INDIVIDUAL REVIEW OPTION CLAIM FORM FOR MEDICAL CLAIMS

Water Contamination Settlement

You should complete this form if:

- Your residence (single family home, apartment, condominium) was provided tap water service from West Virginia American's Kanawha Valley Water Treatment Plant (the "KVTP") **as of January 9, 2014, AND**

- You are requesting payment for a medical claim.

A medical claim is a claim for compensation for medical treatment for a physical injury that you incurred as a result of the Freedom Chemical Spill. For more information about the types of claims that you can file, see the Instructions.

The deadline to submit a claim is February 21, 2018. If you have questions about this form or which claim form you should file, contact the Settlement Administrator for assistance by calling 1-855-829-8121 or submit a question at www.wvwaterclaims.com

READ THE INSTRUCTIONS BEFORE COMPLETING THIS FORM. THE INSTRUCTIONS CONTAIN IMPORTANT DEFINITIONS AND INFORMATION ABOUT HOW TO DOCUMENT YOUR CLAIMED LOSS.

INDIVIDUAL REVIEW OPTION CLAIM FORM FOR MEDICAL CLAIMS

PART I – CLAIMANT INFORMATION.

Last Name: _____

First Name: _____

Middle Name: _____

Maiden Name [or other names used]: _____

_____

Street Address of your Residence **ON JANUARY 9, 2014** (including city, state and zip code AND Apartment or Unit Number, if any)

Your **Current** Mailing Address to which all future correspondence should be sent (if different from above):

☐ Check here if your current mailing address is the same as the address above.

If different, fill out the section below.

Current Street Address (including apartment or unit number if applicable): _____

Current City: _____

Current State: _____

Current Zip Code: _____

List any other states (in addition to those listed in the addresses above) where you lived after January 9, 2014 if you received medical treatment for the medical condition claimed while living in those states: _____

_____

Your Date of Birth (mm/dd/yyyy)

Your Gender: _____

_____

Your Social Security Number

_____

Your Current Telephone Number (including area code) (Provide the phone number that you prefer to use if the Settlement Administrator needs to contact you.)

_____

Your Current Email Address (if any)

If you received a notice of this settlement in the mail, please provide the claim identification number that appears on that notice here. The identification number is located on the top left portion of the Simple Claim Forms that were enclosed with the notice:

_____

If your name was listed on the West Virginia American Water account for the residence above in 2014, provide that account number here: _____

Medical Insurance

Health Insurance Carriers: Identify each health insurance carrier that provided you with medical coverage and/or pharmacy benefits ***from*** January 9, 2014 or (if later) the time of first exposure to contaminated tap water or, in the case of Water Interruption Claims, from the time of water interruption, ***until*** the present. Please include the following items if they apply to you:

Carrier Plan Name (Medicare/ Medicaid /Private Insurance/ Military)	Policy Number or Medicare/ Medicaid Number	Dates of Coverage	Employer Name During Treatment (if applicable)	Name of Insured and SSN (if not claimant)	Military Branch of Service, (if applicable)	VA Facility Where Treated for this Specific Incident

Attorney Information

If you are being represented by an attorney for this claim, please provide the following information:

_____
Attorney Name and Law Firm

_____
Attorney Address

_____
Attorney Telephone Number (including area code)

_____
Attorney Email Address

☐ Check here if you would like you and your attorney to both receive communications from the Settlement Administrator; OR

☐ Check here if you would like only your attorney to receive communications from the Settlement Administrator

PART II – ELIGIBILITY: RESIDENT AT AN ELIGIBLE RESIDENTIAL LOCATION.

To be eligible for a payment for a Medical Claim you must have been a resident at an Eligible Residential Location as of January 9, 2014.

☐ Check here if you or another resident of your household (as of January 9, 2014) submitted an Individual Review Option Claim Form or Simple Claim Form for Residential Household Water Users. If you checked this box, go to Part III.

☐ Check here if you intend to submit an Individual Review Option Claim Form or Simple Claim Form for Residential Household Water Users. If you checked this box, go to Part III.

☐ Check here if you did not or do not intend to file a Residential Claim Form. If you check this option, you must provide the information requested below to confirm your eligibility.

☐ Check here if you received water bills in your name from West Virginia American Water as of January 9, 2014 for the residence in which you lived on January 9, 2014. If you checked this box, go to Part III.

☐ Check here if you did not receive water bills in your name. If you did not receive water bills in your name, you must provide proof of your residence at the address you have listed. The type of proof you must submit is described below.

Required documentation: Please attach a copy of a document (utility bill, lease or rental agreement, a canceled check or check image from January 2014, a sworn statement from someone who does not live with you, or other similar document) that shows you lived at this residence during the period including January 9, 2014.

If you or any household member leased or rented the residence identified in Part I on January 9, 2014, and you did not receive water bills directly from West Virginia American for that residence please provide the following information for the owner or landlord of your residence on January 9, 2014:

Owner/Landlord/Condo Name: _____

Address: _____

_____

_____

Telephone: _____

PART III. YOUR CLAIM.

In this section, you must identify and describe your Medical claim. There are three types of "Medical Claims". You may submit only one type of Medical Claim.

