

UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

IRON WORKERS DISTRICT  
COUNCIL OF NEW ENGLAND  
HEALTH AND WELFARE FUND, UTAH-IDAHO  
TEAMSTERS SECURITY FUND, JACKSONVILLE  
POLICE OFFICERS AND FIRE FIGHTERS  
HEALTH INSURANCE TRUST, and NYST  
COUNCIL HEALTH & HOSPITAL FUND, on  
behalf of themselves and others similarly situated,

Plaintiffs

v.

TEVA PHARMACEUTICAL INDUSTRIES LTD.;  
TEVA PHARMACEUTICALS USA, INC.; TEVA  
BRANDED PHARMACEUTICAL PRODUCTS  
R&D LLC; and NORTON (WATERFORD) LTD.,

Defendants.

Civil Action No. 1:23-cv-11131 (NMG)

**INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR 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 requested by 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 requested by 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. If any conflicts arise that require resolution, you may be required to provide such written authority to the Claims Administrator.**

If you are submitting a Claim Form only as 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, as long as you provide the information required 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 Members, completing Section B.

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form. You can submit your Claim Form by mail or electronically on the Settlement website ([www.QVARantitrustsettlement.com](http://www.QVARantitrustsettlement.com)). You may need to provide certain requested documents to prove your claim.

If you do not complete and submit your Claim Form postmarked (if mailed) or received (if submitted online) by **July 31, 2026**, you will not receive a payment from this Settlement. Submitting a Claim Form does not guarantee you will receive payment from the Settlement. If the Claims Administrator rejects or reduces your Claim, you may follow the dispute resolution process described on pages 5-6.

## **CLAIM INFORMATION AND DOCUMENTATION REQUIREMENTS**

You must provide information to support your claim and show that you are a TPP Class Member, which for TPPs is defined as follows:

All persons or entities that, for consumption by their members, insureds, or beneficiaries, purchased, paid, and/or provided reimbursement for some or all of the purchase price of QVAR and/or QVAR Redihaler in the Class States other than for resale, at any time from January 1, 2015 through July 31, 2025 (the "Class Period").

"Class States" means the following states and territories: Alaska, Arkansas, Arizona, California, Connecticut, Delaware, D.C., Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

The Class **does not include** the following entities:

- a) Teva and their respective subsidiaries and affiliates;
- b) Federal and state governmental entities; and/or
- c) Anyone that excluded themselves from (or opted out of) the Class.

Provide the following information 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; or Drug Name – e.g., QVAR;
- c) Fill Date or Date of Purchase – e.g., 06/01/2023;
- 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, please 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.QVARantitrustsettlement.com](http://www.QVARantitrustsettlement.com). Please use this format and provide the electronic data in Microsoft Excel, ASCII flat file pipe "|", tab-delimited, or fixed-width format.

It is mandatory that you provide data and/or information demonstrating you are a TPP Class Member. If, after an audit, the Claims Administrator still has questions and you have not provided sufficient documentation to prove your claim, the Claims Administrator may reject your claim.

Please contact the Claims Administrator at 1-866-588-8524 with any questions about the required claims information or documentation. Please do not contact the Court concerning these issues.

**MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY, JULY 31, 2026.**

**QVAR Antitrust Settlement**

**THIRD-PARTY PAYOR CLAIM FORM**

Use Blue or Black Ink Only.

**Attention: This form should only be filled out on behalf of a Third-Party Payor (or its authorized agent).** If you are a Consumer, please fill out the Consumer Claim Form, available at [www.QVARantitrustsettlement.com](http://www.QVARantitrustsettlement.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 June 14, 2008.

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 how your relationship with the TPP Class Member is best described: (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

**Section C: Purchase Information**

Please type or print in the box below, the total amount, from January 1, 2015 through July 31, 2025, that you paid or reimbursed for QVAR or QVAR Redihaler, for consumption by your members, employees, insureds, participants, or beneficiaries, where the person(s) purchased the drug in a pharmacy, or received QVAR or QVAR Redihaler by mail-order prescription, in Alaska, Arkansas, Arizona, California, Connecticut, Delaware, D.C., Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin, or Wyoming.

Please note: For retail purchases, the State of purchase is the State where the pharmacy is physically located. If any purchases were made by mail order, the State to which the prescription was sent is considered the place of purchase. For example, if QVAR or a QVAR Redihaler was purchased by mail order and the prescription was sent to Alaska, Alaska would be considered the place of purchase for that transaction and the purchase would be eligible for a recovery. On the other hand, if QVAR or QVAR Redihaler was purchased by mail order and the prescription was sent to South Carolina, that transaction would not be eligible for a recovery because the place of purchase would be considered South Carolina, which is not one of the Class States covered by the Settlement.

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 information required for each TPP Class Member on whose behalf you are submitting this Claim Form. An exemplar spreadsheet containing the required categories of information can be downloaded from the Settlement website, [www.QVARantitrustsettlement.com](http://www.QVARantitrustsettlement.com).

Do not submit a Claim Form for or on behalf of any of the following entities:

- a) Teva and their respective subsidiaries and affiliates;
- b) Federal and state governmental entities;
- c) All entities that purchased QVAR or QVAR Redihaler for purposes of resale or directly from Teva or its affiliates;
- d) 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); or
- e) Pharmaceutical benefit managers.

Total amount (net of co-pays, deductibles, and co-insurance) you paid or reimbursed for <b>QVAR</b> and/or <b>QVAR Redihaler</b> , in the Class States, from <b>January 1, 2015 through July 31, 2025</b> , for consumption by your members, insureds, or beneficiaries:	\$
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Check this box and sign the certification in Section E to confirm that the Claimant indicated in Section A is a TPP Class Member and none of the exclusion criteria above is applicable. If any of the exclusion criteria is applicable to the Claimant, the Claims Administrator may reject the 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**. If, after an audit, the Claims Administrator still has questions and you have not provided sufficient documentation to prove your claim, the Claims Administrator may reject your claim. During the review process, the Claims Administrator may request the business records you used to establish the list of transactions claimed; please keep this information.

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 request further review. If the dispute concerning your claim cannot be resolved by the Claims Administrator and Class Counsel, you may ask the Court to review your claim.

To request Court review, you must send the Claims Administrator a signed written statement (a) stating your reasons for contesting your claim's rejection or payment determination and (b) specifically stating 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 Class Counsel will present the dispute to the Court for review, which may include publicly filing your claim and any supporting documentation with the Court. Please note: Court review should only be sought if you disagree with the Claims Administrator's determination regarding your claim.

## Section E: Certification

By signing below, I hereby swear and affirm that (1) I read and am familiar with the contents of the instructions accompanying this Claim Form; (2) the information I provided in this Claim Form and any documents I attached are true, correct, and complete to the best of my knowledge; and (3) I provided all the information requested above to the extent I have it.

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

- a) am/is/are an entity that purchased, paid for, or reimbursed some or all of the purchase price of QVAR or QVAR Redihaler for consumption by my/its/their members, insureds, or beneficiaries in one or more of the Class States, from January 1, 2015 through July 31, 2025; and
- b) am/is/are not one of the following:
  - i.) Teva and its respective subsidiaries and affiliates;
  - ii.) Federal and state governmental entities;
  - iii.) All entities that purchased QVAR or QVAR Redihaler for purposes of resale or directly from Teva or its affiliates;
  - iv.) 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); or
  - v.) Pharmacy benefit managers.

I certify that neither I, nor the TPP Class Member(s) I represent, asked to be excluded ("opted out") from the Class in this lawsuit.

I certify that I, and the TPP Class Member(s) I represent, have read and are familiar with the releases stated in Paragraph 12 of the Settlement Agreement. The releases in that Paragraph state as follows:

- a) Upon the occurrence of the Effective Date as defined in Paragraph 6 [of the Settlement Agreement], and in consideration for the Settlement Fund Amount described in this Settlement Agreement, End-Payor Plaintiffs and the End-Payor Class subject to the Court's approval, will, on behalf of all End-Payor Class members 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 Parties"), release and forever discharge, and covenant not to sue Teva and its respective past, present,

and future parents, subsidiaries, divisions, affiliates, joint ventures, stockholders, general partners, limited partners, officers, directors, management, supervisory boards, insurers, employees, agents, servants, trustees, associates, attorneys, and any of their legal representatives (and the predecessors, successors, heirs, executors, administrators, and assigns of each of the foregoing) (the "Released Parties") from all past, present, or future liabilities, claims, demands, obligations, suits, damages, penalties, levies, executions, judgments, debts, charges, actions, or causes of action, at law or in equity, whether class, individual, or otherwise in nature, and arising out of or relating to any conduct, events, or transactions (i) whether known or unknown, that were alleged, or which reasonably could have been alleged, in the End-Payor Class Action concerning the alleged anticompetitive scheme to prevent and delay approval and market entry of AB-rated generic equivalents of QVAR or QVAR Redihaler, or (ii) whether known or reasonably capable of being known as of the effective date of the Settlement Agreement, concerning end-payor purchases of QVAR, QVAR Redihaler, and/or AB-rated generic equivalents of QVAR or QVAR Redihaler arising under the Sherman Act, 15 U.S.C. §§ 1 & 2, et seq., or any other federal or state statute or common-law doctrine relating to antitrust or consumer protection (collectively, the "Released Claims"). Upon the Effective Date, the Releasing Parties will be forever barred and 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, asserting the Released Claims against the Released Parties. Releasing Parties' release shall not extend to claims of any sort that do not relate specifically to the purchase of QVAR or QVAR Redihaler, or that are not contained in, are not based on, or do not arise out of the identical factual predicate alleged in the Complaint.

- b) Upon the occurrence of the Effective Date as defined in Paragraph 6 [of the Settlement Agreement], Defendants and each of the Released Parties release and forever discharge, and covenant not to sue, the Releasing Parties, including End-Payor Plaintiffs, members of the Settlement Class, and End-Payor Plaintiffs' Counsel, from all past, present, or future liabilities, claims, demands, obligations, suits, damages, penalties, levies, executions, judgments, debts, charges, actions, or causes of action, at law or in equity, whether class, individual, or otherwise in nature, whether arising under federal, state, common, or foreign law, that arise out of or relate in any way to the institution, prosecution, assertion, settlement, or resolution of the End-Payor Class Action or the Released Claims (the "Released Parties' Claims"). Released Parties' Claims shall not include any: (i) future claims relating to the enforcement of the Settlement Agreement; or (ii) claims against any person or entity that submits a request for exclusion from the Settlement Class in connection with the Notice and whose request is accepted by the Court. For the avoidance of doubt, the release in this paragraph is intended only to cover litigation conduct in this End-Payor Class Action.
- c) In addition, End-Payor Plaintiffs, on behalf of themselves and all other Releasing Parties, and Defendants and each of the Released Parties, hereby expressly waive, release, and forever discharge, upon the Settlement becoming final, any provisions, rights, and benefits conferred by Section 1542 of the California Civil Code, which reads:

Section 1542. General Release; extent. 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 other jurisdiction, or principle of common law, which is similar, comparable, or equivalent to Section 1542 of the California Civil Code. The Releasing Parties and Released Parties may hereafter discover facts other than or different from those which he, she, or it knows or believes to be true with respect to the claims which are the subject matter of this Paragraph 12, but each Releasing Party and each Released Party hereby expressly waives and fully, finally, and forever settles, releases, and discharges, upon this Settlement becoming final, any known or unknown, suspected or unsuspected, asserted or unasserted, contingent or non-contingent claim that would otherwise fall within the definition of Released Claims or Released Parties' Claims, as applicable, whether or not concealed or hidden, without regard to the subsequent discovery or existence of such different or additional facts.

- d) This Settlement is not intended to and does not release claims arising in the ordinary course of business between the Releasing Parties and the Released Parties that are unrelated to the allegations in the End-Payor Class Action, such as claims under Article 2 of the Uniform Commercial Code (pertaining to Sales), the laws of negligence or product liability or implied warranty, breach of contract, breach of express warranty, or personal injury.

To the extent I was authorized to submit this Claim Form on behalf of one or more TPP Class Members and accordingly am

submitting this Claim Form as an authorized agent, and to the extent I have been authorized to receive on behalf of the TPP Class Member(s) any and all amounts from the Settlement Fund 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 any conflicts arise that require resolution, and I will fulfill all duties I may owe the TPP Class Member(s). If amounts from the Settlement Fund 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, Class 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 Massachusetts 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 Claim Administrator requests supplemental documentation to prove the information I provided in this Claim Form is correct, I will provide it.

**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 1-3 above, to the address below, postmarked no later than **July 31, 2026**, or submit the information online at the website below by that date:

QVAR Antitrust Settlement  
c/o A.B. Data, Ltd.  
P.O. Box 173034  
Milwaukee, WI 53217  
Toll-Free Telephone: 1-866-588-8524  
Website: [www.QVARantitrustsettlement.com](http://www.QVARantitrustsettlement.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@QVARantitrustsettlement.com](mailto:info@QVARantitrustsettlement.com) or via U.S. Mail at the address above.

