Exhibit D

DOW CORNING SETTLEMENT PROGRAM AND CLAIMS RESOLUTION PROCEDURES

ANNEX A
TO SETTLEMENT FACILITY AND FUND DISTRIBUTION AGREEMENT

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

Effective Date, the Claims Office may distribute preliminary status letters as specified at Section 7.04. The preliminary status letter will include language designating it as a confidential communication from the Settlement Facility and the District Court. It will request that the claimant maintain confidentiality by conferring only with her attorney, physician(s), Claims Assistance Program, and/or Tort Claimants' Committee regarding the content of the preliminary status letter and/or the submission of her Settlement Options.

7.06 ***Notification of Status for Disease Payment Option Claims.***

(a) ***Content.*** The Notification of Status letter shall inform the Breast Implant Claimant and her counsel of the results of the evaluation of the Claim, as specified at Section 6.02(d) herein, and shall inform the Claimant of the election options.

(b) ***Deficiency.*** If the Claim has a deficiency, the Notification of Status letter shall specifically identify the deficiency, state whether it is a minor or major deficiency, and inform the Claimant of procedures for correcting the deficiency and/or appealing the ruling to the Claims Administrator. For Claims with deficiencies, the Notification of Status letter shall also inform the Claimant that she may release all present and future rights to the Disease Payment Option and instead, receive $2,000 as an Expedited Release Payment. If the Claim is approved at a lower compensation level or Covered Condition than that applied for, the Notification of Status letter shall state the deficiency or the reason(s) why the higher level or Covered Condition was not approved.

(c) ***Timing of Distribution of Notification of Status letters.*** Disease Notification of Status letters may be distributed only after the Effective Date. Prior to the Effective Date, the Claims Office may distribute preliminary status letters as specified at Section 7.04. The preliminary status letter will include language designating it as a confidential communication from the Settlement Facility and the District Court. It will request that the claimant maintain confidentiality by conferring only with her attorney, physician(s), Claims Assistance Program, and/or Tort Claimants' Committee regarding the content of the preliminary status letter and/or the submission of her Settlement Options.

(d) ***Types of Deficiencies.*** The Claims Office shall inform the Breast Implant Claimant of any of the following deficiencies:

1. Failure to document specific ACTD symptoms.

   The word "documented" precedes several ACTD symptoms. It is not possible to give one precise definition of the word "documented" because its meaning is often dependent on the particular symptom involved. Generally, it 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. For others, particularly those that are entirely subjective, it can mean that the physician has 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. "Documented" can also mean that written notations of that symptom are found several times in the Claimant's past medical records. This deficiency can be cured, then, by providing (1) proof of verification of the symptom through physical examination; (2) a supplemental statement from the Claimant's Qualified Medical Doctor ("QMD")

as defined at Schedule II, Part A revealing that (s)he questioned the Claimant sufficiently about this symptom and concluded that the complaint is valid; or (3) additional medical records reflecting that the Claimant complained about this symptom on other occasions.

2. All the records on which the QMD based his/her determination of the Claimant's disability were not submitted with the Claim.

   If the Claimant's QMD indicated that (s)he relied on some documents in making a disability determination, but those other documents have not been submitted the Claim will be deemed deficient. Before the Claims Office can confirm the Claimant's disability, the Claims Office must have all of the records that the QMD used to make the disability determination. The Claimant can cure this deficiency by filing those documents.

3. The Claimant needs one more symptom to qualify for a compensable condition.

   This deficiency can be cured by providing medical records or a supplemental statement from the Claimant's QMD reflecting any additional symptoms that the Claimant has that satisfy the criteria of Schedule II, Part A.

4. Information contained in the Claimant's documents indicate that the Claimant is not disabled by a compensable condition.

   The Claimant's documentation affirmatively reveals that the Claimant is not disabled. If this is correct, this deficiency can possibly be cured by providing a statement from the Claimant's QMD or treating physician describing the Claimant's current disability and providing a satisfactory explanation for the contradictory information submitted earlier.

5. Information contained in the Claimant's documents indicates that the disability determination is inconsistent with the disease criteria of Schedule II, Part A.

   The Claimant's QMD or treating physician made a determination of the Claimant's disability, but information about the Claimant's pain or limitations on his/her activities (either in the QMD's statement or elsewhere in the Claimant's records) conflicts with the requirements for that disability level. This deficiency can possibly be cured by a statement from the Claimant's QMD or treating physician assigning a disability level that is appropriate for the Claimant's condition or providing information about the Claimant's disability that is consistent with criteria for that level. If the Claimant's supplemental documentation provides new information in support of the disability level the Claimant originally claimed, the Claimant should provide an explanation for the contradictory information submitted earlier.