1) ***Contemporaneous Medical Treament Claim*: You may submit a Contemporaneous Medical Treatment Claim if you sought treatment for an immediate reaction or illness that you believe was caused by exposure to tap water contaminated as a result of the Freedom Chemical Spill between January 9, 2014 and February 15, 2014. The Settlement Administrator must determine that you had a reasonable basis for seeking medical treatment.**

2) ***Other Medical Issues Claim*: You may submit an "Other Medical Issues Claim" if you assert that you suffered an illness, injury or wrongful death caused by exposure to tap water contaminated as a result of the Freedom Chemical Spill on or after January 9, 2014 and before February 28, 2014, and you have incurred more than $5,000 in medical expenses for treatment of that illness, injury or wrongful death.**

3) ***Water Interruption Medical Claim*: You may submit a Water Interruption Medical Claim if your treatment for a pre-existing chronic illness was delayed solely because of the interruption of water service at the medical service provider's facility resulting from the Freedom Chemical Spill during the Do Not Use Period, and as a result your condition was aggravated or progressed and you have incurred more than $5,000 in medical expenses for treatment of the aggravation or progression of your pre-existing chronic illness.**

SECTION 1. Contemporaneous Medical Treatment Claim.

Check here ☐ and complete this section if you are making a Contemporaneous Medical Treatment Claim. If you qualify for a Contemporaneous Medical Treatment Claim, you may receive up to $5,000 for the unreimbursed cost of documented medical care plus an additional payment of $750. Please review the information below and the Instructions for information about the requirements for a Contemporaneous Medical Treatment Claim and the documents you must submit to qualify.

To qualify, you must have been exposed to tap water contaminated by the Freedom Chemical Spill between January 9, 2014 and February 15, 2014 and you must have sought and received diagnostic evaluation and/or treatment between January 9, 2014 through February 15, 2014 for a Physical Injury or condition that you believed to be a Physical Injury based on such exposure to contaminated tap water. The Settlement Administrator must determine that you had a reasonable basis for seeking medical treatment. By signing the Claim Form and attestations at the end of this form, you are attesting to the manner and time period of your exposure to tap water contaminated by the Freedom Chemical Spill as stated in your responses to the questions in this Form and that you had or believed that you had a Physical Injury caused by that exposure to the tap water. The Instructions provide additional information on the requirements.

a. Use the space below to explain the reason you sought medical care including the specific symptoms, illness or reaction you believe was caused by the exposure to contaminated tap water. You may attach a separate page if necessary.

_____

_____

_____

b. Date on which you first went to a doctor/medical facility for diagnosis or treatment of the symptom, illness or reaction that you believe was caused by exposure to contaminated tap water: _____ (mm/dd/yyyy).

c. If you were treated on more than one date, provide:

Date of last treatment _____ (mm/dd/yyyy).

Add additional dates of treatment if applicable.

d. Date of Diagnosis: _____ (mm/dd/yyyy).

e. Contact information of the doctor or medical facility that provided the diagnosis or treatment:

_____

Name of Doctor or Medical Facility

_____

Address of Doctor or Medical Facility

_____

Telephone Number of Doctor or Medical Facility

f. Dates on which you were exposed to tap water contaminated by the Freedom Chemical Spill: _____ (mm/dd/yyyy) TO _____ (mm/dd/yyyy).

g. Describe the way in which you were exposed to tap water contaminated by the Freedom Chemical Spill.

_____

_____

h. Were any of the costs for your treatment/diagnosis paid for or reimbursed by your health insurance provider (a private insurer) listed above or through a government health care program (like Medicare, Medicaid, Medicare Advantage or any other program)?

YES☐ NO☐ (choose one)

If the answer is YES, please identify the amount paid by your insurance provider or through a government health care program: $_____

i. Has the insurer or government entity listed above claimed a lien against any amount you may recover from any other person or entity for this condition?

YES☐ NO☐ (choose one)

If the answer is YES, please list the amount of any lien by your insurer or government entity: $_____

j. **TOTAL COST** incurred for treatment or diagnosis for the condition/illness (this should be your out-of-pocket costs for treatment and should not include any portion paid for or reimbursed by your health insurance provider or government health care program): **$_____. Note: The maximum you can recover under this option is $5,000 of documented out of pocket medical costs plus $750.00.**

DOCUMENTATION: If you request compensation for out-of-pocket costs you paid for the diagnosis and treatment for the injury, illness or reaction you experienced, you must submit (1) documents that show the out of pocket costs you paid, and (2) contemporaneous medical documents showing that you sought and received diagnostic evaluation and/or treatment for the injury, illness or reaction (Physical Injury) that you believed was a Physical Injury based on exposure to tap water from the KVTP at any time between January 9, 2014 through February 15, 2014, and (3) documents that show the date you

sought diagnosis and treatment for Physical Injury or condition you believed to be a Physical Injury.

The Instructions provide additional information about the types of documents you should submit.

SECTION 2. Other Medical Issues Claim.

Check here ☐ and complete this section if you are making an Other Medical Issues Claim. Please refer to the "How Much Can I Receive for My Medical Claim?" section in the Instructions for an explanation of what you can receive if you qualify for an Other Medical Issues Claim.

To make an Other Medical Issues Claim, you must have medical expenses in excess of $5,000 for the treatment of the illness or condition, or exacerbation of an existing condition. Please review the information below and the Instructions for more information about the requirements for an Other Medical Issues Claim.

To qualify, you (i) must have been exposed to tap water contaminated by the Freedom Chemical Spill on or after January 9, 2014 and before February 28, 2014, (ii) your illness, condition or exacerbation of an existing condition must have "manifested" (become apparent) between January 9, 2014 and February 28, 2014; (iii) your illness, condition or exacerbation of an existing condition must have been diagnosed by a treating licensed health care provider; and (iv) your illness, condition or exacerbation of an existing condition must be documented in a contemporaneous medical record. You must also submit a sworn statement of a Qualified Medical Expert, as explained below and in the Instructions. The Instructions provide additional information about the requirements.

