STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

IN RE: ALL ASBESTOS PERSONAL INJURY CASES

IN RE ALL ASBESTOS v CHEMSTEEL CO
Hon. Robert J. Colombo, Jr. 04/01/2003
03-310422-NP

CMO ORDER #20
AMENDING CMO #17 as to
Participants in Garretson Firm Resolution group Asbestos Non-Malignant Global Resolution Process
and Modifying Reporting Requirements

At a session of said Court in the
Coleman A. Young Municipal Center
in the City of Wayne, County of Wayne
and State of Michigan on MAR - 8 2013

PRESENT: HON. ROBERT J. COLOMBO, JR
CIRCUIT COURT JUDGE

The Court, having met with plaintiff and defendant representatives of the Wayne County Steering Committee, and having discussed the relative merits of permitting certain non-malignant plaintiffs to utilize the Garretson Resolution Group (GRG) Asbestos Non-Malignancy Global Resolution Process to resolve their obligation to Medicare, and to modify other aspects of CMO #17 to further its purposes:

IT IS HEREBY ORDERED that Case Management Order #17 shall be amended to read as follows:

1. For Future Service in Wayne County Asbestos-Related Personal Injury Actions:

a) **Form A - Query Information**: Within 90 days of filing the complaint Plaintiff(s) shall complete and serve electronically, on Lexis/Nexis or other service as the Court may order, Form

A (Exhibit A) enabling Defendants to obtain by query to Medicare or its agency, such as the Centers for Medicare and Medicaid Services ("CMS"), a determination as to whether Plaintiff is Medicare eligible at the time of the query. No signature of a Plaintiff or counsel is required on Form A;

b) **Form B-Reporting Information, Effective as of the May 2013 Trial Group:** Where it has been determined that Plaintiff(s) and/or Plaintiff's Decedent is/was Medicare eligible, Plaintiff(s) shall complete and serve electronically Form B (Exhibit B), except for information requested in boxes 12, 13, 100 and 101 on that Form that shall be discussed at time of settlement, thus providing all defense counsel with information necessary to comply with reporting requirements of MMSEA sec 111. If there are co-personal representatives, then plaintiff's counsel shall also complete "Section D cont." on page 3 of Form B for the additional co-personal representative.

For the May 2013 and July 2013 trial groups, if plaintiff has already served a Form B, then plaintiff's counsel only needs to electronically serve p. 2 of the attached Form B for any plaintiff's spouse who has filed a loss of consortium claim.

No signature of a Plaintiff or counsel is required on Form B. No settlement involving a Plaintiff and/or Plaintiff's Decedent who is or was a Medicare beneficiary is final and enforceable until Form B(s) is(are) provided by Plaintiff(s).

(i) **Loss of consortium claimants**: If there is a loss of consortium claim filed by the plaintiff's spouse who is Medicare eligible, then a Defendant may incorporate the following language in it release:

"I [plaintiff spouse] hereby represent and warrant that I have no bodily or psychological

injury and received no medical treatment related to the injury of [exposed plaintiff]. More specifically, I did not seek any paid professional counseling nor did I receive any medication as a result of psychological distress brought on by the illness of [exposed plaintiff]. I waive any and all past, present and future claims for any such injury. I am not waiving any claims that may exist from my personal exposure to asbestos."

If the loss of consortium plaintiff spouse is not Medicare eligible, then a Defendant may incorporate the following language in its release:

> "I [plaintiff spouse] hereby represent and warrant I am neither eligible to receive, nor a recipient of, Medicare benefits. I have neither received nor applied for Social Security Disability benefits. I have not been diagnosed with end-stage renal failure nor amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease."

Plaintiffs shall not be required to complete any other forms or documents concerning loss of consortium claimants.

