UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

IN RE:	§	**CASE NO. 00-CV-00005-DT**
	§	**(Settlement Facility Matters)**
DOW CORNING CORPORATION,	§	
	§	**Hon. Denise Page Hood**
REORGANIZED DEBTOR	§	**(Excerpt submitted in-camera)**

MOTION OF CLAIMANTS' ADVISORY COMMITTEE FOR THE DISCLOSURE OF SUBSTANTIVE CRITERIA CREATED, ADOPTED AND/OR BEING APPLIED BY THE SETTLEMENT FACILITY AND REQUEST FOR EXPEDITED CONSIDERATION

The Claimant's Advisory Committee ("CAC") respectfully submits this motion and requests that this Court use its inherent powers and authority as the Judge supervising the implementation of the Amended Joint Plan of Reorganization of Dow Corning Corporation ("Joint Plan") to order the disclosure of substantive criteria created, adopted and/or being applied by the Claims Administrator for the Settlement Facility. Because claims processing is ongoing and cure deadlines have begun to run for some claimants affected by the outcome of this motion, the CAC respectfully requests the Court to expedite consideration of this motion and for other equitable relief as detailed herein.

FACTUAL BACKGROUND

In 1994, a "global" settlement was reached on breast implant claims between various U.S. manufacturers of breast implants and suppliers of materials and the Plaintiffs' Steering Committee ("PSC") in MDL-926. The settlement included carefully crafted and specific criteria for disease claims and required that all claimants who wished to be a "Current Disease Claimant" submit a detailed disease claim by September 1994. The disease criteria were the

result of lengthy, protracted negotiations where each symptom and criteria to qualify was exhaustively scrutinized before the various entities finally reached agreement. In addition to meeting disease criteria, a claimant must also document that she has a disability – based either on the severity of her disease or on her functional capacity to perform activities of vocation, avocation and/or self-care. The diseases that use the functional capacity test provide for three levels of disability:

> A. Death or total disability resulting from the compensable condition. An individual will be considered totally disabled if she demonstrates a functional capacity adequate to consistently perform none or only a few of the usual duties or activities of vocation **or** self-care.
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> B. A Breast Implant Claimant will be eligible for category B Compensation if she is 35% disabled due to the compensable condition. An individual shall be considered 35% disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her usual activities of vocation, avocation, **and** self-care, or she can perform them only with regular or recurring severe pain.
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> C. A Breast Implant Claimant will be eligible for category C compensation if she is 20% disabled due to the compensable condition. An individual shall be considered 20% percent disabled if she can perform some of her usual activities of vocation, avocation, and self-care only with regular or recurring moderate pain.

(emphasis added). See Exhibit 1 hereto, excerpt from global settlement disease criteria. As noted by the bolded language in levels A, B, and C, the negotiators in the global settlement purposely distinguished the criteria for disability level A by requiring an impact on "vocation **or** self-care." Disability levels B and C, in

contrast, expressly required that claimants demonstrate an impact on "vocation, avocation, **and** self-care..."

In 1995, when the global settlement was renegotiated, a cornerstone of the Revised Settlement Program was that the disease and disability criteria in the global settlement would remain unchanged. Thus, the global settlement disease and disability criteria was adopted wholesale and designated as the "Fixed Benefit Amount Schedule" available to Current Disease Claimants. See Exhibit 2 attached hereto, excerpt from Revised Settlement Program Notice, 1996. The primary reasons adopting the global settlement disease criteria were twofold: 1) to allow for prompt processing and payment of pending disease claims and 2) to ensure that those claimants who relied on the global disease criteria would not incur additional expense or delay to be re-evaluated with new criteria. Processing of the Current Disease claims that were submitted in late 1994 began in January 1996 and was largely completed by the third quarter of 1997. Claimants who wished to appeal the results of their individual claim review could do so to the MDL Claims Administrator and then to the MDL Court. Id. at Paragraph 34. As noted in Paragraph 34 of the Revised Settlement Program Notice, the appeal was limited to individual claim reviews and therefore, neither the PSC nor defendants were provided notice or information about individual claim decisions. Paragraph 34 did not contemplate that the individual claim review process would result in global interpretations of substantive criteria without the parties' knowledge or participation. Paragraph 34 provides that:

> 34. **Court Review of Claims Office Determinations.**
> A claimant dissatisfied with the decision made by Claims Officers may appeal to the Claims Administrators and, if still dissatisfied, may seek a further review, on the basis of the record evidence, by the Court (or a person designated by the Court to conduct such review). No other appeals or reviews are permitted, and the settling defendants will have no right of appeal or review from determinations made by the Claims Office.

These appeals were handled by Judge Pointer until May 13, 1998 when Judge Pointer designated the Honorable Frank Andrews to serve as the appeals judge. See Exhibit 3 hereto, copy of October 27L in MDL-926 ("Judge Andrews may exercise the same degree of equitable discretion on such matters as timeliness of filings and other similar administrative questions as has been exercised by the court in conducting such reviews.")

Decisions of the appeals judge were not made publicly available so as to protect the identity and confidentiality of individual claimants in the settlement process. To date, these decisions are not publicly available to anyone. The CAC understands though from discussions with plaintiffs' representatives in MDL-926 that Judge U.W. Clemon has indicated that the Appeals Judge's decisions should be appropriately redacted and posted on the MDL Claims Office website. We further understand that this process is near completion.

In the Dow Corning bankruptcy proceedings, the Tort Claimants' Committee ("TCC") and Dow Corning reached an agreement in 1998 on a plan of reorganization and, as part of the agreement, the disease and disability definitions in the Revised Settlement Program were adopted wholesale. See Exhibit 4 attached hereto, Option 1 Disease Schedule in Annex A, the Claims

Resolution Procedures. Like the Revised Settlement Program, a guiding principle in the Joint Plan is that claimants can rely on their 1994 disease submission and global disease criteria without the need for further delay or expense in being re-evaluated.[1] Subsequently, the Plan Proponents and Claims Administrator developed claim forms and a Disease Claimant Information Guide with extensive Q&A's on Plan criteria which were mailed in February 2003. The Q&A's were adopted verbatim from the RSP's Q&A Booklet and materials. Q&A1-10 in the Disease Claimant Information Guide – provided to claimants in February 2003 – provides in relevant part that:

> Q1-10: What is the definition of Level "A: disability for ANDS and ACTD in Disease Option 1?
>
> Answer: Read the criteria for ANDS and ACTD disability level "A" at Tab 1.
>
> You are eligible for Level "A" disability for death or Total disability resulting from your compensable disease or condition. You will be considered totally disabled if you demonstrate a functional capacity adequate to consistently perform none or only a few of your usual duties or activities of vocation or self-care.

(emphasis added). See Exhibit 5 attached hereto, excerpts from Class 5 Disease Claimant Information Guide.

In the Claims Resolution Procedures, claimants in the Settlement Option were provided with the same right to appeal claim review decisions as afforded in the Revised Settlement Program. See Sections 8.03, 8.04, and 8.05. As noted

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[1] Question 3-5 in the Disease Claimant Information Guide asks:

> Q. Can I rely on the medical records that I sent to the MDL Claims Office in Houston years ago, or do I have to resend these documents to the Settlement Facility?
>
> A. You can rely on the medical records that you submitted to the MDL Claims Office in Houston, Texas. You do not have to re-submit any records.

See Exhibit 5 attached hereto, excerpts from the Class 5 Disease Claimant Information Guide (emphasis added).

in Section 8.05, Appeals to the Appeals Judge, "An appeal that involves a new interpretation of the substantive eligibility criteria must be submitted to the Debtor's Representatives and the Claimants' Advisory Committee consistent with Section 5.05 of the Settlement Facility Agreement."

When the Joint Plan went effective on June 1, 2004, the Settlement Facility began to process disease claims. At some point during the third quarter of 2004, it began to send Notification of Status letters to claimants identifying deficiencies in disease claims. Almost immediately, the CAC began to receive numerous inquires from law firms that had submitted claims in the RSP as well as the Settlement Facility. They reported almost universally that they believed that the disability criteria being applied by the Settlement Facility was more difficult than that applied by the RSP Claims Office. They also provided the CAC with copies of Notification of Status letters listing deficiencies in disability level A claims if the claimant had documented functional capacity for vocation only or for self-care only. The deficiency notice included a page that restated the Plan's disability criteria, and on that page the SF-DCT used language that stated that claimants must document functional capacity for both vocation and self-care for disability level A claims. See Exhibit 6 hereto, copy of redacted claimant Notification of Status letter with disability criteria that is different from the criteria in the Plan and Claimant Information Guides. The language in the Notification of Status letters contradicts the Plan language and Claimant Information Guide that provides that functional capacity must affect vocation or self-care.

On October 18, 2004, the Claims Administrator provided the CAC and Debtor's Representatives with a copy of an unredacted individual claimant appeals decision entered by Judge Pointed dated September 30, 1997.[2] See Exhibit 7 attached. That order provided for a more relaxed standard for "A" disability claims. Specifically, Judge Pointer noted that, "inclusion of the phrase 'or only few' was intended to provide some relaxation from the standard, by making a determination of total disability even though the person might to be able to perform a few of the vocation or self-care activities..." (emphasis added)

In subsequent discussions with the Claims Administrator, it was disclosed that after the September 30, 1997 order was entered, there was a series of correspondence between the then-MDL Claims Administrator and Judge Pointer and possibly one or more decision from Judge Andrews that further clarified, amended or purportedly modified the September 30, 1997 order. The CAC requested to be provided with this supplemental correspondence and appeals judge decisions and posed a specific question as to what the substantive criteria is that is being applied by the SF-DCT. See Exhibit 8 hereto, E-mail dated 11/24/04 from D. Pendleton-Dominguez to W. Trachte-Huber and others. The Claims Administrator responded that the answers to the questions were part of MDL-926 annotations and questioned whether she was authorized to disclose the annotations. See Exhibit 9 hereto, E-Mail dated 11/24/04 from W. Trachte-Huber to D. Pendleton-Dominguez. The CAC responded that substantive criteria

[2] Because of the confidentiality provisions in the Revised Settlement Program and Joint Plan, a claimant's identity should not be disclosed. Therefore, for purposes of this motion, the CAC has redacted the claimant's name from the Exhibit attached to this motion. The CAS is concerned that the MDL order in question may have been provided – in an unredacted way – to others.

should not be considered "confidential annotations" that remain secret and hidden from claimants only to be disclosed for the first time when claimants receive a deficiency notice. We noted our concern that some claimants currently have cure deadlines running on their disease claims – and may be barred from a disease payment if they do not cure – if this issue is not resolved promptly. On November 29, 2004, the Claims Administrator provided additional information to the CAC and Debtor's Representatives and stated:

> We agree with Dianna's statements: claimants and attorneys are confused by the plan language and the CIG AND do not have the benefit of understanding the applicability of those words by the MDL-926 Administrator and Judge Pointer. CAP nurses get calls on this frequently. Our Disease NOS letter deficiency statements already spell out the requirement is vocation and self-care, so claimants are, in fact, notified when they get a NOS letter.
>
> We have annotations that give more detail about how to credit disability Level A, but we may are not [sic] authorized to publish those. Since Judge Andrews has indicated that he will be shortly posting his opinions we are authorized to share a pretty clear statement from two of Judge Andrews' appeals in 1998. Both state:
>
> "Ms. XXXX argues that the language of the Disease Compensation schedule with regard to disability allows a finding of total disability where the claimant is unable to perform only one or the other of her vocational and self care activities. The Court has consistently ruled that his reading is incorrect; total disability requires disability in both categories of activity."

See Exhibit 10 attached hereto, E-Mail dated 11/29/04 from W. Trachte-Huber to various persons.

[The following paragraph is submitted in-camera and is not to be including in the motion filed with the Court:

[The following paragraphs is being submitted in-camera.]