By signing the Claim Form and attestations at the end of this Form, you are attesting to your exposure to contaminated tap water in the manner and during the time period you describe in this Form.

a. Identify the illness or injury or exacerbation of an existing condition that your treating licensed health care provider diagnosed and that was caused by exposure to the tap water contaminated by the Freedom Chemical Spill:
_____

b. Dates on which you were exposed to tap water contaminated by the Freedom Chemical Spill: _____ (mm/dd/yyyy) TO _____(mm/dd/yyyy).

c. Identify the manner and amounts of exposure to contaminated tap water during the time period above:
_____
_____
_____
_____

d. Date on which the illness, injury or exacerbation of an existing condition manifested: _____ (mm/dd/yyyy).

e. Date of on which you first went to a doctor/medical facility for diagnosis or treatment of the illness, injury or exacerbation of an existing injury: _____ (mm/dd/yyyy).

f. If you were treated on more than one date, provide:

Date of First Treatment: _____ (mm/dd/yyyy).

Add additional dates of treatment if applicable

g. Date of Diagnosis: _____ (mm/dd/yyyy).

h. Contact information of doctor or medical facility where you received treatment/were diagnosed:

_____
Name of Doctor or Medical Facility

_____
Address of Doctor or Medical Facility

_____
Telephone Number of Doctor or Medical Facility

i. Were any of the costs for your treatment/diagnosis paid for or reimbursed by your health insurance provider (a private insurer) listed above or through a government health care program (like Medicare, Medicaid, Medicare Advantage or any other program)?

YES ☐ NO ☐ (choose one)

If the answer is YES, please identify the amount paid by your insurance provider or through a government health care program: $_____

j. Has the insurer or government entity listed above claimed a lien against any amount you may recover from any other person or entity for this condition?

YES ☐ NO ☐ (choose one)

If the answer is YES, please list the amount of any lien by your insurer or government entity: $_____

k. **TOTAL COST** incurred for treatment or diagnosis for the condition/illness you described at question (a) above: **$_____**.

l. Check one of the following to describe your Other Medical Issues Claim and provide the additional information requested:

☐ Check here if your claim is for partial blindness or for permanent visual impairment not correctable with glasses and state the Vision Impairment Rating percentage in the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.) attributable to the water contamination event: _____

☐ Check here if your claim is for wrongful death and provide the date of death: _____.

☐ Check here if your claim is for permanent total occupational disability and provide the date of total disability: _____.

☐ Check here if your claim is for other injury or illness. If you were hospitalized for the diagnosis or treatment of the claimed injury or illness, state the number of nights you were in the hospital: _____.

m. **TOTAL CLAIM: State the total amount of your claim using the guidelines in the instructions under the "How Much Can I Receive for My Medical Claim." The total amount you claim (subject to the maximum amount of compensation for Other Medical Issues Claims) is the maximum amount you may receive from the Settlement for your Other Medical Issues Claim.** $____

DOCUMENTATION: If you request compensation for an Other Medical Issues Claim, you must submit contemporaneous medical records that document that you sought and received medical care for an illness or injury, or exacerbation of an existing condition and that a treating licensed health care provider diagnosed the illness, injury or exacerbation of an existing condition. The contemporaneous medical records must contain the diagnosis and the basis for the diagnosis. The diagnosis must be based on physical examination, physician observation, and appropriate diagnostic standards or tests. You must also submit an affidavit or sworn declaration of a Qualified Medical Expert that explains the expert's opinion as to the causal relationship between the exposure to the contaminated tap water and the illness, injury or exacerbation of an existing condition. The specific requirements are explained in the Instructions.

The Instructions provide additional information about the types of documents and the content of the documents you should submit.

SECTION 3. Water Interruption Medical Issues Claim.

Check here ☐ and complete this section if you are making a Water Interruption Medical Issues Claim. Please refer to the "How Much Can I Receive for My Medical Claim?" section in the Instructions for an explanation of what you can receive if you qualify for a Water Interruption Medical Issues Claim.

To make a Water Interruption Medical Issues Claim, you must have medical expenses in excess of $5,000; the medical expenses must be for medical care for aggravation or progression of the pre-existing chronic illness or condition; the aggravation or progression must have been caused by the delay in treatment; and the delay in treatment must have resulted solely from the fact of water interruption at the medical service provider's facility during the applicable Do Not Use Period. Please review the information below and the Instructions for more information about the requirements for a Water Interruption Medical Issues Claim.

a. Identify the pre-existing chronic illness or condition that was aggravated or that progressed as a result of delayed treatment:
_____

b. Explain how your condition progressed or was aggravated by the delay in treatment:
_____
_____
_____
_____

c. Date(s) of Water Interruption at the medical service provider's facility:
_____ (mm/dd/yyyy) TO _____(mm/dd/yyyy).

d. Date of First Treatment for aggravation or progression of chronic illness or condition: _____ (mm/dd/yyyy).

e. Date of Last Treatment for aggravation or progression of chronic illness or condition: _____ (mm/dd/yyyy).

f. Contact information of doctor or medical facility where you received treatment:
_____
Name of Doctor or Medical Facility
_____
Address of Doctor or Medical Facility
_____
Telephone Number of Doctor or Medical Facility

g. Were any of the costs for your treatment/diagnosis paid for or reimbursed by your health insurance provider (a private insurer) listed above or through a government health care program (like Medicare, Medicaid, Medicare Advantage or any other program)?

