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 #21
AMENDING CMO #17 and #20 as to Release Language

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 JUN 21 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 the inclusion of particular release language when certain non-malignant Plaintiffs utilize the Garretson Resolution Group Asbestos Non-Malignancy Global Resolution Process (GRG Process) to resolve their obligation to Medicare, and to modify other aspects of CMO #17 and #20 to further its purposes:

IT IS HEREBY ORDERED that Case Management Order #17 and #20 shall be amended to include the following:

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

b) **Form B-Reporting Information, Effective for Trial Groups after July 31, 2013:**

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 A), except for information requested in boxes 12, 13, 100 and 101 on that Form, which shall be discussed at the time of settlement, thus providing all Defense counsel with information necessary to comply with reporting requirements of MMSEA sec. 111. Box 15 need not be completed.

For the July 2013 trial group, 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).

Where the exposed individual is deceased, Plaintiff need not provide answers to Fields 104 – 117 and 119 – 130 on Form B.

*[b)(i) **Loss of consortium claimants** unchanged from CMO 20]*

b)(ii) **Exposed Claimants, not Medicare eligible:** If the exposed claimant is not Medicare eligible, then a Defendant may incorporate the following language in its release:

"I hereby make the following representations and warranties in affirming that I am not eligible for Medicare and that Medicare has not made any conditional payments for any medical expenses or prescription expense related to my injury: I have not applied for Medicare; I am not currently receiving Social Security Disability Benefits (SSD), or if I am, then I have been a recipient of SSD for less than 24 months; I am not in End Stage Renal Failure; I have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease."

Where the exposed claimant is deceased, a Defendant may incorporate the following language in its release:

"I [estate administrator] hereby represent and warrant that to my knowledge, Decedent was neither eligible to receive, nor a recipient of, Medicare benefits; Decedent did not receive Social Security Disability Benefits (SSD) prior to his death, or if he did, then Decedent was a recipient of SSD for less than 24 months; Decedent was not diagnosed with End Stage Renal Failure nor with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease."

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

[sections a), b) i) and ii), and c) unchanged from CMO 17 and 20]

b)(iii) **Special Release Language for Plaintiff(s) or Decedent(s) enrolled in the GRG Process:**

Where there is a settlement with a GRG Process Plaintiff/Decedent, a Defendant may incorporate the following language in its release:

"Releasors represent and warrant that they are aware that if Releasors have sought and/or obtained any treatment from a Medicare Part C and/or D provider, then Releasors may be obligated to reimburse the Medicare Part C and/or D provider. Should a Medicare Part C and/or D provider assert a lien prior to the release of settlement funds, then Releasors agree to instruct their Counsel to escrow the amount of funds at issue with the Medicare Part C and or D provider until the reimbursement is resolved. If the settlement funds have been released, Releasors remain obligated to resolve the Medicare Part C and/or D provider's conditional payment and/or lien. Upon resolution with a Medicare Part C and/or D provider, Releasors shall provide Releasees with proof of same."

IT IS SO ORDERED.

ROBERT J. COLOMBO, JR.
Circuit Court Judge

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (MI Rev 06-13)

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	Part B	Part C	Part D
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Section A ALLEGED INJURED PARTY INFORMATION *(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) optional field:

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 ☐ Unknown

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):

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

Section D 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) ☐ Unknown

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):*

ection E SETTLEMENT INFORMATION

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

EXHIBIT A

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (MI Rev 06-13)

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

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)

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

he 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 3.4 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 (MI Rev 06-13)

Case Name:	Case Number:
Defendant Name:	

Optional 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):

Optional 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):*

ection B cont. — **Additional ICD-9 fields, if necessary**

1. 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:
1. 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:

1. 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 (MI Rev 06-13)

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	OPTIONAL FIELD 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	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The

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	ENTITY/ORGANIZATION NAME	Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
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.