ARGUMENT

The disability language in the 1994 global settlement, 1996 Revised Settlement Program and 1999 Joint Plan of Reorganization are identical with respect to the different standards adopted by the negotiators for disability A, B, and C. At no time have the negotiators changed the criteria nor have they been asked to provide an interpretation on why the standard for disability level A is different than for disability levels B and C. As late as November 2001, the Plan Proponents were not even aware that the disability language for level A had been interpreted and purportedly modified by Judge Pointer in an individual claimant appeals decisions. See Exhibit 12 attached hereto, Memo dated 11/19/01 from D. Greenspan to W. Trachte-Huber in which Ms. Greenspan stated, "We do not believe that Judge Pointer issued an order changing the wording of the disability guideline." Had they been made aware of the change in criteria, the Plan Proponents could have clarified their intent on the different standards in the disability criteria.

Subsequent to the response of Ms. Greenspan noted above indicating that we did not believe the disability language had been changed, the claim forms and Claimant Information Guides were finalized for mailing to claimants. They contained the same definitions for disability that are in the Plan, The Revised Settlement Program and the global settlement, further leading the Tort Claimants'

Committee/Claimants' Advisory Committee to conclude that there had not been any change in disability criteria. Further, as of December 2004, none of the appeals decisions in the Revised Settlement Program that may impact claim criteria have been made publicly available to claimants or to the CAC and Debtor's Representatives.

We believe it is fundamentally unfair to give claimants a set of disease criteria in their claim forms and materials and then to process the claims using different criteria. If the disease criteria was interpreted in such a way by either the MDL Claims Office or an appeals decision from an individual claim, then it was done without the input or knowledge of the parties who negotiated the criteria and without the disclosure of this crucial information to anyone outside of the claims office and appeals judge. If plaintiffs in the Revised Settlement Program had been made aware that the criteria was being interpreted in a way that negated the carefully crafted, hard-fought-for language in the global settlement, the appropriate steps could have been taken at the time to challenge it. Instead, claimants are only now finding out that claims that have been pending for 10 years are being found deficient because of an unknown, undisclosed interpretation of the disability criteria that apparently only applied to disease claims in the MDL Post-1998.

The CAC has been informed by plaintiffs' counsel in the Revised Settlement Program that a motion to challenge the disability A interpretation and application and to compel disclosure of the applicable criteria to qualify is being filed simultaneously with this motion with the MDL Court.

We respectfully request that this Court order the disclosure of all processing applications that impact or purport to change the settlement benefit criteria. Until this issue is resolved, we further request that the Court enter an Order to toll the deadlines to cure deficiencies for any claimant whose claim was found deficient based on criteria that they were not informed about.

Respectfully submitted,

FOR THE CLAIMANTS' ADVISORY COMMITTEE

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CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing "MOTION OF CLAIMANTS' ADVISORY COMMITTEE FOR THE DISCLOSURE OF SUBSTANTIVE CRITERIA CREATED, ADOPTED AND/OR BEING APPLIED BY THE SETTLEMENT FACILITY AND REQUEST FOR EXPEDITED CONSIDERATION" was served on the Debtor's Representatives and Finance Committee by electronic mail on December 6, 2004.

Jacqueline Chatmon, Paralegal
Blizzard, McCarthy & Nabers, LLP

LIST OF EXHIBITS

Exhibit 1	Global Settlement Disease and Disability Criteria, 1994
Exhibit 2	Revised Settlement Program Notice, 1996
Exhibit 3	MDL Order 27L appointing Frank Andrews as the Appeals Judge
Exhibit 4	Option 1 Disease Schedule in Annex A, the Claims Resolution Procedures
Exhibit 5	Excerpt from the Class 5 Disease Information Guide
Exhibit 6	Redacted claimant Notification of Status letter from SF-DCT
Exhibit 7	MDL Order, Sept. 30, 1997
Exhibit 8	E-Mail dated 11/24/04 from D. Pendleton-Dominguez to W. Trachte-Huber and others
Exhibit 9	E-Mail dated 11/24/04 from W. Trachte-Huber to the CAC, Debtor's Representatives and Finance Committee
Exhibit 10	E-Mail dated 11/29/04 from W. Trachte-Huber to the CAC, Debtor's Representatives and Finance Committee
Exhibit 11	Excerpt from SF-DCT Monthly Claims Report for the Period Ending October 31, 2004][3]
Exhibit 12	Memo from D. Greenspan to W. Trachte-Huber dated Nov. 19, 2001

[3] Exhibit 11 is submitted in-camera and is not to be included in the motion filed publicly with the Court.

EXHIBIT 1

EXHIBIT A TO STATEMENT OF PRINCIPLES
FOR GLOBAL RESOLUTION OF BREAST IMPLANT CLAIMS

September 3rd, 1993.

MEDICAL CONDITIONS AND CHARACTERISTICS
OUTLINE OF DEFINITIONS AND CLASSIFICATION CRITERIA

The Disease Compensation Program will compensate claimants who have met the diagnostic criteria for the diseases and symptom complexes listed herein. Claimants who have met the diagnostic criteria will be classified in accordance with the various Compensation Categories.

If the claimant's Qualified Medical Doctor determines that her death or total disability is clearly and specifically caused by a disease or occurrence other than the compensable disease, she will not be eligible for compensation in compensation subcategory A.

SYSTEMIC SCLEROSIS/SCLERODERMA:

(1) A diagnosis of systemic sclerosis in accordance with criteria established in Kelley, et al, Fourth Ed., at 1113, et seq.

(2) The application of these diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of classical systemic sclerosis but who nonetheless have a systemic sclerosis-like (scleroderma-like) disease, except that the parties do not intend that a claimant whose symptomology more closely resembles MCTD, ACTD, or any other defined disease or condition will be compensated in this category. A "systemic sclerosis-like" or "scleroderma-like" disease is defined as an autoimmune/rheumatic disease that fulfills most of the accepted standards for the diagnosis of systemic sclerosis but is in some manner atypical of systemic sclerosis or scleroderma.

Compensation categories

(A) Total disability/death. An individual will be deemed totally disabled based on either the functional capacity test set forth in subcategory A of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome or if the individual suffers from systemic sclerosis with associated severe renal involvement manifested by a decrease in glomerular filtration rates.

(B) Cardio-pulmonary involvement or diffuse (Type III) scleroderma as defined by Barnett, A Survival Study of Patients with Scleroderma Diagnosed Over 30 Years (1953 - 1983): The Value of a Simple Cutaneous Classification in the

Early Stages of the Disease, 15 The Journal of Rheumatology 276 (1988) and Masi, Classification of Systemic Sclerosis (Scleroderma): Relationship of Cutaneous Subgroups in Early Disease to Outcome and Serologic Reactivity, 15 The Journal of Rheumatology, 894 (1988).

(C) Other including CREST, limited, or intermediate scleroderma, except that any claimant who manifests either severe renal involvement, as defined above, or cardio-pulmonary involvement, will be compensated at either category A or B as appropriate.

(D) Other including Localized Scleroderma

SYSTEMIC LUPUS ERYTHEMATOSUS

(1) A diagnosis of systemic lupus erythematosus in accordance with 1982 Revised Criteria for the Classification of Systemic Lupus Erythematosus, 25 Arthritis and Rheumatism No. 11 (November 1982) adopted by the American College of Rheumatology. See Kelley, 4th ed. at 1037.

(2) The application of the ACR diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of SLE but who nonetheless have a systemic lupus erythematosus-like disease, except that the parties do not intend that a claimant whose symptomology more closely resembles MCTD, ACTD, or any other defined disease or condition will be compensated in this category.

Compensation categories:

(A) Total Disability or death resulting from SLE or an SLE-Like condition. An individual will be deemed totally disabled based on either the functional capacity test set forth in subcategory A of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome or severe renal involvement.

(B) SLE with major organ involvement defined as SLE with one or more of the following: glomerulonephritis, central nervous system involvement (i.e. seizures or Lupus Psychosis), myocarditis, pneumonitis, thrombocytopenic purpura, hemolytic anemia (marked), severe granulocytopenia, mesenteric vasculitis. See Immunological Diseases, Max Samter, Ed. at 1352, Table 56-6.

(C) Non-major organ SLE requiring regular medical attention including doctor visits and regular prescription medications. A woman is not excluded from this category for whom prescription medications are recommended but who, because of the side effects of those medications, chooses not to take them.

(D) Non-major organ SLE requiring little or no treatment. By

little or no treatment, a woman will fall into this category if she is able to control her symptoms through the following kinds of conservative measures: over-the-counter medications, avoiding sun exposure, use of lotions for skin rashes, and increased rest periods.

ATYPICAL NEUROLOGICAL DISEASE SYNDROME

The diagnosis of an atypical neurological disease syndrome shall be based upon the clinical findings and laboratory tests set forth below. The clinical and laboratory presentation of these neurological syndromes will have an atypical presentation from the natural disease and will also have additional neuromuscular, rheumatological or nonspecific autoimmune signs and symptoms. Eligibility for Atypical Neurological Disease Syndrome requires satisfying the requirements for one of the four disease types set forth in section A, below, and 3 of the additional neuromuscular, rheumatic or nonspecific symptoms set forth in section B, below.

A claimant will fit into this category if her primary symptoms are characteristic of a neurological disease as diagnosed by a board certified neurologist or by a physician board certified in internal medicine.

If the claimant's Qualified Medical Doctor determines that a symptom is clearly and specifically caused by a source other than breast implants, that symptom will not be utilized in the diagnosis of Atypical Neurological Disease Syndrome unless the Claims Office determines that other submissions indicate that the symptom should be utilized. A symptom that may be caused only in part by a source other than breast implants is not excluded from such utilization.

A. Neurological disease types

1. Polyneuropathies

Eligibility for this disease category requires a diagnosis of a polyneuropathy confirmed by one or more of the following:

a. Objectively demonstrated loss of sensation to pinprick, vibration, touch or position;

b. Proximal or distal muscle weakness;

c. Tingling and/or burning pain in the extremities;

d. Signs of dysesthesias; or

e. Loss of tendon reflex.

Plus one or more of the following laboratory findings:

a. Abnormal levels of anti-mag or anti-sulfatide or anti-GM1 antibodies;

b. Abnormal sural nerve biopsy; or

c. Abnormal Electrodiagnostic testing (EMG or Nerve conduction studies, etc).

2. Multiple Sclerosis-like Syndrome

Eligibility for this disease category requires definite evidence of central nervous system disease, with history and physical findings compatible with Multiple Sclerosis or Multiple Sclerosis-like syndrome, involving one or more of the following signs and symptoms:

a. Weakness in the pyramidal distribution

b. Evidence of optic neuritis documented by ophthalmologist

c. Increased Deep Tendon reflexes

d. Absent superficial abdominal reflexes

e. Ataxia or dysdiadochokinesia as the sign of cerebellar involvement

f. Neurologically induced tremors

g. Internuclear ophthalmoplegia and/or bladder or speech involvement secondary to central nervous system disease.

Plus one or more of the following:

a. Abnormal Brain MRI with foci of increased signal abnormality suggestive of demyelinating lesions

b. Delayed visual evoked responses or abnormal evoked potentials

c. Abnormal CSF with oligoclonal bands

3. ALS-like Syndrome.

Eligibility for this disease category requires documented evidence of progressive upper and widespread lower motor neuron disease and/or bulbar involvement.

Plus one or more of the following:

a. Neurological autoantibodies such as anti-mag, anti-sulfatide, anti-GM1;

b. Abnormal sural nerve biopsy;

c. Chronic inflammation on muscle or nerve biopsies;

d. Abnormal EMG; or

e. Documentation on neurological exam of both upper and lower motor neuron disease and/or bulbar involvement.

4. Diseases of Neuromuscular Junction.

Eligibility for this disease category requires a diagnosis of Myasthenia Gravis or Myasthenia Gravis-like syndrome or disorders of the NMJ, made by a board certified neurologist and confirmed by abnormal EMG showing typical findings of decrement on repetitive stimulation testing and/or elevated acetylcholine receptor antibodies.

B. Additional Neuromuscular, Rheumatic or Non-specific symptoms

Any three nonduplicative symptoms or findings set forth in the definition for ACTD.

