Forward-Looking Statements

Except for the historical information contained herein, this presentation contains forward-looking statements made pursuant to the “safe harbor” provisions of the Private Securities Litigation Reform Act of 1995. Investors are cautioned that statements in this presentation regarding: (i) continued development of imetelstat by Janssen for MDS in the Phase 3 portion of IMerge and continued conduct by Janssen of IMbark and/or IMerge; (ii) data that suggest clinical benefit and potential overall survival benefit of imetelstat in MF; (iii) a planned data package will be provided to the FDA for IMerge; (iv) that Janssen will evaluate more mature data including overall survival for IMbark; (v) potential outcomes of any data reviews conducted by Janssen for IMbark; (vi) any future presentation of data from IMerge by Janssen at a medical conference; (vii) that if Janssen decides to proceed with the Phase 3 portion of IMerge, the clinical trial will be opened for patient enrollment in the fourth quarter of 2017; (viii) imetelstat having activity in MF, MDS or any other hematologic myeloid malignancies, including acute myeloid leukemia; (ix) imetelstat treatment suppressing the malignant clones underlying the disease in hematologic myeloid malignancies; (x) the safety and efficacy of imetelstat; (xi) the potential receipt by Geron of additional payments up to a potential total of $900 million for the achievement of development, regulatory and commercial milestones, and royalties from sales of imetelstat under the collaboration agreement with Janssen; (xii) Geron’s desire to diversify; (xiii) financial projections and expectations; and (xiv) other statements that are not historical facts, constitute forward-looking statements. These statements involve risks and uncertainties that can cause actual results to differ materially from those in such forward-looking statements. These risks and uncertainties, include, without limitation, risks and uncertainties related to: (i) whether imetelstat will succeed in IMbark and IMerge by overcoming all of the clinical safety and efficacy, technical, scientific, manufacturing and regulatory challenges; (ii) whether health authorities permit IMbark or IMmerge to continue to proceed; (iii) Janssen’s ability to collect additional and more mature data from current clinical trials; (iv) whether Janssen continues to conduct IMbark or IMmerge; (v) Geron’s total dependence on Janssen for the development, regulatory approval, manufacture and commercialization of imetelstat, including the risks that if Janssen were to breach or terminate the collaboration agreement or otherwise fail to successfully develop and commercialize imetelstat and in a timely manner, or at all, Geron would not obtain the anticipated financial and other benefits of the collaboration agreement with Janssen and the clinical development or commercialization of imetelstat could be delayed or terminated; (vi) whether imetelstat is safe and efficacious, and whether any future efficacy or safety results may cause the benefit/risk profile of imetelstat to become unacceptable; (vii) whether imetelstat can be applied to any or to multiple hematologic malignancies; (viii) the fact that Geron may not receive any or limited milestone, royalty or other payments from Janssen because Janssen may terminate the collaboration agreement for any reason or because imetelstat is unsuccessful developmentally or commercially; (ix) the ability of Geron and Janssen to protect and maintain intellectual property rights for imetelstat; (x) the need for future capital; and (xi) whether Geron is able to acquire any new product candidates, programs or companies to enable it to diversify. Additional information on the above risks and uncertainties and other factors that could cause actual results to differ materially from those in the forward-looking statements are contained in Geron’s periodic reports filed with the Securities and Exchange Commission under the heading “Risk Factors,” including Geron’s quarterly report on Form 10-Q for the quarter ended March 31, 2017. Undue reliance should not be placed on forward-looking statements, which speak only as of the date they are made, and the facts and assumptions underlying the forward-looking statements may change. Except as required by law, Geron disclaims any obligation to update these forward-looking statements to reflect future information, events or circumstances.
Imetelstat’s clinical activity suggests impact on underlying disease in hematologic myeloid malignancies

- Inhibiting telomerase activity impedes production of malignant cells
- First telomerase inhibitor in clinical development
- Molecular responses seen in essential thrombocythemia (ET) and remissions observed in myelofibrosis (MF) indicate disease-modifying activity in hematologic malignancies
- Phase 2 clinical development being pursued in MDS and MF

Conventional treatments for lower-risk myelodysplastic syndromes inadequate

- No new drugs approved for >10 years; many patients are dependent on transfusions to treat chronic anemia characteristic of this disease
- Transfusions shorten median survival and increase risk of transformation to AML

Insufficient options for myelofibrosis patients when front-line JAK inhibitor therapy ineffective