9. Procedures for Protection of Medicare's Right of Recovery:

b)(i) **Payment of Medicare Reimbursement; Release of Funds from Escrow/Trust Account:** Once Plaintiff's counsel has received a waiver, final demand or no conditional payment letter from CMS, and Plaintiff's counsel has paid the Medicare recovery claim, if any, Plaintiff's counsel may then pay the net settlements to the client(s) upon providing to Defendants a copy of the waiver, final demand, or no conditional payment letter and proof of payment of said amount. Proof of payment pursuant to terms of the release and this Order means a copy of a draft payable to Medicare or its recipient entity with an amount matching that of the final demand. Plaintiff's counsel may redact the bank name, routing number, account number and signature from the check.

(ii) **Special Procedures for Non-malignant cases;** For non-malignant Plaintiffs enrolled in the GRG Asbestos Non-Malignancy Global Resolution Process, the exposed Plaintiff/Plaintiff's Decedent may satisfy his/her obligations set forth in sub-paragraph (b)(i) by providing Defendants a copy of his/her "Garretson Resolution Group (GRG) Asbestos Non-Malignancy Global Resolution Process Participation Form" (hereafter the "GRG Process Participation Form"), indicating that his/her Medicare recovery claim and reporting obligations have been satisfied. The GRG Process Participation Form - an example of which is attached hereto as Exhibit "C" - must indicate the applicable claim has been "Paid in Full," for the exposed Plaintiff/Plaintiff's Decedent as well as provide the date of the Reconciliation Spreadsheet submitted by GRG listing the Plaintiff/Plaintiff's Decedent, which was approved by CMS.

Plaintiff must further provide a copy of the related correspondence from CMS acknowledging full payment of exposed Plaintiff/Plaintiff's Decedent's Medicare-related claim, including completion of Medicare recovery claim and reporting obligations by applicable parties, for those Plaintiffs/Plaintiff's Decedents listed on the Reconciliation Spreadsheet attached to said CMS correspondence. Plaintiffs shall not be required to produce the Reconciliation Spreadsheet submitted to CMS, however, the CMS correspondence must state that it "represents CMS' approval of the attached Reconciliation Spreadsheet," and specifically reference the date of said Reconciliation Spreadsheet such that the date referenced corresponds with the date on the GRG Process Participation Form. The CMS payment acknowledgment and recovery claim approval letter-an example of which is attached hereto as Exhibit "D" - shall also indicate that MSSEA section 111 reporting has been fulfilled.

In the event an error or mistake arises with regard to a Plaintiff/Plaintiff's Decedent's payment in full of his or her Medicare-related claim as handled under the GRG Asbestos Non-Malignancy Global Resolution Process, and it is subsequently brought to the attention of Plaintiff's Counsel and/or GRG, then Plaintiff's Counsel shall have a reasonable time to correct the error or mistake ensuring payment in full of the Medicare recovery claim, otherwise the underlying settlement shall be deemed void and settlement proceeds promptly returned to the respective Defendants/Releasees.

IT IS SO ORDERED.

ROBERT J. COLOMBO, JR

ROBERT J. COLOMBO, JR.
Circuit Court Judge

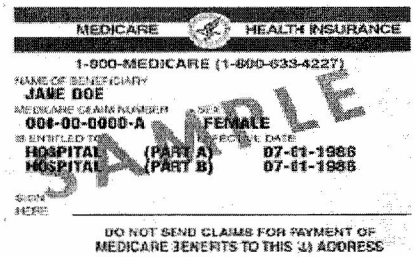
A TRUE COPY
CATHY M. GARRETT
WAYNE COUNTY CLERK
DEPUTY CLERK
BY

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□Yes	□No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)*	- -	**Sex** □Female □Male

Section II

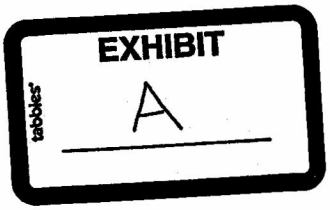
I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.



Section III

_____ _____

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form **Date**

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 02-15-2013 MI)

Case Name:	Case Number:	17. State of Venue: (USPS Abbreviation)
Defendant Name:		

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A and/or B?