YES ☐ NO ☐ (choose one)

If the answer is YES, please identify the amount paid by your insurance provider or through a government health care program: $_____

h. Has the insurer or government entity listed above claimed a lien against any amount you may recover from any other person or entity for this condition?

YES ☐ NO ☐ (choose one)

If the answer is YES, please list the amount of any lien by your insurer or government entity: $_____

i. **TOTAL COST** incurred for medical care for the aggravation or progression of the chronic illness or condition caused by the delay in treatment: **$_____**

j. Check one of the following to describe your Water Interruption Medical Issues Claim and provide the additional information requested:

☐ Check here if your claim is for partial blindness or for permanent visual impairment not correctable with glasses and state the Vision Impairment Rating percentage in the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.) attributable to the water contamination event: _____

☐ Check here if your claim is for wrongful death and provide the date of death: _____.

☐ Check here if your claim is for permanent total occupational disability and provide the date of total disability: _____.

☐ Check here if your claim is for other injury or illness. If you were hospitalized for the diagnosis or treatment of the claimed injury or illness, state the number of nights you were in the hospital: _____.

k. **TOTAL CLAIM: State the total amount of your claim using the guidelines in the instructions under "How Much Can I Receive for My Medical Claim." The total amount you claim (subject to the maximum amount of compensation for Water Interruption Medical Issues Claims) is the maximum amount you may receive from the Settlement for your Water Interruption Medical Issues Claim. $_____**

DOCUMENTATION: If you request compensation for Water Interruption Medical Issues, you must submit contemporaneous medical records demonstrating that medical care for your pre-existing chronic illness or condition was delayed solely because of the interruption in water service at the medical service provider's facility as a result of the Freedom Chemical Spill during the applicable Do Not Use Period. You must also submit a sworn statement of your treating physician or a Qualified Medical Expert containing specific information that is explained in the Instructions.

The Instructions provide additional information about the types of documents and the content of the documents you should submit.

Part IV. VERIFICATION AND ATTESTATION.

1. Verification Required for ALL Medical Claimants:

By signing this Claim Form, I hereby certify under penalty of perjury that:

(a) all of the information contained in this Claim Form is true and correct;

(b) the supporting documents attached to or submitted in connection with this Claim Form and the information contained in those documents are true, accurate, and complete to the best of my knowledge;

(c) I am authorized to make this Claim;

(d) I understand that there can be only one Medical Claim Form per person and I have not filed a separate Medical Claim Form nor am I aware of one that has been filed on my behalf;

(e) I understand that I cannot file a Medical Claim Form and a Pregnancy Claim Form and I have not filed a separate Pregnancy Claim Form;

(f) I authorize the Settlement Administrator to contact the health care providers identified on this Form;

(g) I understand that Settlement Class Counsel will seek an order from the Court – called a Qualified Protective Order – that would authorize disclosure of my medical information and personal identifiers to health plans, certain health care providers or health plan clearinghouses for the purpose of identifying and, if applicable, resolving any liens that any such health plans, health care providers or health plan clearinghouses may assert against my settlement payment and I do not object to such disclosures or to the resolution of liens on my behalf; and

(h) I am not excluded from the Settlement Class.

_____ _____

Date Signature

2. Additional Attestation Required for Contemporaneous Medical Treatment Claimants.

By signing this Claim Form, I hereby certify under penalty of perjury that:

(a) I was exposed to tap water contaminated by the Freedom Chemical Spill as described in this Claim Form between January 9, 2014 and February 15, 2014; and

(b) I sought medical treatment based on a belief or a diagnosis that any identified symptoms and conditions were due to exposure to tap water from the KVTP between January 9, 2014 and February 15, 2014.

_____ _____

Date Signature

3. Additional Attestation Required for Other Medical Issues Claimants.

By signing this Claim Form, I hereby certify under penalty of perjury that: I was exposed to tap water contaminated by the Freedom Chemical Spill in the manner and amount as described in this Claim Form on or after January 9, 2014 and before February 28, 2014:

_____ _____

Date Signature

If you are a legal representative completing this form on behalf of a minor or an incapacitated or deceased claimant, you must complete the following:

Name of Legal Representative:	**Legal Representative Address:**	**Telephone Number:**	**Email Address:**

If claimant is deceased, provide date of death: _____ (mm/dd/yyyy).

This Claim Form must be submitted online or postmarked no later than **February 21, 2018**.

Mail the Claim Form to: WV Water Settlement Administrator
P.O. Box 4227
Charleston, WV 25364

INCOMPLETE CLAIM FORMS WILL NOT BE PROCESSED UNTIL COMPLETED

INDIVIDUAL REVIEW OPTION CLAIM FORM FOR MEDICAL CLAIMS

INSTRUCTIONS

Please read this entire Claim Form before you begin to fill it out.

Type or print legibly all information in blue or black ink if you are using a hard copy form. You may find it easier to use the online form.

Answer all applicable questions and provide all information and documents asked for on the Claim Form. ONLY COMPLETE FORMS WILL BE PROCESSED.

If you do not submit supporting documents your claim will be found deficient and may be denied. Make a copy of your completed Claim Form and supporting documents for your records. **Do not submit your only copy of the supporting documents.** Materials submitted will not be returned. All copies of documentation submitted in support of this Claim should be clear, legible and complete.