- High discontinuation rate (~75%) due to suboptimal response or loss of therapeutic effect
- Short median survival (~7 months) after ruxolitinib failure or discontinuation
- Challenging patient populations: COMFORT I spleen volume response rates not replicated in subsequent front- or second-line studies with other JAKis
- New treatment approaches needed to alter underlying disease

Ongoing clinical trials being conducted by Janssen; second internal data reviews completed in April 2017

- IMerge (Phase 2/3 MDS clinical trial) initiated in January 2016
  - Benefit/risk profile of imetelstat in the Phase 2 patients supports continued development in lower risk MDS
  - A data package and proposed design refinements to the Phase 3 component are planned to be provided to the FDA
- IMbark (Phase 2 MF clinical trial) initiated in September 2015
  - Current results suggest clinical benefit and a potential overall survival benefit associated with imetelstat treatment in relapsed or refractory MF
  - Trial continues unchanged to evaluate maturing efficacy and safety data, including an assessment of overall survival

Financial position provides strategic business options

- ~$122 million in cash and investments as of March 31, 2017
- Ability to act on potential imetelstat development opportunities
- Pipeline diversification through possible acquisitions of new oncology products, programs or companies
Telomerase
A molecular target in oncology

Telomerase enzyme

Comprised of an RNA template component (hTR) and a reverse transcriptase catalytic protein subunit (hTERT)

Binds to the 3’ strand of DNA and adds TTAGGG nucleotide repeats to offset the loss of telomeric DNA at the end of chromosomes that occurs with each replication cycle
Telomerase transiently upregulated to support controlled proliferation; not active in somatic cells

Telomerase highly upregulated, enabling continued and uncontrolled proliferation
Imetelstat
A first-in-class telomerase inhibitor

- **Proprietary:** 13-mer thio-phosphoramide oligonucleotide complementary to hTR, with covalently-bound lipid tail to increase cell permeability/tissue distribution
- **Long tissue residence time** in bone marrow, spleen, liver (0.19 – 0.51 µM observed in human bone marrow at 41 – 45 hours post 7.5 mg/kg dose)
- **Potent competitive inhibitor of telomerase:** IC50 = 0.5 – 10 nM (cell-free)
- **Target:** malignant progenitor cell proliferation
- **Clinical experience:** over 500 patients treated in Phase 1 and 2 trials; safety profile generally consistent
  - reported adverse events (AEs) and laboratory investigations include cytopenias, gastrointestinal symptoms, constitutional symptoms, hepatic biochemistry abnormalities
  - myelosuppression is dose-limiting toxicity observed (managed through dose holds and modification rules)
Hematologic Myeloid Malignancies
Arise from malignant progenitor cells in the bone marrow

- ~3,000 cases diagnosed per year in the US
- ~13,000 people in the US living with MF
  - ~70% of patients have high/intermediate-2 risk disease (population for most ongoing clinical trials)

- ~12,000 cases diagnosed per year in the US
- ~60,000 people in the US living with MDS
  - ~70% of patients have lower risk disease

- ~20,000 cases diagnosed per year in the US
- ~27% of patients diagnosed are alive after 5 years

Mehta et al, Leuk Lymphoma 2014, 55:595-600
Gangat et al, J Clin Oncol 2011, 29:392-397
Fenaux et al, Blood 2013; 121:4280-4286
NCI SEER database: www.seer.cancer.gov
Targeting MDS and MF
Telomerase: A mechanism to address the underlying disease

Myelodysplastic Syndromes

- Driver mutations unknown
- Excessive growth factor signaling/defects in cell maturation
- Anemia and other peripheral cytopenias

Disease targets:
- Erythropoiesis stimulation
- Growth factor function
- Telomerase

Myelofibrosis

- Phenotypic drivers: JAK/STAT signaling pathway gain-of-function mutations JAK2V617F, CALR, MPL
- Malignant megakaryocyte clone (growth factor independent)
- Release of inflammatory cytokines and growth factors (interleukins, TGF-β)
- Collagen and reticulin fibers (fibrosis)

Disease targets:
- JAK/STAT signaling
- Cytokine/growth factor function
- Telomerase
Proof-of-concept in essential thrombocythemia

- Molecular responses and allele burden reductions in patients with JAK2V617F, CALR or MPL mutations, and others
- Increases in average telomere length in patients’ granulocytes at time of best molecular response suggest recovery of normal hematopoiesis
- Ex vivo suppression of growth factor independent proliferation of megakaryocytes from patients