☐ Yes ☐ No

Section A ALLEGED INJURED PARTY INFORMATION *(If a party is DECEASED, also complete Section D. If living, provide address in Section G)*

4. Medicare Claim Number: (also known as HICN)

5. Social Security Number:	6. Injured Party Last Name: (Please print name as it appears on Social Security card.)
7. Injured Party First Name: (Please print name exactly as it appears on Social Security card.)	8. Injured Party Middle Name: (Please print name exactly as it appears on Social Security card.)

9.Gender: ☐ Male ☐ Female	10. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):

Section B ALLEGED INCIDENT INFORMATION

12. CMS Date of Incident: Please state the date of the accident or date of **first exposure**, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

13. Industry Date of Incident: Please state the date of accident or date of **last exposure**, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

15. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes):

19. ICD-9 Diagnosis Code 1 (no decimal):

Provide valid ICD-9-CM Codes for any injury or illness you allege arose from the allegations made against settling defendant.

21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:

Description of Illness/Injury (Free Form Text Description):

Section C ALLEGED INJURED PARTY'S ATTORNEY or OTHER REPRESENTATIVE INFORMATION

84. Claimant Representative Type (please check one):

☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

85. Claimant Representative Last Name:	86. Claimant Representative First Name:	87. Claimant Representative Firm Name:
88. TIN/EIN, if Firm Entity; SSN. if Individual:	89-90. Representative Mailing Address:	

91. City:	92. State:	93-94. Zip Code +4:	95. Phone:	96. Ext. (if any):

Section D CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

If Section D Claimant has a representative other than Section C Representative, complete Section F

104. Claimant Relationship to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

105. TIN/EIN (Social Security, if individuals):	106. Claimant Last Name:
107. Claimant First Name:	108. Claimant Middle Initial:

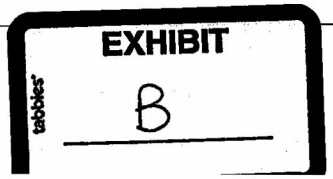
109. Claimant Entity/Organization Name:

110. Mailing Address:

112. City:	113.State:	114. Zip Code+4:	116. Phone:	117. Ext. (if any):

Section E SETTLEMENT INFORMATION

100. Date of Settlement:	101. Amount of Settlement:



Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 02-15-2013 MI)

Section A-LOC	LOSS OF CONSORTIUM PLAINTIFF INFORMATION THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT PROVIDE ESTATE INFORMATION IN SECTION D

4-LOC. Medicare Claim Number: (also known as HICN)			
5-LOC. Social Security Number:	6-LOC. Last Name: (Please print name exactly as it appears on Social Security card.)		
7-LOC. First Name: (Please print name exactly as it appears on Social Security card.)		8-LOC. Middle Name: (Please print name/initial exactly as it appears on Social Security card.)	
9-LOC Gender: ☐ Male ☐ Female	10-LOC. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):
15-LOC. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes): (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 19-LOC)			
19-LOC. ICD-9 Diagnosis: (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)			

Signature of Attorney representing Plaintiff/Claimant(s) _____ Date _____ Printed Name

The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this form and that all information stated herein is well grounded in fact to the best of his/her knowledge, information and belief formed after reasonably inquiry.