6. The Claimant's documents contain insufficient information about the Claimant's condition to evaluate whether the disability determination is consistent with disease criteria of Schedule II, Part A.

Although the Claimant's QMD or treating physician made a determination of the Claimant's disability, there is not enough information in the Claimant's file to allow the Claims Office to determine if that disability level was appropriately assigned by the physician. This deficiency can be cured by providing a supplemental statement from the Claimant's treating physician or QMD describing the Claimant's level of pain or limitations on his/her activities. If the Claimant's disability is caused in part by a disease or condition that is not compensable under Disease Payment Option I, the Claimant can only be approved for the level of his/her disability that is caused by the Covered Condition. In that situation, the Claimant should make sure that in describing the Claimant's Covered Condition, the physician clearly indicates the extent of the Claimant's disability caused by the Covered Condition covered by Schedule II, Part A.

7. Information contained in the Claimant's documents indicates that the Claimant is no longer disabled by a Covered Condition.

The Claimant's documentation clearly indicates that the Claimant is no longer suffering from any earlier disability the Claimant may have had. This deficiency can only be cured if the Claimant is once again disabled. The Claimant should provide a statement from her QMD or treating physician describing the Claimant's current disability and explaining the change from her earlier-reported condition.

8. The Claimant's documents did not contain a determination by a treating physician or QMD of the Claimant's disability.

The Claimant's file contained no determination of the Claimant's disability by either the Claimant's treating physician or a QMD. If the Claimant's file did contain a disability determination from a physician, this deficiency can be assigned if the Claims Office is unable to confirm that the physician who made that disability determination was either a treating physician or an appropriate Board-certified specialist. This deficiency can be cured by obtaining a determination of disability from the Claimant's treating physician or a physician Board-certified in one of the specialties qualifying as QMD specialties.

9. The Claimant needs more than one additional symptom to qualify for a compensable condition.

The Claimant needs two or more additional symptoms to qualify for the applicable disease or condition. This deficiency can be cured by providing medical records or a supplemental statement from the Claimant's QMD reflecting any additional symptoms the Claimant has that meet the criteria for that Covered Condition.

10. Specific ACTD symptoms existed before the Claimant received her first breast implant.

The Claimant's records reflect that she suffered from the specified ACTD symptoms before she had her first breast implant. The Claims Office is not permitted to credit those pre-existing symptoms. The only time this deficiency

can be cured is if there are typographical errors in the dates in the Claimant's records. If there are indeed typographical errors in those dates, the Claimant must provide an affirmative statement from the physician whose records contain those errors explaining in detail the nature of those errors and the true dates that should have been reflected in those records.

11. The Claimant's QMD statement or diagnosis was not signed.

This deficiency can be cured by submitting the signed QMD statement or diagnosis.

12. The Claimant's QMD determination of disability or severity level was not signed.

A statement or diagnosis from a QMD must have that physician's signature. A Claimant can cure this deficiency by having the QMD sign a copy of the original statement or diagnosis, and filing that signed copy with the Claims Office. If the deficiency noted is lack of signature on the disability statement, the Claimant should ensure that the statement which the physician signs is the one that contains his or her determination of the Claimant's disability.

13. Information contained in the Claimant's documents indicates that the compensable condition from which she suffered before her first beast implant has not increased in severity or disability since that breast implant was implanted.

The Claimant's records show that she suffered from the disease noted on her Notification of Status letter before she received her first breast implant. That condition is compensable only if it increased in severity or in its impact on the Claimant's disability after implantation. The Claimant can cure this deficiency by providing either a supplemental report from her treating physician or QMD that affirmatively reveals that her condition has worsened to the point that she is now in a higher compensation category or medical records that demonstrate that increase.

14. The Claimant's medical records did not reveal whether the specified lab tests were performed by the method required by the criteria in Schedule II or if the results of those tests meet the criteria in Schedule II.

The Settlement Program requires that the lab tests noted be performed by a certain stated method or that the results of those tests meet certain minimum values. If the Claimant's tests did meet that stated criteria but her original documentation failed to reveal that fact, the Claimant can cure this deficiency by providing a statement from either the lab or the physician who ordered the test reflecting the method by which it was run and the results reported in the value required by the settlement. If the Claimant's tests did not, in fact, meet the stated criteria, the Claimant can cure the deficiency by having them re-taken in the manner required by Schedule II.

15. Specified signs and symptoms do not meet the criteria of Schedule II.

The symptoms noted were not shown in the Claimant's file to meet the criteria that Disease Payment Option I specifies. The complaints may not rise to the level required for the Claims Office to credit the Claimant with that particular symptom, or the records revealed that the complaint fell within a category affirmatively excluded by the Disease Payment Option. This deficiency can be cured by providing either a supplemental statement from the Claimant's QMD or the medical records demonstrating that her symptom does indeed meet the criteria stated in Disease Payment Option I.