Pilot study in myelofibrosis

- Unprecedented complete and partial remissions
  - CR or PR: 21.2% (7/33) patients
  - median duration for CR 18 months (range 7 – 20+ at Dec, 2014)
- Molecular remissions in CR patients

Reversal of Bone Marrow Fibrosis in CR Patient

Baerlocher et al, NEJM 2015;373:920-928
Oppliger Leidengut et al, ASH 2015
Haubitz et al, ASH 2016
Tefferi et al, NEJM 2015;373:908-919
Myelodysplastic Syndromes

Disease characteristics

- **Diverse group of clonal hematologic malignancies** with disordered and ineffective production of the myeloid lineage in the bone marrow characterized by abnormal cell morphology and counts (anemia and other cytopenias)
- **Median age at diagnosis is ~70 years**
- **Up to 30% of patients progress to acute leukemia (AML)**
- **Chronic anemia** is predominant clinical problem in lower risk MDS and many patients become dependent on transfusions
- **Transfusion dependency** may lead to iron overload and is associated with shorter survival (2 units red blood cells per month may reduce life expectancy by 50%) and increased risk of transformation to AML

Sekeres, Natl Compr Canc Netw 2011; 9:57-63
Malcovati et al, JCO 2007; 25:3503-3510
Greenberg et al, Blood 1997; 89:2079-2028
Bejar & Steensma, Blood 2014; 124:2793-2803
Treatment Paradigm for Lower Risk MDS
No new drugs approved for >10 years

Approved or conventional treatments

- **Del 5q**
  - cytogenetic abnormality (5-20% patients)

- **Lenalidomide**
  - 55% to 65% RBC-TI (≥8 wk)
  - median duration: 2-2.5 years

- **Erythropoiesis stimulating agents (ESAs)**
  - improvement in anemia in ~50% of patients
  - median duration: ~2 years

- **HMAs**
  - mostly reserved for higher risk disease

- **Red blood cell transfusion dependent**

- **Clinical trials**
  - e.g., imetelstat, luspatercept

Fenaux and Adès, Blood 2013; 121:4280-4286
Clinical Development in Lower Risk MDS
Chronic anemia remains an unmet need

**Imetelstat**
telomerase inhibitor

**Mayo Pilot Study:**
IPSS int-1/int-2 RARS
3/8 (37.5%) transfusion dependent patients achieved RBC-TI ≥8 weeks
Median duration 28 weeks; 9, 28 and 37 weeks respectively

**IMerge Phase 2/3:**
Being conducted by Janssen (First patient: Jan 2016)

**Ringed sideroblast positive** (~20% of lower risk MDS patients)

**Ringed sideroblast negative** (~80% of lower risk MDS patients)

**Luspatercept**
ligand trap inhibiting TGF-β superfamily

**PACE Phase 2:**
IPSS low/int-1
11/22 (50%) patients transfused prior to study achieved RBC-TI ≥8 weeks; range: 9-80+ weeks
*(Higher response rates in RS+ patients)*

**MEDALIST Phase 3:**
(vs. placebo) Ongoing

ClinicalTrials.gov: NCT02598661 (IMerge), NCT02631070 (MEDALIST)
Platzbecker et al, EHA 2016; Platzbecker et al, ASH 2016
A multi-center, two part clinical trial being conducted by Janssen

- Objectives:
  - Part 1 (Phase 2) to evaluate safety and efficacy of imetelstat to advance to Part 2 based on positive assessment of benefit-risk profile in significant unmet medical need population
  - Part 2 (Phase 3) to compare imetelstat to placebo using an established regulatory endpoint

- Dosing regimen used in Mayo Clinic Pilot Study MDS-RARS cohort
- First patient dosed in January 2016; Part 1 fully enrolled

Supportive care permitted in both arms: RBC transfusions, myeloid growth factors per investigator discretion as clinically needed and local guidelines

More information on ClinicalTrials.gov (NCT02598661)
Current Status of IMerge
Initiation of Part 2 to be determined

Second internal review completed in April 2017
• Data from all ~30 patients enrolled in Part 1

Safety profile was consistent with previous imetelstat clinical trials in hematologic myeloid malignancies
• No new safety signals were identified

Benefit/risk profile of imetelstat supports continued development in lower risk MDS
• Assessments included 8-week and 24-week transfusion independence and hematologic improvement by erythroid (HI-E) response
• Activity observed across multiple MDS sub-types

Part 1 of the trial continues unmodified
• Patients remaining in the treatment phase may continue to receive imetelstat