PART I (Claimant Information)

Please provide your address as of January 9, 2014, your current address and the other requested information.

PART II (Eligibility – Resident at an Eligible Residential Location)

You must select one of the three options and provide the requested information for the option you select.

If you or another resident in your household as of January 9, 2014 submitted an Individual Review Option Claim Form or Simple Claim Form for Residential Household Users, the Settlement Administrator will determine your eligibility based on the Residential Household Claim already filed.

If you or another resident in your household have not submitted an Individual Review Option Claim Form or Simple Claim Form for Residential Household Users, you should indicate if you intend to file such a claim. If you do indicate you will file such a claim, the Settlement Administrator will not process this Medical Claim until you (or another resident) submits a claim form for Residential Household Users.

If you do not wish to file a claim for Residential Household Users, then you must provide information that will allow the Settlement Administrator to determine whether you resided at an

Eligible Residential Location on January 9, 2014. If your name was listed on the water account – *i.e.,* the West Virginia American Water account – for the Eligible Residential Location on January 9, 2014, you do not need to provide any more information. If your name was not listed on the West Virginia American Water account, you must provide proof that you were a Resident at an Eligible Residential Location on January 9, 2014.

Examples of the types of documents that you should submit to show you were a Resident at an Eligible Residential Location on January 9, 2014 include:

a. A utility bill from January 2014 addressed to you at the Eligible Residential Location (your residence on January 9, 2014 identified in Part I);

b. A lease or rental agreement for the Eligible Residential Location showing your status as a tenant at that location as of January 9, 2014;

c. A canceled check or check image from January 2014 showing your address and rent paid for the Eligible Residential Location;

d. A mortgage statement for the period January 2014 showing your name and the address of the Eligible Residential Location;

e. A Sworn Verification of Residence from someone who does not live with you attesting to your residence at the Eligible Residential Location as of January 9, 2014 (you can obtain a Sworn Verification of Residence Form by visiting the website at www.wvwaterclaims.com or by calling the Settlement Administrator at 1-855-829-8121); or

f. Other document (such as an employment related document) that shows you lived at the Eligible Residential Location during a period that includes January 9, 2014.

PART III (Your Claim)

Section 1. Contemporaneous Medical Treatment Claims

Eligible Time Period. You must have been exposed to tap water provided by the KVTP at any time between January 9, 2014 and February 15, 2014 AND you must have sought and received diagnostic evaluation and/or treatment between January 9, 2014 and February 15, 2014 for a Physical Injury or a condition you believed to be a Physical Injury caused by exposure to tap water contaminated by the Freedom Chemical Spill.

Documentation. To be eligible for a Contemporaneous Medical Treatment Claim, you must submit:

1. Contemporaneous medical records that show that you sought and received diagnostic evaluation and/or treatment for a Physical Injury or a condition that

you believed to be a Physical Injury because of your exposure to tap water contaminated by the Freedom Chemical Spill at any time between January 9, 2014 through February 15, 2014.

2. Documents showing the out-of-pocket costs you incurred for the diagnosis/treatment that is documented in the contemporaneous medical records. Out-of-pocket costs are costs that you paid and were not reimbursed for (by an insurer or other entity or source).

Examples of the types of documents that you should submit include:

a) medical records from a licensed medical professional who diagnosed or treated your Physical Injury;

b) receipts or invoices showing the cost of treatment; and/or

c) explanations of benefits (EOBs) or other statements you received from your insurance company documenting expenditures for medical care for the Physical Injury.

Attestation: You must attest to the manner and time period of your exposure to tap water contaminated by the Freedom Chemical Spill.

Section 2. Other Medical Issues Claims

Eligible Time Period. You must have been exposed to tap water contaminated by the Freedom Chemical Spill on or after January 9, 2014 and before February 28, 2014 and the complained of medical condition must have manifested (become apparent) between January 9, 2014 and February 28, 2014.

Documentation. To be eligible for an Other Medical Issues Claim, you must submit contemporaneous medical records and an affidavit or sworn declaration from a Qualified Medical Expert that the illness or injury, wrongful death, or exacerbation of an existing condition is causally related to the exposure to tap water contaminated by the Freedom Chemical Spill, and in some cases a sworn statement of another qualified expert expressing the opinion that the Other Medical Issue could generally have been caused by exposure to tap water contaminated as a result of the Freedom Chemical Spill.

You must submit the following contemporaneous medical records:

1) Records showing that you sought and received medical care for an illness or injury, or exacerbation of an existing condition and had medical expenses in excess of $5,000;

2) Records showing that a treating licensed health care provider diagnosed the illness, injury or exacerbation of an existing condition and that provide the basis

for that diagnosis;

3) Records showing that the diagnosis was based on physical examination, physician observation, and application of appropriate diagnostic standards or tests;

4) An affidavit prepared by a medical expert that demonstrates to a reasonable probability that the medical expenses are causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

The affidavit or sworn declaration of the Qualified Medical Expert must state that the illness or injury, or exacerbation of an existing condition is causally related, to a reasonable medical or scientific probability, to exposure to contaminated water resulting from the Freedom Chemical Spill. The affidavit or declaration of the Qualified Medical Expert must set forth the qualifications of the Qualified Medical Expert and must include:

(a) information about the nature and degree of exposure to contaminated water the Claimant experienced;

(b) the medical condition from which the Claimant suffers and the basis for the diagnosis of that condition;

(c) the Qualified Medical Expert's opinion to a reasonable degree of medical probability as to how the medical condition was causally related to exposure to contaminated water resulting from the Freedom Chemical Spill; and

(d) the materials reviewed by the Qualified Medical Expert.