***Numbers reflect claim input file field numbers, as set forth in Version 3.2 of the Official NGHP User Guide by CMS.**

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 02-15-2013 MI)

Case Name:	Case Number:
Defendant Name:	

Section F CLAIMANT'S (found in Section D) ATTORNEY OR OTHER REPRESENTATIVE INFORMATION

119. Claimant Representative Type (please check one):

☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

120. Claimant Representative Last Name:	121. Claimant Representative First Name:	122. Claimant Representative Firm Name:
123. TIN/EIN, if Firm Entity; SSN. if Individual:	124. Representative Mailing Address:	

126. City:	127. State:	128. Zip Code +4:	129. Phone:	130. Ext. (if any):

Section G ALLEGED INJURED PARTY'S ADDRESS

Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section D cont. ADDITIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Claimant Relation to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:
Claimant Entity/Organization Name:	
Mailing Address:	

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):

☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:
TIN/EIN, if Firm Entity; SSN. if Individual:	Representative Mailing Address:	

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section B cont. Additional ICD-9 fields, if necessary

31. ICD-9 Diagnosis Code 7:	33.ICD-9 Diagnosis Code 8:	35 ICD-9 Diagnosis Code 9:	37.ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43.ICD-9 Diagnosis Code13:	45.ICD-9 Diagnosis Code 14:	47.ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:

51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:

If additional Section D Claimants exist, use page 3 and duplicate page, if necessary.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 02-15-2013 MI)

Field#	Field Name	Definition:
4	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Injured Party's Medicare Health Insurance Claim Number (if one has been issued).This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Injured Party's Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide last name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
7	FIRST NAME	Provide first name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
8	MIDDLE INITIAL	Provide middle initial of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITYCARD** or Medicare Card if available.
9	GENDER	Indicate Alleged Injured Party's gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Injured Party's Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
12	CMS DATE OF INCIDENT	Provide Date of Incident (DOI). DOI as defined by CMS: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of FIRST exposure. For claims involving ingestion (for example, a recalled drug), it is the date of FIRST ingestion. For claims involving implants it is the date of the implant (or date of the first implant if there are multiple implants).
13	INDUSTRY DATE OF INCIDENT	Provide Industry Date of Incident (DOI) routinely used by the insurance/workers' compensation industry: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, or implantation, the date of incident is the date of LAST exposure, ingestion, or implantation.
15	ALLEGED CUASE OF INJURY, ILLNESS OR INCIDENT	Claimant must provide either: 1) **both** a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) **and** at least one valid ICD-9 Diagnosis Code (Field 19) **OR** 2) the Description of Illness/Injury(Field 57). **Claims submitted on or after 1/1/11**, Claimant must provide **both** a valid Alleged Cause of Injury, Incident,or Illness Code (Field 15) **and** at least one valid ICD-9 Diagnosis Code. (See notes above for Spouse injury codes)
17	STATE OF VENUE	Provide the US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Use "US" where the claim is a Federal Tor Claims Act liability insurance matter or a Federal workers' compensation claim.
19-55	ICD-9 DIAGNOSIS CODE 1 - 19	(International Classification of Diseases, Ninth Revision, Clinical Modification) - Must be on the current list of valid codes accepted by CMS found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp At least one valid diagnostic code must NOT be on the list of insufficient codes (found in Appendix H to the NGHP User Guide, V. 2.0,and NOT an E or a V Code). (See notes above for Spouse injury codes)
57	RESERVED FOR FUTURE USE	Formerly used for the obsolete – Description of Illness / Injury
84	REPRESENTATIVE TYPE	Indicate the type of representative that the Alleged Injured Party has. Select from the options provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O= Other. If Alleged Injured Party has more than one representative, provide attorney information, if available.
85	REPRESENTATIVE LAST NAME	Provide Last Name of Representative.
86	REPRESENTATIVE FIRST NAME	Provide First Name of Representative.
87	REPRESETNATIVE FIRM NAME	Provide the Name of the Representative's Firm.
88	TIN/EIN, IF FIRM/ENTITY;SOCIAL SECURITY NUMBERIF INDIVIDUAL	Provide Alleged Injury Party's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
89	MAILING ADDRESS	Provide mailing address for the alleged injured party's representative named above.
91	CITY	Provide mailing address city for the alleged injured party's representative named above.
92	STATE	Provide mailing address state for the alleged injured party's representative named above
93	ZIP CODE +4	Provide mailing address zip code for the alleged injured party's representative named above. IncludeZip+4 code if known; if not known enter 0000.
95	PHONE	Provide telephone number of alleged injured party's representative.
96	PHONE EXTENSION, IF ANY	Provide telephone extension of alleged injured party's representative, if extension is available.
100	DATE OF SETTLEMENT	Date the Release is signed unless court approval is required - then it is the later of the date the Release is signed or thedate of court approval. If there is no written agreement, then it is the date of payment.
101	AMOUNT OF SETTLEMENT	Provide total amount of Settlement
104	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe")Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
105	TIN/EIN, IF ENTITY;SOCIAL SECURITY NUMBER,IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number(TIN)/Employer Identification Number (EIN) if claimant is an entity.
106	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
107	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
108	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
109	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 02-15-2013 MI)