A data package, as well as proposed refinements to the trial design for Part 2 of IMerge, is planned to be provided to the FDA
• If Janssen moves forward with Part 2, the Phase 3 trial may be open for enrollment in Q4 2017

Clinical data from Part 1 expected to be submitted for presentation at a future medical conference
Myelofibrosis
Disease characteristics

- **Malignant clonal proliferation** and atypical megakaryocytic hyperplasia leads to bone marrow fibrosis and impaired hematopoiesis
  - **Fibrosis** thought to be induced by inflammatory cytokines produced by megakaryocytes originating from the malignant progenitor cell clone
  - **Constitutional symptoms** (e.g., fever, weight loss, night sweats, pruritus) present in approximately 35% of patients also thought to be due to cytokines produced by malignant megakaryocytes
  - Impaired bone marrow hematopoiesis shifts blood production to spleen and liver (palpable splenomegaly in approximately 80% of patients)
- **Serious and life-threatening** illness
  - Leukemic transformation to AML (blast-phase MF)
  - Thrombohemorrhagic complications associated with dysfunctional hematopoiesis

Tefferi, JCO 2005; 23:8520-8530
Tefferi, Mayo Clin Proc 2012; 87:25-33
Gangat et al, JCO 2011; 29:392-397
Evolution of Therapy in High/Int-2 Risk MF  
Treatment paradigm before ruxolitinib approval in Nov 2011

High or  
Intermediate-2  
Risk MF

Conventional treatments
- drug therapies: e.g., hydroxyurea, steroids, immunomodulatory agents, androgens
- splenectomy, radiotherapy
- allogeneic hematopoietic cell transplantation (limited to very few eligible patients)

Clinical trials
- e.g., ruxolitinib (oral JAK1/JAK2 inhibitor)

COMFORT I  
(vs. placebo at 24 weeks)  
SVR: 42% vs. <1%  
TSS: 46% vs. 5%  
3-yr survival: 70% vs. 61%

COMFORT II  
(vs. BAT incl. 47% HU, 16% steroids, 33% no therapy at 48 weeks)  
SVR: 29% vs. 0%  
3-yr survival: 79% vs. 59%

Regulatory co-primary endpoints established:
- ≥35% reduction in spleen volume (SVR) by imaging
- ≥50% improvement in Total Symptom Score (TSS)

Ruxolitinib (Jakafi®) approved
- High/Intermediate Risk MF November 2011

Gangat et al, JCO 2011; 29:392-397  
Tefferi et al, Blood 2011; 117:3494-3504  
Harrison et al, 2012 NEJM 366:787-798  
Jakafi prescribing information

Median survival: 1-3 years
Evolution of Therapy in High/Int-2 Risk MF
In 2017 a high unmet medical need remains

**Symptoms or splenomegaly**
- treatment with ruxolitinib
- stay on drug as long as tolerated (conventional drugs viewed as ineffective, especially in advanced disease)

**5-year discontinuation rate is ~75% (COMFORT I & II)**
- major reasons:
  - suboptimal response
  - loss of therapeutic effect

After failure or discontinuation **median survival is ~7 months** (claims database analysis)

Harrison et al, ASH 2015
Gupta et al, ASCO 2016
Mehra et al, ASH 2016
Evolution of Therapy in High/Int-2 Risk MF
Defining patient populations in clinical trials

- **Frontline (JAK inhibitor naïve)**
  - No prior treatment with a JAK inhibitor

- **Second line (JAK inhibitor exposed)**
  - Prior treatment with a JAK inhibitor (e.g., for ≥28 days)

- **Relapsed/Refractory (JAK inhibitor failed)**
  - Disease progression during or after treatment with a JAK inhibitor
  - Never responded to JAK inhibitor treatment
Evolution of Therapy in High/Int-2 Risk MF
Additional JAK inhibitors with Phase 3 results reported

- **momelotinib**
  - JAK1/JAK2 inhibitor (oral)
  - *SIMPLIFY 1* (vs. ruxolitinib)
    - SVR: 26.5% vs. 29.0%
    - TSS: non-inferiority not achieved

- **pacritinib**
  - JAK2/FLT3/IRAK1/CSF1R inhibitor (oral)
  - *PERSIST 1* (vs. BAT no JAKi incl. ~38% no therapy)
    - SVR: 19% vs. 5%

* TSS was a secondary endpoint

ClinicalTrials.gov
Mesa et al, ASCO 2015
Gilead press release, Nov 16, 2016
Evolution of Therapy in High/Int-2 Risk MF
Additional JAK inhibitors with Phase 3 results reported