16. The Claimant's documents contain insufficient information about the Claimant's condition to evaluate whether the disability determination is consistent with the criteria in Schedule II.

This deficiency means that there is not enough information about the Claimant's symptoms for the Claims Office to know that the criteria for the claimed disability level have been satisfied.

For Disease Payment Option I Disability Level C: Under Disease Payment Option I, the definition of Level C provides that the Claimant must be experiencing moderate pain on a regular or recurring basis. The pain must be due to the Claimant's ACTD or ANDS. To cure the deficiency, the Claimant should look at her claim documentation to see what ACTD or ANDS symptoms she has to check if all of the ACTD or ANDS symptoms are ones that normally have no pain component, like alopecia, chronic fatigue, or loss of function of the breast. If that is the case, then the Claims Office cannot approve a "C" disability rating unless there is evidence that the Claimant is experiencing pain from one of these symptoms or unless the Claimant supplies evidence that she has an additional symptom from the Disease Payment Option I that does cause pain. If the claim documentation does mention a pain-related symptom, the Claimant should look at her Notification of Status letter to see if another deficiency is listed that specifically mentions that symptom. For example, if the Claimant has had myalgias but her Notification of Status letter says that the myalgias have not been "documented" and myalgia was her only pain-related symptom, then the Claims Office cannot verify a "C" disability level until the Claimant has provided a supplemental documentation to satisfy the "documented" requirement. This deficiency might also be assigned because there is nothing upon which the Claims Office could base a conclusion that the pain is "regular or recurring" if the Claimant's physician described the pain as being only "mild" or "slight."

For Disease Payment Option I Disability Level B: If the Claimant's physician assigned disability level "B" and her Notification of Status letter states the deficiency listed above, the Claimant should read the definition of that level and look to see whether the "B" level is based on severe pain or an inability to do certain activities. If the "B" determination was pain-related, the Claimant should look to see what ACTD or ANDS symptoms are found in the Claimant's documentation. If there are no symptoms that cause pain, that fact may explain this deficiency. If there are pain-producing symptoms, the Claimant should look to see if there is any evidence that these symptoms result in severe pain on a regular or recurring basis. Generalized statements about "severe pain" may not be enough. The Claims Office needs to be able to verify that the ACTD/ANDS

symptoms themselves are the cause of that severe pain. If the "B" level is based on limitations of the Claimant's activities, the Claimant should look to see if there is any information provided concerning what activities are limited. A conclusory statement alone, with no information about the Claimant and her limitations, will result in this deficiency being assigned. Is there a connection between the specific activities that the Claimant can no longer do and the ACTD/ANDS symptoms that she has? The Claimant's disability must be due to the Claimant's compensable condition. The Claims Office must have enough information about what the Claimant's limitations are and the cause of those limitations to be able to verify that her condition meets the settlement's requirements for a "B" disability level.

For Disease Payment Option I Disability Level A: If the Claimant's physician assigned disability level "A," the Claimant should keep in mind that the settlement's definition of this assigned disability level is a difficult one to meet. The Claimant must be unable to do any of her normal activities or only be able to do a very few of them. The Claimant should review the Claim documents carefully to ensure that there is enough description of her daily life and limitations to allow a reader to know that she does indeed meet this strict definition of total disability. It must be clear that the Claimant's total disability is due to the symptoms of her applicable disease or condition.

7.07 ***Notification of Status for Other Products/Medical Condition.***

(a) ***Content.*** The Notification of Status letter shall inform the Covered Other Products Claimant and her counsel of the results of the evaluation of the Claim as specified at Section 6.03.

(b) ***Deficiency.*** If the Claim has a deficiency, the Notification of Status letter shall specifically identify the deficiency, state whether it is a minor or major deficiency, and inform the Claimant of procedures for correcting the deficiency and/or appealing the ruling to the Claims Administrator.

(c) ***Pre-Effective Date Notification of Status/Waiver of Opt Out and Evaluation.*** Pre-Effective Date review and evaluation of Other Products Claims (including communications to Claimants) shall be conducted in accordance with the provisions of Section 7.04.

7.08 ***Notification of Status for Silicone Material Claims and Participating Foreign Gel Claims.***

(a) ***Content.*** The Notification of Status letter shall inform the Silicone Material Claimant and her counsel of the results of the evaluation of the Claim as specified at Section 6.04.

(b) ***Deficiency.*** If the Claim has a deficiency, the Notification of Status letter shall specifically identify the deficiency, state whether it is a minor or major deficiency, and inform the Claimant of procedures for correcting the deficiency and/or appealing the ruling to the Claims Administrator.