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PERRINE MEDICAL MONITORING PROGRAM (THE "PROGRAM")
MEDICAL PROVIDER QUESTIONS AND ANSWERS

Q1: WHAT MEDICAL SERVICES ARE COVERED BY THE PROGRAM AND WHAT SERVICES ARE NOT COVERED?

A. The Program is only designed to provide medical monitoring and not medical care. Program services are described in the Schedule of Benefits attached. All additional services will not be paid by the Program and must be paid for by the Claimant. Before any medical services not described in the Schedule of Benefits are provided, the Program Medical Provider and the Claimant should discuss them, to make sure that the Claimant understands that the Claimant, and not the Program, will pay for them.

Q2: WHICH SPECIALIST SHOULD I USE?

A. CTIA has secured all of the required Program specialists. Please refer to CTIA for an exhaustive list as it changes from time to time, except for toxicology specialists and CT Scan services.

Q3: WHO IS THE APPROVED TOXICOLOGIST?

A. All toxicology services are provided by the Department of Emergency Medicine ("UPP") of the University of Pittsburg Medical Center ("UPMC").

Q4: WHO IS THE APPROVED CT SCAN PROVIDER?

A. All CT Scans are facilitated by the United Hospital Center ("UHC") in conjunction with Radiological Physicians Associates ("RPA").

Q5: WHAT KIND OF CT SCANS ARE UTILIZED AND APPROVED?

A. Both CT Scans with contrast and CT Scans without contrast have been approved.

Q6: WHAT IF I AM THE CT SCAN PROVIDER AND I DO NOT SECURE A CT SCAN RELEASE FORM FROM THE REFERRING PHYSICIAN?

A. The Program will not reimburse for CT Scan services in the absence of the CT Scan Release Form.

Q7: IF I AM A MEDICAL MONITORING PROVIDER, CAN I PERFORM AND BILL FOR ANY SPECIALTY SERVICES?

A. You can bill for (i) a dermatology 30 minute office visit; and (ii) ordering a biopsy tissue exam. These are the only two specialty services for which you can perform and bill to the Settlement.

Q8: CAN I RE-TEST RATHER THAN REFER TO A SPECIALIST?

A. Yes. You may order another urine test if (i) the test specimens were lost or damaged by the laboratory; (ii) the test results appear to be unreliable, unrealistic, or improbable based upon the claimant's medical history; and (iii) test results were very close to exceeding the normal range and other symptoms of poor health were present. The additional codes for billing for re-tests have been provided by CTIA.

Q9: I HAVE PATIENTS WITH CRYSTALS IN THEIR URINE. IS IT OK TO REFER TO UROLOGY?

A. As the physician, it is up to you to utilize your best medical judgment within the applicable standard of care to make the best decision for the patient.

Q10: IS THERE A DESCRIPTION OF PATIENT SKIN LESIONS THAT YOU WANT THE PROVIDERS TO LOOK AT SPECIFICALLY?

A. Please refer to Provider Orientation Package, including the Dr. Werntz Report.

Q11: SHOULD I REFER A PATIENT TO A SPECIALIST WHEN I'VE SEEN RASHES?

A. As the physician, it is up to you to utilize your best medical judgment within the applicable standard of care to make the best decision for the patient.

Q12: IF THE PATIENT'S LABORATORY RESULTS ARE SLIGHTLY ABNORMAL, CAN THE TEST BE REPEATED BEFORE THE TWO YEAR PERIOD RUNS (AND BE PAID BY THE PROGRAM) OR DO I NEED TO MAKE A DECISION NOW ON WHETHER TO REFER THE PATIENT TO A TREATING PHYSICIAN?

A. Under the Program, patients are to be tested every two years. Therefore, you are to decide on whether to make a referral at this time based on current test results.

Q13: WHAT DO YOU DO IF A PATIENT HAS EXISTING CONDITIONS? SHOULD WE SEND INFORMATION TO THE PATIENT'S REGULAR PRIMARY CARE PHYSICIAN?

