

**UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY**

IN RE: METFORMIN MARKETING
AND SALES PRACTICES
LITIGATION

Case No. 2:20-cv-2324

INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

If you are a Class Member who is a third-party payor (“TPP”) and would like to qualify to receive a payment from the Settlements with Teva and Granules and Heritage, you must complete and submit this Claim Form.

A third-party payor (“TPP”) Class Member, or an authorized agent for a TPP, can complete this Claim Form. If both a TPP Class Member and its authorized agent submit a Claim Form, the Claims Administrator will consider only the TPP Class Member’s Claim Form. The Claims Administrator may ask for supporting documents in addition to the documents and information requested below. The Claims Administrator may reject a claim if the TPP Class Member or its authorized agent does not provide all requested documents in a timely manner.

If you are a TPP Class Member submitting a Claim Form on your own behalf, complete “Section A – COMPANY OR HEALTH PLAN THIRD-PARTY PAYOR CLASS MEMBER ONLY,” in addition to the other information in this Claim Form.

If you are an authorized agent of one or more TPP Class Members, you must provide the information requested in “Section B – AUTHORIZED AGENT ONLY,” in addition to the other information in this Claim Form. **Do not submit a Claim Form on behalf of any other TPP Class Member unless that TPP Class Member provided you with prior written authorization to submit this Claim Form. You may be required to send the Claims Administrator such written authority to resolve any conflicts that arise.**

If you are submitting a Claim Form as only an authorized agent of one or more TPP Class Members, you may submit a separate Claim Form for each TPP Class Member OR you may submit one Claim Form for all such TPP Class Members, so long as you provide the required information for each TPP Class Member on whose behalf you are submitting this Claim Form.

If you are submitting Claim Forms on both your own behalf as a TPP Class Member AND as an authorized agent on behalf of one or more TPP Class Members, you should submit one Claim Form for yourself, completing Section A, and another Claim Form or Claim Forms as an authorized agent for the other TPP Class Member(s), completing Section B.

You can submit your Claim Form by mail or electronically on the Settlement website, www.inremetforminsettlement.com. You need to provide documents, as described below, to substantiate (or prove) your claim.

If you do not complete and submit your Claim Form postmarked (if mailed) or received (if submitted online) **by July 10, 2026**, you will not receive a payment from these Settlements. Submitting a Claim Form does not guarantee you will get a payment from the Settlements. If the Claims Administrator rejects or reduces your Claim, you may follow the dispute resolution process described on page 6-7.

CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS

Please provide information to show you (or the entity you represent) is a Class Member.

The TPP Teva Settlement Class is defined as:

All entities in the United States and its territories and possessions who paid any amount of money for a

metformin-containing drug (intended for personal or household use) that was manufactured, distributed, or sold by Teva from July 20, 2015 through June 2, 2020 (the “Class Period”).

The TPP Granules and Heritage Settlement Class is defined as:

All individuals in the United States and its territories and possessions who paid any amount of money for a metformin-containing drug (intended for personal or household use) that was manufactured, distributed, or sold by Granules or Heritage from July 20, 2015 through June 2, 2020 (the “Class Period”).

Persons or entities “purchased” a metformin-containing drug if they paid or reimbursed some or all of the purchase price.

Please note, certain entities are **not included** in the Settlement Classes. Do not file a claim for any entity that is one of the following:

- a) Teva Pharmaceuticals USA, Inc.; Teva Pharmaceutical Industries Ltd.; Actavis Pharma, Inc.; and Actavis LLC (“Teva”); Granules USA, Inc., and Granules Pharmaceuticals, Inc. (“Granules”); and Heritage Pharmaceuticals, Inc. (doing business as Avet Pharmaceuticals Inc.) (“Heritage”) and their respective subsidiaries and affiliates;
- b) Federal government entities;
- c) State and local government entities that can only make claims under applicable state law only by the state Attorney General, or are otherwise prohibited by applicable law from being asserted by private counsel on a contingent fee basis;
- d) All entities that purchased metformin-containing drug for purposes of resale or directly from Teva, Granules, Heritage, or their affiliates;
- e) Fully insured health plans (*i.e.*, plans that purchased insurance from another third-party payor covering 100% of the plan’s reimbursement obligations to its members);
- f) Pharmaceutical benefit managers; and
- g) Entities who excluded themselves from (or opted out of) the Settlements.

The following information should be provided to support your claim as a TPP Class Member:

- a) Name of TPP Class Member;
- b) NDC Number (the Settlement website provides a list of the NDCs the Claims Administrator will accept) – *e.g.*, 00000-0000-00;
- c) Fill Date or Date of Purchase – *e.g.*, 06/01/2017;
- d) Location (State) of Purchase – *e.g.*, CA;
- e) Location (State) of insured or beneficiary; and
- f) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – *e.g.*, \$20.00.

If you are submitting a Claim Form on behalf of multiple TPP Class Members, also provide the following information for each purchase or reimbursement:

- g) Plan or Group Name; and
- h) Plan or Group FEIN – provide group number for each transaction.

An exemplar spreadsheet containing these categories and a list of applicable NDC Numbers can be downloaded from the Settlement website, www.inremetforminsettlement.com. Please use this format if possible, and provide the electronic data in Microsoft Excel, ASCII flat file pipe “|”, tab-delimited, or fixed-width format.

Data and/or information demonstrating membership in the class is mandatory. Transaction data is mandatory for claims of \$100,000 or more, but the Claims Administrator may also require transaction data for claims of less than \$100,000, so keep related transaction data and any other documents supporting your claim in case the Claims Administrator requests them later. If your claim is for less than \$100,000, you should still provide the transaction data with your claim submission

if you can. If, after an audit of your claim, the Claims Administrator still has questions about your claim and you have not provided sufficient data and/or documentation, the Claims Administrator may reject your claim.

Please contact the Claims Administrator at 1-866-302-6835 with any questions about the required claim information and documentation. Please do not contact the Court about these issues.

**MUST BE POSTMARKED ON
OR BEFORE,
OR SUBMITTED
ONLINE BY JULY 10, 2026**

*In Re: Metformin Marketing and
Sales Practices Litigation
Teva Settlement and Granules and
Heritage Settlement*

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

Attention: You should only fill out this Claim Form if you are a Third-Party Payor (or its authorized agent).

If you are a Consumer, please fill out the Consumer Claim Form, available at www.inremetforminsettlement.com.

- Complete Section A only if you are filing as an individual TPP Class Member.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP Class Members.

Section A: Company or Health Plan Class Member Only

Company or Health Plan Name

Contact Name

Address 1

Address 2

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since July 20, 2015.

Health Insurance Company/HMO Self-Insured Employee Health or Pharmacy Benefit Plan

Self-Insured Health & Welfare Fund
 Other (Explain):

Section B: Authorized Agent Only

As an authorized agent, please check the box that best describes your relationship with the TPP Class Member. (You must provide documents demonstrating this relationship.)

- Third-Party Administrator or Administrative Services Only Provider
- Pharmacy Benefits Manager
- Other (Explain):

Authorized Agent's Company Name

Contact Name

Address Floor/Suite

City State Zip Code

Area Code - Telephone Number

Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every TPP Class Member (*i.e.*, company or health plan) for which you were authorized to submit this Claim Form. (Attach additional sheets to this Claim Form as needed.) Alternatively, you may submit the requested list of TPP Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file. Please contact the Claims Administrator to determine which formats are acceptable.

TPP CLASS MEMBER'S NAME	TPP CLASS MEMBER'S FEIN
<input style="width: 430px; height: 25px;" type="text"/>	<input style="width: 430px; height: 25px;" type="text"/>
<input style="width: 430px; height: 25px;" type="text"/>	<input style="width: 430px; height: 25px;" type="text"/>
<input style="width: 430px; height: 25px;" type="text"/>	<input style="width: 430px; height: 25px;" type="text"/>
<input style="width: 430px; height: 25px;" type="text"/>	<input style="width: 430px; height: 25px;" type="text"/>

Section C: Purchase Information

Please type or print in the box below, the total amount, from July 20, 2015 through June 2, 2020, that you paid or reimbursed for generic versions of metformin-containing drugs, for consumption by your members, employees, insureds, participants, or beneficiaries, where the person(s) purchased the drug in the United States for personal or household use.