Compensation Categories

The compensation level for ANDS will be based on the degree to which the claimant is "disabled" by the condition, as the claimants' treating physician determines in accordance with the following guidelines. The determination of disability under these guidelines will be based on the cumulative effect of the symptoms on the claimants' ability to perform her vocational[1], avocational[2], or usual self-care[3] activities. In evaluating the effect of the claimants' symptoms, the treating physicians will take into account the level of pain and fatigue resulting from the symptoms. The

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[1] Vocational means activities associated with work, school, and homemaking.

[2] Avocational means activities associated with recreation and leisure.

[3] Usual self-care means activities associated with dressing, feeding, bathing, grooming, and toileting.

disability percentages appearing below are not intended to be applied with numerical precision, but are, instead, intended to serve as a guideline for the physician in the exercise of his or her professional judgment.

(A) A Claimant will be eligible for category A compensation if she is totally disabled (100% disabled) due to the compensable condition or has died as a result of the compensable condition. A woman shall be deemed 100 percent disabled if she demonstrates a functional capacity adequate to consistently perform only few or none of the usual duties or activities of vocation or self-care.

(B) A claimant will be eligible for category B compensation is she is 35% disabled due to the compensable condition. A woman shall be deemed 35 percent disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her activities of usual occupation, avocation, and self-care, or if she can only perform them with regular or recurring severe pain.

(C) A claimant will be eligible for category C compensation if she is 20% disabled due to the compensable condition. A woman shall be deemed 20 percent disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her usual activities of vocation, avocation, and self-care, or if she can only perform them with regular or recurring moderate pain.

MIXED CONNECTIVE TISSUE DISEASE/OVERLAP SYNDROMES

(1) A diagnosis of MCTD in accordance with the following: the presence of clinical symptoms characteristic of two or more rheumatic diseases (systemic sclerosis, SLE, myositis, and Rheumatoid Arthritis) accompanied by positive RNP Antibodies. See, e.g., Kelley, Table 63-1, at p. 1061.

(2) A Diagnosis of Overlap Syndrome: defined as any one of the following three (a) Diffuse cutaneous scleroderma, (b) limited cutaneous scleroderma, (c) or Sine scleroderma, occurring concomitantly with diagnosis of systemic lupus erythematosus, inflammatory muscle disease, or rheumatoid arthritis. See Kelley, p. 1114, table 66-2.

(3) The application of the above diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of MCTD but who nonetheless have an Overlap Syndrome, except that the parties do not intend that a claimant whose symptomology more closely resembles an atypical connective tissue disease condition/atypical rheumatic syndrome/non-specific autoimmune condition will be compensated in this category.

Compensation Categories

(A) Total Disability or death resulting from MCTD or Overlap Syndrome. An individual will be deemed totally disabled based on the functional capacity test set forth in subcategory A of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome.

(B) MCTD or Overlap Syndrome, plus major organ involvement or major disease activity including central nervous system, cardio-pulmonary, vasculitic, or renal involvement or hemolytic anemia (marked) or thrombocytopenic purpura or severe granulocytopenia.

(C) Other.

POLYMYOSITIS/DERMATOMYOSITIS

(1) A diagnosis of polymyositis or dermatomyositis in accordance with diagnostic criteria proposed by Bohan and Peter, i.e., 1) symmetrical proximal muscle weakness; 2) EMG changes characteristic of myositis including (a) short duration, small, low amplitude polyphasic potential, (b) fibrillation potentials, (c) bizarre high-frequency repetitive discharges; 3) elevated serum muscle enzymes (CPK, aldolase, SGOT, SGPT, and LDH); 4) muscle biopsy showing evidence of necrosis of type I and II muscle fibers, areas of degeneration and regeneration of fibers, phagocytosis, and an interstitial or perivascular inflammatory response; 5) dermatologic features including a lilac (heliotrope), erythematous, scaly involvement of the face, neck, shawl area and extensor surfaces of the knees, elbow and medial malleoli, and Gottron's papules. A diagnosis of dermatomyositis requires presence of three of the criteria plus the rash (fifth criterion). A diagnosis of polymyositis requires the presence of four criteria without the rash. See, Kelley, et al, at 1163.

(2) The application of the above diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of polymyositis or dermatomyositis but who nonetheless have a polymyositis or dermatomyositis-like disease, except that the parties do not intend that a claimant whose symptomology more closely resembles an Atypical Connective Tissue Disease will be compensated in this category.

Compensation categories:

(A) Total Disability or death resulting from polymyositis or dermatomyositis. An individual will be deemed totally disabled based on the functional capacity test set forth in subcategory A of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome.

(B) Polymyositis or dermatomyositis with associated

malignancy and/or respiratory muscle involvement.

(C) Other, including polymyositis or dermatomyositis with muscle strength of Grade III or less.

PRIMARY SJOGREN'S SYNDROME

(1) A clinical diagnosis of Primary Sjogren's Syndrome in accordance with diagnostic criteria proposed by Fox et al. See Kelley, et al. at 932, Table 55-1 or **Fox, RI et al, "Primary Sjogren's Syndrome: Clinical and Immunopathologic features", Seminars Arthritis Rheum., 1984; 4: 77-105.**

(2) The application of the above diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of primary Sjogren's syndrome but who nonetheless have a primary Sjogren's-like disease.

Compensation Categories

A. Total disability or death. An individual will be deemed totally disabled based on the functional capacity test set forth in subcategory A of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome.

B. Primary Sjogren's with associated central nervous system or severe cardio-pulmonary involvement or primary Sjogren's with pseudolymphoma or associated lymphoma.

C. Other.

ATYPICAL CONNECTIVE TISSUE DISEASE/ATYPICAL RHEUMATIC SYNDROME/NON-SPECIFIC AUTOIMMUNE CONDITION

This category will provide compensation for claimants experiencing symptoms that are commonly found in autoimmune or rheumatic diseases but which are not otherwise classified in any of the other compensable disease categories. This category does not include persons who have been diagnosed with classical rheumatoid arthritis in accordance with ACR criteria, but will include patients diagnosed with undifferentiated connective tissue disease. However, such inclusion is not intended to exclude from this category persons who do not meet the definitions of UCTD. It is the intention that such persons not meeting the classic definitions of UCTD will be compensated pursuant to the provisions contained herein relative to ACTD,ARS, and nonspecific autoimmune.

As with other women who fit within this disease compensation program, the fact that a recipient has been in the past mis-diagnosed with classic rheumatoid arthritis or the fact that the symptoms of classic RA may coexist with other symptoms will not

exclude the claimant from compensation herein. Persons who meet the criteria below and may have a diagnosis of atypical rheumatoid arthritis will not be excluded from compensation under this category.

Eligibility criteria and compensation levels for eligible claimants are set forth below in the Compensation Categories, which classify claimants in accordance with the following groups of symptoms.

If the claimant's Qualified Medical Doctor determines that a symptom is clearly and specifically caused by a source other than breast implants, that symptom will not be utilized in the diagnosis of Atypical Connective Tissue Disease/Atypical Rheumatic Syndrome unless the Claims Office determines that other submissions indicate that the symptom should be utilized. A symptom that may be caused only in part by a source other than breast implants is not excluded from such utilization.

Symptom Groupings

Paragraph A:

1. Raynaud's phenomenon evidenced by the patient giving a history of two color changes, or visual evidence of vasospasm, or evidence of digital ulceration.

2. Polyarthritis defined as synovial swelling and tenderness in three or more joints lasting greater than six weeks and observed by a physician.

3. Keratoconjunctivitis Sicca: subjective complaints or dry eyes and/or dry mouth accompanied by one of the following:

   a. lacrimal or salivary enlargement;
   b. parotid enlargement;
   c. abnormal Schirmer test;
   d. abnormal Rose-Bengal staining;
   e. filamentous keratitis;
   f. abnormal parotid scan or ultrasound;
   g. abnormal CT or MRI of parotid; or
   h. abnormal labial salivary biopsy.

Paragraph B:

1. Myalgias determined by tenderness on examination.

2. Immune mediated skin changes or rash as follows:

   a. changes in texture or rashes that may or may

not be characteristic of SLE, Systemic Sclerosis (scleroderma), or dermatomyositis;

b. diffuse petechiae, telangiectasias, or livedo reticularis.

3. Pulmonary symptoms or abnormalities, which may or may not be characteristic of SLE, Systemic Sclerosis (scleroderma), or Sjogren's Syndrome, as follows:

   a. pleural and/or interstitial lung disease;
   b. restrictive lung disease;
   c. obstructive lung disease as evidenced by characteristic clinical findings and either:
      i. characteristic chest X-ray changes or
      ii. characteristic pulmonary function test abnormalities in a non-smoker (e.g. decreased DLCO or abnormal arterial blood gases).

4. Pericarditis defined by consistent clinical findings and either EKG or echocardiogram.

5. Neuropsychiatric symptoms: cognitive dysfunction (memory loss and/or difficulty concentrating) which may be characteristic of SLE or MCTD as determined by a SPECT scan or PET scan or MRI or EEG or neuropsychological testing.

6. Peripheral neuropathy diagnosed by physical examination showing one or more of the following:

   a. loss of sensation to pinprick or vibration or touch or position;
   b. tingling, paresthesias or burning pain in the extremities;
   c. loss of tendon reflex;
   d. proximal or distal muscle weakness (loss of muscle strength in extremities or weakness of ankles, hands, or foot drop);
   e. Signs of dysesthesias; or
   f. entrapment neuropathies

7. Myositis or myopathy:

   a. diagnosed by weakness on physical examination or by muscle strength testing;
   b. abnormal CPK or aldolase;
   c. abnormal cybex testing;
   d. abnormal EMG;
   e. abnormal muscle biopsy.

8. Serologic abnormalities:

   a. ANA > or equal to 1:40 (using Hep2);
   b. positive ANA profile such as Anti-DNA, SSA, SSB, RNP, SM, Scl-70, centromere, Jo-1, PM-Scl or dsDNA (preferable to use ELISA with standard cutoffs);
   c. other autoantibodies, including thyroid antibodies, anti-microsomal, or anti-cardiolipin, or RF (by nephelometry with 40 IU cutoff);
   d. elevation of immunoglobulin (IgG, IgA, IgM); or
   e. serologic evidence of inflammation such as elevated ESR, CRP.

9. Lymphadenopathy (as defined by at least 1 lymph node greater than or equal to 1x1 cm) documented by a physician.

10. Dysphagia with positive cine-esophagram, manometry or equivalent imaging.

Paragraph C:

1. Documented arthralgias

2. Documented Myalgias

3. Chronic fatigue (>6 months)

4. Documented Lymphadenopathy

5. Documented Neurological symptoms including cognitive dysfunction or paresthesias

6. Photosensitivity

7. Documented Sicca symptoms

8. Documented dysphagia

9. Documented Alopecia

10. Documented sustained balance disturbances

11. Documented sleep disturbances

12. Documented easy bruisability or bleeding disorder

13. Documented chronic cystitis or bladder irritability

14. Documented colitis or bowel irritability

15. Persistent Low grade fever or night sweats

16. Mucosal ulcers confirmed by physician

17. Burning pain in the chest, breast, arms or axilla or substantial loss of function in breast due to disfigurement or other complications from implants or explantation.

18. Pathological findings: granulomas or siliconomas or chronic inflammatory response, or breast infections

DIAGNOSTIC CRITERIA:

A diagnosis of this category will be made in accordance with the following criteria:

1. One of the signs or symptoms listed in Paragraph A above and one of Paragraph B; or

2. Three signs or symptoms from Paragraph B; or

3. Two signs or symptoms from Paragraph A; or

4. Two signs or symptoms from Paragraph B plus one non-duplicative sign or symptom from Paragraph C; or

5. A total of five non-duplicative signs or symptoms from any of the Paragraphs A through C.

Compensation Categories

The compensation level for ACTD/ARS will be based on the degree to which the claimant is "disabled" by the condition, as the claimants' treating physician determines in accordance with the following guidelines. The determination of disability under these guidelines will be based on the cumulative effect of the symptoms on the claimants' ability to perform her vocational[4], avocational[5],

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[4] Vocational means activities associated with work, school, and homemaking.

