SUPPLEMENTAL EXHIBIT 18

Memorandum from David Austern dated 8/31/05

S F D C T

SETTLEMENT FACILITY
DOW CORNING TRUST

MEMORANDUM

TO: Attorneys Representing SF-DCT Claimants and Other Interested Parties

FROM: David Austern

DATE: August 31, 2005

Subject: Different Outcomes Between MDL-926 Claim Office Reviews and SF-DCT Claim Reviews

During the past year, the Honorable Denise Page Hood, the Claimants' Advisory Committee (CAC), and the Settlement Facility – Dow Corning Trust (SF-DCT), have received questions concerning why claims that were accepted at a discrete disease level by the MDL-926 facility, have been found to be unacceptable by the SF-DCT or, in the alternative, have been accepted but at a lower disease level.

Based on these communications, there appears to be a perception that the SF-DCT will invariably resolve claims in the same manner as they were resolved by the MDL-926 facility. It is neither surprising nor unreasonable that such a perception exists because Section 4.03 of the Settlement Facility Agreement states, "It is expressly intended that the Settling Breast Implant Claims shall be processed in substantially the same manner in which Claims filed with the MDL-926 Claims Office under the Revised Settlement Program were processed except to the extent criteria or processing guidelines are modified by this Settlement Facility Agreement or the Claims Resolution Procedures. . . " Thus, where claim resolution outcomes have been different as between the SF-DCT and the MDL-926 – and sometimes they have been different – some people have concluded that either the SF-DCT is uninformed about the MDL-926 processing rules or, worse, that the SF-DCT staff is perversely ignoring the "express intent" of the Settlement Facility Agreement.

There appears to be a fundamental disconnect concerning the temporal nature of the phrase "criteria or processing guidelines" established by the MDL-926 Claims Office. Stated differently, to the extent the phrase quoted in the preceding sentence assumes that the referenced guidelines and protocols were inert from MDL-926 inception to the present, that assumption is incorrect. In fact, the MDL-926 guidelines and protocols changed (some might say, "evolved") over time. In short, claims that were resolved by the MDL-926 at one discreet point in time might have been resolved differently had the claims been submitted to that facility at a later date.

This memorandum addresses some of the reasons why an SF-DCT claim resolution might be different than the MDL-926 resolution of the same claim. Some of what follows describes changes that have been made in the MDL-926 guidelines and protocols. The changes described below are not inclusive of all MDL-926 changes but, rather, they are the changes the SF-DCT has identified that have resulted in some of the different claim outcomes at the SF-DCT.

One might speculate that SF-DCT personnel might have inaccurately transcribed or interpreted the MDL-926 guidelines and protocols. However, the Analysis Research Planning Corporation (ARPC) recently completed an audit of the SF-DCT, and verified that SF-DCT had correctly transcribed almost all of the documents, memoranda, guidelines and protocols from the MDL-926 into the SF-DCT claim processing rules. ARPC did find minor transcription errors, but only in one case, the disease transcription of an MCTD disease annotation, could that error have resulted in a different outcome at the SF-DCT from the MDL-926 claim outcomes. In fact, no claimant was adversely affected by this error. ARPC also found that the SF-DCT annotations could benefit from grammar, word choice and redundancies, and the SF-DCT is in agreement with this statement. However, the annotations were transcribed as received by the MDL-926 and SF-DCT personnel were careful not to edit grammar and redundancies in the transcription process to ensure that no critical instructions were lost.

The MDL-926 annotations and processing guidelines described below are based on the written material given to the SF-DCT by the MDL-926, plus information provided by the SF-DCT employees who were formerly employed at the MDL-926. These former employees represent, in the aggregate, over one century of MDL-926 claims processing experience. Certain changes to both MDL-926 processing practices and SF-DCT practices have resulted in claims found unacceptable at MDL-926 but accepted at the SF-DCT. Although we have not received any complaints about such outcomes, we have included a few of the practices that have led to these results.

1. <u>Cure Deadlines</u>

MDL-926 had no deadlines for curing deficiencies. Claimants could (and still can) continue to submit additional records for Disease Review up to December 15, 2010. SF-DCT claimants have either one year (disease claims) or six months (rupture claims) to cure deficiencies. The imposition of a cure deadline will result in some claimants being unable to cure deficiencies within the cure deadline period where the claim was curable at MDL–926. In order to assist claimants who respond to deficiency notices, the SF-DCT has treated Review of Additional Information (RAI) requests as expedited reviews in order to reduce the amount of time before a cure deadline expiration.

2. <u>Age of Records</u>

MDL-926 processed scores of thousands of claims which had medical records dated within a few years of the implementation of the MDL-926 program. At the SF-DCT, however, because Dow Corning's bankruptcy effective date was over nine years after the bankruptcy filing (and when MDL-926 began to process claims), there is a

growing population of claimants whose most recent medical records are more than ten years old and, in many cases, substantially older. The age of these records has proven to be a hardship for claimants who are faced with a deficiency. Claimants are reporting that medical facilities are closed, their records have been purged, their initial treating physicians are deceased, and for these and other reasons, they are unable to cure deficiencies.

3. Claim Form Elections

MDL-926 made the selection of the disease to review for a claimant based on which type of disease best fit the claimant's symptoms and disability, and which review outcome would be the most beneficial for the claimant. For many claims this involved changing a claimant's disease selection to ACTD. In addition, claimants could select multiple diseases on the MDL–926 Disease Election Forms. MDL-926 claimants frequently were unaware they were being paid based on the results of their "other disease" review, rather than for the disease selected on their claim form.