General Causation: To prove that the illness or injury, or exacerbation of an existing condition, can generally be caused by exposure to contaminated water resulting from the Freedom Chemical Spill, you should submit the affidavit or declaration of another qualified expert stating the opinion, to a reasonable medical or scientific probability, that the illness, injury or exacerbation of an existing condition can be caused by such exposure.

If you are claiming **wrongful death**, you MUST submit a death certificate that attributes the primary or contributing cause of death to a specific medical condition alleged to be caused by exposure to contaminated water resulting from the Freedom Chemical Spill.

If you are claiming **permanent total occupational disability**, you MUST submit a decision from a governmental agency that has found you to be occupationally disabled from the specific claimed medical issue. A "governmental agency" includes the Social Security Administration, Workers Compensation Commission, or a disability pension board for employees of a State, City or County, or similar organization. A permanent and total loss of vision resulting from legal blindness shall be considered a total occupational disability for these purposes.

If you are making a Medical Claim based on **permanent visual impairment**, you must submit a signed examination record by a person qualified to perform vision examinations establishing the Vision Impairment Rating percentage in the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (5th Ed.) attributable to the water contamination event. If you have permanent loss of vision resulting in legal blindness you may elect to recover either for partial blindness/permanent visual impairment not correctable with glasses or for permanent total occupational disability, but not both. A claimant is considered to be legally blind if the person would be considered to be blind under the Social Security Administration's statutory guidelines, 42 U.S.C. § 1382c(a)(2).

If you are not claiming permanent visual impairment, permanent total occupational disability or wrongful death, but you are claiming that you were **hospitalized** for one or more night, you MUST submit an expert medical affidavit demonstrating to a reasonable probability that the hospitalization was causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

Section 3. Water Interruption Medical Issues Claims

Eligible Time Period. To be eligible you must have been required to delay treatment of an existing chronic illness because of interruption of water service at the medical service provider's facility resulting from the Freedom Chemical Spill during the applicable Do Not Use Period.

You must produce evidence demonstrating to a reasonable probability that the delay in treatment caused an aggravation or progression of the illness or condition and the aggravation or progression of the illness would not have occurred but for the delay.

Documentation. To be eligible for a Water Interruption Claim, you must submit the following contemporaneous medical records:

1) Records demonstrating that you had a pre-existing chronic illness or condition and identifying that illness or condition;

2) Records that show that your medical care for that pre-existing chronic illness or condition was delayed solely because of water interruption at the medical service provider's facility during the applicable Do Not Use Period;

3) Records that show that you incurred medical expenses in excess of $5,000 for the diagnosis and treatment of that illness or condition as a result of the delay caused by water interruption; and

4) An affidavit prepared by a medical expert that demonstrates to a reasonable probability that the medical expenses are causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

You MUST also submit an affidavit or attestation by your treating physician or a Qualified Medical Expert, as defined in the Instructions, which clearly sets forth:

(a) the physician/expert's qualifications;

(b) the physician/expert's opinion as to how there was a delay in medical treatment because of water service interruption at the medical service provider's facility; and,

(c) the physician/expert's opinion to a reasonable degree of medical probability (i) that the delay in medical treatment caused or was a substantial contributing factor causing progression or aggravation of the pre-existing an existing illness or injury and (ii) an explanation of the basis for the physician/expert's conclusion.

If you are claiming **wrongful death**, you MUST submit a death certificate that attributes the primary or contributing cause of death to a specific medical condition alleged to have been aggravated or to have progressed because of delayed treatment due to water interruption.

If you are claiming **permanent total occupational disability**, you MUST submit a decision from a governmental agency that has found you to be occupationally disabled because of the aggravation or progression of a pre-existing illness or injury due to delay in treatment as a result of water interruption. A "governmental agency" includes the Social Security Administration, Workers Compensation Commission, or a disability pension board for employees of a State, City or County, or similar organization.

If you are making a Medical Claim based on **permanent visual impairment**, you must submit a signed examination record by a person qualified to perform vision examinations establishing the Vision Impairment Rating percentage in the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (5th Ed.) attributable to the water contamination event. If you have permanent loss of vision resulting in legal blindness you may elect to recover either for partial blindness/permanent visual impairment not correctable with glasses or for permanent total occupational disability, but not both. A claimant is considered to be legally blind if the person would be considered to be blind under the Social Security Administration's statutory guidelines, 42 U.S.C. § 1382c(a)(2).

If you are not claiming permanent visual impairment, permanent total occupational disability or wrongful death, but are claiming that you were **hospitalized** for one or more night, you MUST submit an expert medical affidavit demonstrating to a reasonable probability that the hospitalization was causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

PART IV

You **MUST** sign the verification. Without a signed verification, your claim will **NOT** be processed.

Additionally, if you are submitting a Contemporaneous Medical Treatment Claim or an Other Medical Issues Claim, you **MUST** also sign the additional respective attestation. By signing the verification, you acknowledge that under the terms of the Amended Settlement Agreement you are releasing all claims you have or may in the future have against the Defendants. You may also submit a claim form to make a Wage Earner Claim or a Residential Claim consistent with the Amended Settlement Agreement.

The Settlement Administrator may contact you to obtain authorization to contact your health care provider if necessary to process your claim under the Amended Settlement Agreement.

