

| SULZER SETTLEMENT TRUST CLAIMS ADMINISTRATOR PROCEDURE | | | |
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| CAP No. | 23 | Effective Date | OCTOBER 7, 2002 |
| SUBJECT | Health Care Provider Requests for Payment of Unpaid Coinsurance and Deductible Bills | | |

Purpose. The Class Action Settlement Agreement in *In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation* (“Settlement Agreement”) provides that the Claims Administrator shall “use all reasonable efforts to make payments to Class Members as early as possible pursuant to guidelines approved by the Court with input from Class Counsel and the State Special Counsel Committee.” [SA§ 4.6(i)]. Under the Settlement Agreement, each Class Member is financially responsible for any coinsurance and deductibles which the Class Member may owe in connection with an Affected Product Revision Surgery. This Claims Administrator Procedure (“CAP”) establishes a procedure to permit payment to certain health care providers of unpaid coinsurance and deductible bills from Class Member Settlement benefits. For purposes of this CAP, “coinsurance” is the fixed percentage of the total amount paid for health care services that is the responsibility of the Class Member and “deductible” is the amount of medical services that must be incurred before benefits (subject to the deductible) becomes payable. Coinsurance and deductibles do not include any amounts above a provider’s contracted reimbursement rate or fee schedule established by a third-party payor. Capitalized terms not otherwise defined in this CAP shall have the meanings given them in the Settlement Agreement.

Procedure for Collecting Provider Requests for Payment. Health care providers and suppliers (“Providers”) who request payment for unpaid coinsurance and/or deductibles may request an appropriate Provider Coinsurance Form, attached as Exhibit A to this CAP, from the Claims Administrator. Upon receipt of a Provider Coinsurance Form, and a valid and complete Claim for Settlement benefits, the Claims Administrator shall ask the Class Member whose benefits are the subject of the Provider Coinsurance Form whether the Class Member authorizes the Claims Administrator to deduct any unpaid coinsurance or deductible expenses from the Class Member’s Settlement benefits and to pay directly such amounts to the Provider seeking reimbursement. If the Class Member refuses to authorize the deductions, the Claims Administrator shall (1) inform the Class Member that no additional Settlement benefits are available to pay for the unpaid coinsurance and/or deductible amount being asserted by the Provider and, further, that the Class Member will be responsible for satisfying any coinsurance or deductible claims validly asserted by the Provider, and (2) notify the Provider that the Class Member has refused to authorize the deduction from their Settlement benefits.

Limitations on Payments. In no event shall any coinsurance or deductible payment made to a Provider pursuant to this CAP be paid from any Class Member’s Guaranteed Payment Option payment pursuant to Article 8 of the Settlement Agreement. In no event shall any coinsurance or deductible payment be made to a Provider without the affected Class Member’s written consent or an order from the Court directing such payment. Neither the Claims Administrator nor the Sulzer Settlement Trust shall be liable to any person or entity for payment, or non-payment of a Provider, pursuant to this CAP. Providers and Class Members who

participate individually or jointly in any payment agreement pursuant to this CAP agree to indemnify and hold harmless the Claims Administrator, his agents and employees, and the Sulzer Settlement Trust for any alleged liability stemming from any payment, or non-payment alleged to have been made, or not made, pursuant to, or in derogation of, this CAP. No payment pursuant to this CAP shall be greater than \$2500 with respect to any Affected Product Revision Surgery.

Duration of this CAP. This CAP shall be effective from the Effective Date stated above and shall terminate upon the earlier of: (i) cancellation or modification of this CAP by the Claims Administrator, or (ii) an order of the Court canceling or modifying the terms of this CAP.

APPROVED:

CLAIMS ADMINISTRATOR

By: _____

(signature)

Name: James J. McMonagle

Date: October 5, 2002

CLASS COUNSEL

By: _____

(signature)

Name: R. Eric Kennedy

Date: October 7, 2002

Exhibit A

In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401

**Application for Payment of Coinsurance and/or Deductible Payments
From Class Members' Class Action Settlement Benefits**

Instructions for Completing this Form:

- This Form should be completed by a health care provider ("Provider") who believes he or she is owed money by an Affected Product Recipient for unpaid coinsurance or deductible payments.
- For purposes of this form "coinsurance" is the fixed percentage of the total amount paid for health care services that is the responsibility of the Class Member and "deductible" is the amount of medical services that must be incurred before benefits (subject to the deductible) becomes payable. Coinsurance and deductibles do not include any amounts above a provider's contracted reimbursement rate or fee schedule established by a third-party payor.
- This Form must be fully completed for the Claims Administrator to process payment. The Claims Administrator shall only make payments to Providers pursuant to this Form if the Affected Product Recipient whose Claim is affected consents in writing, by signing this Form.
- All payments made pursuant to this Form shall be made from the Class Member's Settlement benefits, if any, after the Class Member makes appropriate application as required by the Settlement Agreement and after the Class Member's Claim for benefits has been processed by the Claims Administrator in accordance with the Settlement Agreement.
- All capitalized terms not defined in this Form shall have the meaning given them in the Settlement Agreement in *In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401*.
- If this Form does not have the Class Member's signature authorizing payment from his or her Settlement benefits, the Claims Administrator shall forward this Form to the Class Member for his or her signature. If the Class Member fails to return a signed copy of this Form to the Claims Administrator, the Claims Administrator shall not pay any amount to the requesting Provider unless the Court issues an order directing such payment. If the Class Member does not authorize this deduction, the Class Member is responsible for making payments to the submitting Provider for the coinsurance and deductible obligations relating to an Affected Product Revision Surgery.
- **Payments made pursuant to this Form are not an additional benefit for Class Members or Third Party Payors or other health care providers. Payments pursuant to this Form are a deduction from Class Members' Settlement benefits. By way of example, if a Class Member agrees to payment of \$1,000 pursuant to this Form, and was otherwise eligible for Settlement benefits in the amount of \$160,000, the Claims Administrator shall pay \$159,000 to the Class Member, and \$1,000 to the Provider named in this Form. No payment made pursuant to this Form shall be deducted from a Class Member's GPO Payment, if any.**
- This Form must be completed by the Provider and the Affected Product Recipient and/or the Representative Claimant to whom it applies no later than 10 days after the Claims Administrator issues a Final Determination regarding the Class Member's Claim.