The SF-DCT claim form requires the claimant to select only one disease for review. The SF-DCT is without authority to perform a discretionary ACTD review unless the claimant does not qualify for payment for the disease selected on the claim form. There are SF-DCT claimants who were approved at MDL–926 in the "other disease" review for higher compensation levels than the SF-DCT can approve because the disease selected on the SF-DCT claim form is not the disease for which the claimant was paid at the MDL–926.

MDL-926 Notification of Status letters did not give detailed information about how to cure deficiencies. With the exception of some Long-term (Option II) letters, the MDL-926 gave brief statements about deficiencies in the Fixed Benefits letters (Option I). MDL-926 treated the annotations as confidential. Thus, letters sent to claimants were carefully edited to ensure that processing practices were not revealed. In response to the Election Form selection issues described above, SF-DCT Notification of Status letters include a statement that describes what is needed to cure deficiencies. Additionally, SF-DCT personnel have prepared hundreds of letters that are specific to an individual claimant's deficiency in an effort to give the claimant as much information as possible about curing a deficiency as possible.

4. Addenda and Statements

Records submitted to MDL-926 frequently were prepared at or around the time that claims office began processing. However, at SF-DCT these same documents are now ten to twenty years old. As a result, large numbers of SF-DCT claimants are submitting supplementary statements or addenda. These statements are being written by physicians years after the medical records to which they refer were written. These new statements add disease symptoms and/or increase the severity/compensation level. However, frequently there is no substantive information to support the new statements.

This problem was discussed with the SF-DCT Quality Assurance Advisory Committee in December 2004. At that time the Committee agreed that addenda or new statements must include either a copy of current medical records that support the physician's statement, or a copy of an examination performed by the physician during the period the statement was written. This processing practice was added to SF-DCT processing rules on December 15, 2004.

5. MDL-926 Fixed Benefits/SF-DCT Option 1 Reviews

a) Level "A" Vocation and Self-Care Requirement

Fixed Benefits reviews completed by MDL-926 prior to Judge Pointer's Order confirmed Level A, total disability on "vocation **or** self-care". Judge Pointer's Order dated September 30, 1997 defined "or" to mean "and" for Level A disability based on "vocation **and** self care".

The Order affects a large number of claimants reviewed by MDL-926 for disease prior to September 1997 and subsequently paid based on the prior processing practices. MDL-926 processed any disease review that was in progress prior to the September 1997 Order using the "vocation **or** self-care" criteria. The result is that MDL-926 claimants who received a deficiency notice prior to September 1997 may have been approved in 2000 based on vocation alone. Those claimants did not have to meet the revised criteria of vocation and self-care.

i) The Fixed Benefits reviews performed during the evolution of the Annotations described in MDL-926 memoranda listed below changed the requirements for Level A disability in the area of self-care and over time produced a variety of outcomes.

ii) MDL-926 Claims Administrator November 1, 2001 memorandum addressing Level A Disability: The record must contain medical proof that the claimant is totally disabled both in the areas of work and self-care. To meet Level A, a claimant must be unable to do anything to take care of herself or be able to do only a very few things to take care of herself. In other words, she must be totally disabled in things like getting out of bed, getting dressed, going to the bathroom, feeding herself, and taking a bath.

iii) Revised by MDL-926 Claims Administrator November 11, 2002 memorandum addressing self care: In order to support a claimant's ability to perform few or none of the aspects of self-care, descriptions of "requiring assistance" must be supported with someone physically present to assist claimant on a consistent basis. If she is totally disabled in three areas of self-care, she meets settlement definition for total disability.

iv) Revised by MDL-926 Claims Administrator September 16, 2004 memorandum addressing Level A Disability: The Settlement defines "usual self-care" as "activities associated with dressing, feeding, bathing, grooming and toileting". The settlement's definition of total disability in the area of self-care describes a person in an "assisted living" situation. The claim documentation must answer these questions: Can she get dressed without help? Can she take a bath or shower and go to the toilet alone?

Can she perform her usual grooming tasks (wash her face; brush her teeth and hair, etc.)? Can she feed herself? (Remember that shopping and cooking is homemaking, not self-care activities). Unless the answer to at least two of these questions are clearly "no", the Claimant cannot be approved at level "A".

b) Definition of "current"

The MDL-926 Claims Administrator, in a January 5, 2004 memorandum, defined "current" as follows: Only persons who are currently disabled from a covered disease or condition will be compensated. MDL–926 only confirms disability based on the claimant's current disability as assigned by the QMD or treating physician. (When this definition of "current" is applied to SF-DCT Option 1 claims, and the claimant is seeking a disability based on mild, moderate, or severe pain, the claimant must have "current" pain.)

Prior to the MDL-926 2004 memorandum cited above, some claimants at MDL–926 were compensated for pain that did not meet the above definition of "current". Some claimants with a history of severe pain were compensated despite later records which reflected that the pain symptom was no longer present.

The SF-DCT adopted the MDL-926 2004 definition of "current" very shortly after inception of its disease reviews in 2004.

c) Compensable and Non-Compensable pain as the basis for assignment of disability levels.

With respect to pain, the MDL–926 practice is as follows: If a claimant suffers from both compensable and non-compensable pain, assign a deficiency. Because MDL–926 does not have a process to assign, on first review, a lower disease level than the claimant requested, the MDL-926 practice is to assign "no compensation".