- **momelotinib**
  - JAK1/JAK2 inhibitor (oral)
  - SIMPLIFY 1 (vs. ruxolitinib)
    - SVR: 26.5% vs. 29.0%
    - TSS: non-inferiority not achieved
  - SVR: 26.5% vs. 29.0%
  - TSS: non-inferiority not achieved

- **pacritinib**
  - JAK2/FLT3/IRAK1/CSF1R inhibitor (oral)
  - PERSIST 1 (vs. BAT no JAKi incl. ~38% no therapy)
    - SVR: 19% vs. 5%
  - PERSIST 2: ≤10⁴/µL plts (vs. BAT incl.~45% rux, 19% HU, 19% no therapy)
    - SVR: 18% vs. 3%
    - TSS: 25% vs. 14% (~44% received prior rux; remainder naïve)
  - PAC203** (≤10⁴/µL plts and have failed prior rux)
    - SVR: 18% vs. 3%
    - TSS: 25% vs. 14% (~44% received prior rux; remainder naïve)

- **Frontline (JAK inhibitor naïve)**
  - **SIMPLIFY 1** (vs. ruxolitinib)
    - SVR: 26.5% vs. 29.0%
    - TSS: non-inferiority not achieved

- **Second line (JAK inhibitor exposed)**
  - **SIMPLIFY 2**: >28days rux, thrombocytopenic/anemic (vs. BAT incl. ~88% rux)
    - SVR: 6.7% vs. 5.8%
    - TSS (2⁰): not reported*

- **Relapsed/Refractory (JAK inhibitor failed)**
  - **PERSIST 2**: ≤10⁴/µL plts (vs. BAT incl.~45% rux, 19% HU, 19% no therapy)
    - SVR: 18% vs. 3%
    - TSS: 25% vs. 14% (~44% received prior rux; remainder naïve)

* Differences in favor of momelotinib were observed for the pre-specified secondary endpoints of TSS and one of the three anemia-related endpoints (transfusion independence), however, formal sequential statistical testing was not undertaken because the primary superiority endpoint was not achieved.

** To start in Q2 2017; definition of “failed” not disclosed

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ClinicalTrials.gov
Mesa et al, ASCO 2015
Mascarenhas et al, ASH 2016
Gilead press release, Nov 16, 2016
CTI Biopharma press release, Jan 5, 2017

Gilead press release, Jan 24, 2017
Gilead press release, Mar 3, 2017
Gilead press release, Oct 25, 2017
Gilead press release, Dec 22, 2017
Gilead press release, Mar 8, 2018
Gilead press release, May 22, 2018
Gilead press release, Aug 28, 2018
Gilead press release, Dec 14, 2018
Gilead press release, Dec 18, 2019
Gilead press release, Oct 27, 2020
Gilead press release, Jan 27, 2021
Gilead press release, Mar 3, 2021
Gilead press release, Apr 27, 2021
Gilead press release, Aug 25, 2021
Gilead press release, Aug 25, 2022
Gilead press release, Nov 1, 2022
Evolution of Therapy in High/Int-2 Risk MF
Focusing imetelstat on relapsed or refractory patients

Mayo Pilot Study
(All-comers High/Int-2 Risk MF incl. 48% JAKi exposed)
CR or PR: 21.2% (7/33)
median duration for CR: 18 months (range 7 to 20+)
Spleen responses (by palpation): 34.8% (8/23)
Spleen responses in JAKi exposed subgroup: 27.3% (3/11)

• Unprecedented complete and partial remissions suggested disease-modifying activity

IMbark
Phase 2 clinical trial being conducted by Janssen
(First patient: Sep 2015)
Define dosing and confirm activity in rigorously defined R/R population using established regulatory co-primary SVR/TSS endpoints

Tefferi et al, NEJM 2015;373:908-919
Tefferi, et al. ASH 2014
A multi-center, open label, Phase 2 clinical trial being conducted by Janssen

- **Objectives:**
  - Define proper dosing by evaluating potential therapeutic range of the drug
    - 4.7 mg/kg q3w: lowest dose where telomerase inhibition is predicted
    - 9.4 mg/kg q3w: max dosing regimen derived from the Mayo Pilot Study
  - Confirm efficacy in high unmet need population using current established regulatory endpoints

- First patient dosed in September 2015; over 100 patients enrolled as of October 2016 (enrollment currently suspended)

**Intermediate-2 or high risk myelofibrosis patients relapsed/refractory to JAK inhibitor Treatment (N = ~200)**

Randomize (1:1)