110	MAILING ADDRESS	Provide mailing address for claimant.
112	CITY	Provide mailing address city of the claimant.
113	STATE	Provide mailing address state of the claimant.
114	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
116	PHONE	Provide telephone number of the claimant
117	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
119	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of representative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored
120	CLAIMANT REPRESENTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
121	CLAIMANT REPRESENTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
122	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
123	TIN/EIN, IF FIRM/ENTITY; SOCIALSECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
124	CLAIMANT REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
126	CLAIMANT REPRESENTATIVE CITY	Provide mailing address city for the claimant's representative.
127	CLAIMANT REPRESENTATIVE STATE	Provide mailing address state for the claimant's representative.
128	CLAIMANT REPRESENTATIVE ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
130	CLAIMANT REPRESENTATIVE PHONE	Provide telephone extension of claimant's representative, if extension is available.
131	CLAIMANT REPRESENTATIVE PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

GARRETSON
RESOLUTION GROUP

February 13, 2013

The Garretson Resolution Group Asbestos Non-Malignancy Global Resolution Process
Process Participation Form

This letter is to confirm [redacted]'s enrollment in the Garretson Resolution Group ("GRG") Asbestos Non-Malignancy Global Resolution Process (the "Process"), for Medicare's Fee-For Service Parts A & B Recovery Claim (the "Claim"). The Process is designed to ensure Medicare is properly considered and satisfied for asbestos Level I-III non-malignancy liability insurance (including self-insurance) settlements. This Process includes entitlement screening and exposure screening to establish [redacted]'s last date of exposure. Further, please find information relating to [redacted]'s status in the Process.

Claimant Status Detail:

Law Firm:	Zamler, Mellen & Shiffman
Claimant Last Name:	[redacted]
Claimant First Name:	[redacted]
SSN #:	[redacted]
DOB:	[redacted]
DOD:	
Gender:	Male
Process Enrollment Date:	12/16/2011
Medicare Entitled:	YES
Process Status:	EP80F
Exposure on or after December 5, 1980:	YES
Injury Classification Secured/Level:	YES /LEVEL II
Global Recovery Obligation:	YES
Global Recovery Payment Type:	PAID IN FULL
Global Recovery Amount:	$175.00
CMS Approved Reconciliation Spreadsheet Date:	8/8/2012

A pre-determined Medicare recovery amount was deducted from [redacted]'s settlement. Gerald Bradshaw has been determined to be a Medicare-entitled Asbestos Non-Malignancy claimant with post-1980 exposure. This one-time payment satisfies the Claim, which is associated with all Asbestos Levels I-III non-malignancy awards for [redacted] with a total payment obligation to claimants ("TPOC") made prior to 1/1/2017. As detailed in the CMS letter dated March 15, 2012 (on file with GRG and located on the Asbestos Non-Malignancy web portal), mandatory reporting for Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), is not required for a liability TPOC settlement. This Process is in no way meant to satisfy Medicare's interest against future recoveries for any injury outside of the nationally recognized asbestos non-malignancy injuries, Levels I-III. If [redacted] pursues a secondary injury (including transition within Levels I-III) and secures a settlement, judgment, award, or other payment, a new reimbursement obligation may arise, which will require a separate and unique resolution. Zamler, Mellen & Shiffman is to report to GRG, via the Process web portal, any claimant's injury progression inside the qualified Levels I-III in addition to any secondary injury progression (i.e. severe asbestosis, cancer, mesothelioma).