Under the Amended Settlement Agreement, a Settlement Class Member does not include a natural born person or Business excluded from the Settlement Class. The following entities and individuals are excluded from the Settlement Class:

1. West Virginia American and its officers, directors, and employees and any affiliates of West Virginia American and their officers, directors, and employees;
2. Eastman and its officers, directors, and employees and any affiliates of Eastman and their officers, directors, and employees;
3. Judicial officers assigned to this case and their immediate family members and associated court staff assigned to this case, other than court reporters;
4. Settlement Class Counsel and attorneys who have made an appearance for the Defendants in this case;
5. The Settlement Administrator, Notice Administrator, Guardian ad Litem, or other consultants and associated staff assigned to this case; and
6. Opt Outs as defined in Amended Settlement Agreement.

If you are uncertain about whether you are excluded from the Settlement Class or have questions, you should contact the Settlement Administrator.

HOW MUCH CAN I RECEIVE FOR MY MEDICAL CLAIM?

Contemporaneous Medical Treatment Claims. If you qualify for a Contemporaneous Medical Treatment Claim, you may receive up to $5,000 for documented unreimbursed cost of medical care treatment for the eligible condition plus an additional payment of $750.

- *Example*: If you had $200 in qualifying unreimbursed documented medical care, you may receive $950 computed as follows:

Your qualifying unreimbursed documented medical costs = *$200*	*Plus* $750	*Equals* total claim of ***$950***

- *Example*: If you had $2,500 in qualifying unreimbursed documented medical care, you may receive $3,250 computed as follows:

Your qualifying unreimbursed documented medical costs = *$2,500*	*Plus* $750	*Equals* total claim of ***$3,250***

Other Medical Issues and Water Interruption Medical Issues Claims. If you qualify for an Other Medical Issues Claim or for a Water Interruption Medical Issues Claim, the amount you may receive depends on the nature of your claim:

For partial blindness or for permanent visual impairment not correctable with glasses: (i) a base payment of $6,000 times the Vision Impairment Rating percentage in the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.) attributable to the water contamination event, with the total payment under this subsection (i) not to exceed $300,000 after accounting for all adjustments; (ii) plus two times qualifying past medical costs that are demonstrated by expert medical affidavit to a reasonable probability to be causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

- *Example*: If your Vision Impairment Rating percentage attributable to the water contamination event is 35 and you had $5,500 in qualifying past medical costs , you may receive $221,000 computed as follows:

Base of $6,000 times 35 Vision Impairment Rating = *$210,000*	*Plus* your $5,500 in qualifying medical costs times two = *$11,000*	*Equals* total claim of ***$221,000***

- *Example*: If your Vision Impairment Rating percentage attributable to the water contamination event is 50 and you had $6,000 in qualifying past medical costs, you may receive $312,000 computed as follows:

Base of $6,000 times 50 Vision Impairment Rating would be the maximum base payment of *$300,000*	*Plus* your $6,000 in qualifying medical costs times two = *$12,000*	*Equals* total claim of ***$312,000***

For wrongful death: (i) a base payment of $290,000, adjusted upwards by $10,000 for every year under age 66 on the date of death and downwards by $10,000 for every year over 66 on the date of death , with the total payment under this subsection (i) not to exceed $500,000 after accounting for all adjustments; (ii) plus four times qualifying past medical costs that are demonstrated by expert medical affidavit to a reasonable probability to be causally related to and incurred for diagnosis or treatment of the claimed injury or illness that caused the wrongful death; (iii) up to a total maximum of $750,000 for both (i) and (ii).

- *Example*: If decedent was age 60 at the time of death and had $40,000 in qualifying medical costs, the claim may receive $510,000 computed as follows:

$290,000 base adjusted upwards by $60,000 ($10,000 for each year under age 66) = adjusted base payment of *$350,000*	*Plus* the $40,000 in qualifying medical costs times four = *$160,000,*	*Equals* total claim of ***$510,000***

- *Example*: If decedent was age 75 at the time of death and had $20,000 in qualifying medical costs, the claim may receive $280,000 computed as follows:

$290,000 base adjusted downwards by $90,000 ($10,000 for each year over age 66) = adjusted base payment of *$200,000*	*Plus* the $20,000 in qualifying medical costs times four = *$80,000,*	*Equals* total claim of ***$280,000***

For permanent total occupational disability: (i) a base payment of $380,000, adjusted upwards by $10,000 for every year under age 62 on the date of total disability and downwards by $10,000 for every year over age 62 on the date of total disability, with the total payment under this subsection (i) not to exceed $750,000 after accounting for all adjustments; (ii) plus five times qualifying past medical costs that are demonstrated by expert medical affidavit to a reasonable probability to be causally related to and incurred for diagnosis or treatment of the claimed injury or illness that caused the total occupational disability; (iii) up to a total maximum of $1,000,000 for both (i) and (ii).