Early in 2004, SF-DCT followed this practice and assigned "no compensation". However, on April 1, 2005, SF-DCT changed this practice to allow reviewers to assign a lower level disability where possible, and to audit and to correct any reviews that were previously assigned "no compensation".

6. MDL-926 Long Term/SF-DCT Option 2

The Disease outcome differences between the MDL–926 Long Term Claims and SF-DCT Option 2 Claims are, in part, the result of changes MDL–926 has made to its Disease Annotations. The most notable of these changes are as follows:

a) Exclusion Statement No Longer Required for Systemic Scleroderma (SS)

Systemic Scleroderma (SS) Annotations received from the MDL–926 Claims Office on February 5, 2004, changed the requirement for the localized scleroderma exclusion statement. SF-DCT has adopted the new annotation. Prior to the MDL-926 Claims Administrator waiving the localized Scleroderma exclusion statement, the statement was required in MDL-926 Disease Review for all levels of compensation, except on a case-by-case basis.

b) Additions to Annotations Systemic Scleroderma (SS)

New annotations received from the MDL–926 on February 5, 2004 also documented additional ways to credit the following disease symptoms: Proximal Scleroderma, Sclerodactyly, Digital Pitting and Bibasilar Pulmonary Fibrosis. The SF-DCT has adopted the new annotations.

c) General Connective Tissue Disease (GCTS) reviews: Other Methods of Crediting of Peripheral Neuropathy. General Connective Tissue Disease (GCTS) Annotations received from the MDL–926 Claims Office on February 5, 2004, made it easier to credit Peripheral Neuropathy. The SF-DCT has adopted the new annotation.

d) General Connective Tissue Disease (GCTS) Reviews: Added Requirements necessary to credit Malar Rash. GCTS Annotations received from the MDL–926 Claims Office on February 5, 2004 added requirements for crediting the finding of Malar Rash and clarified acceptable objective tests that could be used as evidence of Raynard's Phenomenon. GCTS Annotations received from the MDL–926 Claims Office on November 18, 2004 added requirements for crediting the finding of Malar Rash. Application of the new changes in Disease Review at SF-DCT now requires additional documentation before the SF-DCT can credit the finding of Immune Mediated Malar Rash.

7. Explant Assistance Program

MDL-926 did not require acceptable Proof of Manufacturer (POM) to participate in the Explant Assistance Program (EAP). SF-DCT requires acceptable POM to participate in the EAP. SF-DCT currently processes POM and a request for an EAP participation in the same review. An EAP packet is sent only if the POM for the implant(s) the claimant wants to have explanted has acceptable Dow Corning POM.

8. Rupture Claims

At the MDL–926, the claimant could list on the Claim Form the implant they wanted to have reviewed for rupture benefits. MDL–926 would review that implant for rupture regardless of the POM status. At SF-DCT, claimants apply for a Rupture Claim without designating which implant. Therefore, only implants with acceptable Dow Corning proof are reviewed for rupture

At the MDL-926, Rupture Claims were paid only if the claimant had an approved Disease Claim. At SF-DCT Rupture Claims are processed separately from Disease Claims.

9. Unequal Treatment Among SF-DCT Claimants

The SF-DCT practice is to pay MDL-926 "pass through" claims in the exact manner the claim was processed at the MDL-926 even where the MDL-926 processing practice has changed, and even where if the claimant had applied to the MDL-926

Facility today, the claim would be denied. But this leads to unequal treatment at the SF-DCT of claimants who never settled their claim with the MDL-926, have claims that are the same or similar to the MDL-926 pass through claims, but will not be compensated because the MDL-926/SF-DCT practices have changed.

10. Proof of Manufacturer (Pom)

SF-DCT processing of POM prior to the Effective Date resulted in a need to modify POM Notification of Status (NOS) letters so that claimants would not receive negative results which could increase the opt out rate. The NOS letters contained requests for additional information that were not specific enough for claimants to understand what was required or which implants had acceptable POM and which implants had deficiencies. As a result, some claimants were unaware until the Rupture or Explant Reviews (generally, over six months later) that the implant they wanted to be reviewed did not have acceptable POM.

Error Management

At some point MDL-926 adopted a practice of not correcting errors found in later reviews if a claimant had already received a Notification of Status Letter. For example, if MDL-926 later discovered that a claimant should have been approved for a higher level than was approved, the Facility would not automatically correct the mistake. The SF-DCT's processing practice is to amend all mistakes, and we have reversed the denial of eligibility on numerous occasions after the claimant was told they were ineligible, and we have increased awards where we have determined our initial award was at an improperly low level.

SUPPLEMENTAL EXHIBIT 19

Excerpts from Tab 2 and 3 to National Economic Research Associates Report, Frederick C. Dunbar, 6/23/1999

NATIONAL ECONOMIC
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1166 AVENUE OF THE AMERICAS
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TEL: 212.345.3000 FAX: 212.345.4650
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Consulting Economists

To: Objecting Parties to the Dow Corning Corp. Amended Joint Plan of Reorganization

From: Frederick C. Dunbar

Re: NERA Analysis and Backup

Date: June 23, 1999

The attached materials supplement the NERA analysis previously produced to you.

These materials are confidential and cannot be used for any purpose other than in connection with the trial on the Confirmation of the Dow Corning Corp. Amended Joint Plan of Reorganization. In addition, these materials include data that is covered by the order regarding access to MDL 926 data signed on March 16th, 1999 by the Honorable Sam Pointer. Use of this material in violation of that order is prohibited.