[5] Avocational means activities associated with recreation and leisure.

or usual self-care[6] activities. In evaluating the effect of the claimants' symptoms, the treating physicians will take into account the level of pain and fatigue resulting from the symptoms. The disability percentages appearing below are not intended to be applied with numerical precision, but are, instead, intended to serve as a guideline for the physician in the exercise of his or her professional judgment.

(A) A Claimant will be eligible for category A compensation if she is totally disabled (100% disabled) due to the compensable condition or has died as a result of the compensable condition. A woman shall be deemed 100 percent disabled if she demonstrates a functional capacity adequate to consistently perform only few or none of the usual duties or activities of vocation or self-care.

(B) A claimant will be eligible for category B compensation is she is 35% disabled due to the compensable condition. A woman shall be deemed 35 percent disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her activities of usual occupation, avocation, and self-care, or if she can only perform them with regular or recurring severe pain.

(C) A claimant will be eligible for category C compensation if she is 20% disabled due to the compensable condition. A woman shall be deemed 20 percent disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her usual activities of vocation, avocation, and self-care, or if she can only perform them with regular or recurring moderate pain.

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[6] Usual self-care means activities associated with dressing, feeding, bathing, grooming, and toileting.

EXHIBIT 2

NORTHERN DISTRICT OF ALABAMA
UNITED STATES DISTRICT COURT

Notice of Rights under Breast Implant Litigation

To Settlement Class Members (and others identified as possibly being breast implant recipients[1]):

Enclosed for your attention and consideration are:

• a Notice (white) describing the status of the previously approved global settlement; the terms of a revised "claims-made" settlement program being offered to certain breast implant recipients by Bristol, Baxter, 3M, McGhan, and Union Carbide; your options, if eligible, to accept or reject the revised settlement; your options to remain in, exclude yourself from, or possibly rejoin the "Lindsey" class; and the status of claims against Mentor, Bioplasty, and Dow Corning.

• a "Question and Answer" Booklet (pink), answering questions frequently asked by implant recipients.

• four Forms:

(1)an Election Form (white), to be used by all breast implant recipients to elect, at least initially, among various options. (May also be used as a Registration Form by eligible implant recipients who have not previously registered with the Claims Office or as an election to rejoin the class by eligible recipients who previously opted out of the global settlement.)

(2)a Proof of Manufacturer Form (blue), to be used (with the Election Form) if you may be eligible and may want to participate in the revised settlement.

(3)an Explantation Claim Form (yellow), to be used (with the Election and Proof of Manufacturer forms) if you may be eligible and may want to participate in the revised settlement and if you have a Bristol, Baxter, or 3M implant removed after April 1, 1994.

(4)a Rupture Claim Form (green), to be used (with the Election and Proof of Manufacturer forms) if you may be eligible and may want to participate in the revised settlement, have previously filed a Current Disease Compensation Claim under the global settlement, and can prove by December 16, 1996, the rupture of a silicone-gel Bristol, Baxter, or 3M implant.

• a Synopsis (manila), briefly describing the revised settlement, highlighting important dates, and explaining the Forms. I urge you, however, to consult the Notice and the Question and Answer Booklet for more detailed information concerning your rights and options.

Before returning any forms, you should carefully read the attached Notice. If you have an attorney, you

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1. This Notice is being sent not only to all persons who have registered with the Claims Office, but also to all others who have provided the Claims Office or the Court with their names and addresses. It is also being sent to those who have previously opted out of the Lindsey class since some of them may want at this time to rejoin the class to participate in the revised settlement.

should consult with that attorney about your rights and options. If you do not have an attorney, you can call 513-651-9770 to request legal advice. To learn about regional informational meetings, call 800-938-7357. The Claims Office, at 800-600-0311 (toll-free in U.S.) or 713-951-9106, can answer questions about the forms and general processing information, but cannot provide legal advice. Save these materials (as well as a copy of any form you return) for future reference.

Sam C. Pointer, Jr.
Chief Judge

EXHIBIT 3

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
Southern Division

HEIDI LINDSEY, et al., Plaintiffs;	)	
-vs-	)	No. CV 94-11558-S
DOW CORNING CORPORATION, et al., Defendants.	)	

Order 27L
(Referral of Claimant Appeals)

In Paragraph 34 of the Notice of the Revised Settlement Program ("RSP"), the court provided that claimants who were dissatisfied with a decision made by the Claims Officers could appeal to the Claims Administrator and, if still dissatisfied, could seek a further review, on the basis of the record evidence, by the court or by some other person designated by the court to conduct such review. Over the past year, the court has received numerous such appeals from the Claims Administrator's decisions. While many of these appeals have involved relatively straightforward questions concerning compliance with the deadlines or other requirements of the RSP, other appeals have required detailed review of claim files containing voluminous medical records. Due to the number of these appeals and the other demands on the court's time, claimants unfortunately have often waited several months for this review.

After consultation with Plaintiffs Liaison Counsel and Steering Committee, and consistent with the provisions of the RSP Notice, the court has decided to appoint the Honorable Frank Andrews to serve as the court's designee for purposes of deciding all appeals from the decisions of the Claims Administrator. The court anticipates that the referral of claimant appeals to Judge Andrews will result in more prompt determination of such appeals.

This court hereby appoints the Honorable Frank Andrews to decide all appeals from the decisions of the Claims Administrator, effective May 13, 1998.[1/] Judge Andrews may exercise the same degree of equitable discretion on such matters as timeliness of filings and other similar administrative questions as has been exercised by the court in conducting such reviews. Judge Andrews' decisions will be final; no appeals or reviews will be permitted from such decisions.

1. This court will retain and rule upon all administrative appeals submitted to the court prior to May 13, 1998.

Inquiries concerning the status of any appeals submitted for ruling on or after that date should be addressed to Judge Andrews in Dallas, Texas, at (214)956-0050.

This the 19th day of May, 1998.

/s/ Sam C. Pointer, Jr.
Chief Judge Sam C. Pointer, Jr.

Service List:
Ms. Ann Cochran, Claims Administrator
Plaintiffs Liaison Counsel
Defendants Liaison Counsel

EXHIBIT 4

3. Photocopies of the certificate for certified medical records are acceptable. The original certificate and original records do not have to be submitted as long as a photocopy is submitted.

F. ***Acceptable Forms of Proof Based on Explantation.*** Specified unique identifiers of Dow Corning Small Joint Orthopedic Implants and Large Joint Orthopedic Implants shall be considered acceptable proof when demonstrated as specified at paragraphs (a), (b), and (c) below.

(a) Medical records of the explanting physician, created at or within 30 days of the time of explantation, that describe a Unique Identifier from Section C of this Schedule I, Part II of a Dow Corning Large Joint Orthopedic Implant or Small Joint Orthopedic Implant product.

(b) A photograph of an explanted implant depicting one of the Unique Identifiers of a Dow Corning Large Joint Orthopedic Implant or Small Joint Orthopedic Implant as set forth at Schedule I, Part II, Section C. The photograph must be accompanied by a statement from the explanting physician identifying the implant in the photograph as one (s)he removed from the claimant. The photograph must also be accompanied by statement advising of whether this implant has been preserved. The Claims Administrator may require the presentation of a removed implant if preserved.

(c) The implant, if preserved, along with the identity and location of the custodian of the implant. The Claims Administrator may require the presentation of the removed implant(s) for examination by an individual or entity designated by the Claims Administrator.

G. ***Unacceptable Proof.*** Only proof specifically described herein as acceptable proof or proof expressly agreed to by Dow Corning in a writing provided to the Claims Office will be sufficient to establish Proof of Manufacturer of a Dow Corning Other Product. Any other proof will be deemed unacceptable proof of a Dow Corning implant. The following are examples of unacceptable proof:

(a) A Claimant's own recollection (or that of a friend or relative) regarding the brand name or manufacturer of his/her implants.

(b) Records from the International Implant Registry.

(c) Records from the explanting surgeon attempting to supply the acceptable proof at Section C above if identifiers not on the list of unique identifiers are the basis of the identification, or the physician fails to specify the characteristics assumed to be unique, or the physician merely opines, based on his or her experience, that the prosthesis was made by a certain manufacturer.

(d) A non-contemporaneous statement by the implanting physician qualifying the statement concerning the type of implant used in a particular patient by phrases like "if I remember correctly" or "to the best of my memory." Statements from physicians describing their typical or general practices concerning implant usage during a given time period will be unacceptable proof (for example, a statement that "we usually used Dow Corning implants").

(e) A non-contemporaneous statement by the implanting physician, attempting to provide the acceptable proof set forth in Section D (e), above, that does not name the Claimant as a person receiving a particular type or brand of implant will be treated as unacceptable proof.

(f) Records indicating the brand or manufacturer of implants the surgeon planned to use, without confirmation from the implanting physician (or in records relating to the implant surgery) that type of implant was actually used.

(g) The mere use of the word "Silastic" without capitalization of the first letter and other indications of a Dow Corning product shall be unacceptable proof that a Dow Corning product was used in the Claimant.

(h) Records containing the catalog number, lot number, brand name, dimensions, chemical make-up and unique identifiers consistent with a non-Dow Corning implant.

H. ***Cooperation.*** Dow Corning will assist the Claims Office including the staff of the Claims Office by providing a list of lot numbers, catalog numbers and any other identifying information about Dow Corning Other Products.

PART III. Silicone Material Claimants

A. ***Brand/Manufacturer Names.*** For purposes solely of the Settlement Program for Silicone Material Claimants, the brand/manufacturer names listed at Exhibit G to the Revised Settlement Program (as reproduced at Section C. below) and Exhibit G2 to the Foreign Revised Settlement Program (as reproduced at Section D. below) as attributable to Baxter, Bristol, Cox-Uphoff, Mentor or Bioplasty shall identify a breast implant product covered under the Silicone Material Claimant Settlement Program if the Claimant submits acceptable Proof of Manufacturer as defined at Section B below.

B. ***Acceptable Proof.*** The types of proof defined as acceptable under the Revised Settlement Program along with the unique identifiers specified in the Revised Settlement Program for breast implants manufactured by the entities listed at Section A above shall be acceptable Proof of Manufacturer for purposes of the Silicone Material Claimant Settlement Program. The types of proof identified as unacceptable proof under the Revised Settlement Program for such manufacturers shall be deemed as unacceptable proof for purposes of the Silicone Material Claimant Settlement Option.

C. *EXHIBIT G -- Implant Brands and Manufacturers.*

(Adjusted to include only those identified as Baxter, Bristol, Cox-Uphoff (CUI), Mentor, or Bioplasty. (3M is identified solely for purposes of Section 6.02(d)(v).))

The left-hand column is a list of companies, implant brands, "designer" implant names, and other names or phrases that might be used in medical records to describe a particular type of breast implant. The column to the right identifies the company with which that brand is associated for purposes of the Revised Settlement Program. If implantation date ranges are supplied for an implant, an appropriate notation is to the right of each date range.

Implants noted as Mentor that have a star (*) before Mentor will be treated as Baxter implants if a Baxter lot number can be supplied for that implant.