A. The Program does not provide for any services other than those in the fee schedule attached to the Provider Contract. If a patient presents with pre-existing conditions, the physician should provide follow up as required by the reasonable standard of care by, for example, referring the patient back to his or her primary care physician or otherwise, but the provider should remind the patient that the Program **only** pays for medical monitoring and not for medical care.

Q14: IS THERE REIMBURSEMENT FOR NO-SHOWS?

A. No. The Program does not pay for no-shows.

Q15: SOME OF THE PATIENTS MAY NOT COME BACK IN FOR A FOLLOW UP EXAM. WHAT DO I DO?

A. First, you must comply with the applicable standard of care. To the extent it requires something more than the Program requires, the Program cannot excuse you from that obligation. Second, the Program requires the following: If a patient fails to appear for a follow-up exam in which the Physician intended to relay test results that were paid for by the Program, the Physician should notify the patient that the Physician is available to review the results with the patient and ask the patient to re-schedule the appointment. In addition, if the results are abnormal, the Physician should notify the patient of the results and advise the patient that the results are abnormal and urge the patient to discuss the results with the Physician or the patient's primary care doctor or some other reasonable physician. The Physician should remind the patient that the Program pays only for follow-up with the Physician and not with other doctors or for medical treatment.

The following format may be useful as a template:

Dear Patient_____:

We missed you at your recent appointment, which was scheduled for _____. We intended to discuss your test results with you at the appointment. We ask that you call to re-schedule your appointment. If you prefer, you may discuss your results with your primary care doctor. Remember that the Program pays for your testing and for follow-up with this office but does not pay for follow-up with other physicians or for any medical treatment.

For your information:

_____The results of your testing are attached, and they are normal.

_____The results of your testing are attached and they are abnormal in some respects. We urge you to call us to discuss the test results. The abnormal results are:

_____

Q16: SOME PROVIDERS BELIEVE THAT THE PROGRAM B2 MICROGLOBULIN SERUM TEST IN THE WERNTZ REPORT (AS OPPOSED TO A URINE TEST) IS NOT THE PREFERRED TESTING METHOD. LABCORP SUGGESTS THE SERUM APPROACH. BOTH HAVE THE SAME CPT CODE. THE COST OF THE TWO TESTS ARE $20 AND $24 RESPECTIVELY. WHICH IS CORRECT?

A. The Program has been updated to provide for the Program B2 Microglobulin Serum in addition to the urine test. Additional approved CPT codes have been provided to you by CTIA.

Q17: CAN THE PROVIDER DO A URINE CYTOLOGY, WHICH IS NOW TO BE DONE BY A SPECIALIST UNDER THE PROGRAM. THIS IS A TEST UNDER THE SPECIALIST CATEGORY. EITHER WAY, THE LAB TEST GOES THROUGH LABCORP.

A. Yes.

Q18: HOW AND WHEN CAN A PROVIDER DO A PATIENT RETEST?

A. As the physician, it is up to you to utilize your best medical judgment within the applicable standard of care to make the best decision for the patient. Only the physician can determine when a retest is necessary.

Q19: SOME OF THE PATIENTS REFUSE TO FILL OUT THE MEDICARE FORM. WHAT SHOULD WE DO?

A. All patients are required to complete the Medicare Form. If they refuse to do so, they cannot receive Program services. It is for both the protection of the Program and for the protection of the patient. None of the patient's Medicare or Medicaid benefits will be used for any service that is covered by the Program.

Q20: IS THERE A FLIER EXPLAINING WHY THE PATIENT MUST COMPLETE THE MEDICARE FORM?