TAB 2

Preliminary and Unchecked
Settlement Claims and $ (All Claim Rates), Claims, 6/23/99, 9:20 AM, OP

Privileged and Confidential

Estimated Breast Implant Claims
Domestic Claims (RSP Incidence)

		Current Calculation/ Unmanifested Calculation	Current Rate (1)	Unmanifested Rate (2)	Current Claims (3)	Unmanifested Claims (4)	Total (5)
[a]	Total Breast Implant Claims	=[b]+[c]					137,502
[b]	Total Personal Claims[1]						135,188
[c]	3005 Claims[2]	=[b]x(rate)	1.71%	1.71%			2,314
[d]	Litigation[3]	=[a]x(rate)	4.71%	4.71%			6,474
[e]	Settlement[4]	=[a]	95.29%	95.29%	131,028		131,028
[f]	No Disease Manifested/Expedited	=(3)[e]-([h]+[i])			131,028	62,664	
[g]	Not Explanted	=(3)[e]-[v]			131,028	107,648	
	Estimated Claims:						
[h]	Expedited Release Payment	=[e]x(rate)	28.13% [5]	0.00%	36,858	0	36,858
[i]	Total Disease Claims[6]	=[j]+[n]	24.05%	14.29%	31,507	8,957	40,464
[j]	Option I: Level I	=[k]+[l]+[m]	23.61%	14.08%	30,930	8,822	39,751
[k]	A	=[f]x(rate)	3.40%	2.03%	4,453	1,270	5,723
[l]	B	=[f]x(rate)	10.17%	6.06%	13,323	3,800	17,123
[m]	C/D	=[f]x(rate)	10.04%	5.99%	13,153	3,752	16,905
[n]	Option II: Level II	=[o]+[r]+[s]	0.4403%	0.2163%	577	136	713
[o]	SS/SLE Total	=[f]x(rate)	0.3131%	0.1531%	410	96	506
	SS/SLE A	=[o]x(rate)	43.04%	5.61%	177	5	182
	SS/SLE B	=[o]x(rate)	13.75%	11.31%	56	11	67
[r]	SS/SLE C	=[o]x(rate)	43.21%	83.08%	177	80	257
[s]	GCTS/PM/DM A	=[f]x(rate)	0.0506%	0.0103%	66	6	73
[t]	GCTS B	=[f]x(rate)	0.0766%	0.0529%	100	33	134
[u]	Rupture (Overall Prevalence)[7] Of Not Explanted	=[g]x(rate)	13.34%	3.83%	17,481	4,121	21,602
[v]	Explantation[8]	=[g]x(rate)	17.84%	16.13%	23,381	17,359	40,739
[w]	Total Disease + Expedited	=[h]+[i]		14.29%	68,364	8,957	77,322
[x]	Not Claiming Disease or Expedited	=[e]-[w]					53,706
[y]		=([h]+[i])/[e]				Disease+Expedited	59%
[z]		=(1-[y])				Proportion of Claims not Approved for Benefit [9]	40.99%
[aa]						Zero Benefit Rate (difference from RSP)	0.000%
[ab]	Option I Benefit Claimants not eligible under RSP		16.52%	100.00%	5,110	8,822	13,932
							35.0%
[ac]	Option I Claims per cent of All Settling			6.73%			

Estimated Breast Implant Claims
Domestic Claims (RSP Incidence)

Notes and Sources:

[1] From Price Waterhouse Proof of Claims Data: Includes Dow Corning's share of Unknown or No Response.

[2] Calculated as the number of Late Registrants in the RSP as a proportion of Total Domestic Registrants.

[3] Opt-Out Rate is based on the RSP Experience and adjusted for the effect of enhanced benefits under the Plan. See NERA Table, "Opt-out Rate Adjusted for Effect of Enhanced Benefits".

[4] One minus Opt-Out rate.

[5] Current and Future Expedited Release rate calculated as the difference between the proportion qualifying for payment in the RSP and the proportion claiming for disease.

[6] Disease claims consist of current and unmanifested disease claims over the next 15 years. The same proportion of settling claims have current disease claims as observed in the RSP to date, increased to account for the wider availability of Option I (Fixed Benefit) and disease development up to the Effective date of the Plan. Unmanifested disease claims are estimated with an annual incidence of diseases over the 15 future years of the Plan. The annual disease incidence is estimated to be the rate of incidence over the adult lifetimes to date of current disease claimants that produces their observed disease prevalance.

[7] Rupture claims consist of current and unmanifested claims over the next 2 years. The observed prevalence of rupture -- as of 12/16/96 -- in the RSP Fixed Benefit claim population was imposed on all claims indicating a current injury on their POC form (adjusted for Proof of Manufacture). Annual rupture rates were estimated that would yield the observed prevalance; the annual rupture rates increase with age of implant; the rate of increase is such that the annual rupture rate in 1996 is twice the average annual rupture rate for the twelve years prior. These increasing annual rates are used to bring forward the 12/16/96 prevalence to the Effective date and to estimate future claims for the two year period after the Effective Date. Annual rates are applied in each case to the surviving population not explanted (without re-implant) in a prior year.

[8] Explant claims consist of historical explants -- reported on Proofs of Claim -- and future explants over the next 10 years. Only half the historical explants reported between 1991and 1996 as Dow Corning and Other Manufacturer are attributed to Dow Corning. Explants from 1997 to the Effective date and 10 years into the future are estimated to occur at the same rate as observed in the RSP during 1998 -- only surviving implantees who have not already had their implants removed are prone to explant.