Brand/Manufacturer Name	Status in Revised Program
3M	3M
AHS	Baxter
Aesthetech	Bristol
American Heyer-Schulte	Baxter
American Hospital Supply	Baxter
Ashley Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Baxter	Baxter
Becker	Mentor
Biomanufacturing	Bioplasty
Bio-oncotic	Bioplasty
Bioplasty	Bioplasty
Birnbaum	Baxter
Capozzi Implanted before 9/1/71 Implanted after 8/31/71	 Bristol Baxter
Cavon	Bristol
CBI Medical	Bristol
Cooper Surgical	Bristol
Corbet	Bristol
Cox Uphoff	CUI
CZV/CRS (Croissant Versafil Low Profile)	CUI
Dahl	Bristol
Directa Span	Mentor
DRI	CUI
DRIE	CUI
Edward Laboratories	Baxter
EHP (Enhanced High Profile)	CUI
Edward Weck & Co. Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Flat Span	Mentor
FZV/SFV (Round Versafil LP Tissue Expander)	CUI
Georgiade	Bristol
Gibney	CUI

Guthrie Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Hartley	Baxter
Heyer-Schulte Implanted before 3/31/84 Implanted after 3/30/84	 Baxter *Mentor
Heyer-Schulte Mentor	Mentor
Intrashiel Implanted before 8/3/84	 3M
Intravent	CUI
IOC (Cylindrical Intraoperative Tissue Expander)	CUI
IOM (Intravent Intraoperative Expander)	CUI
IOS (Spherical Intraoperative Tissue Expander)	CUI
Isle	Mentor
Jenny	Baxter
Jobe	Baxter
Klein	Bioplasty
Mammatech	Bioplasty
Mark/M Surgical Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Markham Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Markham Medical Int'l Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
McGhan Implanted before 8/3/84	 3M
MEC	Bristol
Medical Engineering Corporation	Bristol
Meme	Bristol
Meme ME	Bristol
Meme MP	Bristol
Mentor	Mentor
MFE (Man Facelift Expander)	CUI
Microcell	CUI
Misty	Bioplasty
Misty Gold	Bioplasty
Mueller, V. Implanted 11/1/78 to 3/30/84	 Baxter

Munna	Bristol
Natrashiel	3M
Natural Y Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Norman	Bristol
OHP (Oval High Profile)	CUI
OLP (Oval Low Profile)	CUI
Optimam	Bristol
Pangman	Baxter
Papillon	Bristol
Perras	Bristol
Perras-Papillon	Bristol
Polyurethane Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Poly Plastic Implanted before 9/1/71 Implanted after 8/31/71	 Bristol Baxter
Poly Plastic Adjustable	Baxter
Quin-Seal	Bristol
Radovan	Mentor
RCP (Round Conical Profile)	CUI
RCR (Ruiz-Cohen Expanders)	CUI
RDD (Reverse Double Lumen DRIE)	CUI
RDL (Reverse Double Lumen)	CUI
RDL-XPAND	CUI
RDX (Round Double Lumen)	CUI
Replicon	Bristol
Reverse Double Lumen	CUI
RHD (Round High Profile)	CUI
RHP (Round High Profile)	CUI
RLD (Round Low Profile DRIE)	CUI
RLP (Round Low Profile)	CUI
Roger Klein	Bioplasty
RTV/RTT (Smooth/Textured)	CUI
Ruiz-Cohen	CUI
RZV/SRV (Rectangular Versafil Tissue Expander)	CUI
SCC (Cylindrical Tissue Expander)	CUI
SCL	Bristol

SCS (Crescent Tissue Expander)	CUI
SEE (Mini-crescent Tissue Expander)	CUI
Seropian	Baxter
SFS (Saline Fill Skin and Tissue Expander)	CUI
SGO (Saline Gel Oval)	CUI
SGR (Saline Gel Round)	CUI
Siltex	Mentor
Siltex Becker	Mentor
Siltex Spectrum	Mentor
SLP (Single Lumen Adjustable)	CUI
SLS (Longitudinally Curved Tissue Expander)	CUI
Snyder	Bristol
SOE (Small Oval Tissue Expander)	CUI
SOS (Ear Shaped Tissue Expander)	CUI
Spectrum	Mentor
SPS (Pear Shaped Tissue Expander)	CUI
SRS (Rectangular Tissue Expander)	CUI
SSS (Spherical Tissue Expander)	CUI
Sterling	Baxter
Summit Medical	Bristol
Surgical Specialties	Bristol
Surgitek	Bristol
SWS (Wedge Shaped Tissue Expander)	CUI
SZR (Round Low Profile Sizer)	CUI
Tabari	Baxter
Tecknar	Mentor
TLL (Triple Lumen Round)	CUI
Travenol	Baxter
Tri-Lumen	CUI
TRL (Tri-Lumen Implants)	CUI
TSO (Triple Lumen Low Profile Oval)	CUI
TSR (Triple Lumen Round Low Profile)	CUI
Uroplasty	Bioplasty
Versafil	CUI
V. Mueller Implanted 11/1/78 to 3/30/84	Baxter
Vogue	Bristol
Wagner	Baxter
Webster	Bristol

Weck Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	 Bristol Baxter Bristol
Williams	Baxter
Wood	Bristol

D. *EXHIBIT G2--Implant Brands and Manufacturers.*

(Adjusted to include only those identified as Baxter, Bristol, Cox-Uphoff (CUI), Mentor, or Bioplasty. (3M is identified solely for purposes of Section 6.02(d)(v).))

The left-hand column is a list of companies, implant brands, "designer" implant names, and other names or phrases that might be used in medical records to describe a particular type of breast implant. The column to the right identifies the company with which that brand is associated for purposes of the Foreign Settlement Program ("FSP"). If implantation date ranges are supplied for an implant, an appropriate notation is to the right of each date range.

BRAND/MANUFACTURER NAME	STATUS IN FOREIGN SETTLEMENT PROGRAM
3M	3M
AHS	Baxter
Aesthetech	Bristol
American Heyer-Schulte	Baxter
American Hospital Supply	Baxter
Ashley Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Baxter	Baxter
Birnbaum	Baxter
Capozzi Implanted before 9/1/71 Implanted after 8/31/71	Bristol Baxter
Cavon	Bristol
CBI Medical	Bristol
Cooper Surgical	Bristol
Corbet	Bristol
Dahl	Bristol
Edward Laboratories	Baxter
Edward Weck & Co. Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Georgiade	Bristol
Guthrie Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol

Hartley	Baxter
Heyer-Schulte Implanted before 3/31/84 Implanted after 3/30/84	Baxter Generally not covered; may be Baxter on special proof--see explanation following table
Intrashiel Implanted before 8/3/84 Implanted after 8/2/84	3M Generally not covered; may be 3M on special proof--see explanation following table
Jenny	Baxter
Jobe	Baxter
Mark/M Surgical Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Markham Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Markham Medical Int'l Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
McGhan Implanted before 8/3/84 Implanted after 8/2/84	3M Generally not covered; may be 3M on special proof--see explanation following table
MEC	Bristol
Medical Engineering Corporation	Bristol
Meme	Bristol
Meme ME	Bristol
Meme MP	Bristol
Mueller Implanted 9/1/74 to 10/31/78	Baxter
Munna	Bristol
Natrashiel	3M
Natural Y Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Norman	Bristol
Optimam	Bristol
Pangman	Baxter
Papillon	Bristol
Perras	Bristol
Perras-Papillon	Bristol
Polyurethane Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol

Poly Plastic Implanted before 9/1/71 Implanted after 8/31/71	Bristol Baxter
Poly Plastic Adjustable	Baxter
Quin-Seal	Bristol
Replicon	Bristol
SCL	Bristol
Seropian	Baxter
Snyder	Bristol
Sterling	Baxter
Summit Medical	Bristol
Surgical Specialities	Bristol
Surgitek	Bristol
Tabari	Baxter
Travenol	Baxter
V. Mueller Implanted 9/1/74 to 10/31/78	Baxter
Vogue	Bristol
Waguer	Baxter
Webster	Bristol
Weck Implanted before 9/1/71 Implanted 9/1/71 to 12/8/78 Implanted after 12/8/78	Bristol Baxter Bristol
Williams	Baxter
Wood	Bristol

SCHEDULE II
MEDICAL CONDITIONS AND CHARACTERISTICS
OUTLINE OF DEFINITIONS AND CLASSIFICATION CRITERIA

PART A. DISEASE AND DISABILITY/SEVERITY DEFINITIONS: DISEASE PAYMENT OPTION 1

GENERAL GUIDELINES

The following are general guidelines, which are adopted from and are intended to be applied consistently with the Revised Settlement Program and interpretations thereof, to be used in the submission and evaluation of a Claim for compensation under Disease Payment Option I:

There are two ways to document a claim for Disease Payment Option I compensation: (a) a Claimant can provide a statement or diagnosis from a physician Board-certified in an appropriate specialty, together with the medical records upon which that statement or diagnosis is based or (b) a Claimant can provide the medical records that, themselves, will enable the Claims Office to place the Claimant on the Disease Payment Option I Schedule.

A Claimant should submit all records that contain information relevant to the criteria for Disease Payment Option I, including (1) records relating to the relevant signs, symptoms, findings and test results set forth in Disease Payment Option 1 and (2) records showing the severity of a Claimant's disease or, if applicable, a determination of disability level by either a Qualified Medical Doctor or the Claimant's treating physician. In general, whatever the physician relied upon in arriving at the diagnosis and findings in the statement or diagnosis should be provided. Typically, this might include a patient questionnaire, physical findings obtained from an assistant's notes in the office chart, and certain lab or other test reports. If the doctor needed to review earlier medical records obtained from other physicians to make a definitive statement about the Claimant's condition or disability, then those records must also, if available, be submitted. If, however, based on an examination of the Claimant, the physician has first-hand knowledge of everything that is the basis for his or her opinion, and the statement or diagnosis sets out that knowledge in sufficient detail, it is possible that no additional records will be required.

As used herein, the term "Qualified Medical Doctor" or "QMD" means a physician who is Board-certified (not Board-eligible) in internal medicine, rheumatology (a sub-specialty of internal medicine), neurology, neurological surgery, or immunology who prepares the statement or diagnosis that the Claimant must file in support of a Disease Payment Option I Claim. Only a Board-certified physician can submit the statement or diagnosis of one of the compensable diseases included in Disease Payment Option I. The physician writing a statement or diagnosis of one of the compensable diseases in Disease Payment Option I must be Board-certified in an appropriate specialty. The type of specialty depends on the complaints and symptoms with which a Claimant presents. "Board-certified" means certification in a particular medical specialty by the American Board of Medical Specialists. A Doctor of Osteopathy can be a Qualified Medical Doctor if he or she is Board-certified by the same Board that certifies Medical Doctors. A Doctor of Osteopathy may also submit diagnoses or disease compensation claims so long as his or her certification is within an appropriate specialty.

The Claims Office is authorized to determine whether physicians in other countries have degrees or certifications that are the equivalent of those accorded in the United States and should therefore be treated as Qualified Medical Doctors. The Claims Office shall determine which certification systems of foreign countries are the equivalent of U.S. Board certification using the procedures applied by the MDL 926 Claims Administrator in the Foreign Settlement Program. The Plan Proponents or the Claimants' Advisory Committee and Debtor's Representatives shall specify the categories, degrees or certification of doctors that will qualify as Qualified Medical Doctors in Class 6.2 countries.

As used herein, the term "treating physician" is one who has seen, examined, and treated the Claimant on several occasions, and not a doctor whom the Claimant has seen only for purposes of getting an evaluation to make a claim under this Disease Payment Option. Treating physician includes a Qualified Medical Doctor if such Qualified Medical Doctor states that he or she has the information necessary to form a professional opinion about the Claimant's disability and sets forth in the statement or diagnosis (or in a supplemental statement) the information upon which that opinion is based and the source of that information.

As used herein, the term "documented" means that it is based on some reliable information other than simply the Claimant's complaint or oral history. For some symptoms, "documented" means that the physician has verified the symptom on physical examination or through a lab test. For others, primarily those that are entirely subjective, it can mean that the physician has performed a physical examination and questioned the Claimant sufficiently to be able to form a professional opinion, utilizing all that doctor's knowledge and training, that the complaint is a valid one. (In this situation, it is important that the physician relying on these complaints does not qualify the diagnosis by stating that these "findings" are based solely on the patient's history given at the time of the single visit to the Board-certified specialist. The physician needs to feel confident in concluding that the problems do indeed exist.) "Documented" can also mean that written notations of that symptom are found several places in the Claimant's medical records. Thus, to show that a symptom is "documented," a Claimant can submit (1) proof of verification of the symptom through physical examination; (2) a statement from the Claimant's QMD revealing that (s)he questioned the Claimant sufficiently about the symptom and concluded that the complaint is valid; or (3) medical records reflecting that the Claimant had complained about this symptom on other occasions.

To the extent the severity of a Claimant's disease is based on a disability rating, as defined herein, the Claimant must submit all of the records that the physician relied upon in making his or her disability determination. This would include, as an example, any disability questionnaire that the Claimant completed in order to assist in the physician's determination. A non-Board-certified treating physician can provide a disability determination.

