2017 Report to the Court in Exhibit F to the Claims Administrator's and Panel's September 15, 2017 Report to the Court, the Panel has carefully considered this question, and the unanimous answer is **"Yes."**

As Jim Arnold, DuPont's Counsel, argued at our July 18, 2017 hearing, "what the medical monitoring program was designed to do was to afford to this medical monitoring class the remedies and benefits under West Virginia's Medical Monitoring Law. And that was to

provide diagnostic examinations and tests for people who could demonstrate exposure to certain toxic material and those tests have to be reasonable and necessary and what would – what a normal physician – a physician would normally prescribe to try to diagnose those particular illnesses." Hearing Regarding Distribution of the Surplus in the Property Remediation Fund, July 18, 2017, page 18, lines 8-17.

The Court finds that the Panel's recommended updated Medical Monitoring Testing Protocols regarding the tests for the toxic materials involved in the case at bar were vetted with CTIA, the Settlement's Third-Party Administrator. The Court finds that CTIA analyzed the costs of the suggested updated Medical Monitoring Testing Protocols, and the Court finds the same to be reasonable.

Given the scope of the recommended updates to the Medical Monitoring Testing Protocols, now testing for numerous additional maladies possibly associated with the heavy metals involved, based on advances in scientific research since 2011, the Panel recommends all 4,000 Class Members who originally registered for Program testing be invited again to participate in the Program.

As part of the Medical Monitoring Program, the Claims Administrator has proposed that at least one of the Medical Panelists speak with groups of people at local churches and the senior citizen center. At these meetings, the Panelist could explain the program, which would likely increase participation among the registered claimants. The Court finds this to be a reasonable tool of communication with the community.

One concern which may be presented is the safety and risks of such testing procedures, to the extent they use radiation. The Court previously addressed the risks of a CT Scan in the Order entered October 21, 2011. In that Order, the Court noted that "[t]he Parties have

stipulated that the Medical Monitoring Program is a primary plan for medical testing benefits, with DuPont being responsible for all costs thereof." The Court went on to find that "CT Scans cannot be baseline or routine even at the commencement of Medical Monitoring." The approach suggested by the Claims Administrator best carries out the terms of the MOU, which provides:

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

The Court Orders that similar safeguards be implemented for such new tests.

The Court finds that the estimates and costs set out in the Claims Administrator's September 15, 2017, Report, are a fair and adequate representation of the cost of the proposed health study and protocol modifications. Thus, the Court adopts and ratifies the proposals and modifications.

C. Making Claimant Wellness Exam Form Uniform

In carrying out its duties, the Court understands that the Panel was provided protected access to the confidential medical testing information compiled by CTIA, in conjunction with LabCorp, for participating Class Members who consented to make the information for research. The Court understands that this data is maintained in a uniform database, that may be sorted and analyzed. The Court understands that the Panel also reviewed a sample of the Claimant wellness exam results for the Program. The Court understands that the medical data obtained from wellness exams by Program participating Physicians was not compiled in a uniform manner and is therefore not being compiled by CTIA into a database, so that its accessibility for a health study or other scientific research is limited.

The Court understands that the Panel recommends that a uniform wellness exam form substantially in the form of Exhibit I to the Claim Administrator's and the Panel's September 15, 2017 Report be utilized by the Program to facilitate compilation and study of the resulting medical records, but with the form to be modified from time to time as reasonable necessary.

The Court hereby approves the use of a proposed wellness exam form substantially in the form presented by the Claims Administrator and the Panel in their September 15, 2017 Report. The Court grants the Claims Administrator and the Panel the ability to modify this form in the future, without the need for Court approval.

D. Proposed Use of Settlement Automobile

The Court finds that the Settlement currently owns a vehicle, which was formerly used for the Remediation Program. The Court finds that the Settlement is no longer using the vehicle.

The Claims Administrator and the Panel have proposed that the vehicle be donated to the Spelter Volunteer Fire Department, with the stipulation that the vehicle be made available for loan from the Fire Department to the Settlement to use for transporting disabled Medical Monitoring Claimants or as otherwise necessary for the Settlement.

The Court understands that the Claimants' Committee recommended, when the vehicle is used to transport disabled Medical Monitoring Claimants, that the driver be trained in CPR and shall have passed a drug test within the preceding six (6) months.

The Court hereby finds that the Claims Administrator's and the Panel's request and recommendations are fair and reasonable. The Court hereby ORDERS that the Settlement vehicle ownership be transferred, in gift, to the Spelter Volunteer Fire Department. Furthermore, the Court ORDERS that the transfer be subject to the stipulations stated herein.

E. Proposed Claimant Participation Incentive Payments

The Court finds that the Claims Administrator and the Panel propose that incentive payments be made to the participating claimants.

Based upon a survey of other similar programs by the Claims Administrator and as discussed in his Report, for those registered participating claimants, the Claims Administrator and the Panel propose that transportation be provided to those needing such. The Courts finds that the Claims Administrator and the Panel propose that each registered participating claimant receive a $25 Walmart gift card at testing and a $25 Walmart gift card upon receiving testing result.

The Court finds that, assuming 3,000 participants, the cost of the Walmart gift card incentive program would be $150,000 for the next round of Program testing.

The Court hereby ORDERS that the incentive and transportation program as set out herein and in the Claims Administrator's and the Panel's Report be adopted and approved.

After a careful review of this matter and based upon the foregoing Report, and all other matters and things which the Court deems to be appropriate, it is hereby ORDERED, ADJUDGED and DECREED as follows:

1. That a Health Study be implemented, at the expense of DuPont;
2. That the cost of the Health Study is a reasonable and fair expense to be undertaken by DuPont;
3. That the proposed Medical Monitoring Testing Protocols be adopted and ratified, and that the costs of the suggested updated Medical Monitoring Testing Protocols are reasonable;
4. That the Court hereby approves the use by the Medical Monitoring Plan of a uniform participant wellness exam form submitted by the Claims

Administrator and the Panel in substantive form in Exhibit I to their September 15, 2017 Report, with Claimants being allowed to complete and sign the Form, at their option, during their initial Medical Monitoring Provider visit, and with the Claims Administrator and the Panel being allowed to modify and implement the Form as necessary without prior Court approval.

5. That the Settlement vehicle ownership be transferred, in gift, to the Spelter Volunteer Fire Department, subject to the stipulations stated herein.

6. That the incentive and transportation program as set out herein and in the Claims Administrator's Report be adopted and approved.

7. That the supplement to the September 1, 2017 to August 31, 2018, Settlement Budget is approved; and

8. That provided that the Claims Administrator and his staff act substantially in accordance with the Court's Order in this matter, the Claims Administrator and his staff are granted judicial immunity.

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.

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

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ENTER: _____

_____
Thomas A. Bedell, Circuit Judge