[9] Proportion of Claims not Approved for Benefit onsist of Claimants who did not pursue a Claim or did not qualify for benefits. (Claimants that had no Proof of Manufacturer, Failed Pre-Screen or had insufficient evidence of a condition.)

Estimated Nominal Settlement Fund Liability
Breast Implant Benefits
Foreign Claims (RSP Rates)

		Settlement Rates			
	Total Claims	Base Per Claim	Premium Per Claim	Settlement Payout With Premium	Discounted Total[1]
	(1)	(2) ($)	(3) ($)	(6) ($)	(7) ($)
Expedited Release	5,917	2,000		11,834,667	5,795,851
Disease					
Option I: Level I					
A	919	50,000	10,000	55,132,606	26,335,695
B	2,749	20,000	4,000	65,976,159	31,515,434
C/D	2,714	10,000	2,000	32,568,329	15,557,211
Option II: Level II					
SS/SLE					
SS/SLE A	29	250,000	50,000	8,762,872	4,185,841
SS/SLE B	11	200,000	40,000	2,590,699	1,237,523
SS/SLE C	41	150,000	30,000	7,425,656	3,547,081
GCTS/PM/DM A	12	110,000	22,000	1,543,150	737,131
GCTS B	21	75,000	15,000	1,929,643	921,750
Rupture	3,391	20,000	5,000	84,768,530	41,514,120
Explant	8,235	5,000		41,174,552	20,164,622
Total	24,039			313,706,862	151,512,257

Notes:

1 Discount includes Multi-Manufacturer discount of 50% (see calculation below) and aggregate foreign claim discount of: 49 %. (Disclosure Statement, Annex A - 13).

Breakdown of DCC Claims	Claims	Percent of Known Dow Claims	Discount Factor
DCC Only + DCC and Others (non RSP)	32,411	95%	100%
DCC and Others (RSP)	1,678	5%	50%
	34,089	100.00%	0.98

TAB 3

Calculation of Current Disease Incidence
Based on the RSP Experience

			Current Claims (1)	Registrants & Late Claims (2)	Total (3)
[a]	Total Settling Domestic Claims				147,619
[b]	Current Fixed Benefit Claims Approved[2]		28,462	5,633	34,095
[c]	A		4,098	811	4,909
[d]	B		12,260	2,426	14,686
[e]	C/D		12,104	2,395	14,499
[f]	Current Long Term Claims Approved	=(g)+(k)+(l)	533	105	638
[g]	SS/SLE[3]		394	60	454
[h]	A[4]		94	14	109
[i]	B[4]		54	8	62
[j]	C[4]		246	37	283
[k]	PM/DM A[3]		9	2.49	11
[l]	GCTS[3]		130	43	173
[m]	A[5]		29	10	39
[n]	B[5]		101	33	134
[o]	GCTS/PM/DM A	=[k]+[m]	159	12	171
[p]	Current Fixed + Long Term Approved	=[b]+[f]	28,995	5,738	34,733

Total Claims Filed (incl. Failed pre-screen)	39,423	
Proportion Approved for disease out of those who clai	73.5%	
Proportion of Option I claimants who would not have been eligible under RSP		16.5%

Notes:

[1] Calculated as the sum of Current Severity Approved Claims (RSP Tables 13 & 14) minus Current Failed Pre-Screen and No POM Submitted (RSP Table 3). For a count, see NERA Table, "Count of Severity Approved."

[2] Calculated as the Current Fixed Benefit Claims Approved for each severity (RSP Tables 13 & 14). Includes Current Fixed Benefit and Current Fixed After Long Term. See NERA Table, "Count of Severity Approved."

[3] For Current Claimants Total Disease is calculated as the sum of Current Long Term benefits approved as Single Alleged Injuries and Multiple Alleged Injuries for the respective disease. RSP Table, What Long-Term Benefit Disease Allegations have been Evaluated and Approved for Payment?" is inconsistent with RSP Table, "What has been the Accepted Disability Level for each Accepted Disease?". We use the Current Long Term Benefits Approved from the first table because it allows us to count GCTS separately.

[4] Calculated as [g] times the respective severity level approved for SS/SLE. RSP Tables 13 & 14. For a count, see NERA Table, "Severity Levels by Disease."

[5] Calculated as [l] times the respective severity level approved for ACTD. RSP Tables 13 & 14. For a count, see NERA Table, "Severity Levels by Disease."