In preparing submissions for Disease and Disability Option 1 and in curing any deficiencies that may be noted when the submission is processed, Claimants and their physicians (and their counsel if applicable) should be aware that the disability must be related to the compensable condition. That is, the pain must be due to the Claimant's Atypical Connective Tissue Disease or Atypical Neurological Disease. Thus, a threshold requirement in evaluating a disability submission is whether the Claimant's qualifying symptoms are ones such as alopecia, chronic fatigue, or loss of breast function that normally have no pain component. A disability determination cannot be approved unless there is evidence that the Claimant is experiencing pain from at least one of her qualifying symptoms or unless the Claimant, in response to a deficiency

determination, supplies evidence that she has an additional qualifying symptom that does cause pain. In addition, Claimants and their physicians (and their counsel if applicable) should be aware that a "C" level disability requires that the pain be "regular or recurring." Thus, if a Claimant's pain is described in her records as being only "mild" or "slight," the disability determination will not be approved.

With respect to a claim for a "B" level disability, the claim must be based on severe pain or an inability to do certain activities. In order to qualify, there must be pain-producing symptoms that result in severe pain on a regular or recurring basis. Generalized statements about "severe pain" may not be enough. The Claims Office must be able to verify that the Atypical Connective Tissue Disease or Atypical Neurological Disease symptoms themselves are the cause of the severe pain. If the "B" level disability claim is based on limitations on a Claimant's activities, the claim submission must provide information concerning the activities that are limited. A conclusory statement, with no information about the Claimant and her limitations, will result in a deficiency being assigned. The disability assessment must demonstrate a connection between the specific activities that the Claimant can no longer perform. The disability must be due to the compensable condition. The Claims Office must have enough information about what the limitations are and the cause of those limitations to be able to verify that the Claimant's condition indeed meets the requirements for a "B" disability level.

In preparing a claim for an "A" level disability, Claimant's and their physicians (and their counsel, if applicable) should be aware that the definition of this assigned disability level is a difficult one to meet. A Claimant must be unable to do any of her normal activities or only be able to do a very few of them. In preparing a submission, it should be reviewed to determine whether there is enough description of the Claimant's daily life and limitations to allow a reader to know that she does indeed meet this strict definition of total disability. In addition, it must be clear that the Claimant's total disability is due to the symptoms of the applicable disease or condition.

Generalized statements by the QMD that track the disease and disability language cannot replace the responsibility of the Claims Office to review, on a detailed level, all of the claim documentation provided.

If the Breast Implant Claimant's Qualified Medical Doctor determines that her death or total disability is clearly and specifically caused by a disease or occurrence other than the compensable disease, she will not be eligible for compensation in Severity/Disability Category A.

DISEASE PAYMENT OPTION I: DEFINITION OF COVERED CONDITIONS

SYSTEMIC SCLEROSIS/SCLERODERMA (SS)

1. A diagnosis of systemic sclerosis shall be made in accordance with the criteria established in Kelley, et al., Textbook of Rheumatology (4th ed.) at 1113, et seq.

2. Application of these diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of classical systemic sclerosis but who nonetheless have a systemic sclerosis-like (scleroderma-like) disease, except that an individual will not be compensated in this

category if her symptomology more closely resembles MCTD, ACTD, or any other disease or condition defined below. A "systemic sclerosis-like" or "scleroderma-like" disease is defined as an autoimmune/rheumatic disease that fulfills most of the accepted standards for the diagnosis of systemic sclerosis but is in some manner atypical of systemic sclerosis or scleroderma.

3. Severity/Disability Compensation Categories

A. Death or total disability resulting from SS or an SS-like condition. An individual will be considered totally disabled if the individual satisfies the functional capacity test set forth in Severity/Disability Category A for ACTD/ARS/NAC or if the individual suffers from systemic sclerosis with associated severe renal involvement manifested by a decrease in glomerular filtration rates.

B. Cardio-pulmonary involvement or diffuse (Type III) scleroderma as defined by Barnett, A Survival Study of Patients with Scleroderma Diagnosed Over 30 Years (1953 - 1983): The Value of a Simple Cutaneous Classification in the Early Stages of the Disease, 15 The Journal of Rheumatology 276 (1988) and Masi, Classification of Systemic Sclerosis (Scleroderma): Relationship of Cutaneous Subgroups in Early Disease to Outcome and Serologic Reactivity, 15 The Journal of Rheumatology, 894 (1988).

C. Other including CREST, limited, or intermediate scleroderma, except that any Breast Implant Claimant who manifests either severe renal involvement, as defined above, or cardio-pulmonary involvement, will be compensated at either category A or B as appropriate.

D. Other not covered above, including localized scleroderma.

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

1. A diagnosis of systemic lupus erythematosus (SLE) shall be made in accordance with 1982 Revised Criteria for the Classification of Systemic Lupus Erythematosus, 25 Arthritis and Rheumatism No. 11 (November 1982) adopted by the American College of Rheumatology. See Kelley, 4th ed. at 1037, Table 61-11: A diagnosis of lupus is made if four of the eleven manifestations listed in the table were present, either serially or simultaneously, during any interval of observations.

CRITERION	DEFINITION
Malar rash	Fixed erythema, flat or raised, over the malar eminences, tending to spare the nasolabial folds
Discoid rash	Erythematous raised patches with adherent keratotic scaling and follicular plugging; atrophic scarring may occur in older lesions
Photosensitivity	Skin rash as a result of unusual reaction to sunlight, by patient history or physician observation

Oral ulcers	Oral or nasopharyngeal ulceration, usually painless, observed by a physician
Arthritis	Nonerosive arthritis involving two or more peripheral joints, characterized by tenderness, swelling or effusion
Serositis	(a) Pleuritis — convincing history of pleuritic pain or rub heard by a physician or evidence of pleural effusion or (b) Pericarditis — documented by ECG or rub or evidence of pericardial effusion
Renal disorder	(a) Persistent proteinuria greater than 0.5 g/day or greater than 3 + if quantitation not performed or (b) Cellular casts - may be red cell, hemoglobin, granular, tubular, or mixed
Neurologic disorder	(a) Seizures - in the absence of offending drugs or known metabolic derangements; e.g., uremia, ketoacidosis, or electrolyte imbalance or (b) Psychosis - in the absence of offending drugs or known metabolic derangements; e.g. uremia, ketoacidosis, or electrolyte imbalance
Hematologic disorder	(a) Hemolytic anemia - with reticulocytosis or (b) Leukopenia - less than 4000/mm total on 2 or more occasions or (c) Lymphopenia - less than 1500/mm on 2 or more occasions or (d) Thrombocytopenia - less than 100,000/mm in the absence of offending drugs
Immunologic disorder	(a) Positive LE cell preparation or (b) Anti-DNA - antibody to native DNA in abnormal titer or (c) Anti-Sm - presence of antibody to Sm nuclear antigen or (d) False positive serologic test for syphilis known to be positive for at least 6 months and confirmed by Treponema pallidum immobilization or fluorescent treponemal antibody absorption test
Antinuclear antibody	An abnormal titer of antinuclear antibody by immunofluorescence or an equivalent assay at any point in time and in the absence of drugs known to be associated with drug-induced lupus syndrome

2. The application of the ACR diagnostic criteria is not intended to exclude from the compensation program individuals who present clinical symptoms or laboratory findings atypical of SLE but who nonetheless have a systemic lupus erythematosus-like disease, except that an individual will not be compensated in this category if her symptomology more closely resembles mixed connective tissue disease (MCTD), ACTD, or any other disease or condition defined below.

3. Severity/Disability Compensation Categories:

A. Death or total disability resulting from SLE or an SLE-like condition. An individual will be considered totally disabled based on either the functional capacity test set forth in Severity/Disability Category A for ACTD/ARS/NAC or severe renal involvement.

B. SLE with major organ involvement defined as SLE with one or more of the following: glomerulonephritis, central nervous system involvement (i.e. seizures or Lupus Psychosis), myocarditis, pneumonitis, thrombocytopenic purpura, hemolytic anemia

(marked), severe granulocytopenia, mesenteric vasculitis. See Immunological Diseases, Max Samter, Ed. Table 56-6, at 1352.

C. Non-major organ SLE requiring regular medical attention, including doctor visits and regular prescription medications. An individual is not excluded from this category for whom prescription medications are recommended but who, because of the side effects of those medications, chooses not to take them.

D. Non-major organ SLE requiring little or no treatment. An individual will fall into this category if she is able to control her symptoms through the following kinds of conservative measures: over-the-counter medications, avoiding sun exposure, use of lotions for skin rashes, and increased rest periods.

ATYPICAL NEUROLOGICAL DISEASE SYNDROME (ANDS)

1. A diagnosis of Atypical Neurological Disease Syndrome (ANDS) shall be based upon the clinical findings and laboratory tests set forth below. The clinical and laboratory presentation of these neurological syndromes will have an atypical presentation from the natural disease and will also have additional neuromuscular, rheumatological or nonspecific autoimmune signs and symptoms.

2. Eligibility for Atypical Neurological Disease Syndrome requires both:

   •• satisfying the requirements for one of the four neurological diseases set forth in paragraph 5 below, and

   •• any three additional (nonduplicative) neuromuscular, rheumatic, or nonspecific symptoms or findings set forth in the definition for Atypical Connective Tissue Disease (ACTD).

3. An individual will fit into this category if her primary symptoms are characteristic of a neurological disease as diagnosed by a Board-certified neurologist or by a physician Board-certified in internal medicine.

4. If the individual's Qualified Medical Doctor determines that a symptom is clearly and specifically caused by a source other than breast implants, that symptom will not be utilized in the diagnosis of Atypical Neurological Disease Syndrome unless the Claims Office determines that other submissions indicate that the symptom should be utilized. A symptom that may be caused only in part by a source other than breast implants is not excluded from such utilization.

5. Neurological disease types:

   Polyneuropathies. This disease category requires either (1) a diagnosis of a polyneuropathy that is confirmed by one or more of the following or (2) submission of sufficient evidence of, and the required findings confirming, such condition:

   •• Objectively-demonstrated loss of sensation to pinprick, vibration, touch, or position

EXHIBIT 5

DISEASE CLAIMANT INFORMATION GUIDE

DOW CORNING BREAST IMPLANT CLAIMANTS
(CLASS 5)

DISEASE CLAIMANT INFORMATION GUIDE
DOW CORNING BREAST IMPLANT CLAIMANTS
(CLASS 5)

A note about the use of capitalized terms in this Claimant Information Guide:

When you see capitalized terms that are not otherwise defined, they have the meaning assigned to them in the following documents in the following order:

1. Amended Joint Plan
2. Amended Disclosure Statement
3. Dow Corning Settlement Program and Claims Resolution Procedures
4. Funding Payment Agreement
5. DCC Litigation Facility, Inc. Agreement (this document and the preceding ones in this list are collectively referred to as the "Plan Documents")
6. Bankruptcy Code

Contact us at:

Settlement Facility-Dow Corning Trust
P.O. Box 52429
Houston, Texas 77052
(Toll Free) 1-866-874-6099

www.dcsettlement.com

December 2002

Q1-9. What are the criteria for a disability statement for ANDS or ACTD in Disease Option 1?

The payment amounts for ANDS and ACTD are based on the degree to which you are "disabled" by the condition in question, as determined by your treating physician or "Qualified Medical Doctor" (QMD) in accordance with the following guidelines. *(Read Q4-3 for a definition of a treating physician and Q4-4 for a definition of a QMD.)*

1. The determination of disability will be based on the cumulative effect of the symptoms on the claimant's ability to perform her vocational, avocational, or usual self-care activities.

2. Vocational means activities associated with work, school and homemaking.

3. Avocational means activities associated with recreation and leisure.

4. Usual self-care means activities associated with dressing, feeding, bathing, grooming, and toileting.

5. In evaluating the effect of your symptoms, the treating physician or QMD must take into account the level of pain and fatigue resulting from the symptoms.

6. The disability percentages for Levels "A," "B," and "C" *(described at Q1-10 through Q1-12)* are not intended to be applied with numerical precision, but are, instead, intended to serve as a guideline for the treating physician or QMD in the exercise of his or her professional judgment.