The aforementioned illustrates the multiple benefits derived by participating in a "global" resolution process with Medicare. However, it should be noted that as opposed to the traditional method of Medicare claims resolution, Medicare does not issue individual recovery letters to those individuals participating in a "global" resolution process. Therefore, by participating in the "global" resolution process, Zamler, Mellen & Shiffman, in acting as authorized representative for [redacted], has waived [redacted]'s individual rights to seek a waiver, compromise, and/or appeal of Medicare's reimbursement claim, which may have otherwise been available pursuant to 42 U.S.C. §1395ff. The information provided can be relied on as accurate and complete for all parties involved as of the date on this letter, February 13, 2013.

Please verify that all the information contained herein is correct. Please contact GRG (866.694.4446) for any additional information or to secure a copy of the CMS March 15, 2012 letter.

From: Martin, Nicholas R. (CMS/OFM)
Sent: Tuesday, September 11, 2012 5:29 PM
To: Sylvius von Saucken
Cc: Jason Wolf (garretsonfirm); Kristen Marino; Debra Forsythe; Dianne Trull; Martin, Nicholas R. (CMS/OFM); [redacted] (CMS/OFM); Wright, Barbara J. (CMS/OFM); [redacted] (CMS/OFM); [redacted] (CMS/OFM)
Subject: Asbestos Non-Malignancy Global Reconciliation - August 2012

Dear Sylvius,

1. Please refer to the attached March 15, 2012 letter from Barbara Wright regarding The Garretson Firm Resolution Group (GFRG) Asbestos Non-Malignancy Global Resolution Process.

2. Regarding the following terms in the bullets set forth below –
   - " MSP Part A and Part B fee-for-service recovery claim obligations" refers to such obligations with respect to each Medicare beneficiary's asbestos related settlements, judgments, awards or other payments which are included in either Universe referenced in the March 15, 2012 letter.
   - "Reconciliation Spreadsheet" means the GFRG reporting and accounting spreadsheet referenced in the March 15, 2012 letter, which was titled "GFRG Asbestos Non-Malignancy Global Resolution Process Detail Reconciliation Spreadsheet."

3. In accord with the March 15, 2012 letter, this email confirms that CMS has received check [redacted], dated August 15, 2012, for [redacted] from GFRG for the period of April 2012 – June 2012 related to this matter.

4. This email also represents CMS' approval of the attached Reconciliation Spreadsheet dated **August 8, 2012**.

5. Review of the payment received and the Reconciliation Spreadsheet confirms [redacted] Medicare beneficiaries have completed their MSP Part A & Part B fee-for-service recovery claim obligation under the terms of the March 15, 2012 letter, provided these individuals do not incur additional obligations resulting from a change in their asbestos non-malignancy injury categories. There were [redacted] additional Medicare beneficiaries included in this payment and reconciliation, but their entire MSP Part A & Part B fee-for-service recovery claim obligation has not been met at this time. These Medicare beneficiaries' obligations will be released at a later date, pending future payments to Medicare.

6. See the March 15, 2012 letter with respect to MMSEA section 111 reporting. Section 111 reporting is deemed fulfilled with respect to each liability insurance TPOC settlement, judgment, award, or other payment released pursuant to this correspondence. Similarly, Section 111 reporting is deemed fulfilled with respect to each TPOC settlement, judgment, award, or other payment for which partial payment is acknowledged in this correspondence. To the extent there is associated liability insurance ORM, the reporting requirements for such ORM remain in effect.

Regards,

Nicholas Martin
Centers for Medicare & Medicaid Services
Office of Financial Management
Financial Services Group
Division of Medicare Debt Management
[redacted]

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT