

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

GOVERNMENT EMPLOYEES HEALTH
ASSOCIATION, on behalf of itself and all
others similarly situated,

Plaintiff,

v.

ACTELION PHARMACEUTICALS Ltd., *et*
al.,

Defendants.

Civil Action No. GLR-18-3560

THIRD-PARTY PAYOR CLAIM FORM INSTRUCTIONS

If you are a Class Member who is a third-party payor (“TPP”) and would like to qualify to receive a payment from the Settlement with Actelion Pharmaceuticals Ltd., Actelion Pharmaceuticals US, Inc., and Janssen Research & Development, LLC (collectively, “Defendants”), you must complete and submit this Claim Form.

Only a TPP Class Member, or an authorized agent for a TPP Class Member, 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 a Claim Form on its behalf. You will be required to send the Claims Administrator such written authority if you file a claim on behalf of a TPP Class Member.**

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.TracleerLitigation.com). You need to provide supporting documents, as described below.

If your completed Claim Form is not postmarked (if mailed) or received (if submitted online) by **August 3, 2026**, you will not receive a payment from this Settlement. Submitting a Claim Form does not guarantee you will get a 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

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

The certified Class is defined as:

All entities that, for consumption by their members, employees, insureds, participants or beneficiaries, purchased, paid and/or provided reimbursement for some or all of the purchase price of Tracleer or bosentan, other than for resale, in Arizona, California, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, the District of Columbia, or Puerto Rico, at any time during the period from December 29, 2015, through and until September 6, 2024.

The Class **does not** include:

- a) Defendants and their subsidiaries and affiliates, and
- b) Federal and state governmental entities.

Please provide the necessary information to support your claim as a TPP Class Member, including:

- 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; and Drug Name – *e.g.*, TRACLEER®;
- 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 all categories of information to submit and a list of applicable NDC Numbers can be downloaded from the Settlement website, www.TracleerLitigation.com. Please use this format and provide the electronic data in Microsoft Excel, ASCII flat file pipe “|”, tab-delimited, or fixed-width format.

Data and/or information demonstrating class membership is mandatory. Transaction data is mandatory for all claims. 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 1-877-354-3839 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 AUGUST 3, 2026**

*Gov't Employees Health
Association v. Actelion Pharms Ltd.
et al., No. 18-cv-3560 (D. Md.)
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).

- 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 December 29, 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

Section C: Purchase Information

Please type or print in the box below, the total amount, from December 29, 2015, through September 6, 2024, that you paid or reimbursed for Tracleer and/or bosentan, for consumption by your members, employees, insureds, participants or beneficiaries, where the person(s) purchased these drug(s) not for resale, in Arizona, California, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, the District of Columbia, or Puerto Rico.

The state (or territory) of purchase is where the pharmacy is physically located if the purchase was made in-person. If any purchases were made by mail order, the state or territory to which the prescription was sent is considered the place of purchase. For example, if Tracleer or bosentan was purchased by mail order and the prescription was sent to California, California would be considered the place of purchase for that transaction and the purchase would be eligible for a recovery. On the other hand, if Tracleer or bosentan was purchased by mail order and the prescription was sent to Alaska, that transaction would not be eligible for a recovery because the place of purchase would be considered Alaska, which is not one of the states or territories 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 required information for each TPP Class Member on whose behalf you are submitting this Claim Form, including proof of authorization to file a claim on behalf of each such TPP Class Member. An exemplar spreadsheet containing the required categories can be downloaded from the Settlement website, www.TracleerLitigation.com.

Total amount (net of co-pays, deductibles, and co-insurance) you paid or reimbursed for Tracleer and/or bosentan , from December 29, 2015, through September 6, 2024 , for consumption 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 Settlement, 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. 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 that support 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 and/or provided reimbursement for some or all of the purchase price of Tracleer or bosentan, for consumption by my/their members, employees, insureds, participants or beneficiaries, other than for resale, in Arizona, California, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, the District of Columbia, or Puerto Rico, at any time during the period from December 29, 2015, through and until September 6, 2024; and
- b) am/are not Defendants, Defendants’ subsidiaries or affiliates, or federal or state governmental entities.

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

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 these TPP Class Member(s) any and all amounts from the Settlement 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, and I will fulfill all duties I may owe the TPP Class Member(s). If amounts from the Settlement 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 Maryland 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 is true and correct to the best of my knowledge and 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 page 2 above, to the address below, postmarked no later than **August 3, 2026** or submit the information online at the website below by that date:

Tracleer Litigation
c/o A.B. Data, Ltd.
P.O. Box 173072
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-354-3839
Website: www.TracleerLitigation.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@TracleerLitigation.com or via U.S. Mail at the address above.