SUPPLEMENTAL EXHIBIT 20

Excerpt from Webster's New World Dictionary and Thesaurus

WEBSTER'S NEW WORLD™ DICTIONARY AND THESAURUS

Compiled by the Staff of
Webster's New World Dictionary

Michael Agnes
Editor in Chief

With Principal Thesaurus Text by
Charlton Laird

MACMILLAN • USA

op·ti·mum (-məm) *n., pl.* **-mums** or **-ma** (-mə) [see prec.] the best or most favorable degree, condition, etc. —*adj.* most favorable; best: also **op'ti·mal** (-məl)
op·tion (äp'shən) *n.* [< L *optare,* to wish] 1 a choosing; choice 2 the right of choosing 3 something that is or can be chosen 4 the right to buy, sell, or lease at a fixed price within a specified time —**op'tional** *adj.*
op·tom·etry (äp täm'ə trē) *n.* [< Gr *optikos,* optic + *metron,* a measure] the profession of testing and examining the eyes and prescribing glasses to correct vision problems —**op·tom'etrist'** *n.*
opu·lent (äp'yoo lənt, -yə-) *adj.* [< L *ops,* riches] 1 very wealthy 2 abundant —**op'u·lence** *n.*
opus (ō'pəs) *n., pl.* **opera** (ō'pə rə, äp'ə rə) or **o'pus·es** [L, a work] a work; composition; esp., any of the numbered musical works of a composer
or (ôr) *conj.* [OE *oththe*] a coordinating conjunction introducing: *a)* an alternative [red *or* blue] or the last in a series of choices *b)* a synonymous word or phrase [oral, *or* spoken]
-or (ər, ôr) [< L] *suffix* 1 a person or thing that (does a specified thing) [*inventor*] 2 quality or condition [*favor*]
ora·cle (ôr'ə kəl, är'-) *n.* [< L *orare,* pray] 1 among the ancient *Greeks* and *Romans, a)* the place where, or medium by which, deities were consulted *b)* the revelation of a medium or priest 2 *a)* a person of great knowledge *b)* statements of such a person —**oracu·lar** (ō rak'yoo lər) *adj.*
oral (ôr'əl, ōr'-) *adj.* [< L *os,* the mouth] 1 uttered; spoken 2 of or near the mouth —**o'ral·ly** *adv.*
-orama (ə ram'ə, -räm'ə) *combining form* a greater-than-usual number, volume, etc. of a specified thing [*panorama*]
orange (ôr'inj, är'-) *n.* [< Sans *naranga*] 1 a round, edible, reddish-yellow citrus fruit, with a sweet, juicy pulp 2 the evergreen tree it grows on 3 reddish yellow
orange·ade (ôr'inj ād', ôrnj'ād') *n.* a drink made of orange juice, water, and sugar
orangu·tan (ō raŋ'oo tan'; ô raŋ'-, ə-) *n.* [< Malay *orañ,* man + *utan,* forest] an ape of Borneo and Sumatra with shaggy, reddish-brown hair and very long arms
orate (ō rāt', ô-) *vi.* **-rat'ed, -rat'ing** to make an oration; speak in a pompous or bombastic way
ora·tion (ō rā'shən, ô-) *n.* [< L *orare,* speak] a formal speech, esp. one given at a ceremony
ora·tor (ôr'ət ər, är'-) *n.* an eloquent public speaker
ora·to·rio (ôr'ə tôr'ē ō') *n., pl.* **-os'** [It, small chapel] a long, dramatic musical work, usually on a religious theme, but not acted out
ora·tory (ôr'ə tôr'ē, är'-) *n., pl.* **-ries** [< L *oratoria*] skill in public speaking —**or'a·tor'i·cal** *adj.*
orb (ôrb) *n.* [L *orbis,* a circle] a sphere, or globe
or·bit (ôr'bit) *n.* [< L *orbis,* a circle] 1 the path of a celestial body during its revolution around another 2 the path of an artificial satellite or spacecraft around a celestial body —*vi., vt.* to move in, or put into, an orbit —**or'bital** *adj.*
or·chard (ôr'chərd) *n.* [OE *ortgeard*] 1 land for growing fruit trees 2 the trees
or·ches·tra (ôr'kis trə, -kes'-) *n.* [< Gr *orcheisthai,* to dance] 1 the space in front of a theater stage, where the musicians sit: in full **orchestra pit** 2 *the seats on the* main floor of a theater 3 *a)* a group of musicians playing together *b)* their instruments —**or·ches'tral** (-kes'trəl) *adj.*
or'ches·trate' (-trāt') *vt., vi.* **-trat'ed, -trat'ing** to arrange (music) for an orchestra —**or'ches·tra'tion** *n.*
or·chid (ôr'kid) *n.* [< Gr *orchis,* testicle: from the shape of the roots] 1 a perennial plant having flowers with three petals, one of which is lip-shaped 2 this flower 3 pale purple
or·dain (ôr dān') *vt.* [< L *ordo,* an order] 1 to decree; establish; enact 2 to invest with the office of minister, priest, or rabbi —*vi.* to command —**or·dain'ment** *n.*
or·deal (ôr dēl', ôr'dēl') *n.* [OE *ordal*] any difficult or painful experience
or·der (ôr'dər) *n.* [< L *ordo,* straight row] 1 social position 2 a state of peace; orderly conduct 3 arrangement of things or events; series 4 a definite plan; system 5 a military, monastic, or social brotherhood 6 a condition in