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| 1. | Name and Address of Affected Product Recipient. | |
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In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401

Application for Payment of Coinsurance and/or Deductible Payments

From Class Members' Class Action Settlement Benefits

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| 2. | Name and Address of Representative Claimant, if any and if known, of Affected Product Recipient. (Representative Claimants are the estate, administrator or other legal representative, trust or "special needs trust" of an Affected Product Recipient). | |
| 3. | Name, address, and telephone number of Provider claiming that Affected Product Recipient owes coinsurance or deductible. (Include contact person at Provider's billing department, office or finance department). | |
| 4. | Dates and nature of services provided for which coinsurance or deductible is owed to Provider. | Provider must attach to this Form the claim form for services rendered (i.e., the HCFA-1500 or UB-92 forms). |
| 5. | Total amount that Provider seeks to be paid for coinsurance and/or deductibles. | In addition to noting in this block the total amount Provider requests, Provider must attach to this Form a copy of the remittance advice or explanation of benefits (EOB) received from the Affected Product Recipient's third-party payor. |

In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401

Application for Payment of Coinsurance and/or Deductible Payments

From Class Members' Class Action Settlement Benefits

6.

Signature of Provider seeking payment of coinsurance or deductible.

I certify that the above-stated amounts are due and owing from the Class Member to the Provider identified above in Line 3. I am authorized to act on behalf of the Provider identified in Line 3. I agree that neither the Sulzer Settlement Trust, nor the Claims Administrator, nor any of his agents or employees are responsible for any lien payment, or failure to make a lien payment, as described in this form. I understand that the Claims Administrator shall not make any payment to me on behalf of the Provider in Line 3 unless and until the Affected Product Recipient or Representative Claimant identified in Lines 1 and 2 agree to the payment or until the Claims Administrator receives an Order from the United States District Court for the Northern District of Ohio directing such payment. I understand that no payment made pursuant to this Form shall be made from a Class Member's Guaranteed Payment Option payment, if any. I agree to hold the Sulzer Settlement Trust, the Claims Administrator, and any or his agents or employees harmless for any action arising from payment, or not, pursuant to this Form.

_____ Date

_____ Provider Signature / Title

Instructions to the Affected Product Recipient and/or Representative Claimant:

- By signing this Form, you authorize the Claims Administrator to pay the Provider named above the amount specified above from your Settlement Benefits. Any amount paid pursuant to this Form will reduce the amount of Settlement benefits paid to you by the same amount.
- **Payments made pursuant to this Form are not an additional benefit for Class Members or Third Party Payors or other health care providers. Payments pursuant to this Form are a deduction from Class Members' Settlement benefits. By way of example, if a Class Member agrees to payment of \$1,000 pursuant to this Form, and was otherwise eligible for Settlement benefits in the amount of \$160,000, the Claims Administrator shall pay \$159,000 to the Class Member, and \$1,000 to the Provider named in this Form. No payment made pursuant to this Form shall be deducted from a Class Member's GPO Payment, if any.**
- Sign this Form as indicated in Row 7 if you agree to payment to the Provider named in this Form as indicated above. After signing return this Form to the Claims Administrator at:

Claims Administrator (c/o Sulzer Settlement Trust)
P.O. Box 94558
Cleveland, Ohio 44101-4558

- **The Claims Administrator must receive this Form no later than 10 days after issuing a Class Member's Final Determination.**

In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401

Application for Payment of Coinsurance and/or Deductible Payments

From Class Members' Class Action Settlement Benefits

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| 7. | Signature of Affected Product Recipient. | <p>I authorize the Claims Administrator to deduct the amount in Line 5 above from my Settlement benefit award, if any, and to pay that amount directly to the Provider identified on Line 3. I agree that neither the Sulzer Settlement Trust, nor the Claims Administrator, nor any of his agents or employees are responsible for any lien payment, or failure to make a lien payment, as described in this Form and shall not be held liable by me and shall be held harmless by me for any action arising from any payment, or not, pursuant to this Form.</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Affected Product Recipient Signature (or Representative Claimant if applicable).</p> |
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