A. Yes. A copy is attached for your convenience.

Attachments:

1. Schedule of Benefits
2. Description of Medicare Benefits Questionnaire.

DRAFT

Perrine Medical Monitoring Plan – Schedule of Benefits

The Perrine Medical Monitoring Plan (Plan) provides limited medical testing benefits. Testing is provided as the result of a court settlement in the matter of Perrine, et al., v. E. I. DuPont DeNemours and Company, Inc. Testing protocols have been established to look for positive findings of disease possibly associated with exposure to zinc, cadmium, arsenic, or lead. **This Plan is for medical monitoring purposes only and does not cover any type of treatment.**

The purpose of this Schedule of Benefits is to provide you an outline of the benefits covered in the Medical Monitoring Plan. Benefits are limited to the procedures identified in this document. If additional procedures and/or tests are performed, it is the responsibility of the patient, or patient's medical insurance, to pay for the additional services. **Please discuss the services performed with the physician first to make certain they are covered.**

Testing is provided once every two years (biennial) for 30 years starting in 2011. You are authorized to provide medical monitoring in accordance with the Plan benefits. The Plan has the following components:

1. **Biennial Testing-**
    a. Participants younger than age 15 will receive a blood test.
    b. Participants ages 15 – 17 will receive blood and urine tests.
    c. Participants ages 18 & above will receive blood and urine tests and be given a stool hemocult card.
    d. Participants age 35 and older are eligible for CT Scans.

2. **Physician's Consultation-** Primary Care Physician (PCP) will consult with Participant to review the test results and perform a physical examination. The Participant may be referred for a CT Scan by the Primary Care Physician.
    a. If a CT Scan is recommended, (age 35 and over and not pregnant) the Primary Care Physician **must contact CTI Administrators to obtain and complete the necessary CT Scan Verification form.**
    b. Female Participants (ages 35 – 55) must be tested for pregnancy if a CT Scan is recommended. The pregnancy test is paid for by the plan. CT Scans are not allowed for pregnant participants.
    c. CTI Administrators will assist the Primary Care Physician in selecting an Imaging Facility and Radiologist as well as other specialists.

3. **Referrals to Specialists-** Based upon test results and recommendations of the Primary Care Physician, the Patient may be referred to a Specialist for additional Testing. Testing is limited and must be in accordance with the procedures specified by the Plan. The PCP may perform the services specified for the Dermatologist; however, all other specialty services must be performed by the designated specialist.

Step 1- Biennial Testing

Covered Procedures for the Primary Care Physician (PCP)

5 minute office visit for established patients or 10 minute for new patients

Tests Must Be Ordered Depending on Age of Participant

Under Age 15	PCP will perform a blood test only
Age 15 - 17	PCP will perform a blood and urinalysis test
Age 18 or older	PCP will perform a blood, urinalysis and stool sample test

Retests- Retests should be taken based upon the best judgment of the physician using the following guidelines:

- Retest if specimens were lost or damaged.
- Retest if test results appear to be unreliable or improbable based upon the patient's medical history
- Retest if results were very close to exceeding the normal range and other symptoms of bad health were present. In this case, a retest should be taken in six months.

STEP 2- Physician's Consultation

The consultation should consist of a physical exam, review of laboratory findings, pros and cons of having a CT scan (if the participant is 35 years of age or older and not pregnant) and additional testing with a specialist on an as needed basis.

Covered Procedures for the Primary Care Physician

The Primary Care Physician will either have a 30 minute office visit (for existing patients) or a 40 minute office visit (for new patients) in step 2.

STEP 3 Referrals to Specialists

If the PCP determines an individual needs to have a CT scan or see a specialist, please contact CTI Administrators at 800-245-8813 to identify an approved imaging facility or specialists in your area.

Specialists allowed by the Plan include:

Dermatologist*,	**Urologist,**	**Nephrologist,**
Gastroenterologist,	**Pulmonologist,**	**Psychologist,**
Toxicologist,	**Anesthesiologist,**	**Cardiothoracic Surgeon,**
Radiologist & Imaging Facility		

** The Primary Care Physician may perform the services of the Dermatologist; however, all other specialty services must be performed by the designated specialist*

COVERED PROCEDURES BY SPECIALIST

Dermatologist
Procedure
30 minute office visit for established patients or 40 minute for new patients
Description
Dermatologist or PCP will perform a biopsy of a skin lesion and send to a Pathologist for examination.

