

## **BAYCOL THIRD PARTY PAYOR PROOF OF CLAIM FORM INSTRUCTIONS**

**IMPORTANT NOTICE:** IN ORDER FOR A THIRD-PARTY PAYOR CLASS MEMBER TO BE ELIGIBLE TO RECEIVE A SHARE OF THE SETTLEMENT PURSUANT TO THE PLAN DESCRIBED IN THE ACCOMPANYING NOTICE, A COMPLETED, PROPERLY PREPARED AND SIGNED PROOF OF CLAIM FORM WITH SUPPORTING DOCUMENTATION MUST BE SENT BY THE CLASS MEMBER OR ON ITS BEHALF BY ITS AUTHORIZED AGENT TO THE SETTLEMENT ADMINISTRATOR AT THE ADDRESS LISTED BELOW, VIA CERTIFIED FIRST-CLASS MAIL, RETURN RECEIPT SERVICE, SO THAT IT SHALL BE RECEIVED NO LATER THAN SEPTEMBER 16, 2006:

**Baycol TPP Settlement Administrator  
c/o The Garden City Group, Inc.  
P.O. Box 9000 #6386  
Merrick, NY 11566-9000**

Class Members are all “Third-Party Payors” (TPPs) throughout Pennsylvania and the United States (excluding all governmental entities, Defendants and Defendants’ respective subsidiaries and affiliates) who have purchased Baycol, or reimbursed their Insureds/Beneficiaries for their purchases of Baycol, that is unusable and/or have incurred additional expenses associated with Baycol’s withdrawal and who did not previously opt-out of the Certified Class.

The Class Member or its Authorized Agent may complete this Claim Form. In the event that Claim Forms are filed by both a Class Member and another entity that purports to be the Authorized Agent of that Class Member, the Settlement Administrator will consider only one of the submitted Claim Forms, at the discretion of the Settlement Administrator.

The Settlement Administrator or Defendants may request additional information or supporting documentation in order to verify the accuracy of the Claim and to prevent duplication or other improper payment. Failure to provide documentation reasonably required by the Settlement Administrator or Defendants constitutes grounds for rejection of the Class Member’s claim.

If you are an Authorized Agent and a Class Member has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section C in addition to the other information requested by this Claim Form. You must submit a separate Claim Form for each Class Member that has duly authorized you to submit a claim on its behalf. If you are submitting Claim Forms both on your own behalf as a Class Member AND on behalf of a Class Member that has authorized you to do so, you should submit one Claim Form for yourself and another Claim Form for the other Class Member. **Do not submit a Claim Form on behalf of any Class Member without specific prior authorization from that Class Member.**

The completed Claim Form and supporting documentation submitted by a Class Member shall be kept as confidential except that it may be disclosed to Defendants, Defense Counsel, Class Counsel, the Settlement Administrator, and any necessary administrative personnel involved in administering the Settlement or auditing claims. Such information may also be disclosed by Defendants in other proceedings to the extent reasonably necessary to defend against claims resolved by the Stipulation of Settlement.

**Class Members that have released Bayer and/or GlaxoSmithKline pursuant to any Baycol-related settlement agreement are not entitled to participate in this Settlement.**

If you have any questions, please call the Settlement Administrator at 1-800-283-9804.

**Must Be Received  
No Later Than  
September 16, 2006**

**BAYCOL THIRD PARTY PAYOR  
PROOF OF CLAIM FORM**

**SECTION A – TYPE OF CLAIMANT**

This Claim Form is being filed by: (select one)

- A.  Class Member on its own behalf **OR**
- B.  Authorized Agent of a Class Member. The Authorized Agent’s relationship with the Class Member is best described as:
  - Third Party Administrator (other than Pharmacy Benefits Manager)
  - Pharmacy Benefits Manager
  - Other. Explain: \_\_\_\_\_

If you checked A, complete Sections B and D through G, but skip Section C  
 If you checked B, complete Sections C through G, but skip Section B

**SECTION B – CLAIMANT IDENTIFICATION**

\_\_\_\_\_  
 Class Member’s Name

\_\_\_\_\_  
 Class Member’s Name as of August 8, 2001 (if different than listed above)

\_\_\_\_\_  
 Street Address City State Zip Code

(\_\_\_\_)\_\_\_\_\_  
 Area Code – Telephone Number

(\_\_\_\_)\_\_\_\_\_  
 Area Code – Fax Number

\_\_\_\_\_  
 Federal Employer Identification Number (FEIN)

Any other name(s) by which you have been known or other FEIN(s) you have used after January 1, 2001, and the time period during which such other name(s) or FEIN(s) were used:  
 \_\_\_\_\_

Please identify the name of the entity to whom any settlement check should be written and where such check should be mailed (if different than the Class Member name and the address listed above):  
 \_\_\_\_\_

**SECTION B – CLAIMANT IDENTIFICATION (CONTINUED)**

Check the term below that best describes your company/entity:

- Health Insurance Company/HMO
- Self-Insured Employee Health Plan
- Self-Insured Union Health & Welfare Fund
- Other. Explain: \_\_\_\_\_

From July 1, 2001 to August 8, 2001, have payments for Baycol been made on your company/entity’s behalf by another entity, such as a health insurance company, third party administrator (TPA) or pharmacy benefits manager (PBM)?

( ) YES ( ) NO

If your answer to the above question is “YES”, identify all insurance companies, TPAs or PBMs or other entities that have paid for Baycol on your behalf, and provide the name of the entity and the region where the entity provided the services (e.g., a particular state or area of the country):

\_\_\_\_\_  
\_\_\_\_\_

**SECTION C – CLAIM BY AUTHORIZED AGENT OF CLASS MEMBER**

Authorized Agent’s Name

Authorized Agent’s Name as of August 8, 2001 (if different than listed above)

Street Address	City	State	Zip Code
(____)_____		(____)_____	
Area Code – Telephone Number		Area Code – Fax Number	

Authorized Agent’s Federal Employer Identification Number (FEIN)

Please list the name of the plan, the entity sponsoring the plan and the FEIN of the plan or the sponsoring entity for the Class Member for whom you have been duly authorized to submit this Claim Form.