If you are an authorized agent completing this Claim on behalf of more than one TPP Class Member, enter the total amount paid by all the TPP Class Members included in this Claim. You must also provide the required information for each TPP Class Member on whose behalf you are submitting this Claim Form. An exemplar spreadsheet containing the required categories can be downloaded from the Settlement website, www.inremetforminsettlement.com.

Total amount (net of co-pays, deductibles, and co-insurance) you paid or reimbursed for generic versions of metformin-containing drugs in the United States, from July 20, 2015 through June 2, 2020 , for personal or household use, by your members, employees, insureds, participants, or beneficiaries:	
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\$

- Check this box and sign the claim form in *Section E* to confirm that the claimant(s) indicated in Section A and/or Section B are TPP Class Members and they are not excluded (based on the criteria above). If any claimants are excluded from the Settlements, the Claims Administrator may reject this Claim.

Section D: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested above in the “CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS” section in the instructions as possible.

Transaction data supporting claims is **mandatory** for claims of \$100,000 or more, but the Claims Administrator may also require you to provide transaction data for claims of less than \$100,000. Please keep related transaction data, business records used to create the transaction list, and any other documents supporting your claim (*e.g.*, invoices) in case the Claims Administrator requests them later. If, after an audit of your claim, the Claims Administrator still has questions about your claim and you did not provide sufficient data and/or documents, the Claims Administrator may reject your claim.

If the Claims Administrator rejects or reduces your claim and you believe the rejection or reduction is in error, you may contact the Claims Administrator to ask for further review. If the dispute concerning your claim cannot be resolved by the Claims Administrator and Co-Lead Counsel, you may ask the Court to review your claim.

To request Court review, you must send the Claims Administrator a signed written statement that states: (a) the reasons you disagree with your claim being rejected or your claim’s payment determination and (b) specifically that you “request that the Court review the determination regarding this claim.” You must include all documents supporting your argument(s). The Claims Administrator and Co-Lead Counsel will present the dispute to the Court for review, which may include publicly filing your claim and any supporting documents with the Court. Please note, you should only ask for Court review if you disagree with the Claims Administrator’s determination regarding your claim.

Section E: Certification

By signing below, I hereby swear and affirm that I have read and am familiar with the Claim Form instructions. I certify the information I provided in this Claim Form and any documents I attached are true, correct, and complete to the best of my knowledge.

I certify I provided all the information requested above to the extent I have it.

I further certify that I, or the TPP Class Member(s) I represent:

- a) purchased, paid for, or reimbursed some or all of the purchase price for a generic version of a metformin-containing drug (intended for personal or household use) in the United States that was manufactured, distributed, or sold by Teva, Granules, and/or Heritage from July 20, 2015 through June 2, 2020; and
- b) am/is/are not one of the following:
 - i.) Teva, Granules, and Heritage, or their respective subsidiaries and affiliates;
 - ii.) A federal government entity;
 - iii.) A state or local government entity that can only make claims under applicable state law only by the state Attorney General, or are otherwise prohibited by applicable law from being asserted by private counsel on a contingent fee basis;
 - iv.) An entity that purchased metformin-containing drug for purposes of resale or directly from Teva, Granules, Heritage, or their affiliates;
 - v.) A fully insured health plan (i.e., plan that purchased insurance from another third-party payor covering 100% of the plan's reimbursement obligations to its members); or
 - vi.) A pharmaceutical benefit manager.

I further certify that neither I, nor the TPP Class Member(s) I represent, asked to be excluded ("opted out") from the Settlements with Teva and Granules and Heritage.