Q1-10. What is the definition of Level "A" disability for ANDS and ACTD in Disease Option 1?

Read the criteria for ANDS and ACTD disability level "A" at Tab 1.

You are eligible for Level "A" disability for death or total disability resulting from your compensable disease or condition. You will be considered totally disabled if you demonstrate a functional capacity adequate to consistently perform none or only a few of your usual duties or activities of vocation or self-care.

In preparing a claim for a Level "A" disability, be aware that the definition of this assigned disability level is a difficult one to meet. You must be unable to do any of your normal activities or only able to do very few of them. Disability Level "A" claims will be reviewed to determine if there is a sufficient description of your daily life and limitations to determine that you meet this strict definition of total disability. It must also be clear in your submission that your total disability is due to the symptoms of your disease or condition and not to other medical conditions or injuries.

If your QMD determines that the death or total disability is clearly and specifically caused by a disease or occurrence other than the compensable disease or condition, the Level "A" disability determination will not be approved.

SECTION 3 – HOW TO APPLY FOR A DISEASE PAYMENT

Q3-1. Do I have to choose between Disease Option 1 and Disease Option 2 when I apply for a Disease Payment?

No. Simply check the box on the Claim Form indicating the disease or condition that you want to be evaluated for and submit supporting medical records for that disease or condition and a related disability or severity level.

Q3-2. If I receive a Disease Option 1 Payment, can I later receive payment for one (1) of the diseases or conditions in Disease Option 2?

No.

Q3-3. My disease is not on the list of eligible diseases or conditions in either Disease Option 1 or Disease Option 2. Can I still apply for a Disease Payment?

No. Not every disease or medical condition is covered by the Disease Option. If you do not have one (1) of the eligible diseases or conditions, then you cannot receive payment for your disease or condition.

Q3-4. I was diagnosed with Fibromyalgia. I don't see this on the list of eligible diseases or conditions in either Disease Option 1 or Disease Option 2. Can I still apply for a Disease Payment?

Fibromyalgia is not an eligible disease, so you cannot receive payment based solely on this diagnosis. Many - if not most - of the symptoms of Fibromyalgia though are listed in the criteria for Atypical Connective Tissue Disease (ACTD).

Q3-5. Can I rely on the medical records that I sent to the MDL Claims Office in Houston years ago, or do I have to resend these documents to the Settlement Facility?

You can rely on the records that you submitted to the MDL Claims Office in Houston, Texas. You do not have to re-submit any records.

Q3-6. I submitted medical records to the MDL Claims Office in 1994. Since that time, my condition has changed and I have new and additional records. Can I send those in and have them considered by the Settlement Facility?

Yes.

Q3-7. Can I get a copy of the medical records and documents that I submit to the Settlement Facility?

Keep a copy of the Claim Forms and documents that you submit. If you did not keep a copy, write or call the Settlement Facility to get a copy. Depending on the number of pages in your file, there may be a minimal copying charge.

EXHIBIT 6

S F D C T
SETTLEMENT FACILITY
DOW CORNING TRUST

P.O. Box 52429
Houston, Texas 77052

Telephone 713.874.6099
888.874.6099

June 1, 2004

Redacted

r - Class 5

We have completed the review of your Disease Claim. This Notification of Status (NOS) letter provides you with a recap of your Claim activity to date and the results of our disease review.

Disease Claim Review Results

Disease Reviewed	Disease Approved	Compensation Level Approved	Eligible for Payment
Atypical Connective Tissue Disease (ACTD) Option 1	Yes	None	No

Recap of Claim Activity

Your Proof of Manufacturer:

You submitted documents that reflect you were implanted with the following breast implants:

Implant #	Date of Implantation	Manufacturer	Type of Proof	Proof Evaluation
1	04/28/1989	Dow Corning	Hospital records of the implant surgery	ACCEPTABLE
2	04/28/1989	Dow Corning	Hospital records of the implant surgery	ACCEPTABLE
3	01/09/1990	Dow Corning	Hospital records of the implant surgery	ACCEPTABLE

You have one year from the date of the original Notification of Status letter to cure any deficiency in your Disease Claim. If you do not cure the deficiency within this deadline, then you will be barred from receiving payment for the same disease claim in the future. You may, however, submit another disease claim for a "new compensable condition that manifests after the conclusion of the one-year period..."
Annex A, §7.09(b)(ii)

Please read this letter carefully to understand the deficiencies in your Disease Claim. If you have questions or would like to schedule a time to speak about your Disease Claim, call Claims Assistance at the toll free number 1-866-874-6099. It is important for you to proceed with obtaining additional medical records while you wait for Claims Assistance to schedule a time to speak with you about your claim.

Your deadline to cure the deficiencies in your Disease Claim is June 1, 2005

Disease Claim Deficiencies - General:

You applied for ACTD. To determine what deficiencies we noted in your Disease Claim, please carefully read the attached "Disease Claim Deficiencies - General." Each of these deficiencies must be cured before your claim can be approved.

Disease Claim Deficiencies - Symptoms:

We have also provided you with specific deficiencies on the symptoms found in your file in the attached "Disease Claim Deficiencies - Symptoms." You may not need to cure all of these deficiencies as long as you submit additional medical records that adequately document enough symptoms to qualify. (For example, you may have 8 eligible symptoms noted in your medical records which are all deficient, but you do not need to cure all 8 symptom deficiencies; you only need 5 non-duplicative symptoms to qualify for ACTD.)

Disease Claim Deficiencies – Compensation:

In addition to meeting the requirements for the disease and specific symptoms, you must also provide documentation for a severity/disability level in order to be eligible for payment. The section of this Notification of Status letter labeled "Disease Claim Deficiencies – Compensation" details any deficiencies for your severity/disability level. If you are not approved for a compensation level or are approved at level lower than you requested, this section will give you specific information about your deficiencies.

Actions you may take if you are eligible for payment:

- Accept payment for any approved Disease Payment Claim by completing the Supplemental Disease Review Form and returning it to the Settlement Facility; *or*
- On or before one year from the date of the original Notification of Status letter, you can submit additional medical records to cure your deficiencies. To avoid confusion and possibly another review of your claim before you are ready, please do not send your records until you have collected all of them needed to cure the deficiencies; *or*
- If you do not take any action listed in the two options above, then we will automatically issue payment to you for any approved Disease Claim at the end of the Cure Deadline. (If you wish to receive payment earlier, please read the first action statement in this section.)

Actions you may take if you have deficiencies in your Disease Claim:

- On or before one year from the date of the original Notification of Status letter, you can submit additional medical records to cure your deficiencies; *or*
- If you do not cure your deficiencies on or before one year from the date of this letter, then you will be barred from receiving payment for the same disease claim in the future. You may, however, choose the $2,000 Expedited Release Payment (and waive all right to submit a Disease claim) or submit another disease claim for a "new compensable condition that manifests after the conclusion of the one-year period."

Claims Assistance Program

If you have questions or would like to schedule a time to speak about your Disease claim, call Claims Assistance at the toll free number 1-866-874-6099, or through electronic mail at info@sfdct.com. It is important for you to proceed with obtaining additional medical records while you wait for Claims Assistance to schedule a time to speak about your claim.

When submitting additional information to be reviewed in your Disease Claim, complete the enclosed "Supplemental Disease Review Form" in its entirety. Attach any medical records or other documents to this form. Please write your name and SID on any documents you submit.

Submit all Disease Claim correspondence to:
Disease Claim Review
The Settlement Facility- Dow Corning Trust
P.O. Box 52429
Houston, Texas 77052

Sincerely,

Claims Operations
Settlement Facility – Dow Corning Trust

CC:

Encl: Supplemental Disease Review Form

DS-OL-5050

NOTIFICATION OF STATUS
DISEASE CLAIM REVIEW

Date: June 1, 2004	Cure Deadline: June 1, 2005
Name:	

Atypical Connective Tissue Disease (ACTD)/ Atypical Rheumatic Syndrome (ARS)/ Non-specific Autoimmune Condition (NAC)

Review of Disease Claim for Option 1 ACTD

General Requirements		Approved
Group	**Symptoms in each Group**	**Status**
Group I:	Keratoconjunctivitis Sicca	Approved
	Raynaud's Phenomenon	Deficient
Group II:	Immune Mediated Skin Rash	Approved
	Myalgia	Approved
Group III:	Burning pain/ Loss of function	Approved
	Chronic Fatigue	Approved
	Documented Arthralgia	Approved
	Persistent low grade fever or night sweats	Approved
	Mucosal Ulcer	Deficient
	Sleep disturbance	Deficient

To qualify for ACTD/ARS/NAC, you need one of the following combinations of approved signs and symptoms:

1. Any two symptoms from Group I.
2. Any one symptom from Group I, plus any one symptom from Group II.
3. Any three symptoms from Group II.
4. Any two symptoms from Group II, plus any one (non-duplicative) symptom from Group III.
5. Any five non-duplicative symptoms from Group I, II, or III.

Deficiencies in your ACTD Claim

DISEASE CLAIM DEFICIENCIES - GENERAL
The General Requirements Criteria contains no deficiencies.

DISEASE CLAIM DEFICIENCIES - SYMPTOMS

The Disease portion of your claim has been approved.

Review of Compensation Information for ACTD	
Compensation Level Approved in Disease Review:	None

DISEASE CLAIM DEFICIENCIES - COMPENSATION

PRE-EXISTING DISABILITY:
Under the ACTD category, a Claimant will not be compensated for a disability related to a symptom that existed before the date of the first breast implant. The Settlement Facility is not permitted to credit those pre-existing symptoms.

Dr. Richard A. H. Jimenez, has assigned or described Level B disability. However, your medical records reflect documentation that your severe pain and limitations may be due to a cause other than ACTD. Specifically, your medical records dated 1983-09-26, 1984-07-05, 1984-12-31, 1985-10-16, 1987-01-09, 1987-07-13, 1988-01-19, and 1989-04-01 contain documentation that your recurring severe pain and/or inability to perform your activities may be related to bilateral shoulder pain, which existed before your first breast implantation, and cannot be credited.

Additionally, your medical records dating from 1989-10-30 thru 1992-12-08, as well as Dr. Jimenez's 1994 letter, reflect that you have continued to have bilateral shoulder pain. Disability cannot be based on any symptom that existed prior to the first breast implantation, and the disability determination must be based on the current level of disability.

In order for the SF-DCT to confirm Level B, you need to submit documentation of your daily life and limitations in performing two of the following: your activities of vocation, avocation, and self-care. Your documents must demonstrate a loss of functional capacity which renders you unable to perform some of your usual activities of vocation, avocation and self-care, or you can perform them only with regular or recurring severe pain. Your limitations or pain must be caused by the ACTD symptoms for which you have been approved.

Severity / Disability Level Compensation for Option 1 ACTD

Level A. Death or total disability resulting from the compensable condition. An individual will be considered totally disabled if she demonstrates a functional capacity adequate to consistently perform none or only few of the usual duties or activities of vocation and self-care.

Level B. A Breast Implant Claimant will be eligible for category B compensation if she is 35 percent disabled due to the compensable condition. An individual shall be considered 35 percent disabled if she demonstrates a loss of functional capacity which renders her unable to perform some of her usual activities of vocation, avocation, and self-care, or she can perform them only with regular or recurring severe pain.

Level C. A Breast Implant Claimant will be eligible for category C compensation if she is 20 percent disabled due to the compensable condition. An individual shall be considered 20 percent disabled if she can perform some of her usual activities of vocation, avocation, and self-care only with regular or recurring moderate pain.

You may download a copy of the Settlement Facility Agreement, Annex A from our Internet website at www.dcsettlement.com.

EXHIBIT 7

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
Southern Division

FILED
97 SEP 30 PM 3:37
U.S. DISTRICT COURT
N.D. OF ALABAMA

HEIDI LINDSEY, et al.,
Plaintiff(s);

-vs-

DOW CORNING CORPORATION, et al.,
Defendant(s).