\_\_\_\_\_  
\_\_\_\_\_

Please identify the name of the entity to whom any settlement check should be written and where such check should be mailed (if different than the Authorized Agent name and address listed above):

\_\_\_\_\_  
\_\_\_\_\_

**SECTION D – INFORMATION NECESSARY TO CALCULATE CLASS MEMBER’S SHARE OF SETTLEMENT MONEY**

As explained in the Notice, a Class Member that submits an Approved Claim shall be paid an amount determined by application of one of the following Formulas, at the Class Member’s election: (1) **Formula A:** one hundred fifty percent (150%) of the amount that the Class Member demonstrates was its Actual Net Cost for Baycol that was unused by its Insureds/Beneficiaries (“unused Baycol”) as of August 8, 2001; or (2) **Formula B:** eighty-two and one half percent (82.5%) of the amount the Class Member demonstrates was its Actual Net Cost for Baycol prescriptions filled by its Insureds/Beneficiaries during the period from July 1, 2001 to August 8, 2001. **Class Counsel believes that Formula A will generally provide Class Members with a greater recovery than Formula B.**

“Unused Baycol” for each Insured/Beneficiary is defined as the number of tablets in an Insured’s/Beneficiary’s last prescription of Baycol prior to its withdrawal minus the number of days between August 8, 2001 and the date on which that prescription was filled. Thus, for example, the unused Baycol for a 30 tablet prescription filled on August 1, 2001, is deemed to be 23 tablets, *i.e.*, 30 tablets minus 7 days. For a 60 tablet prescription filled on July 1, 2001, the unused Baycol is deemed to be 22 tablets, determined as 60 tablets minus 38 days.

“Actual Net Cost” under either Formula A or Formula B is defined as the amount paid for Baycol less any discounts, credits or other reductions in price, and does not include any co-payments or co-insurance paid by the Class Member’s Insureds/Beneficiaries. Under Formula A, the “Actual Net Cost” for unused Baycol is defined as the per-tablet cost for Baycol (calculated as the net amount paid or reimbursed by the Class Member for a Baycol prescription divided by the total number of tablets in that prescription) multiplied by the number of unused Baycol tablets.

Depending upon which Formula is elected, for the Class Member on whose behalf a claim is submitted, state **EITHER:**

**Formula A.**

The Actual Net Cost paid directly or reimbursed to Insureds/Beneficiaries for Baycol that was unused by Insureds/Beneficiaries as of August 8, 2001:

\$\_\_\_\_\_;

**OR**

**Formula B.**

The Actual Net Cost paid directly or reimbursed to Insureds/Beneficiaries for Baycol prescriptions filled during the period from July 1, 2001 to August 8, 2001:

\$\_\_\_\_\_.

**The Class Member also shall provide supporting documentation of the “Actual Net Cost” claimed above, as described below in Section E.**

*Claimant certifies that the figures are true and accurate and are based upon actual records maintained or otherwise available to the claimant.*

**SECTION E – DOCUMENTATION NECESSARY FOR APPROVED CLAIM**

You must supply with the Claim Form reasonably detailed supporting business records in paper copy or electronic format and a written report (“Baycol Reimbursement Report”) summarizing such information to have your claim considered by the Settlement Administrator. Below is a template for the Baycol Reimbursement Report reflecting the required data fields necessary for your participation in the Settlement. Please provide the required data fields, as presented in the below template spreadsheet, for all paid claims that formed the basis for the amount claimed in Section D. Please provide the detailed supporting business records and Baycol Reimbursement Report along with the Claim Form to the Settlement Administrator no later than *September 16, 2006*:

***If using Formula A:***

1. *NDC Number* – provide the applicable NDC Number for each prescription.
2. *Patient Identifier* – provide a randomly generated patient identification number for each transaction.
3. *Fill Date* – provide the fill date for each transaction.
4. *Number of Tablets* – provide the number of tablets dispensed on the fill date for each transaction.
5. *Group Number* – provide the group number assigned to each transaction. As part of the auditing process, you may be asked to provide the corresponding group name for each group number.
6. *Net Amount Paid* – provide the final amount paid for each discrete transaction, net of co-pays, deductibles, co-insurance, and any other credits and adjustments after initial payment.

***If using Formula B:***

1. *NDC Number* – provide the applicable NDC Number for each group of prescriptions.
2. *Number of Prescriptions* – provide the total number of prescriptions filled during the period from July 1, 2001 to August 8, 2001, separated out by NDC Number.
3. *Net Amount Paid* – provide the final amount paid separated out by NDC Number, net of co-pays, deductibles, co-insurance, and any other credits and adjustments after initial payment for prescriptions filled during the period from July 1, 2001 to August 8, 2001.

***Other Information:***

If you are an Authorized Agent, please provide a list of all self-funded healthcare plans (SFPs) for which you are authorized to make a claim.

**BAYCOL REIMBURSEMENT REPORT – FORMULA A**

<b>NDC NUMBER</b>	<b>PATIENT IDENTIFIER</b>	<b>FILL DATE</b>	<b>NUMBER OF TABLETS</b>	<b>GROUP NUMBER</b>	<b>NET AMOUNT PAID</b>

**BAYCOL REIMBURSEMENT REPORT – FORMULA B**

<b>NDC NUMBER</b>	<b>NUMBER OF PRESCRIPTIONS</b>	<b>NET AMOUNT PAID</b>