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option *n.* 1 [A choice] selection, alternative, dilemma; see CHOICE. 2 [A privilege to purchase] right, prerogative, grant, claim, license, lease, franchise, advantage, security, immunity, benefit, title, prior claim, dibs*.
optional *a.* discretionary, elective, noncompulsory, free, unrestricted, arbitrary, not required, with no strings attached*, take it or leave it*; see also VOLUNTARY.—*Ant.* NECESSARY, compulsory, enforced.
or *conj.* 1 [A suggestion of choice] or only, or but, as an alternative, on the other hand, in turn, conversely, in other words, or else, in preference to; see also EITHER.—*Ant.* NOR, neither, without choice. 2 [A suggestion of correction] or not, or not exactly, in reverse, reversing it, on the contrary, contrary to, oppositely, or rather, instead of, correctly speaking; see also INSTEAD. 3 [A suggestion of approximation] roughly, about, practically; see APPROXIMATELY.
oral *a.* vocal, verbal, uttered, voiced, unwritten, phonetic, sounded, not written, by word of mouth; see also SPOKEN.—*Ant.* WRITTEN, PRINTED, unspoken.
orange *a.* reddish, ocherous, glowing; see ORANGE, *n.* 2.
orange *n.* 1 [Color] red-yellow, apricot, tangerine, burnt orange, peach, coral, salmon; see also COLOR. 2 [Fruit] citrus fruit, tropical fruit, navel orange; see FOOD, FRUIT.
orbit *n.* 1 [Path described by one body revolving around another] course, circle, ring, circuit, apogee, perigee, perigee, lap, round, cycle, flight path; see also REVOLUTION 2 [Range of activity or influence] range, field, boundary; see
orbit *v.* 1 [To revolve around another body] encircle, encompass, ring, move in a circuit, go around, revolve; see also CIRCLE. 2 [To put into orbit] fire, lift off, project; see LAUNCH 2.
orbited *a.* sent into orbit, put up, rocketed; see DRIVEN, SENT.
orchard *n.* fruit trees, fruit farm, apple orchard; see FARM.
orchestra *n.* musical ensemble, symphony, trio, quartet, quintet; see also BAND.
ordain *v.* 1 [To establish] install, institute, appoint; see ENACT. 2 [To destine] determine, foreordain, intend; see INTEND 2. 3 [To invest with priestly functions] install, confer holy orders upon, consecrate, frock, delegate, invest; see also BLESS.
ordained *a.* 1 [Ordered] commanded, determined, established by law; see ESTABLISHED 2, ORDERED 2. 2 [Invested into the ministry] consecrated, anointed, received into the ministry; see NAMED 2.
ordeal *n.* tribulation, distress, calamity; see DIFFICULTY 1, 2.
order *n.* 1 [A command] direction, demand, decree, rule, edict, charge, requirement, ordinance, act, warrant, mandate, injunction; see also COMMAND, LAW 3. 2 [Sequence] progression, succession, procession; see LINE 1, SEQUENCE 1, SERIES. 3 [Orderly arrangement] regulation, plan, disposition, management, establishment, method, distribution, placement, scale, rule, computation, adjustment, adaptation, ordering, ranging, standardizing, lining up, trimming, grouping, composition, cast, assortment, disposal, scheme, form, routine, array, procedure, method, index, regularity, uniformity, symmetry, harmony, placement, layout, lineup, setup; see also CLASSIFICATION, SYSTEM.—*Ant.* CONFUSION, disarray, displacement. 4 [Organization] society, sect, company; see ORGANIZATION 2. 5 [A formal agreement to purchase] engagement, reserve, application, requisition, request, stipulation, booking, layaway, arrangement; see also BUYING, RESERVATION 1. 6 [Kind] rank, hierarchy, degree; see CLASS 1, CLASSIFICATION. 7 [Customary method] ritual, rite, plan; see CUSTOM. —**in order** working, efficient, operative; see EFFECTIVE. —**in order to** for the purpose of, as a means to, so that; see FOR. —**in short order** rapidly, without delay, soon; see QUICKLY. —**on order** requested, on the way, sent for; see ORDERED 1. —**out of order** broken down, defective, faulty; see BROKEN 2.
order *v.* 1 [To give a command] direct, command, instruct, bid, tell, demand, impose, give directions, dictate, decree; see also REQUIRE 2. 2 [To authorize a purchase] secure, reserve, request; see BUY, OBTAIN 1. 3 [To put in order] arrange, plan, furnish, regulate, establish, manage, systematize, space, file, put away, classify, distribute, alphabetize, regularize, pattern, formalize, settle, fix, locate, dress up, sort out, index, put to rights, set guidelines for, adjust, adapt, set in order, assign, place, align, standardize, plan, group; see also ORGANIZE 1.—*Ant.* CONFUSE, disarrange, disarray.
ordered *a.* 1 [On order] requested, requisitioned, sent for, spoken for, engaged, booked, arranged for, retained, written for, telephoned for; see also RESERVED 1. 2 [Commanded] directed, ordained, com-

SUPPLEMENTAL EXHIBIT 21

Arbitration Statement of Dow Corning Corporation And The Tort Claimants' Committee Regarding The Settlement Facility-Dow Corning Trust Access To MDL 926 Claims Office Materials, 11/1/2002

CONFIDENTIAL: THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION INTENDED FOR USE EXCLUSIVELY IN CONNECTION WITH THE ARBITRATION OF THE DISPUTE REGARDING THE SETTLEMENT FACILITY-DOW CORNING TRUST ACCESS TO MDL 926 CLAIMS OFFICE MATERIALS

ARBITRATION STATEMENT OF DOW CORNING CORPORATION AND THE TORT CLAIMANTS' COMMITTEE REGARDING THE SETTLEMENT FACILITY-DOW CORNING TRUST ACCESS TO MDL 926 CLAIMS OFFICE MATERIALS

NOVEMBER 1, 2002

of the overall operation of the MDL 926 Claims Office, equivalent to the amount that it would likely have had to pay had the MDL 926 Claims Office actually processed DCC claims.[16] The Plan Proponents believe that these facts compel only one conclusion: the MDL 926 Claims Office Materials have already been paid for by DCC. Since all of the MDL 926 Claims Office Materials (except for the "ARPC-JTS" software) were created by the MDL 926 Claims Office staff during the course of its operations — commencing in 1994 and continuing throughout the implementation of the RSP — and since DCC contributed an amount equivalent to a full operational share of the MDL 926 Claims Office resulting in a substantial subsidy for the MDL 926 Settling Defendants, DCC has the same right as any of the MDL 926 Settling Defendants to obtain for its claims office the benefit of these materials. Indeed, DCC paid an amount that exceeds that paid by three of the four MDL 926 Settling Defendants without receiving any of the benefits the MDL 926 Settling Defendants received, i.e., claim processing. The only benefit DCC can now receive for its contribution is to obtain access to the materials for the SF-DCT.