Urologist
Procedure
30 minute office visit for established patients or 40 minute for new patients
Description
Urologist will perform an examination of the urinary bladder with removal of tissue. This tissue will be examined by a Pathologist

Nephrologist
Procedure
30 minute office visit for established patients or 40 minute for new patients
Description
Nephrologist will perform a blood and urinalysis test

Gastroenterologist
Procedure
30 minute office visit for established patients or 40 minute for new patients
Description
Gastroenterologist will perform an examination of the upper Gastro Intestinal Tract with removal of tissue. This tissue will be examined by a pathologist

Toxicologist and Psychologist
Procedure
30 minute office visit for established patients or 40 minute for new patients
Description of Procedures for the Toxicologist
Toxicologist will perform a blood test
Description of Procedures for the Psychologist
Psychological testing (up to 4 one hour tests)

COVERED PROCEDURES BY SPECIALIST- Continued

Pulmonologist, Cardiothoracic Surgeon, & Anesthesiologist
Description of Procedures for the Pulmonologist
30 minute office visit for established patients or 40 minute for new patients
Description of Procedures for the Cardiothoracic Surgeon
30 minute office visit for established patients or 40 minute for new patients
Cardiothoracic Surgeon will perform and examination and removal of tissue from the lung and or airways. This tissue will be examined by a pathologist
Description of Procedures for the Anesthesiologist
Anesthesia

CT Scans & Radiologist
At the discretion of the Primary Care Physician or designated specialist, some adults may be recommended to obtain a CT Scan (if over age 35 and not pregnant)
Description of Procedures for CT Scans
CT Scan of the chest and or abdomen and pelvis. These can be ordered with or without contrast
Professional Component for the Radiologist
Radiologist will interpret the results of the CT scans and forward them to the PCP.

Covered benefits are paid in full by the Plan. There are no deductibles, co-payments, or coinsurance.

IMPORTANT REMINDER

Please remember benefits are limited to the procedures identified in this document. If additional procedures and/or tests are performed, it is the responsibility of the patient, or patient's medical insurance, to pay for the additional services.

THE PERRINE MEDICAL MONITORING PROGRAM
MEDICARE BENEFITS QUESTIONNAIRE

All patients in the Perrine Medical Monitoring Program (the "Program") are required to complete a Medicare Benefits Questionnaire.

IF A PATIENT REFUSES TO COMPLETE THE MEDICARE BENEFITS QUESTIONNAIRE, THE PATIENT CANNOT RECEIVE PROGRAM SERVICES. THE COMPLETION OF THE MEDICARE BENEFITS QUESTIONNAIRE FORM AND THE UTILIZATION THEREOF IS FOR BOTH THE PROTECTION OF THE PROGRAM AND TO PROTECT YOU, THE PATIENT.

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), codified at 42 U.S.C. Section 1395y (b)(8), Medicare may require the Program to report to Medicare any patient in the Program who is eligible for Medicare.

Reporting is required when there is a payment obligation, including those that arise due to litigation, and that payment obligation results from a claim potentially involving past or future medical expenses. While the Program was funded with monies resulting from the resolution of litigation, the Program does not provide medical care and/or treatment whether past, present or future.

However, the Program does provide for medical testing to determine any finding of disease possibly associated with exposure to zinc, cadmium, arsenic or lead. Reporting would allow Medicare to refuse payment for future testing costs that should have been paid by the Program. Because medical monitoring itself is relatively new in practice, Medicare has yet to make a final determination if reporting is required in this circumstance.

As there is no final determination on the reporting requirement from Medicare at this time, all patients participating in the Program are required to complete a Medicare Benefits Questionnaire to help us determine Medicare eligibility. If Medicare requires reporting, this Medicare Benefits Questionnaire will assist us with satisfying the reporting requirements.

NONE OF THE PATIENT'S MEDICARE BENEFITS SHOULD BE USED FOR ANY SERVICES THAT ARE COVERED BY THE PROGRAM.