- **Imetelstat 9.4 mg/kg**
  - every 3 weeks

- **Imetelstat 4.7 mg/kg**
  - every 3 weeks

**Co-1° Efficacy:**
- Spleen response rate* and symptom response rate**

**2° Efficacy:**
- CR/PR and CI+, anemia response per 2013 IWG-MRT criteria, duration of responses, overall survival

**Exploratory:**
- Cytogenetic and molecular responses, leukemia free survival

* ≥35% reduction in spleen volume at Week 24 from baseline by imaging scans
** ≥50% reduction in Total Symptom Score at Week 24 from baseline by the modified Myelofibrosis Symptom Assessment Form (MFSAF) version 2.0 diary
+ Complete remission (CR) or partial remission (PR), and clinical improvement (CI) per modified 2013 IWG-MRT criteria

More information can be found on ClinicalTrials.gov (NCT02426086).
Current Status of IMbark
Trial ongoing to evaluate more mature data including OS

Second internal review completed in April 2017
• Data from all ~100 patients who were enrolled in the trial, with each dosing arm analyzed separately

Safety profile was consistent with previous imetelstat clinical trials in hematologic myeloid malignancies
• No new safety signals were identified

Data support 9.4 mg/kg as an appropriate starting dose for the relapsed or refractory MF patient population

Current results suggest clinical benefit and a potential overall survival (OS) benefit associated with imetelstat in relapsed or refractory MF
• In the 9.4 mg/kg dosing arm, the spleen volume response rate observed was less than that reported in front-line MF patients in trials of other drugs
• Activity within multiple outcome measures was observed, suggesting clinical benefit in relapsed/refractory MF:
  - range of spleen volume reductions; decreases in Total Symptoms Score; and improvements in hematologic parameters, such as anemia and peripheral blood counts
  - data suggest a potential OS benefit

Trial continues without modifications
• Patients remaining in the treatment phase may continue to receive imetelstat
• All safety and efficacy assessments, including OS, to be conducted as planned in the protocol
• Enrollment of new patients remains suspended because the total number of patients enrolled to date is adequate to assess longer-term outcome measures when the data are fully matured
Key Milestones for IMerge and IMbark Expectations for 2017

1H 2017

- Internal review of data from all patients in Part 1 (Phase 2)

2H 2017

- Part 2 (Phase 3) opened for patient enrollment in Q4 (if initiated)
- Data from Part 1 submitted for presentation at a medical conference

- Internal review of data from all enrolled patients

- Evaluate maturing efficacy and safety data, including an assessment of overall survival

Note: Projected timelines are dependent on clinical trial continuation.
Partnership with Janssen
Exclusive worldwide collaboration for imetelstat

**First Stage**

**IMbark (Phase 2 MF study)**
- Janssen conducting IMbark and IMerge
- Janssen to provide Continuation Decision following primary analysis of IMbark**

**IMerge (Phase 2/3 MDS study)**

**Continuation Stage**

- Geron has Opt-In right to share further US development and promotion costs
- Under Opt-In, Geron may provide 20% of US selling effort with sales force personnel, in lieu of funding 20% of US promotion costs

**First Stage Economics**

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<tr>
<td>Upfront</td>
<td>$35M</td>
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<tr>
<td>Cost Share</td>
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**Continuation Stage Economics**

<table>
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<tr>
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<th>Opt-In</th>
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<tr>
<td>Cost Share</td>
<td>20% Geron 80% Janssen</td>
<td>100% Janssen</td>
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<td>Continuation/US Rights Fee</td>
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<td>$135M</td>
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<td>Dev/Reg Milestones</td>
<td>up to $470M</td>
<td>up to $415M</td>
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<tr>
<td>Sales Milestones</td>
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<td>up to $350M</td>
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<td>Royalty % Tier***</td>
<td>Mid-teens to low twenties</td>
<td>Double digit to mid-teens</td>
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* Due to the current suspension of enrollment in IMbark, the timing of the protocol-specified primary analysis for the trial is uncertain and may be substantially delayed

** If IMbark is terminated early, or placed on clinical hold or suspended by a health authority for an extended period, then Janssen must instead notify Geron of their Continuation Decision ~24 months after the initiation of IMerge

*** Calculated on worldwide net sales in any countries where regulatory exclusivity exists or there are valid claims under patent rights covering composition of matter or methods of use exclusively licensed to Janssen
Thank you

If you have any questions, please contact us:

investor@geron.com