B. The MDL 926 Claims Office Materials Provided to the SF-DCT Are Not Being Used or Will Provide Modest Benefit.

As described below, the SF-DCT has not really obtained the sort of benefit from the MDL 926 Claims Office that the Plan Proponents had anticipated. Thus, even if, for some reason, DCC's prior payment were not enough, the fact that the benefit obtained was limited should persuade the Arbitrator to conclude that no compensation is warranted.

1. Manuals, Guidelines, and Other Written Materials Regarding Processing of Claims.

As noted, the Plan Proponents wanted to obtain for the SF-DCT any written materials specifying methods for evaluating disease claims under the original global and the RSP. The Plan Proponents assumed that the MDL 926 Claims Office had created claims processing guidelines and decision protocols for the claims reviewers that would determine the results for similarly situated claims. In addition, the Plan Proponents understood that there might be other procedural guidelines such as mechanisms for intake of claims and documents, work flow procedures (i.e., how a claim would flow through the processing track), document verification procedures, and checklists for reviewers to follow that might be useful in designing the SF-DCT procedures. The Plan Proponents expected these manuals would provide the SF-DCT staff with the same guidelines that were used by the RSP staff so that the SF-DCT staff could apply interpretations of criteria and documentation requirements in the same manner as the RSP staff, thereby avoiding inconsistent results among similarly situated claimants, some of whom might be applying to both facilities.

$792,350.16 represents 39.14 percent of those disbursements to the MDL 926 Operating Account listed in Table 1 that did not include payments of KPMG invoices. Even if we deduct that amount from the total of $10,680,263.92, DCC paid 27.45 percent of the MDL 926 Claims Office Expenditures. Attached hereto at Exhibit C are two charts summarizing these calculations based on the data contained in the July 5, 2001 letter.

[16] Again, see Escrow Addendum at p.21, footnote 9 which notes that DCC's share of claims equaled approximately 30 percent.

In fact, the MDL 926 Claims Office did not provide detailed evaluation manuals or guidelines. Instead, the SF-DCT initially received boxes of documents, including letters, memoranda, and annotations for ACTD, GCTS and SLE (under the Long-Term Benefits Option). These boxes contained no training materials or copies of disease manuals. Ann Cochran, the MDL 926 Claims Office Claims Administrator, explained to the then Claims Operations Manager for the SF-DCT that formal annotations had not been developed for the balance of the disease options but that drafts of the annotations existed for the other areas. In a memorandum dated February 27, 2001 the SF-DCT asked for drafts of other annotations and a copy of the RSP training manual. The SF-DCT requested that the information be provided on disk. On April 23, 2001 a list of documents included in a computer directory ("the MDL Directory") was received from the MDL 926 Claims Office, and on May 16, 2001 the MDL 926 Claims Office information was received on eight disks. The information was not edited or organized in any particular fashion. The disks did not include many documents listed in the hard copy of the MDL Directory, such as copies of memoranda that SF-DCT disease reviewers remember receiving, training materials, or documents that the staff hired by the SF-DCT from the MDL facility had left on their computers. The disks included, among other things: confidential information, i.e., employee performance evaluations; numerous versions of the same document without any key to which one was currently applicable; memoranda that were started but not finished, e.g., "Memorandum on the Reconfirm Process" dated March 28, 2001 which detailed new information but was not completed; and copies of forms used to collect productivity and quality monitoring information with no statistical summary reports or outcome reports which could be used to establish the SF-DCT thresholds. Memoranda providing specific determinations on specific disease criteria were also contained on the disks. These memoranda represented issue specific directives to the claims review staff regarding particular items that had arisen in the course of reviewing individual claims. There were no summaries or guidelines provided specifying the procedures for processing a Fixed Benefits Option disease claim.

In the end, after spending over a year culling through the documents, the staff of the SF-DCT has advised that these memoranda and other documents are neither self-explanatory nor organized. Without a table of contents, index, or some other explanation of the documents, different criteria and interpretations may have been applied at different points in time and it is not discernable what the current interpretations and criteria might be. In short, the SF-DCT was not provided with a blueprint for processing and evaluating the claims. Ultimately, the staff of the SF-DCT has developed its own manuals using a combination of the memoranda it was able to cull from the boxes and disks and from interviews of former MDL 926 Claims Office staff.[17] The SF-DCT has not been able to obtain confirmation from the MDL 926 Claims Office regarding its analysis of the memoranda or even regarding certain specific questions. When the SF-DCT requested confirmation of accuracy and consistency by sending its manual to Ann Cochran for review, she indicated, "I will not be reviewing or commenting on your disease deficiencies, NOS'es, etc. Please do not send me any more material."

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[17] The SF-DCT Claims Operations group spent the last year sorting through the MDL 926 Claims Office database documents and interviewing former MDL 926 Claims Office employees in an attempt to re-create MDL 926 Claims Office Processing Protocols. In some cases MDL 926 Claims Office Annotations received were never updated to reflect the actual processing changes that took place. There were instances where the worksheets reflected current information but lacked the detail on why processing changes occurred.