- *Example*, if you were 64 on the date of total disability, and had $50,000 in qualifying medical costs, you may receive $610,000 computed as follows:

$380,000 base adjusted downwards by $20,000 ($10,000 for each year over age 62) = adjusted base payment of *$360,000*	*Plus* your $50,000 in medical costs times five = *$250,000,*	*Equals* total claim of ***$610,000***

- *Example*, if you were 55 on the date of total disability, and had $10,000 in qualifying medical costs, you may receive $500,000 computed as follows:

$380,000 base adjusted upwards by $70,000 ($10,000 for each year under age 62) = adjusted base payment of *$450,000*	*Plus* your $10,000 in medical costs times five = *$50,000,*	*Equals* total claim of ***$500,000***

For other injury or illness: a payment of (i) four times qualifying past medical costs that are demonstrated by expert medical affidavit to a reasonable probability to be causally related to and incurred for diagnosis or treatment of the claimed injury or illness, (ii) plus $5,000 per night of hospitalization that is demonstrated by expert medical affidavit to a reasonable probability to be causally related to and incurred for diagnosis or treatment of the claimed injury or illness.

- *Example*: If you had $7,000 in qualifying past medical costs and were not hospitalized, you may receive $28,000 calculated as follows:

Your $7,000 in qualifying medical costs times four = *$28,000*	*No hospitalization*	*Equals* total claim of ***$28,000***

- *Example*: If you had $8,000 in qualifying past medical costs and had two nights of qualifying hospitalization, you may receive $42,000 calculated as follows:

Your $8,000 in qualifying medical costs times four = *$32,000*	*Plus* $5,000 times 2 nights of qualifying hospitalization = *$10,000*	*Equals* total claim of ***$42,000***

DEFINITIONS

"Do Not Use Period" means the period of time during which you were subject to a Do Not Use notice issued by West Virginia American in consultation with the West Virginia Bureau for Public Health that tap water supplied from the KVTP should not be used other than for toilet flushing or fire protection. The Do Not Use Period differs based on the location of your Residence but does not extend beyond January 18, 2014.

"Eligible Residential Location" means a single-family home (attached or detached) or any unit within a multiple unit residential building that was supplied tap water by the KVTP on January 9, 2014.

"Freedom Chemical Spill" means the January 9, 2014 chemical spill into the Elk River in Charleston, West Virginia from the site owned by Freedom Industries, Inc. including the introduction of water containing the spilled chemicals into the Kanawha Valley Water Treatment Plant and the Kanawha Valley Distribution System operated by West Virginia American.

"KVTP" means the Kanawha Valley Water Treatment Plant.

"Legally Blind" means the person would be considered to be blind under the Social Security Administration's statutory guidelines, 42 U.S.C. § 1382c(a)(2), which provides that "[a]n individual shall be considered to be blind for purposes of this subchapter if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual

field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this subchapter if he is blind as defined under a State plan approved under subchapter X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined."

"Medical Claim" means a claim submitted under the Individual Review Option by or on behalf of a Medical Claimant and includes Contemporaneous Medical Treatment Claims, Other Medical Issues Claims, and Water Interruption Medical Issues Claims.

"Physical Injury" means bodily injury, that is, physical damage to a Claimant's body caused by exposure to, use or loss of use of tap water supplied by the KVTP between January 9 and February 15, 2014. Eligible Physical Injury includes: skin rash or dermatitis, eye irritations, gastro-intestinal or respiratory distress or flu like illness and must have manifested between January 9, 2014 and February 15, 2014. "Emotional distress" alone, without a physical manifestation of injury, does not qualify as a Physical Injury.

"Qualified Medical Expert" means is a physician who is engaged in a specialty relevant to your claim or engaged in relevant scientific research.

"Resident" means a person who resided at an Eligible Residential Location on January 9, 2014; provided that a visitor or guest shall not be considered to be a Resident and shall not be eligible for compensation for a Residential Household Claim, as an Additional Resident, or as a Residential Claimant.

"Residential Direct Customer User" means a person or entity who is a Customer of West Virginia American served by the KVTP who is identified in the West Virginia American Customer List as the account holder for an Eligible Residential Location and who also resided at the Eligible Residential Location on January 9, 2014.

Vision Impairment Rating percentage in the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.) – see summary table below:

AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (FIFTH EDITION)

IMPAIRMENT OF VISUAL ACUITY						
Impairment Classes (Based on ICD-9-CM)		**Visual Acuity**		**Visual Acuity Score (ability)**	**Visual Acuity Impairment Rating (%) (ability loss)**	**Estimated Reading Ability**
		US Notation	**1 m Notation**			
(Near-) Normal Vision	Range of Normal Vision	20/12.5 20/16 20/20 20/25	1/0.63 1/0.8 1/1 1/1.25	110 105 100 95	… … 0 5	Normal reading speed Normal reading distance Reserve capacity for small print
	Near-Normal Vision	20/32 20/40 20/50 20/63	1/1.6 1/2 1/2.5 1/3.2	90 85 80 75	10 15 20 25	Normal reading speed Reduced reading distance No reserve for small print
Low Vision	Moderate Low Vision	20/80 20/100 20/125 20/160	1/4 1/5 1/6.3 1/8	70 65 60 55	30 35 40 45	Near-normal with reading aids Uses low-power magnifier or large-print books
	Severe Low Vision	20/200 20/250 20/320 20/400	1/10 1/12.5 1/16 1/20	50 45 40 35	50 55 60 65	Slower than normal with reading aids Uses high-power magnifiers
	Profound Low Vision	20/500 20/630 20/800 20/1000	1/25 1/32 1/40 1/50	30 25 20 15	70 75 80 85	Marginal with reading aids Uses magnifiers for spot reading but may prefer talking books
(Near-) Blindness	Near Blindness	20/1250 20/1600 20/2000 or less	1/63 1/80 1/100 or less	10 5	90 95	No visual reading Must rely on talking books, Braille, or other nonvisual sources
	Total Blindness	No light	perception	0	100	