No. CV 94-11558-S

ENTERED
SEP 30 1997

Ms. [redacted], acting through her attorney J. David Cawthon, has appealed from the decision of the Claims Administrator, asking that she be determined to be disabled as the "A" level rather than the "C" level under the Fixed Amount Benefit Schedule. In part that decision was based on the fact that the amended QMD evaluation did not address Ms. [redacted] functional capacity to perform "self-care" activities—so that the file reflected (based on an earlier QMD evaluation) that she could perform self-care activities with only moderate pain. Ms. [redacted] argues that, under the wording of the Disease Schedule of the original global settlement, a person may be classified at the "A" level for ACID based solely on inability to perform vocational activities (i.e., without regard to performing self-care activities). The language at issue is "An individual will be considered totally disabled if she demonstrates a functional capacity adequate to perform none or only few of the usual duties or activities of vocation or self-care."

There is some ambiguity or inconsistency in this language. Had the words "or only few" been omitted, the meaning would have been clear, namely a requirement that there be limitations affecting both vocational and self-care activities. The court, acting under its expressly reserved powers to interpret the terms of the settlement, concludes that inclusion of the phrase "or only few" was intended to provide some relaxation from that standard, by enabling a determination of total disability even though the person might be able to perform a few of the vocational or self-care activities—and not, as Ms. [redacted] contends, to dispense with the requirement that there be limitations with respect to both self-care activities and vocational activities. In accordance with this interpretation, the Claims Administrator has consistently applied the language respecting disability level A for other claimants as she has with respect to Ms. [redacted] claim.

Ordinarily, when a claimant has (like Ms. [redacted]) signed a release accepting benefits under the Fixed Amount Benefit Schedule, any further reviews of her claim are limited solely to a review for possible error of the materials on file with the Claims Office at the time of release. In this particular case, the court, in the exercise of its discretion, concludes that it would be appropriate to allow Ms. [redacted] to provide to the Claims Office (within 60 days from the date of this order) any supplemental materials that might affect her disability level determination, and that the Claims Office should then reevaluate that disability level determination, including consideration of whether she might qualify at the B level even if not at the A level.

The appeal is granted to the extent that this matter will be remanded to the Claims Office for further consideration.

This the 30th day of Sept., 1997

Chief Judge Sam C. Pointer, Jr.

10621

EXHIBIT 8

Subj: **Pointer order re disability**
Date: 11/23/2004 6:36:26 PM Eastern Standard Time
From: DPEND440
To: ewhuber@sfdct.com
CC: dgreenspan@thefeinberggroup.com, marcus.worsley@dowcorning.com, j.d.dodd@dowcorning.com, ewrich@dow.com, jschultz@nixonpeabody.com, Ehornsby@fphw-law.com, Sybil G58

Wendy,

I wanted to follow-up with you on an issue we have discussed on many occasions to confirm my understanding of where we left things. On the issue of interpreting the Pointer order regarding disability, you provided us with a copy of the Pointer order by email on October 18, 2004. Folks on my side have read and re-read the Pointer order, and we can't make heads or tails of it. My notes reflect that there may be additional correspondence with Judge Pointer and Ann Cochran clarifying the Pointer order and possibly a decision from Frank Andrews as the Appeals Judge. Our questions are these: 1) Can you provide a copy of the correspondence and Andrews decision that clarifies the Pointer order? and 2) Can you tell us what the substantive criteria is that is being applied by the SF-DCT with regard to the disability issue? In other words, are you following the Pointer order and/or any modifications to the Pointer order and if so, are you requiring documentation of **both** vocation **and** self care or of only vocation **or** self care (which is what the Plan and CIG says)?

Thanks, Dianna

EXHIBIT 9

Subj: **Re: Pointer order re disability**
Date: 11/24/2004 8:24:41 AM Eastern Standard Time
From: EWHuber@sfdct.com
To: DPEND440@aol.com
CC: dgreenspan@thefeinberggroup.com, marcus.worsley@dowcorning.com, j.d.dodd@dowcorning.com, ewrich@dow.com, jschultz@nixonpeabody.com, Ehornsby@fphw-law.com, sybilG58@aol.com, fa1@swbell.net, mcgovern@faculty.law.duke.edu, APhillips@sfdct.com, ebearick@sfdct.com

This raises an issue we probably need to discuss together. The transmission of MDL-926 interpretation/ application/annotations to the parties. Is the Claims Administrator authorized to provide MDL-926 annotations to the parties? We will put this at the top of the agenda. Have a great Thanksgiving.
——Original Message——
From: DPEND440@aol.com
To: Elizabeth Trachte-Huber
Cc: Deborah Greenspan
Cc: Marcus Worsley
Cc: Jeanne D. Dodd
Cc: Edward W. Rich
Cc: Jill K. Schultz
Cc: Ernest "Ernie" Hornsby
Cc: Sybil Goldrich
Sent: Nov 23, 2004 5:36 PM
Subject: Pointer order re disability

Wendy,

I wanted to follow-up with you on an issue we have discussed on many occasions to confirm my understanding of where we left things. On the issue of interpreting the Pointer order regarding disability, you provided us with a copy of the Pointer order by email on October 18, 2004. Folks on my side have read and re-read the Pointer order, and we can't make heads or tails of it. My notes reflect that there may be additional correspondence with Judge Pointer and Ann Cochran clarifying the Pointer order and possibly a decision from Frank Andrews as the Appeals Judge. Our questions are these: 1) Can you provide a copy of the correspondence and Andrews decision that clarifies the Pointer order? and 2) Can you tell us what the substantive criteria is that is being applied by the SF-DCT with regard to the disability issue? In other words, are you following the Pointer order and/or any modifications to the Pointer order and if so, are you requiring documentation of both vocation and self care or of only vocation or self care (which is what the Plan and CIG says)?

Thanks, Dianna

Elizabeth W. Trachte-Huber, Esq.
Claims Administrator/ C.E.O.
Settlement Facility-Dow Corning Trust
3100 Main Street, Suite 700
Houston, TX 77002

EXHIBIT 10

Subj: **re. Potential Plan Interpretation or "Fundamental Process Question"**
Date: 11/29/2004 4:00:59 PM Eastern Standard Time
From: EWHuber@sfdct.com
To: sybilG58@aol.com, dgreenspan@thefeinberggroup.com, DPendleton@blizzardlaw.com, ewrich@dow.com, Ehornsby@fphw-law.com, j.d.dodd@dowcorning.com, jschultz@nixonpeabody.com, marcus.worsley@dowcorning.com, EWHuber@sfdct.com
CC: ebearick@sfdct.com, APhillips@sfdct.com, fa1@swbell.net, MCGOVERN@law.duke.edu, cowsley@sfdct.com, ceatmon@sfdct.com

Fundamental Process Question:

Transmission of MDL-926 interpretation/ application/annotations to the parties (CAC/DR). Is the Claims Administrator authorized to provide MDL-926 annotations to the parties? We have one example presented but numerous others we could consider. Should we open the door to the "annotations"? These were provided confidentially and Court Orders in place seem to dictate they are confidential.

More on the Level A Disability Issue:

SF Response:

We agree with Dianna's statements: claimants and attorneys are confused by the plan language and the CIG AND do not have the benefit of understanding the application of those words by the MDL-926 Administrator and Judge Pointer. CAP nurses get calls on this frequently. Our Disease NOS letter deficiency statements already spell out the requirement is vocation and self care, so claimants are, in fact, notified when they get a NOS letter.

We have annotations that give more detail about how to credit disability Level A, but we may are not authorized to publish those. Since Judge Andrews has indicated he will be shortly posting his opinions we are authorized to share a pretty clear statement from two Judge Andrew's appeals in 1998. Both state:

> " Ms. XXXX argues that the language of the Disease Compensation schedule with regard to disability allows a finding of total disability where the claimant is unable to perform only one or the other of her vocational and self care activities. The Court has consistently ruled that this reading is incorrect; total disability requires disability in both categories of activity."

More on Sample: See below Correspondence

-----Original Message-----
From: DPEND440@aol.com [mailto:DPEND440@aol.com]
Sent: Wednesday, November 24, 2004 7:37 AM
To: Elizabeth W. Trachte-Huber
Cc: dgreenspan@thefeinberggroup.com; marcus.worsley@dowcorning.com; j.d.dodd@dowcorning.com; ewrich@dow.com; jschultz@nixonpeabody.com; Ehornsby@fphw-law.com; SybilG58@aol.com; fa1@swbell.net; mcgovern@faculty.law.duke.edu; Ann M. Phillips; Ellen Bearicks
Subject: Re: Pointer order re disability

Great. Let's add it to the agenda for the next call. But I do not see this as transmitting confidential annotations. If the criteria to qualify for a disease claim has changed because of an order of court or other intrepretation by Judge Pointer, Judge Andrews, or someone else, we do not think that the criteria is or should be part of an internal claims office annotation that the claimants cannot have or know about. Claimants should know what the criteria is to qualify, and our question is simply this: has the disability criteria that is in the Plan and the CIG been changed in any way and if so, what is it. We are concerned about claimants applying for a disease and disability using the language in the Plan and CIG and then receiving a disability NOS because the criteria has been changed, then having the cure deadline run and then potentially being barred from a disease payment because we did not disclose the correct criteria.

Dianna

In a message dated 11/24/2004 8:24:41 AM Eastern Standard Time, EWHuber@sfdct.com writes:

This raises an issue we probably need to discuss together. The transmission of MDL-926 interpretation/ application/annotations to the parties. Is the Claims Administrator authorized to provide MDL-926 annotations to the parties? We will put this at the top of the agenda. Have a great Thanksgiving.

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Thanks, Dianna

EXHIBIT 11 EXCLUDED
IN-CAMERA ONLY
NOT FOR THE PUBLIC

EXHIBIT 12

PRIVILEGED AND CONFIDENTIAL ATTORNEY WORK PRODUCT

MEMORANDUM

TO: E. Wendy Trachte-Huber

FROM: Debby Greenspan

DATE: November 19, 2001

RE: Pending Questions re: Q and A Booklets

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1. Disease Q1-10 - Question regarding A level disability/severity. Question states that Judge Pointer changed the language of the A level disability category such that the language would read "a functional capacity adequate to consistently perform none or only a few of the usual duties or activities of vocation AND self care" - as opposed to "OR self care".

Response: We do not believe that Judge Pointer issued an order changing the wording of the disability guideline. To the extent that Judge Pointer or the MDL Claims Office has interpreted the meaning of the guideline through annotations or other examples, the Settlement Facility is required to apply those interpretations.

2. Disease Q 1-11 - Question regarding wording - should the word "severe" be inserted before the word pain in the definition of level B disability/severity.

Response: yes.

3. Disease Q 4-7. Question is "Can a doctor who is not board certified write my disease diagnosis and/or disability statement?" Question posed is whether the answer is correct since the answer states that "Only Board certified physicians can submit the statement or diagnosis".

Response: The question should be revised to delete the words "and" and "disability" - so that it will read "Can a doctor who is not board certified write my disease diagnosis or statement?"

4. Disease 4-8. The inquiry indicates that there is a typo and that the phrase "D.O.s should be "D.O.'s".

Response: The answer should remain as is. In the answer "D.O." is intended to be plural and not possessive.

5. Disease 5-1,5-8. Query regarding reference to Disease Payment Option II.

Response: We believe we have transmitted the Option II guidelines and definitions as part of the Tab to be included. We can re-transmit.

6. Disease 5-2(6). Query indicates that the referenced question effects a change in the criteria for use of QMD statements.

Response: There is no change and nothing in disease question 5-2 indicates or effects such a change. Question 5-2(6) simply repeats the language of MDL question 137 dated Dec. 27, 1995. Nothing in the Joint Plan or in the Disease Claimant Information Guide modified in any way the MDL guidelines and standards for acceptance of medical records/documentation for Disease Option II (i.e. Long Term Benefits Schedule).

7. Disease Tab 1, p. 37. Question about the indentation for lymphadenopathy and dysphagia.

Response: It appears that in the type set version, the bullets were indented incorrectly and these two findings were indented as if they fit under the heading of serologic abnormalities. In fact, they do not fit under that heading and should not be indented to that level.