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U.S. DISTRICT COURT
N.D. OF ALABAMA

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
Southern Division

In re: SILICONE GEL BREAST IMPLANT PRODUCTS LIABILITY LITIGATION (MDL 926)	)	Master File No. CV 92-P-10000-S
HEIDI LINDSEY, et al., Plaintiffs, -vs.- DOW CORNING CORP., et al., Defendants.	)	Civil Action No. CV 94-P-11558-S

ENTERED
MAY 20 1994

ORDER No. 18
(Proposed Settlement--Further Details)

This Order supplements, clarifies, and, to the extent inconsistent, modifies Orders No. 15 and 16 relating to the proposed settlement.

1. The 30-day period for the Claims Office to notify a claimant of deficiencies in such person's claim under the Disease Compensation Program, as specified in paragraph IV.C.2.b of the Settlement Agreement, does not commence until August 18, 1994, (or such later date that this court approves the proposed settlement) as to claims under that Program received by the Claims Office before such date.

2. In determining eligibility for benefits under Designated Fund III (Rupture Fund), the term "Settling Defendant" as found on page 5 of the Settlement Notice shall be deemed to include the "Mentor Defendants" and the "Bioplasty Defendants." A class member who has had or may have a rupture of a breast implant manufactured or distributed by one of the Mentor or Bioplasty Defendants will be eligible to participate in Fund III to the same extent as class members with ruptures of implants manufactured by the "Settling Defendants."

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3. The term "treating physician, as contained in Exhibit D (Disease Schedule) to the Settlement Notice relating to the determination of disability level for certain of the listed diseases or conditions, shall be deemed to include a "Qualified Medical Doctor" ("QMD") submitting a Statement or Diagnosis under the Disease Compensation Program if such QMD 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.

4. In order to provide advice and assistance to the court and to Settlement Class Counsel, the court hereby establishes a Claims Advisory Committee. The Claims Advisory Committee shall advise the court and Settlement Class Counsel on the creation of procedures for the administration of Designated Fund VI concerning attorneys' fees and expenses, provide suggestions designed to eliminate potential abuses or fraudulent practices in the implementation of the settlement, and make such other recommendations as may assist the court and Settlement Counsel in the fair, efficient, economical, and orderly administration of the claims process. The following are appointed to serve, at the pleasure of the court, as initial members of that Committee: Ernest H. Hornsby (Chairman), Scott Charlton, Fredric L. Ellis, Kristin Houser, Christopher Placitella, Arthur Shearman, and Don Springmeyer.

5. To respond to additional questions frequently asked since preparation of the Question and Answer booklet distributed with the Settlement Notice, the court approves the supplemental materials attached to this order.

This the 20th day of May, 1994.

United States District Judge

BREAST IMPLANT LITIGATION SETTLEMENT

QUESTIONS AND ANSWERS

This information supplements (and, to the extent inconsistent, modifies) that contained in the Queston and Answer booklet earlier approved by the court.

ADDITIONAL QUESTIONS

Q90. **I expect to file claims under Fund I (Medical Evaluation Expenses) and Fund II (Explanation Expenses) when the claims procedures for those Funds are established. I have no insurance to cover those expenses. Will eligibility depend on whether those expenses are paid by me, are paid by my attorney, or are still unpaid and owing to the doctor at the time my claim is presented?**

A. You would be eligible to participate without regard to whether the expenses are paid by you or your attorney or are still unpaid. It is contemplated, however, that the procedures will provide that amounts approved under these Funds are paid to the proper person -- to you if you paid the expenses, to your attorney if paid by such person, or to your doctor if the bill is still unpaid.