I further certify that I, or the TPP Class Member(s) I represent, have read and are familiar with the releases stated in Paragraph 4 of the Settlements (including terms defined in Section 1 of the Settlements).

The releases in Paragraphs 4.2 and 4.3 of the Teva Settlement and the Granules and Heritage Settlement provide as follows:

4.2 Upon the Effective Date of this Settlement and in consideration of the Settlement Amount, Plaintiffs, each Settlement Class Member, and Released Plaintiffs, on behalf of themselves and their respective past and present parents, subsidiaries, and affiliates, general and limited partners, officers, directors, employees, agents, attorneys, servants, predecessors, successors, heirs, executors, administrators, and representatives (the "Releasing Plaintiffs"), shall be deemed to have, and by operation of the Judgment shall have, fully, finally, and forever released, waived, relinquished and discharged, and shall forever be enjoined from commencing, instituting, prosecuting, or continuing to prosecute any action or other proceeding in any forum whatsoever, including any court of law or equity, arbitration tribunal, or administrative forum, all Plaintiffs' Released Claims against Released Defendants, whether or not such Plaintiff, Settlement Class Member, or Released Plaintiff executes and delivers a Claim Form.

4.3 With respect to any and all Released Claims, the Parties, on behalf of themselves and all other Releasing Parties, stipulate and agree that by operation of the Final Judgment, the Releasing Parties shall hereby expressly waive, release, and forever discharge, upon Final Judgment, any and all provisions, rights, and benefits conferred by Section 1542 of the California Civil Code, which states:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY;

or by any law of any state or territory of the United States, or principle of common law, which is similar, comparable, or equivalent to Section 1542 of the California Civil Code. The Releasing Parties may hereafter discover facts other than or different from those which they know or believe to be true with respect to the Released Claims, but the Releasing Parties hereby expressly waive and fully, finally, and forever settle and release, upon Final Judgment, any known or unknown, suspected or unsuspected, contingent or non-contingent claim that they have agreed to release, whether or not concealed or hidden, without regard to the subsequent discovery or existence of such different or additional facts.

To the extent I was authorized to submit this Claim Form on behalf of one or more TPP Class Members, am submitting this Claim Form as an authorized agent, and have been authorized to receive on behalf of the TPP Class Member(s) any and all amounts from the Settlements that may be allocated to them, I certify that such authority has been properly vested in me in writing, I can and will submit such written authorization to the Claims Administrator if requested, and I will fulfill all duties I may owe the TPP Class Member(s). If amounts from the Settlements are distributed to me, and a TPP Class Member later claims I did not have the authority to claim and/or receive such amounts on its behalf, I and/or my employer will hold the Class, Co-Lead Counsel, and the Claims Administrator harmless with respect to any claims made by the TPP Class Member.

I/We hereby submit to the jurisdiction of the United States District Court for the District of New Jersey for all purposes connected with this Claim Form, including resolving disputes related to this Claim Form. I/We acknowledge that if I/we provided any false information or representations related to this claim, I/we may be subject to sanctions, including criminal prosecution. If the Claims Administrator asks for additional supporting documents to supplement this Claim Form and the information in it, I agree to provide them.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____ 2026.

Signature

Position/Title

Print Name

Date

Mail your completed Claim Form, along with any supporting documents as described in the CLAIM INFORMATION AND DOCUMENTATION INSTRUCTIONS on pages 2-3 above, to the address below, postmarked **no later than July 10, 2026**, or submit the information online at the website below by that date:

In re Metformin Marketing and Sales Practices Litigation

c/o A.B. Data, Ltd.

P.O. Box 173012

Milwaukee, WI 53217

Toll-Free Telephone: 1-866-302-6835

Website: www.inremetforminsettlement.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form or complete the online Claim Form. Attach or upload documents supporting your claim.
2. Keep a copy of your Claim Form and supporting documents for your records.
3. If you would also like a receipt acknowledging your Claim Form was received, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.

If you move and/or your name changes, please send your new address and/or your new name or contact information to the Claims Administrator at info@inremetforminsettlement.com or via U.S. Mail at the address above.