Q91. **I want to see a specialist to get a "Statement or Diagnosis." What kind of specialist should I see?**

A. Doctors writing a "Statement or Diagnosis" for purposes of the Disease Compensation Program must be board-certified in an appropriate specialty. What specialty is appropriate depends on the complaints and symptoms you have. Your regular physician is probably in the best position to make this decision and recommendation. The conditions listed in the Disease Schedule generally involve the following specialties: internal medicine, immunology, rheumatology (a sub-specialty of internal medicine), and neurology. The Claims Office is now investigating whether other specialities might be also appropriate, and may later add others to this list. (No specialization is required for those physicians whose medical records are submitted to the Claims Office under the provisions for submitting records for Claims Office review without a Statement or Diagnosis.)

Q92. My doctor, who is Board-certified in an appropriate specialty, says I have one of the conditions listed in the Disease Schedule but says there is currently no scientific basis for finding it was caused by my breast implant. What should I do?

A. Ask your doctor to submit, using the definitions contained in the Disease Schedule, a Statement or Diagnosis of your condition, its severity, and your age at onset of this condition. If the doctor indicates in the statement his or her belief that this cannot be shown to be the result of your implant, this will not necessarily prevent your being eligible for benefits, since affirmative proof of "causation" is not required under the settlement. (You would not, however, be eligible for benefits based on a doctor's statement that

your condition or an essential symptom was clearly and specifically caused by a source other than breast implants or that your disability is clearly and specifically caused by a disease or occurrence other than a condition listed on the Disease Schedule.)

Q93. I will have a Statement or Diagnosis from an appropriately Board-certified specialist showing that I have one of the listed conditions in the Disease Schedule, the severity level, and my age when this condition first appeared. What medical records must be submitted with this Statement or Diagnosis?

A. The Statement or Diagnosis must be accompanied -- or supplemented -- by the medical records upon which the diagnosis is based. It is not possible to define in advance precisely what medical records will be needed by the Claims Office in addition to the Statement or Diagnosis in order to process any particular claim. This will largely depend upon the nature of the examination or review conducted by the doctor and the form and content of the Statement or Diagnosis. In general, whatever the doctor 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 in order to make a definitive statement about the patient's condition or disability, then those records would also be needed. If, however, based on an examination of the patient, 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, there might be no other records that would be needed. The Claims Office will notify claimants if additional records are needed to substantiate their claims.

Q94. I can show I am entitled to be paid under the Current Disease Compensation Program, but am concerned about rumors that my benefits might be paid in installments over the 30-year period of the settlement. Are these rumors correct?

A. No. While the Settlement Notice authorizes payment in installments, these provisions are intended to benefit class members -- by permitting at least partial payment earlier than what might otherwise be possible. The basic problem is that the amount of a particular claimant's benefits may depend in part on the total amount of benefits payable to all claimants. For example, suppose that claims under the Ongoing Disease Compensation Program for a particular year could be paid in full if limited to the claims for that year initially approved by the Claims Office, but might be subject to some reduction if other claims for that year were, on review by the Claims Adminstrator or court, also approved. By authorizing installment payments, the settlement contemplates that persons with the approved claims would not necessarily have to wait until the review process was completed for all claims, but rather -- if they chose not to exercise their potential additional opt-out rights -- could be paid at least part of their claims while the other claims were being reviewed. Then, after completion of those reviews, the balance of their benefits would either be

paid or be carried forward into the Ongoing Disease Compenstion Program for the following year.

A special reason for installment payments exists for claims under the Current Disease Compensation Program. Funding of this Program will be made by payments during a period of 2 years and one day. If -- as is hoped -- the amounts to be paid to eligible class members can be determined before the end of that period, partial payments could be made to the recipients as payments are made by the defendants, rather than delaying all payments until full funding.

So, the answer is that, if installment payments are approved by the court, the period would be relatively short and the effect would not be to delay payments to recipients, but rather to accelerate the time for partial payments. The "30-year" period of the settlement does not mean that payments to a particular claimant would be paid over that length of time, but rather means that class members can file claims during the 30 years if in that period they should develop a covered disease (or a more serious disease), have a rupture, or incur covered medical expenses.